The Meaning and Practice of Psychotherapy

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TORONTO

The Meaning and Practice of Psychotherapy

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New York: THE MACMILLAN COMPANY: *1950*

FIRST PRINTING, JUNE, 1950.

Printed in the United States of America

TO

My Son

PREFACE

THE PURPOSE OF THE PRESENT BOOK is to describe and illustrate such procedures and techniques as the writer has found to be most effective during his twenty years of practice in psychological diagnosis, psychotherapy, and counseling; and, in as far as he is able, to present the rationales which support these methods. Thus, no one certain system of psychotherapy will be found to predominate herein but rather various interpretations, approaches, and procedures, corresponding to the diversity of personalities and their disorders with which the psychotherapist deals.

Although no claim is made that there is anything particularly new in this volume, to make due acknowledgment to the many authors on whose writings and experience the writer has drawn would be impossible.

The writer is fully aware of the trend among psychologists to use the term "client" instead of "patient" in connection with the words "therapy" and "therapist," but he fails to find any good reason for going contrary to long-established usage in this respect. *Therapist-patient* and *counselor-client* seems to him to be more descriptive and appropriate.

This book is addressed to advanced students of psychology in the abnormal, clinical, therapeutic, and counseling fields; to psychotherapists, psychiatrists, psychological counselors, and social workers; and to any other persons who are interested in maladjusted personalities.

V. E. F.

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INTRODUCTION

No single definition of psychotherapy would conceivably be acceptable to all persons who are engaged in the profession. This does not mean that reasonably exact and systematized psychotherapeutic procedures do not exist, or that those using them do not have definite and verbalizable grounds for doing so. The difficulty in agreeing on any one definition results, rather, from the absence of an established and generally accepted terminology; from the wide divergencies of opinion which exist as to the legitimate boundaries of the practice; from a diversity of opinion as to how rigidly procedures should be made to rest on scientifically supported rationales; and even from a lack of agreement as to what constitutes adequate qualifications of the therapist.

It is far less important, however, to construct a generally acceptable definition of the practice than it is to be familiar with its more effective existing techniques and procedures and the rationales underlying them, and the more pressing needs confronting the field at the moment. There are several urgently needed steps to be taken. Among these are the immediate conscientious and energetic practice of psychotherapy by those psychologists who are so inclined and best qualified; the free and open discussion of approaches, procedures, techniques, and rationales; further research directed to the end of identifying and separating the effective elements from the noneffective in psychotherapeutic practice; recognizing and licensing the profession by the states; the establishment of high standards of qualifications and ethics; and further education of the public regarding the need of competent psychological treatment.

Psychotherapy is a planned and systematic application of psychological facts and theories to the alleviation of a large variety of human ailments and disturbances, particularly those of psychogenic origin. The application of the facts and theories comprises the procedures and techniques of the profession. For the most part the methods of psychotherapy are verbal, chiefly vocal. The therapy

is usually carried out, and always should be, in a private, confidential, friendly, and cooperative atmosphere and in a mutually respectful person-to-person relationship.

Although readily distinguishable from it, and comprising broad fields of applied psychology in themselves, both psychological testing and psychological counseling are important adjuncts to psychotherapy. Psychological testing is an essential feature of diagnostic procedure and normally precedes the psychotherapy proper. Psychological counseling (vocational, marital, family, educational) is frequently included by the psychotherapist, particularly during the latter part of a course of treatment.

The writer is not concerned in the present book with making any detailed examination or theoretical evaluation of the various systems and rationales which are prevalent in the field of psychotherapy. Brief mention, however, of certain of the older and more basic of these seems to be appropriate, if only as a token of recognition to the great achievements of their founders.

Suggestion therapy is perhaps the oldest method wherein a conscious and deliberate effort was made to establish a rationally conceived and scientific basis for the procedures. Near the latter part of the eighteenth century, Franz Anton Mesmer initiated what rapidly became an intensive and widespread use of hypnotic suggestion in the treatment of certain psychogenic or personality disorders. The method led to different tangent procedures with the result that suggestion came to be thoughtfully and deliberately used not only in the hypnotic but in the waking, hypnagogic, and hypnoidal states as well. Waking suggestion is still widely used in medical practice.

Most psychotherapists now see hypnotic suggestion as having its chief use with a distinctly limited number of cases as a therapeutic technique, and otherwise as a feature of exploratory and diagnostic procedures. Suggestion in and by itself brings about no permanent inner change in the patient, unless it be an increasing dependence on the therapist or others, and is therefore of little therapeutic value in the treatment of most cases. If used intensively in the traditional manner, it actually tends to obscure the patient's subjective difficulties instead of clarifying them.

Psychoanalysis or the standard psychoanalytic method, as originated by Breuer and Freud, has become rather well known even to

the general reader, as have many of the conceptions and theories on which it is based. Although psychoanalytic therapy appears to be undergoing a healthy and much needed overhauling by various individuals and groups, the older method is still in use by a number of the medical fraternity. One may safely say that the method contains at least four grave and inherent weaknesses. First, it is characterized by a strange and esoteric terminology. The patient must learn to think in a new language, as it were; no small task, particularly if he has only a modest education and mediocre intelligence. The second objection is that only an essentially passive participation in the therapeutic enterprise is required of the patient. He is asked to divulge his free associations, dreams, phantasies, etc., to be sure, but he is not required to make any great effort to think for himself or to understand anything beyond the analyst's interpretations. In the third place the treatment takes an unnecessarily long time and, often, a prohibitive amount of money. Finally, sexual interpretations are freely imposed on him, irrespective of his wishes, needs, or the actual causes and nature of his ailment.

Among the more promising modifications of psychoanalytic therapy which are appearing is the use of more direct questioning of the patient and directing of his thoughts, encouragement of more active participation on his part, energetic attempts to shorten the duration of treatment, and more emphasis on self-interest and less on sex interest in the interpretations. But with all of its older faults, psychoanalysis has stood out as one of our more thoroughly systematized, complete, and effective methods in psychotherapy. And, the reader should bear in mind, a procedure may be essentially psychoanalytic, that is, one in which the patient freely voices his free associations, tells his dreams, and recounts his phantasies, which in turn are interpreted and told back to him by the therapist, without the interpretations having to be strictly Freudian or pansexual.

Traditional therapeutic counseling has been in use for the past fifty years. Its origin and development cannot be attributed chiefly to any one individual or even a small number of individuals. Contributions have been made by many persons, both in and outside the field of psychology proper. The procedures are varied, including suggestion, persuasion, reasoning, reassurance, advice, exhortation,

praise, criticism, and some interpretation of symptoms and the significance of personality disorders to the patient.

In addition to these three older systems of psychotherapy, various methods, procedures, techniques, and devices have been introduced. These include hypnoanalysis, educative and re-educative therapy, extremes of the directive and nondirective procedures, psychodrama, narcosynthesis, active therapeutic procedures, psychotherapy in conjunction with shock treatment, and group therapy. These different methods are in no sense mutually exclusive and they all undoubtedly have their legitimate places and uses within the total field of psychotherapy.

CONTENTS

Part One

A GENERAL ORIENTATION

CHAPTER I

Concerning Approach and Procedure

FOR THE PURPOSE of clarity, the proper approach to a patient's problems and the general procedure in dealing with them are discussed under a number of headings or subtitles. All of the sections do not apply to every condition to be mentioned in later chapters. The intention, rather, is to offer an orientation or guide which will be sufficiently comprehensive to cover all of the various conditions to be taken up later even though parts of it are not applicable to every case.

PRELIMINARY INFORMATION

Many persons who are in need of psychotherapy will not seek professional help of their own volition. In such cases the therapist will be visited first by a member of the patient's family or a friend or perhaps called by the family physician. In all instances of this sort it is well to bear in mind the possibility of an early psychosis.

The informant should be questioned concisely and in detail till the therapist has a clear picture in mind of the patient's behavior, his complaints and symptoms, and his present home environment. If the informant is a parent, particularly a mother, the questioning may have to be persistent and pointed in order to elicit the desired information; for mothers are universally inclined to minimize the seriousness of personality disorders in their sons or daughters. Absurdly enough, often a mother will seek professional advice concerning son or daughter and then the moment she is in the therapist's office she will contend that her offspring is essentially normal in all respects.

The following questions should be included among those which

the informant is asked. How old is the patient? Is he in good physical health? When did symptoms of his disorder first appear? Did the symptoms appear suddenly or gradually? Have there been any previous attacks of the same character? Is he hostile, suspicious, depressed, anxious, agitated, querulous, elated, or apathetic? Do his moods change frequently? Does he talk a great deal, moderately, or not at all? Is his talk rational and coherent? Is his talk relevant to the situation of the moment and to the conversation of others? Does he express phantastic or bizarre ideas? Do his thoughts flow freely or appear to be blocked? Does he appear to hear "voices" or have visual hallucinations? Does he have any fixed or tenacious delusions, that is, grossly false beliefs? Does he have transitory delusions? Does he think others are talking about him or influencing him against his will? Does he manifest any homicidal or suicidal tendencies? Does he complain of peculiar or painful bodily sensations? Does he appear to be childish in his talk or interests? Does he appear to be constantly preoccupied with some idea? Does he condemn himself for past faults or mistakes? Has he lost control of any bodily functions? Has there been any marked change in his attitude toward any member of his family? What changes have occurred in his attitudes toward his work and social activities? Does he like or dislike having visitors? Does the patient have insight, that is, does he realize that there is something wrong with him? Is he averse to doctors?

In addition to the questions mentioned above it is usually well to inquire at this time into possible precipitating causes of the illness. Has the patient suffered recently from a physical illness? Has he lost his job or been financially embarrassed? Has he had difficulties with his spouse or sweetheart? Has he been frustrated in any recent undertaking? Has he recently been unusually successful in any undertaking?

Having gone over these matters with the informant, the therapist is in a much better position than he otherwise would be for the first consultation, particularly if the patient is psychotic.

THE FIRST CONSULTATION

Patients are separable into two classes in regard to the first consultation: those who seek help of their own volition and those

who do not. Many of the latter are psychotic reaction types. We will consider these first and then take up some points which apply to both groups.

An opportunity to help a person suffering from a personality disorder may be lost through mismanagement of the first visit. This is particularly true of the psychotic patient. Hence, assuming the therapist expects to encounter a patient who is suffering from an early but serious mental disorder, certain precautions should always be taken. If the patient is ambulatory, he should be brought to the therapist's office, if such arrangements can possibly be made, rather than the therapist's visiting him at his home or in a hospital. This simply conduces to a better start with the patient than is to be had if the therapist has to go to the patient.

When it is necessary for the therapist to go to the patient's home for the first visit, family members will often suggest that the visit be made in the guise of a merely friendly or social call. Such a suggestion should never be accepted. With the psychotic patient in particular there is nothing so conducive to later success as a frank and honest beginning. The therapist can usually cope with any difficulties inherent in the patient's attitude toward doctors by lightly remarking when introduced that some member of the family felt the patient was not feeling entirely well.

Nothing usually should be attempted during the first visit with the psychotic patient beyond establishing a general rapport. And, even in doing no more than this, care must frequently be exercised. With certain types of patients, the first visit may be easily overdone.

No medical prescription should be recommended at this time unless necessary. Doing so only lessens one's advantages in dealing with the patient along psychological lines. If sedatives must be given, they should be used sparingly. The use of sedatives, unless sedation proper is indicated, makes clear and logical thinking more difficult for the patient and tends to aggravate any mental confusion already present. Moreover, certain patients will immediately get the idea they are being poisoned or drugged, with a subsequent loss of faith in the doctor.

Should the patient refuse to talk, the therapist has no choice but to engage members of the family in conversation along more or less general lines. By closely but discreetly observing the patient's facial expressions and any other reactions, the probable nature of

the disorder may be discerned and a mild rapport established. An occasional, impersonal remark may be directed at the patient without, however, unduly waiting or pressing for an answer.

The patient with manifest psychotic reactions should be seen again on the following day. Even though such a patient refuses to talk to the therapist during the first visit, he will not infrequently accompany a member of the family to the doctor's office on the succeeding day without protest. A suggestion to such an effect is a fairly safe and proper manner of concluding the first interview.

Still further considerations are applicable to all patients, generally speaking, during the first consultation in the therapist's office. The patient should be seated in a comfortable chair across the desk from and half facing the therapist. A good platform rocker is a suitable chair for this purpose. In no instance, of course, should a patient be placed on a couch during the first visit and, in the case of patients of opposite sex, it is usually not advisable on any succeeding visit. If the patient is uneasy or frightened, an effort should be made to place him at ease.

Many patients need to be assured that everything they say will be held in the strictest confidence. The therapist's manner should be friendly but impersonal. Familiarity and overt expressions of sympathy are usually out of place. Joking during the initial interview, a practice indulged in by some psychotherapists, should be rigidly excluded till therapist and patient are better acquainted.

Needless to say, strict attention should be paid not only to what the patient says but to other expressions and movements as well. The patient should not be made to feel, however, that he is being subjected to a microscopic scrutiny. He wishes to be understood but he is not ready yet for a too searching and detailed examination.

It is not only the mediocre therapist who is inclined now and then to try to impress his patient with the keenness and profundity of his understanding of human personalities. He should inhibit such inclinations. He can give safer expression to them later in the treatment. The average patient who is suffering from a personality disorder is naturally guarded, skeptical, and uneasy during the first consultation. Nothing will impress him so favorably as a down-to-earth, unadorned attitude on the part of the therapist. The patient wants to be under-

stood but he does not want to feel too transparent, even under the eyes of a trained psychologist.

Many patients want to tell the therapist the whys and wherefores of their troubles. Ordinarily, there should be neither agreement nor disagreement at this time with the patient's proffered explanations.

There is no consideration in connection with the first consultation which is of greater importance than that the confiding patient be prevented from overtalking. The conversation should be quietly but firmly steered into less personal channels or the consultation brought to an early close. For excessive confidences in a stranger, even though he is a professional person, are likely to lead to a reaction later of an opposite character, namely, to resistance, negativism, or distrust of the therapist's ability or integrity. Early in his work the writer was often perplexed by the fact that a patient who talked very freely during his first visit frequently failed to come in for a second visit. At one time or another most of us have perhaps experienced some degree of chagrin or humiliation for having impulsively overconfided to someone about intimate matters.

No promise or guarantee of help should be given the patient. This is not only unethical, properly speaking, but poor psychotherapy as well. Due to the basic significance of most neurotic and psychotic ailments, *promising* recovery or even improvement is an excellent way of discouraging full cooperation on the part of the patient. One should bear in mind that no patient is going to tolerate easily the inner changes necessary to the reduction of his maladjustive patterns. Therefore, although a promise of results may tend to instill some degree of initial hope and confidence in the treatment or the therapist, at the same time it will tend to arouse the resistance to any subjective change.

The therapist should not commit himself to any specific diagnosis or explanation of the disorder during the first consultation. There is a large chance of error in hasty diagnoses. Even though the condition is so unmistakable as to leave little doubt of its nature, the patient is never prepared for a quick classification of his difficulties. Only a methodical and painstaking study of his case comprising a number of visits will make a suitable and lasting impression on

him. No one more than the person with a psychoneurosis likes to feel that his condition is being given due thought and study.

The patient should be given ample time to describe his complaints and symptoms in his own words. In this connection, the therapist should not argue with the patient irrespective of how absurd or exaggerated the latter's statements may appear to be. Neither should the patient's complaints be scoffed at or belittled. In a subjective sense they are just as serious as the patient claims them to be. On the other hand, the seriousness of the patient's disorder should not be unduly emphasized. This will cause some patients to become frightened or suspicious of the therapist's integrity or competence.

It is inadvisable to make written notes during the first visit other than recording the patient's name, age, sex, social status, etc. Many patients are disturbed by having their remarks taken down in writing at this time. Moreover, such a procedure tends to distract the patient from what he is saying and the therapist from what is being said. Any necessary notes can be made at the end of the interview after the patient has left.

If a course of treatment is decided upon at the end of the visit, a few additional points are in order. Emphasis should be placed upon the necessity of complete honesty and frankness throughout the treatment.

The patient cannot be too strongly impressed with the importance of his not discussing with others the matters that he discusses with his therapist. The purpose here is to rule out the inevitable interference and confusion which would result from the various opinions and interpretations expounded by family members and friends.

No definite statement should be made as to the necessary length of the treatment. The therapist may mention the average duration of his analyses.

A clear understanding should be had with the patient or a member of his family regarding fees.

COMPLAINTS AND SYMPTOMS

Complaints and symptoms should be carefully listed. In as far as possible the two categories should be separated and kept separate in the therapist's thinking and evaluations. In the listing of them, careful attention must be given to the patient's particular use

of various words and expressions. Anxiety, for instance, is often spoken of as worry; the abdomen is referred to as the stomach; sensations of stiffness in the neck may be called a headache; sensations of weakness are often mentioned as tiredness.

Close study of the patient's complaints is frequently necessary to determine whether or not they are symptomatic. A certain woman complained about her husband's misconduct. Discreet inquiry revealed that in all probability her husband was unfaithful on numerous occasions. Her complaint was supported by objective facts and justified by her husband's conduct and was, therefore, not specifically symptomatic of her psychoneurotic condition. But her husband's behavior was an aggravating factor in her neurosis. In the case of a second woman who offered a similar complaint, the facts were very different. Her husband did not misbehave. Her complaint was symptomatic of a paranoid trend.

In a case where a complaint is directly related to a symptom, either the complaint or the symptom may be of the greater psychological significance. A young man complained bitterly and endlessly about a slight twitching (tic) in one side of his face. No one had ever mentioned the tic and he would not swear that he had ever seen it. He said he could feel it, however. He had taken up boxing, swimming, and wrestling in an attempt to overcome this "terrible" weakness. He had played with the idea of suicide. Obviously, in this case the individual's complaint about the symptom was of infinitely greater significance than the symptom itself.

Another case presented the opposite relationship between complaint and symptom. The symptom consisted of an automatic or involuntary horizontal rotary movement of the head which lasted for several minutes and occurred many times during the day. The young man, who was afflicted, stated (complained) that it bothered him mostly when he was reading. Otherwise he did not mind it particularly. When he was told that he would have to be psychoanalyzed and that this would require some time and money, he seemed to lose interest and said he would think the matter over. He is perhaps still thinking about it after many years. In the view of anyone else his symptom was a serious handicap; in his own eyes it was not of much significance one way or another.

Needless to say, patients who complain excessively fail completely to recognize the true causes of their complaints. Accord-

ingly, their complaints often become directed at trivial or even innocent facts. A young woman who was taking steps to secure a divorce had no manifest psychoneurotic or psychotic symptoms and only one complaint, namely, her husband was too affectionate. Questioning showed that he was not extremely demonstrative in his feelings. The actual cause of her complaint, rather, was her own sexually repressed condition, which fact she failed to appreciate or even to recognize. Her own coldness tended to magnify her husband's warmth out of all proportion.

With respect to the symptoms of psychogenic disorders, aside from their relationships to complaints, much could be written. The purpose here is not to go into a discussion of symptoms as such but rather to point out certain peculiarities which the therapist should bear in mind.

The exact character of any given symptom has a number of determinants. Important among these are the patient's intelligence, personality, temperament, education, level of emotional maturity, basic attitudes toward self and others, socioeconomic background, and present situation. More briefly stated, any given symptom is determined by the individual's total make-up at the time and the environmental forces among which he lives. Too much attention has often been given to childhood events and too little to present circumstances and the patient's nonsymptomatic attitudes and interests. In a strict sense, a symptom is always a reaction to the present, or to the future as anticipated, but never to the past.

Symptoms of psychogenic disorders must be recognized as the expression or manifestation of one or more basic *needs* of the patient at the time. Only if seen as such will the therapist be in a position to understand their meaning or significance. And when we say "needs" we have in mind the needs of the patient as a psychobiological unit or organism that is striving to maintain a workable and tolerable degree of inner harmony in the face of the particular inner and outer situations.

With no intention of offering a classification of psychogenic symptoms as such, it may be stated that most of the symptoms observed will reveal or indicate one or more of the following processes in the patient: an attempt to evade or escape from the demands of a reality which is intolerable to the patient as he perceives or interprets it, as in the case of schizophrenic psychoses; an attempt to

neutralize or otherwise to make himself egoistically secure against inner or outer threats, as in the case of various anxiety neuroses; an attempt to fortify himself against the pull of submissive and other unselfish tendencies by the focalization of attention on a function or part of the body, as in the case of neurasthenic and hypochondriacal disorders; an attempt to preserve egoistic integrity and a tolerable degree of inner harmony through the relinquishing of volitional control over a function or part of the body, as in conversion hysteria; an attempt to preserve egoistic integrity and a tolerable degree of inner harmony by tolerating a symptomatic (disguised) expression of an otherwise intolerable and rejected desire or interest, as in obsession-compulsion neuroses; the partial or complete usurpation of the mental and physical capacities of the individual by egoistic aspirations to personal distinction, greatness, or self-sufficiency, as in the case of manic manic-depressive psychoses; self-condemnation and the renunciation of personal rights and abilities because of the presence of abnormally pronounced egoistic aspirations and desires for unlimited personal freedom, as in the case of depressive manic-depressive psychoses and involutional melancholia. A given symptom may embody more than one of these meanings while, on the other hand, a number of different symptoms in the same patient may all have essentially the same meaning.

The patient's symptoms are of significance to the therapist in as far as they shed light on the nature and causes of the disorder itself. Aside from this they should be essentially ignored. In no case is symptomatic treatment, the treatment of symptoms, to be condoned in the field of psychogenic disorders. Such treatment is not only useless and in various ways detrimental, but in certain instances it may be actually dangerous. A young woman who suffered from hysterical blindness was taken to a psychotherapist (?) for treatment. By means of hypnotic suggestion her vision was restored. A few days later she drowned herself in the East River, New York City.

Psychosomatic symptoms in particular tend to invite symptomatic treatment. Once it is fairly established, however, that the etiology is psychogenic, or chiefly so, such symptoms should be accorded no more attention by the therapist than any others. Whatever other significance it may have, a psychosomatic symptom or complaint obviously reveals a symptomatic (involuntary) con-

centration of the patient's attention on himself. The therapist is not particularly interested in the physiological disturbances produced by such attention; he is concerned with the reasons for the concentration of attention and means of relieving it.

Finally, if the therapist will always keep in mind the important fact that the psychogenic symptom partially meets a genuine need of the patient at the time, a need in view of the inner and outer circumstances confronting the patient, the old error of trying to eliminate symptoms without due regard for what they signify and the purpose they serve will not be made. In other words, the aim of the therapist is to make the *symptomatic* expression of inner needs, in relation to other inner needs and outer reality, unnecessary.

PSYCHOLOGICAL TESTING

Persons engaged partly or wholly in psychotherapy differ widely in the diagnostic value which they assign to mental tests. Some employ a wide variety of tests while others dispense with them entirely. Although the writer keeps a fairly wide assortment of tests on hand, he uses only three or four of these in most cases. The tests are measures of general intelligence, free association tests, and inventories of emotional adjustment and disposition to psychogenic disorders.

A test should not be given in any instance till the patient is at ease in the therapeutic situation and willing to be tested. Except in the case of the person who is suffering from an early psychosis, tests usually may be given starting with the second consultation. The value of giving the tests as early as possible lies in the therapist's gaining immediate information concerning the patient's intelligence level, his emotional tolerance or adaptability, and his possible emotional complexes.

With respect to the patient who appears to be suffering from an early psychosis, psychological tests should be given, if at all, only after due thought and a rather thorough acquaintance with the patient. For many patients of this class are prone to turn the fact of being tested into cause for additional complaints, ideas of having their minds violated, being experimented on, etc. Little or no harm can be done by testing chronically psychotic patients.

The particular *intelligence test* to be used will depend on the patient and the exact purpose of giving the test. With cases of early psychosis, and particularly if mental confusion or blocking is present, the revised Stanford-Binet or the Wechsler is preferable if the therapist wishes to try to gauge the actual intelligence capacity of the patient. If, however, the therapist is interested in knowing how much mental work the patient can do in a given period, a time test will be better. The Otis Self-Administering Test of Mental Ability is a good example of this class of tests.

Usually it is helpful and entirely proper to give intelligence tests to hypochondriacal patients, to psychopathic personalities, to cases of reactive depression, and to persons who have regressed mentally. In the first three of these four classes, a time test is most suitable. In the case of the mentally regressed patient, an individual test may be more desirable, depending, however, on the character and extent of the regression. If the patient manifests no mental blocking and is cooperative, a time test is again most satisfactory.

All persons suffering from psychoneuroses should be given intelligence tests before psychotherapy proper is begun. A written time test such as the Otis is best in the majority of cases. The same is true in regard to cases of adult maladjustment, as discussed in Part IV.

In working with maladjusted children, language ability, age, and other matters will determine the test to be used. If the child is obstinate and uncooperative, the Stanford-Binet is usually best. The two forms of the test permit retesting at a later time. For children who have a language handicap, the Pintner Non-Language Primary Mental Test or some other nonlanguage or performance test may be used. For unhandicapped children of the lower school grades, the Detroit First-Grade Intelligence Tests and the Detroit Tests of Learning Aptitude are very good.

The value to the therapist of having intelligence test scores on his patient is manifold. First, he is guarded against unduly underestimating or overestimating his patient's intelligence. Even the trained psychologist cannot estimate a person's intelligence in an offhand manner with any degree of certainty. And in psychotherapy, knowing the level of understanding on which one must work in a given case is a very appreciable asset. Secondly, having obtained a fairly accurate measure of the patient's intelligence, the therapist is in a far better position to evaluate the significance and seriousness

of the symptoms and the maladjustive behavior. A recent patient of the writer's, a young man with an I.Q. of more than 120, married a girl with an I.Q. of 54 as measured with the Stanford-Binet. This act (of marriage) was indicative of far more painful and incapacitating feelings of inferiority and personal inadequacy than the same act, involving the same girl, would have been in the case of a young man with an I.Q. of 80 or 90. Thirdly, the therapist is desirous of knowing if the patient's social and economic adjustments are commensurate with his intelligence. A certain patient who washed dishes for a living revealed much about himself when he made an I.Q. of 129 on a standard intelligence test. Finally, in the case of patients who have regressed or who have difficulty in concentrating, sustaining attention, remembering, etc., test scores, when compared with past educational and vocational attainments, may shed considerable light on the severity of the disorder.

Although not strictly diagnostic, the *free association test* is often very helpful in discovering fruitful lines for study and investigation. Such a test consists of a carefully selected and arranged list of words, comprising banal or emotionally nonsignificant words interspersed with words which usually or frequently carry an emotional significance or implication. Thus, the word "paper," for instance, ordinarily would belong to the first category while the word "guilt" would belong to the second. Needless to say, a given word may arouse an emotional response in one person, due to the individual character of his past experiences and associations, whereas it is without affective significance for a second person.

For the past twelve years the writer has employed the list of words given below. Along with the stimulus words, the response words of a given patient and his reaction time in seconds as taken with a stop watch are also reproduced.

Stimulus word	*Reaction time in seconds*	*Response word*
1. Wood	2	Tree
2. Cigarette	2	Smoke
3. Water	2	Fire
4. Disgust	8	Remorse
5. Apple	2	Cheese
6. Ant	2	Egg

Stimulus word	*Reaction time in seconds*	*Response word*
7. Yellow	2	Blue
8. Glass	6	Green
9. Fear	3	Hope
10. House	6	Home
11. Road	2	Path
12. Wiggle	7	Snake
13. Paper	2	Print
14. Indecent	8	Decent
15. Store	3	Buy
16. Cigar	2	Man
17. Naked	2	Body
18. Book	3	Read
19. Rubber	2	Ball
20. Divorce	2	Marriage
21. Carpet	2	Rug
22. Snake	2	Slimy
23. Desk	2	Write
24. Varnish	2	Floor
25. Disgrace	15	———
26. Sticky	12	Smooth
27. Shoe	6	Foot
28. Failure	2	Success
29. Tablet	3	Write
30. Iron	2	Press
31. Sex	10	Man
32. Tree	6	Birds
33. Orange	2	Banana
34. Kill	2	Murder
35. Tobacco	2	Men
36. Newspaper	2	Read
37. Smell	2	Perfume
38. Dictionary	2	Words
39. Poison	2	Death
40. Peach	2	Seed
41. Black	2	White
42. Suck	2	Suckle
43. Gold	2	Silver
44. Tremble	2	Shake
45. Hammer	2	Pound
46. Leg	2	Arm

timulus word	*Reaction time in seconds*	*Response word*
47. Dress	3	Pants
48. Crawl	2	Creep
49. Illegitimate	2	Birth
50. Bank	2	Money
51. Dirty	2	Foul
52. Chair	2	Sit
53. Love	2	Marriage
54. Window	2	Light
55. Blue	2	White
56. Undress	2	Dress
57. Needle	2	Sew
58. Red	3	Black
59. Steal	2	Strong
60. Basket	2	Woven
61. Money	2	Finance
62. Danger	2	Fear
63. Eraser	2	Water
64. Pocket	2	Money
65. Kiss	5	Love
66. Cardboard	2	Paper
67. Worry	3	Hope
68. Ashes	2	Fire
69. Baby	2	Love
70. Flame	2	Fire
71. School	2	Learn
72. Telephone	2	Hear
73. Body	6	Person
74. Rock	2	Hard
75. Rug	2	Floor
76. Guilty	15	———
77. Finger	3	Hand
78. Wine	2	Liquor
79. Mother	2	Hope
80. Beautiful	2	Lovely
81. Dish	2	Eat
82. Father	2	Strength
83. Fountain	2	Hope
84. Ugly	2	Sordid
85. Smoke	2	Fire
86. Nagging	2	Wife

Stimulus word	*Reaction time in seconds.*	*Response word*
87. Experience	12	Feel
88. Insanity	2	Madness
89. Brother	2	Fall
90. Sin	12	Sinful
91. Checkbook	2	Money
92. Petting	2	Cat
93. Brave	2	Strong
94. Woman	2	Man
95. Darkness	2	Light
96. Hate	2	Fear
97. Laugh	2	Joy
98. Conceal	2	Repent
99. Sister	2	Brother
100. Doorway	2	Window

The therapist is interested in the atypical responses of his patient to the test. These may take any one or more of a variety of forms. The most common atypical response is a delayed response. A delay in responding indicates mental blocking and, inferentially, emotional disturbance.

Other atypical types of response are repetition of the stimulus word, repetition of the response word, responding with opposites whenever possible, persisting in giving sentence instead of word responses, persistently giving a personal evaluation of the stimulus word, giving words which are obviously unassociated with the stimulus word, giving synonyms of the stimulus word, defining the stimulus words, giving "drawing room" responses throughout the test, and giving associated but unusual response words.

Although one may not generalize too freely, the usual inferences to be drawn from certain of these types of response may be mentioned. Repetition of the stimulus word or of the response word indicates either a guardedness in the patient or a marked tendency to stereotypy, a persistent tendency to think or act always in accordance with a fixed pattern. Responding with words of opposite meaning often indicates ambivalent feelings or an antagonistic attitude toward persons and things in general. Giving subjective evaluations of the stimulus word indicates exaggerated self-preoccupation and self-interest. Examples of this type of response are:

Wood—My desk, Cigarette—Hurt me, Disgust—Some people disgust me, Mother—My mother. Associated but unusual response words indicate that those words, the words to which such responses are made, have strictly individual implications or connotations for the patient. An example would be responding to "Mother" with the word "Witch."

For purposes of further clarification of the significations of free association responses, brief examination may be made of some of the responses to the test already reproduced on preceding pages. The patient was a woman of thirty-three, attractive, in good physical health, of high school and business college education, married thirteen years, and the mother of two children. She had suffered from psychoneurotic disturbances for twelve years. She made a score of 60 (I.Q. equivalent of 118) on the Otis, Higher Examination: Form B, and a Norm Centile of 4 on the Watson and Fisher Inventory of Affective Tolerance.*

The patient's chief symptoms included a fear of crowds, acute self-consciousness, a frequent feeling or impression that she had a lustful expression in her eyes, restlessness, sexual frigidity, disturbing dreams, and periods of despondency.

It will be noticed that her reaction time was very constant except for definitely delayed responses. To the words "Disgrace" and "Guilty" she had not responded at the end of fifteen seconds, when the next stimulus word was called out. Her failure to respond to these two words within the time allowed together with her delayed reactions to the words "Wiggle," "Indecent," "Sex," "Experience," and "Sin" definitely suggested a strong conflict over sex. This later proved to be true and her repressed sexual desires the dynamics of her psychoneurosis.

A standardization of this test would perhaps establish as atypical responses the words "Remorse," "Hope," "Fall," and "Repent" when given respectively to the stimulus words "Disgust," "Fear," "Brother," and "Conceal." The first, second, and last of these four responses were determined by the strongly religious character of the patient's resistance to sexual interests. The reason for the response "Fall" to the word "Brother" was not discovered. Incident-

* "Inventory of Affective Tolerance" by Robert I. Watson and V. E. Fisher. Sheridan Supply Co., Beverly Hills, Calif.

ally, the patient had no brothers. It may be added further that the patient had never had any sexual experiences as such outside of her marriage but had been severely troubled at times by symptomatic or involuntary sexual phantasies.

In giving a free association test the examiner should take care to maintain an even inflection of voice. There is a natural tendency to give undue accent to words which experience has shown to be emotionally significant. If the patient appears to become overly tense or nervous, he should be reassured that there is no right or wrong way of responding, that the words or thoughts which come to his mind are just as correct and legitimate as those that might come to the mind of any other person. The therapist should observe the patient as closely as possible while the test is being given. Changes in facial expression, sitting position, movements of the hands and feet, and alterations in the voice all have their significance. A woman of sixty-seven kept crossing and uncrossing her legs while taking the test. When the test was completed it was laid aside, and she was asked if she suffered from sexual tension. She immediately launched into a heated condemnation of the double standard of sexual morality, the hardships imposed by society's narrow views on unattached women like herself, etc. When a certain man patient was given the word "Insanity" he arose and said "I guess I'll be going now" and left the office. His action was far more expressive than any verbal response could have been.

Personality questionnaires of various types, particularly those which are designed to measure the individual's ability to resolve his emotional tensions and conflicts in a healthy manner, are of immediate aid to the psychotherapist. Examples of such questionnaires are the Watson and Fisher Inventory of Affective Tolerance; the Colgate Personal Inventory, Revised, B_2; the Bell Adjustment Inventory; and the Minnesota Multiphasic Personality Inventory. The scores on such tests should always be taken as suggestive or indicative only, never as matters of diagnostic certainty.

Some therapists use still other tests and measures. Although the writer does not wish to deny the desirability of giving tests in addition to the types which have been mentioned, he does wish to emphasize the danger of letting testing supplant the all-important

intensive and searching conversational investigation of the patient and his past history. The Rorschach and other projective techniques belong primarily in the clinic, rather than in the office of the private practitioner, and in the research laboratory, except where the therapist is specially trained in the interpretation of the responses to such tests.

Perhaps it should be pointed out that in connection with the scores of free association tests, personality and adjustment inventories, and interest and attitude questionnaires, some one or a few responses may be of greater significance than the total score. An excellent example of this was the case of the nymphomaniac who failed to respond to the word "indecent" on three repetitions of a free association test. Yet she did not manifest the slightest embarrassment or perturbation. She merely stated that when the word was given, her mind became totally blank.

SECURING THE CASE HISTORY

A case history gives one a longitudinal section of the patient's life, and therein lies its great importance. In it one has a sort of moving picture of his patient from infancy. If secured with due attention to details, the therapist will soon arrive at a fairly workable understanding of the patient's particular course of development, of the principal influences which acted upon him during his development, of the patient's reactions to these influences, and of how the interplay of subjective (personality) and objective (environmental) forces finally resulted in a manifest personality maladjustment or disorder. Much of the material of the case history can be supplied only by the patient himself, and a considerable part of this will be obtained coincidentally with the course of treatment. Other elements in the history may be obtainable only through consultations with parents, siblings, or spouse or close friends. Such consultations are often advisable, but they should be held only with the knowledge and consent of the patient.

The following outline is suggested as a complete coverage of case history material in as far as psychotherapy is concerned. Case history taking begins with the first consultation or, in some cases, with preliminary information as supplied by doctor, relation, or friend. And to some extent it continues to near the end of the treatment.

A. PATIENT'S FAMILY'S HISTORY

(INFORMATION ABOUT EACH PARENT AND EACH BROTHER AND SISTER SHOULD BE OBTAINED IN REGARD TO THE FOLLOWING POINTS)

1. Age
2. Health
   In childhood and adult life
3. Education
   School ability and level reached
4. Social
   Degree of adjustment in childhood and adult life
5. Economic
   Extent of industry and success
6. Personal peculiarities and unusual habits
7. Attitudes toward patient

B. PATIENT'S DEVELOPMENTAL HISTORY

(THE PATIENT'S DEVELOPMENT FROM INFANCY THROUGH THE PUBESCENT PERIOD SHOULD BE PAINSTAKINGLY FOLLOWED AND STUDIED IN REGARD TO THE FOLLOWING MATTERS)

1. Health
2. Attitudes and reactions to family members
3. Attitudes and reactions to playmates
4. Attitudes and reactions to school
5. Attitudes and reactions to religion
6. Early selfless attachments
7. Early ego-identifications
8. Personal interests and habits
9. Unusual and disturbing experiences

C. PATIENT'S INTERMEDIATE HISTORY

(A HISTORY OF THE PATIENT FROM THE BEGINNING OF ADULT LIFE TO THE ONSET OF HIS ILLNESS SHOULD BE SECURED IN RELATION PARTICULARLY TO THE FOLLOWING MATTERS)

1. Family interests and reactions
   Attitudes toward his parents and siblings
2. Social interests and reactions
   Attitudes toward and activities with own and opposite sex
3. Work interests
   Interest in, fitness for, and success in work
4. Recreational interests
   Nature and degree of participation
5. Religious interests
   Origin and character and extent of activities

6. Unusual interests or activities
7. Previous nervous attacks
   Onset, duration, character, and treatment
8. Frustrations or other disturbing experiences

D. HISTORY OF PRESENT ILLNESS

1. Onset (sudden, gradual) and duration
2. Degree of incapacitation
   In work, in other activities
3. Changes in patient's attitudes and interests
   In regard to family members, friends, work, and world of affairs
4. Attitude of patient toward his illness
   Degree of insight and tendency to fight his symptoms or utilize them for personal gain

In a case history details, not generalities, are the important matters. The fact cited by a certain patient that as a child he disliked his father was not in itself particularly instructive. Significant facts about his early emotional development were brought to light, however, when he was encouraged to try to tell exactly why he disliked his father, when his dislike first commenced, under exactly what circumstances he disliked him most, how he expressed his dislike, how his father reacted to such expression, etc.

There is a decided advantage in obtaining as much of the case history as possible early in the course of treatment, or before the actual treatment begins. The more the therapist knows about his patient at any time, the better his position will be for giving help and properly directing the whole course of procedure.

SEEING THE PATIENT AS A PERSONALITY-TEMPERAMENT ORGANIZATION

Personality may be thought of as the over-all pattern of reaction of the individual; and *temperament* as the predominant affective tone or coloring of the reaction continuity.

Only if the therapist insists on seeing his patient as a psychic individuality or organization, instead of a mere list or total of habits, attitudes, tendencies, feelings, etc., will he be in a position to discern gaps, flaws, and inconsistencies in the organization and, in connection with this, the probable significance of symptoms and symptomatic reactions. When studied psychologically, the individual is just as truly an organization or integration of capacities and func-

tions as he is an organization of parts, tissues, or cells when studied organically. Accordingly it is just as essential that the psychotherapist see his patient as an integration as it is for the surgeon.

Personality classifications have been popular for a long time. There is no point here in reviewing the various classifications which have appeared other than to mention briefly those in particular which have shed light in the field of our present interest. *Introversion-extroversion* is a linear personality variant, that is, the more introverted a person is the less extroverted he is and vice versa. Neither extreme constitutes an abnormality in itself, despite the loose thinking and unwarranted contentions of certain psychologists to the contrary. Either extreme is more conducive to the development of personality disorders and maladjustments than in-between positions.

This personality variant is unquestionably inherited, in the same sense that other basic psychic traits and dispositions are inherited. Similarly, it is subject to alteration within limits by environmental influences. If influences induce or coerce an individual, however, into attempting to move too far from his natural position on the scale, injury to his psychic organization and personality maladjustment are inevitable. If an introverted individual is forced to adopt an extroverted pattern and direction of attention, for instance, he will become maladjusted. The obverse of this is equally true.

Introversion-extroversion is primarily a matter of psychic orientation. Since all objective facts of experience are accompanied by subjective facts of experiencing, direction of attention may be predominantly objective (extroverted) or subjective (introverted). To speak of direction of attention as "inward" or "outward" is loose and misleading. Attention, the act of attending, is certainly *always* a fact or process occurring within the individual. It actually, then, cannot take an inward direction. It can be *focused* on either a subjective or objective fact. To extroverted attention the *ice cream* tastes good; to introverted attention the *taste* of the ice cream is good.

An introverted attitude or orientation has neither more nor less to do with egoism, selfishness, or egocentricity than an extroverted attitude. The therapist should avoid making the rather common error of identifying introversion with psychoneuroticism and extroversion with personality adjustment. A certain introverted woman

patient suffers from mild depression, fatigue, and headaches. She is sexually maladjusted, and this becomes manifested through a disturbance of her thoughts and feelings. Her extroverted husband is psychically impotent. He, too, is sexually maladjusted but it does not produce any direct disturbance of thought and feeling. Of the two, incidentally, the husband is much more selfish and egocentric, although his pleasant extroverted manner seemingly belies this fact.

In as far as introversion-extroversion is concerned, the psychotherapist's interest is in detecting any distortions, exaggerations, gaps, or inconsistencies in regard to this personality variant. A young woman who suffered from various vague symptoms and a marked degree of motor incoordination gave the immediate impression of being definitely introverted. Following a few visits it was learned that she cherished the ideal of sedateness, composure, and quiet self-control. Naturally, she was a spontaneous, impulsive, and uninhibited sort of person. She got over her difficulties only when she discarded the inappropriate psychosocial pattern which she had adopted and accepted her own innately determined spontaneous and extroverted way of reacting. One of the major goals of psychotherapy is to help the patient to discover his own most natural modes of response.

So-called *submissive* and *ascendant* personalities are simply introverted and extroverted personalities as observed from the standpoint of social behavior and apparent adjustment. The introverted person is the socially submissive person; the extroverted tends to be socially ascendant. But in connection with submission and ascendance in social situations a fact of great psychological significance appears. Although the introverted person is socially submissive to all outward appearances, inwardly, subjectively, he is not inclined to be submissive; and although the extroverted person appears to be ascendant or aggressive, subjectively he is usually capable of far greater submissiveness than the introverted individual. This is clearly shown by the fact that in general the extroverted person is more suggestible, much more capable of truly yielding to the prestige or domination of other persons. The extroverted person is usually hypnotizable, for instance, whereas the strongly introverted person is not; and becoming hypnotized is perhaps the most submissive (volitionally submissive) of all human reactions. In short, at the very moment that the introverted person is submitting to the prestige or domination of another individual or group he may be

seething with rebellion inwardly or suffering from psychophysical tension or, at least, maintaining a critical attitude toward the very person to whom he is submitting. On the other hand, at the very moment that the extroverted person is dominating another individual or group he may be inwardly thoroughly capable of yielding his position to any other claimant and without inner disturbance of any kind.

Introverted and extroverted, or submissive and ascendant, personalities stand out clearly only when toward an extreme of the variant. And as in the case of many other linear variants, an extreme position on the scale is conducive to maladjustment. Many of us would agree that too high intelligence is not conducive to adjustment (psychosocial) nor is too low intelligence, or extreme height or extreme shortness or even too much laughter or too little. On the other hand the extremes always have their advantages. It is often necessary in psychotherapy, however, to help the patient who is characterized by some extreme of natural variation to discern or discover the advantages which go with it. He usually has his attention on the disadvantages.

The *schizoid* and the strongly introverted personalities should not be confused, assumed to be the same. The most pathological condition to which introversion as such may lead is a psychoneurosis of the neurasthenic type. There is really not much in common between neurasthenia and schizophrenia, which is the acme of maladjustment of the schizoid personality. The former fixes his attention on his bodily functions as a defense against the tug of reality on his selfless capacities; the latter renounces reality, often with slight provocation, for a narrow and phantastic world of narcissistic splendor.

It is more than probable that all of the peculiarities of the schizoid personality have not been clearly discerned or accurately defined. Certain of them, however, can be mentioned.

The most noticeable schizoid characteristic is *affective inarticulateness.* The schizoid person has relatively little ability to give adequate and fitting expression to his affective tensions. He is an emotional stammerer. He is unable to express his affective tensions in his day-to-day life in a manner and to just the degree that would be most satisfying and beneficial.

A few moments of reflection will convince anyone of the great importance to one to be able to express his feelings and emotions in ways and to degrees that are suited to his own individuality or uniqueness. We have all seen the infant become taut and flushed because of its inability to express its desires or feelings, the stutterer become rigid and drool in his desperate efforts to express himself, the deaf-mute become frenzied at his own helplessness. And many of us know from personal experience of the inner dissatisfaction which may result from our failure to express a feeling or desire or even a thought in just the way we wanted. In fact, we pay large sums of money to novelists, speakers, artists, playwrights, and actors to express for us the affective content of everyday life. We pay them because they are able to do it more concisely, more appropriately, and in truer proportion than we.

A young schizoid woman had a quarrel with her sweetheart during her lunch hour. She rushed from the building and walked up and down the middle of the main street of the town till she had brought about a traffic jam. Whatever the exact character of her feelings, certainly her expression of them was utterly inappropriate and irrelevant and did not fit her inner needs. Another young schizoid woman rushed home from work in midafternoon, caught up a broom and began to sweep industriously at the darkest corner of the basement. Presumably she felt that something needed cleaning, but surely it was not the corner of the basement that she was truly concerned about.

As to whether this inarticulateness is a matter of inheritance or the result of early influences, the writer is not in a position to say. It is always present, however, and in working with such persons or with incipient schizophrenic patients the therapist should bear the fact in mind.

A second characteristic of the schizoid personality is a relative *lack of psychic integration.* Basic interests, sentiments. and attitudes tend to live independent existences. Play and work interests, idealistic and practical interests, love and self interests fail to meet in a common root and to become properly related to each other. It is perhaps this relative lack of integration that chiefly accounts for the so-called odd or queer behavior so often noticed in this type of person. The fact that he slaps you on the back one day and inquires after your health and ignores you the next indicates that the atti-

tude or interest of the moment tends to be independent of the modifying influence of other attitudes and interests. A young woman who was already in the incipient stage of schizophrenia rushed up to a police officer (who had been detailed to take her to a mental hospital) in order to slap his face. Very much to the surprise of both she threw her arms around his neck and kissed him instead. First one tendency and then another seemingly dominated her thought and behavior instead of merely modifying each other.

A third characteristic is a relative *lack of psychic flexibility, elasticity*. Possibly this is only a consequent of the lack of integration. Whether or no, once the schizoid person has developed a strong interest, he has great difficulty in modifying it or giving it up. A schizophrenic mother escaped from the affective burden of her children by way of a delusion that they had been kidnaped and that the children in her home were not hers. She then turned, as it were, and ceaselessly demanded that her children be found and brought to her. Here we see two widely disparate attitudes or sentiments existing side by side (lack of integration) and along with them the psychic inflexibility which permitted modification of neither. A young schizoid man came to the writer for help with an unhappy romance. After falling "rigidly" in love with a certain young woman he had learned that she was highly immoral and in no sense the kind of girl he would consider marrying. Yet for months he had been utterly incapable of resolving or altering his absorbing interest in her.

A fourth characteristic is the relative inability, at least hesitancy, in *giving easy vent to affective tensions*. One gets the impression not so much of a tendency in the schizoid person to hold his feelings and emotions in, as of some inner barrier to the expression of them. In fact, it is more as if there were no established patterns for the discharge of affective tensions. Or, on the other hand, this characteristic may be a basic contributing factor to his affective inarticulateness. The less capable he is of venting or letting go of his affective tensions, the more they tend to accumulate as an inner pressure; and the greater this pressure becomes, the more difficult it is to give suitable expression to it once it is discharged. This inner pressure, furthermore, comprises a constant interference with the person's reactions to everyday reality. The most trivial thought or act may suddenly become overloaded with emphasis or importance, producing an illogical and unexpected climax in the thought-action se-

quence, as in the case of a young man who, without previous comment about the matter, abruptly informed his family that he had to see a doctor about his stomach cancer. In other cases the exaggerated emphasis which suddenly invades a thought may result in inner blocking, creating an unaccountable gap in the thought-action sequence. Examples of such gaps or breaks are frequently observed in strongly schizoid personalities.

The value to the therapist of discerning early in the treatment that he is dealing with a schizoid personality lies in whatever knowledge he has of the inherent characteristics involved and of immediately making use of this knowledge. The schizoid personality is particularly in need of help, for instance, in giving correct expression to his exact feelings and thoughts in the therapeutic situation.

The *cyclothymic* (cycloid) personality is, first of all, normally *extroverted in orientation.* He is a neat product of close adherence since early childhood to such guides of implicit and overt activity as traditional beliefs, social standards, the literal aspects of his external environment, and, above all else, parental attitudes and teachings. This in turn means that he has never been genuinely introspective or analytical toward his own feelings and motives. He unconsciously (unwittingly) practices self-deception whenever the demands of the external situation or traditional values or social conventions run contrary to his own personal psychic needs and inclinations. He practices self-deception in overlooking or refusing to recognize the latter facts.

The cyclothymic person is strongly wedded to a middle-of-the-road course in his psychic life. His *mental freedom is severely restricted.* This is his most prominent characteristic and his greatest handicap. He does not repress or rule out basic motives or meanings in their entirety; rather the range or scope of the mental activity which he permits himself with respect to one or more of the basic aspects of life is maladjustively short or narrow. To illustrate: The average respectable woman has occasional thoughts and desires of a promiscuous sexual character, and she accepts these thoughts and desires as her own, as pertaining to herself; the cyclothymic woman, on the other hand, although she may talk freely about sexual thoughts, impulses, desires, and acts, externalizes them and treats them as objective phenomena. As far as she is personally concerned she permits

or tolerates only such thoughts and desires as fit her own established narrow range. Toward thoughts and desires beyond this range she is utterly intolerant. The cyclothymic man graciously accepts his limited achievements, and believes himself to be essentially satisfied. The rigid inner barriers long since erected against a normal (more extended) range of personal *aspiration* effectively prevent his even daydreaming occasionally about personal greatness. Even normal egotistic tendencies are cut in half before they are consciously admitted and granted expression.

As to whether these self-imposed restrictions on mental freedom come about as a result of early influences and training or of some hereditary factor is outside the scope of the present book. The universally recognized prominence of affectivity in this type of person and the psychic elasticity which exists within his established range of thought and feeling suggest both sets of causative factors. Whether or no, the therapist always has the important task of bringing about an extension of the tolerated psychic range in this type of patient.

Due attention to the patient's temperamental characteristics is important. Only some of the more significant ones will be mentioned here. Persons differ widely in respect to their *affective intensity*. Some are emotionally saturated. Every word and act is richly endowed with feeling. They are emotionally responsive even to trivial events. Other persons are emotionally diluted. There is but little affective coloring to their daily reactions. They respond emotionally only to significant events, and even then without much intensity.

Persons vary in regard to their *affective tolerance*,* the inherent capacity to endure and/or to resolve affective tensions. Some persons can love deeply, hate intensely, sympathize widely, or suffer frustrations without inner weakening or loss of efficiency. The emotional tension following a single kiss, on the other hand, may precipitate a psychic dissociation in a Miss Beauchamp. One person will quickly "digest" (resolve) his violent anger and without apparent aftereffects; a second, similarly disturbed, will be mentally and physically partially disorganized for hours afterward or even days. There is perhaps no trait or capacity of the human being which is

* *See* "An Inventory of Affective Tolerance," by V. E. Fisher and Robert I. Watson. *J. Psychol.*, 12:149–57, 1941.

more in the service of personal adjustment than affective tolerance, with the exception of general intelligence. Fear, prejudices, repressions, perfectionistic strivings, and many other acquired and innate traits tend to decrease or preclude affective tolerance.

Wide variations may be observed among individuals in strength of *motivation* or *drive*. Some have more drive than endurance; others have so little drive they live and die without ever once having exerted themselves fully.

Persons differ in respect to the *constancy* or *perseverance* of their attitudes, interests, and feelings. That one person is always wanting the same thing and another is frequently desiring a change may be essentially normal and natural respectively.

At this point it is sufficient to mention that the therapist's broad goal is always that of helping the patient to become adjusted in accordance with his (the patient's) own particular psychic make-up. Psychotherapy is unalterably opposed to the older but still prevalent educational practice of shaping the individual to some pre-established pattern or concept. This may be safely done only in such matters as knowledge, skills, and general social conduct; never in the provinces of motivation, interests, affectivity, and personal peculiarities of expression.

THE PRESENCE OF PHYSICAL ILLNESS MUST BE RULED OUT OR EVALUATED

Physical illness may be known to exist but its contribution to the total picture of symptoms and complaints may be difficult to determine. This is particularly true in the case of gastrointestinal disorders, sinus infections, asthma, bad teeth or tonsils, toxic thyroids, and subluxations of the vertebrae. Nevertheless, an effort must be made to differentiate the physical and the mental from the standpoint of causation. Where the therapist is treating a patient who is afflicted with some chronic and more or less irremediable physical ailment, it is highly important that a share, but only a share, of the suffering be attributed to this factor, and that this stand be rigidly maintained. This prevents the patient from looking to the psychotherapy as a panacea for all his ills and spares him the inevitable disappointment which he otherwise would meet. And, it is better to overemphasize the significance of the physical factor than to

underemphasize it. The less the benefit which a patient expects to derive from a given course of treatment—as long as he is able to be cooperative—the more pleased he will be with any progress made; the more he expects, the less pleased he will be with the same amount of improvement. Since the patient's attitude toward the treatment and the progress made is of such vital importance in the field of psychotherapy, disappointments are to be carefully avoided. Furthermore, if the therapist insists on an acceptance of physical as well as psychogenic causes, the patient will be in a better position to discern and properly identify any changes produced.

In the case of the patient with psychosomatic symptoms and complaints, the therapist should not jump too readily to the conclusion that the whole matter is purely a psychoneurotic picture. Often it is best to allow for and to concede the existence of some vague but real physical irritability or susceptibility. Any patient of average intelligence is capable of understanding the dual causation of various types of symptoms if the matter is properly explained to him.

The possible presence of syphilis should be kept in mind, particularly with cases manifesting depression, marked changes in personality, peculiarity of behavior, or delusional formation. The writer has had cases of early paresis referred to him by physicians. If there is reason for the slightest suspicion of syphilis, nothing should be left to guesswork. Neurological and serological findings should be determined before psychotherapy is undertaken.

Perhaps it is unnecessary to caution the therapist, in case he is medically trained, against trying to be medical therapist and psychotherapist to the same patient at the same time.

THE THERAPIST SHOULD GET IN MIND AS EARLY AS POSSIBLE THE PROBABLE CAUSES AND SIGNIFICANCE OF THE DISORDER

Much time may be wasted in psychotherapy unless the therapist makes a special effort to get the probable causes and significance of the disorder clearly in mind. Marshaling all one's knowledge concerning a given type of disorder and bringing this knowledge to bear on the patient at hand, without forcing the disorder to fit this knowledge in any specific detail, is one of the finer points in psychotherapy. Any given instance of nonpsychotic personality

disorder comprises a fairly definite psychic structure. Moreover, it belongs to a fairly distinguishable class of psychic structures. Getting in mind the similarities of all known instances (known to the therapist) belonging to the class in which the patient falls gives the therapist a valuable orientation early in the course of treatment. An illustrative example may help to make the importance of this point clear.

A man in his late twenties, a former minister, had been to a medical psychoanalyst for approximately two years. Then, in connection with moving to a different part of the country, he came to the writer for help. He appeared uncertain as to whether he had been benefited by the two years of treatment. Following a short history-taking, he was asked what had been learned about the nature of his problems. He said he had complexes and conflicts. When asked what the nature of these was he became angry and said he, and not the therapist, was supposed to do the talking. The writer explained that different therapists use somewhat different procedures and that often some direct questioning can save much time and expense as compared to a complete reliance on the patient's free associations. Questions concerning what had been learned about his subjective difficulties and the interpretations and explanations offered by his therapist were then repeated. The patient replied that he had not supposed that his therapist knew what was ailing him (the patient) but that he was expected to reveal his difficulties through freedom of speech. He said his therapist had mentioned Oedipus complexes, guilt feelings, hostile impulses, anal-erotic fixations, and narcissistic tendencies but that he had never been informed as to which of these comprised his problem.

Not only should the therapist try to arrive at an approximate understanding of the causes and significance of the patient's maladjustment as early as possible in the course of treatment, with certain exceptions to be mentioned later, but this understanding should be imparted to the patient in the clearest possible manner. A psychoneurotic patient will not "talk himself out of" his psychoneurosis. No patient cooperates effectively and fully in the dark.

THE THERAPIST SHOULD GET IN MIND THE SPECIFIC AIMS AND PROCEDURES

To be sure, the aim of the therapy is the cure or adjustment of the patient. But having in mind only this general goal is not sufficient. Moreover, if entertained alone, it conduces to loose thinking or a lack of thinking by the therapist. He should get clearly in mind, as early as possible, the specific subjective changes which must be brought about in the patient, the exact alterations in the psychic arrangement and motivation which are necessary to a readjustment. One patient, for instance, is chiefly in need of the resolution of an Oedipus complex; a second must be helped to recognize, accept, and utilize strong cross-identifications instead of repressing them; a third requires assistance in divesting himself of various defense mechanisms and compensatory devices and in resolving intense feelings of personal inadequacy.

With the specific aims of the therapy in mind, the procedures to be employed can then be determined in the light of the patient's psychological assets and liabilities as revealed by the psychological testing, case history, study of his personality and temperament, and any other information at hand. To use the same procedure with all patients, particularly in the early part of the treatment, is tantamount to ignoring the profoundly important fact of individual differences. Whereas a course of educative therapy may be indicated as the first step in the case of an ignorant and not very intelligent girl suffering from conversion hysteria, a considerable period of nondirective therapy in the beginning is usually necessary in the patient who has repressed homosexual tendencies.

The therapist will hardly be able to foresee and plan the procedures to be used throughout the course of treatment. He will usually have to modify his techniques or discard and introduce more or less as he goes along. Nevertheless, it is important that he get a plan in mind in the beginning of the treatment and as early as possible.

THE USE OF DIRECTIVE AND NONDIRECTIVE PROCEDURES

In directive therapy the therapist endeavors to direct the thoughts and feelings of the patient *within the therapeutic situation*

along such lines or in such directions as he (the therapist) thinks most helpful. If carried to an extreme and effectively administered or enforced, this type of therapy results in the patient's becoming a mere puppet, a sort of automatized reflection of the therapist's conception of personal adjustment. Needless to say, such therapy brings about an extreme emotional dependence on the therapist, a smothering of spontaneity in the patient, a lack of self-examination and insight by the patient, and a blind obedience rooted in the patient's submissive capacities. In fact, if carried to an extreme, directive therapy takes us back to the vicious and medieval conception of education which sought to fit the individual to a preconceived pattern with utter disregard for the person's own uniqueness or individuality. Therapists with overdeveloped paternalistic attitudes, who see the patient as someone to be coaxed and spanked into an acceptance of the "obvious" proper way of life, are prone to overemphasize directive therapy.

Nondirective therapy helps the patient to discover and exercise his own individuality. Theoretically, it imposes nothing on the patient. If carried to an extreme and somewhat loosely applied, it does not even impose understanding and insight on the patient. A patient once came to the writer who had been psychoanalyzed for five years, five visits weekly. After history taking and psychological testing had been completed, he was asked to go ahead and say anything that came to his mind. He immediately began talking very rapidly. His talk was mostly a disconnected, obscene jargon. After about fifteen minutes he was halted and asked what his talk meant or signified. He replied that he was simply letting go of everything in his subconscious, and that he had been doing it for five years. He was then asked what he had been thinking during the fifteen minutes he had been talking. He readily mentioned several thoughts he had had. His thoughts had had nothing to do with what he had been saying. His supposed free association speech was really nothing more or less than a dissociated, automatized, superficial lip-service. He was a finished product of nondirective therapy which had been loosely applied and carried to its ultimate degree. Naturally he had received no benefit from such therapy.

There appears to be some tendency among psychotherapists to debate the relative merits of directive and nondirective procedures. This seems to be about as sound and fruitful as it would be to debate

the relative merits of internal medicine and surgery. There is no patient, child or adult, in whose case a proper combination and judicious use of both procedures are not desirable, perhaps necessary, if a satisfactory adjustment by the patient is to be made. Moreover, except in extreme instances, so extreme that the term "psychotherapy" can hardly be applied at all, the use of both methods is unavoidable. The patient will be more or less directed by the therapist whether or no. Wittingly or unwittingly he will infer from various slight reactions of the therapist the nature of the latter's judgment or wishes. If the therapist endeavors to rule out directive therapy altogether, the patient may even believe he discerns a hidden meaning in the most innocent remark the therapist may make. In fact, there is a definite danger to the patient in trying to rule out directive therapy completely. Not only the paranoid patient but others as well may come to feel that they are being trifled with for hidden reasons.

On the other hand, it is only in a transference situation or in hypnotic therapy that nondirective therapy could very well be ruled out altogether. The exclusion of nondirective therapy entirely would imply a complete domination of the patient by the therapist. Except in the instances just mentioned, only the most abject specimen of mankind could yield his last measure of initiative, spontaneity, and self-guidance to another person, and *still cooperate in any true sense with that person.*

Proper psychotherapy must make judicious use of the directive and nondirective principles. One patient needs more guidance than another. A given patient needs more directing during one part of the treatment than during another part. The therapist should make clear to the patient where directive and nondirective procedures begin and end.

THE USE OF ACTIVE THERAPY

Active therapy includes any kind of *deliberate interference by the therapist with the patient's implicit and overt activities outside the consultation room.* Or, it could be defined as demands made on the patient by the therapist beyond the usual ones made in connection with the therapeutic situation proper.

The therapist has four main purposes in the use of active therapy:

to elicit or gain access to repressed material, to increase the patient's insight, to reveal abilities or capacities to the patient which he did not believe he possessed, to encourage the patient to give the matter of his treatment high priority among his everyday affairs.

Every psychotherapist knows only too well of the plateaus which tend to occur in every course of treatment. The patient appears to come to a standstill. Perhaps the sharpness of his symptoms has been dulled; he is less distressed than in the beginning and seems to want to let well enough alone. He has few or no thoughts to express or dreams to mention. He might continue on such a plateau almost indefinitely unless something were done to force a move. More of the psychic content must be discerned and divulged by the patient if he is to move forward in the treatment. But when he declares that nothing comes to his mind, active therapy is the answer. The therapist must take such steps as will introduce or force more material within the conscious grasp of the patient. Generally speaking, this is accomplished by ruling out in as far as possible all affective outlets which the patient has, often including such activities as sexual intimacy with spouse, moving pictures, reading of fiction, visiting and visitors, and even, in the case of some patients, daydreaming. Quite naturally, such measures tend to increase the affective tensions of the patient, with the usual result of additional thoughts, recollections, and dreams.

Requiring the patient to perform certain acts or to place himself in certain situations which he has formerly avoided because of fear or for some other reason will often give him insight (self-understanding) which no amount of discussion in the therapist's office could ever give. A young college man who was badly maladjusted socially had never had a date with a girl because of a crippling fear of the opposite sex. He stated that he had never been able to ask a girl for a date lest she refuse him. He believed he could never live down such a refusal. At a given point in his treatment he was instructed to ask some girl for a date regardless of what the outcome might be. In keeping with his neurotic make-up and social fears, he finally approached a girl who was perhaps as inhibited, repressed, and maladjusted as he. Moreover, his state of tension at the moment must have given him more the appearance of a would-be rapist than a friendly boy asking for a date. At any rate the girl's reply to his request was a resounding slap to the side of his face. He was smiling

when he came in for his next visit. He declared that he would never again be afraid to ask a girl for a date. The very worst had happened but instead of being so humiliated as never to be able to live down the girl's refusal he discovered that his reaction was very different, in fact the opposite of what he had anticipated. He had gained a bit of insight into himself which he perhaps never could have acquired in the therapist's office.

Many patients have come to believe that they are extremely limited in their capacities in one or more directions, capacities to deal with everyday problems. A man in his early thirties had a phobia of high places. His fear was traced to specific instances of timidity, failure, and humiliation in early childhood. His phobia persisted, nevertheless, and had become condensed into an obsessive fear of jumping off an ordinary diving board into a pool of water. He complained that the thought of doing so and its accompanying fear were in his mind most of the time. When he had reached the point in his treatment where the writer believed he was perhaps capable of jumping off a diving board, he was instructed to go to an indoor pool early in the morning before other bathers were about, to undress and then stand on the very end of the diving board. He was told that he need try to do nothing more than this but to notice carefully just how he felt so he could report his feelings at his next visit. He agreed that he could and would carry out these instructions.

When the patient came in for his next consultation, he said he would never be sure whether he jumped off or fell off the diving board but that he had suddenly found himself in the water. His fear of jumping off a diving board was gone. It had been little more than a shadowy skeleton of his former fear of high places. The phobia could have been completely dissolved in the therapist's office in all probability over a period of an additional six or eight months of treatment. A little active therapy at the right point made this unnecessary.

The most common limitation, perhaps, which patients come to take for granted in themselves is their inability to endure their affective (neurotic) tensions. The neurasthenic patient must have another tablet as soon as her short-lived zest for living begins to decrease; the anxiety hysteric must "stage" an attack with the onset of a repetition of the old sense of frustration, or go out for a drink, or stop his work and play a game of poker; the hypochondriac must lie down or be very quiet until the wave of intense concern

about his health passes over; if nothing better, the conversion hysteric must at least shake violently when the attention of others tends to broaden her field of awareness; the compulsion neurotic must perform his compulsive act at once, particularly if the situation at the moment is opposed to it.

As the patient's affective tolerance, tolerance for affective tensions, increases with treatment, he should be helped to realize this by means of active therapy. At the proper time in the treatment he should be instructed and encouraged not to deny or ignore his affective tensions but simply to endure them. This will hasten their diversion into patterns of adjustive motivation and expression.

Many psychoneurotic as well as psychotic patients will adopt an attitude of timelessness toward the treatment if permitted to do so. It would seem that many medical analysts in the past have encouraged such an attitude rather than discouraged it. By means of active therapy, judiciously employed, the treatment can be given its proper importance in the mind of the patient and also be impressed upon him as something to be concluded at the earliest possible moment. A young man was requested to reside away from his wife for a period of one month without so much as communicating with her by telephone. Although this request was made for stronger reasons, it had the effect of greatly enhancing the significance of the treatment in the mind of the patient.

The effective use of active therapy is perhaps the weightiest single criterion of the competence of the psychotherapist. Many patients would never recover from their personality disorders without it. At the same time it harbors more possible pitfalls for the therapist than any other aspect of his work. No specific rules can be given for it. The effective employment of active therapy is wholly dependent on the comprehensive and detailed understanding of the patient by the therapist. Many examples of successful active therapy will be cited in later chapters.

THE USE OF DREAMS

It must be taken for granted here that the reader is familiar with the principles (mechanisms, dynamisms) of dream formation. If he is not he should acquaint himself with the contributions of

Freud, Jung, Adler, McDougall, and others to our knowledge of this feature of psychic life.

There are many facts about dreams which make them of value to the therapist. With few exceptions dreams relate to the major personal problems of the dreamer. Thus a dream is neither trivial nor nonsensical once its meaning is clear. In general, dreams are the expression and/or the representation of rejected or unacknowledged desires and interescs. As they tend to unfold, these desires meet with inner resistance which diverts them to substitutive or symbolic representation. Or, a dream may be a frank and nonrationalized judgment or intention concerning some anticipated event or undertaking.

The creative forces which produce dreams are the same as those which create psychoneurotic symptoms. A careful study of the patient's dreams, therefore, sheds much light on the patient, his symptoms, and the underlying causes of his disorder. The extent of the indirection and symbolization found in a dream gives a fair indication of the strength of the resistance to the dream motive (subconscious wish). Long, circuitous dreams indicate strong resistance. Farfetched or involved symbolism usually has the same implication. Repetitive dreams are of particular significance, indicating some nuclear, pressing but unsolved inner problem.

Much of the value of dreams in psychotherapy lies in the fact that one cannot lie or even rationalize, strictly speaking, in his dreams. Hence, the patient's dreams comprise a valuable source of information for the therapist. And, as the patient gradually becomes convinced of the validity and significance of dreams, whatever he says about himself in his dreams carries far more weight than anything the therapist might tell him.

The interpretation of dreams is not difficult, provided it is undertaken systematically. Until the therapist is well acquainted with his patient, he should always make use of the latter's free associations to the different elements of the dream. After the dream has been broken down into as many separate parts as possible, free associations should be obtained to each of these. Often it is necessary to obtain a sequence of responses to each element. Although true free associations, these responses may be one or several steps removed from the most direct or relevant response possible, due to resistance. But by studying the possible connections among the different re-

ponses in a sequence, the therapist can usually arrive at the most pertinent one or infer the response that should have been made. If a single, immediate response is given, on the other hand, without evidence of interference or blocking, it may be accepted as the most relevant association to the dream element.

A knowledge of universal dream symbols is highly important, if not necessary, to proficiency in dream interpretation. At the same time due allowance must be made for personal eccentricities and peculiarities of experience of the dreamer. In the case of a certain woman who had frequent dreams of snakes, snakes were not phallic symbols, nor was the patient sexually repressed. Without going into the exact meaning which snakes had in her dreams, suffice it to say that throughout her childhood she lived in a country heavily infested with rattlesnakes, even to the dooryard of her home.

A given interpretation should never be forced on a patient. If the patient is definitely opposed to the interpretation offered, the interpretation is either wrong or has aroused too much resistance. And in this connection, the therapist should carefully avoid the common error of giving the patient interpretations of his dreams too early in the treatment. Doing so may not only arouse such strong resistance that the progress of the treatment is markedly slowed for some time to come, but in some cases the patient will abruptly terminate his visits. The latter is particularly likely to happen in cases with strongly repressed homosexual desires.

A short dream is given below together with its interpretation. The dreamer, a man of twenty-eight and engaged to be married, stated that he had been growing increasingly worse since his engagement, a few weeks earlier. His marriage was about two months distant. He expressed great concern lest his psychoneurosis should prevent his marriage, or at least necessitate a postponement of it. His chief symptoms were insomnia, loss of appetite, distractability in his work, preoccupation with thoughts of his approaching marriage, and periods of acute anxiety and despondency. He dreamed that he and his older brother, who was married, were going to take a trip by train. As they approached the train with traveling bags in their hands, the train began to pull away from the station. They became alarmed and ran as fast as they could to catch the train. The brother succeeded in overtaking and boarding the train; the patient was unable to do so. In telling the dream he remarked that he could not un-

derstand why he had been unable to overtake the train inasmuch as he had always been able to outrun his brother. But obviously the meaning of the dream had nothing to do with running as such. The patient's free associations to the elements of the dream were as follows: journey—trains, Niagara Falls, honeymoon; train—conveyance, trip; brother—my brother, married brother; traveling bag—traveling necessities, inconvenience, burden, heavy, it interfered with my running; running—outrunning my brother; failure—me.

A trip or journey in a dream is a universal symbol of a desired or anticipated major change in one's mode of life. The most significant fact revealed about the dreamer, then, was his very strong inner resistance to getting married, dramatically symbolized by his inability to overtake the train. Other facts about the patient were revealed by the dream. He suffered from feelings of inferiority in relation to his brother; he was strongly attached to his brother and would have preferred to go on through life with him to getting married; his brother's marriage had left the patient feeling lonely and insecure; he felt inadequate to the responsibilities (burdens) of marriage, at least in connection with the girl to whom he was engaged. Incidentally, the patient did not marry the girl to whom he was engaged at the time of his dream.

DETECTING, MANAGING, AND UTILIZING THE TRANSFERENCE

Any fairly competent therapist who seriously undertakes to help a psychoneurotic or other badly maladjusted person will sooner or later find himself the object of a distinctly emotional attitude on the part of the patient. This attitude is known as a *transference.* A transference may be weak or strong, positive or negative.

The strength of a transference depends principally upon the amount of psychic energy invested originally in symptom-formation and the inherent affective intensity of the patient. The more severe the psychoneurosis or maladjustment, the stronger the transference tends to be. Similarly, the more dynamic or strongly motivated the patient, the stronger the transference becomes.

The most common affective components in *positive* transferences are sexual interest, affection, admiration, negative self-feeling (submissiveness, suggestibility), and feelings of identity with the therapist or his field of work. Not all transferences include all of these

components and in a given instance any one of them may predominate.

A *negative* transference is one in which the patient's attitude toward the therapist is predominantly one of suspicion, hostility, or negativism. It is extremely probable that a genuinely negative transference is always an energetic defense against and a concealment of a weaker positive transference. Unless it can be speedily overcome, a negative transference usually anticipates a failure of the therapy. In some cases the patient will abruptly end the treatment despite everything the therapist can do. And, the most the therapist can do in such instances is to explain as clearly and fully as possible the reasons for the negative attitude.

The beginning of a transference is often first discernible in the patient's dreams. It may acquire considerable strength without the patient's becoming discriminatingly aware of it. That is, although the patient's attention may have become largely centered about the therapist, because of resistance to the affective changes which are taking place in him, he may completely overlook the genuinely personal nature of his interest. In most cases and at the proper time the origin and significance of the transference should be fully explained to the patient. In a few cases, on the other hand, particularly with older patients of opposite sex, it is advisable never to mention the matter of the transference.

A transference must be managed by the therapist, not merely ignored or left for the patient to deal with alone. The therapist's skill in doing this has much to do with the progress of the treatment once the transference stage has been reached. The patient should be helped to accept his feelings and thoughts about the therapist and to see them as representing his own released affective capacities. The patient's feelings should never be sharply rebuffed unless such becomes unavoidable. Any obvious encouragement of the transference, on the other hand, is almost certain to have the opposite of the effect desired. Any detailed analysis of the transference relationship should not be made in most instances till the symptoms have become markedly weakened and the therapist is reasonably certain that the patient's affective tolerance will be equal to any tension produced. A premature analysis of the transference is likely to bring about a strong introspective trend, increased resistance, a return of symptoms, and a prolongation of treatment.

The writer has found it advisable to instruct the married patient of opposite sex regarding her conduct toward her spouse during the period of the transference. She is asked to keep her temporary loss of interest in her husband, which usually accompanies the transference, from being any more apparent than necessary. In addition she may be asked to explain to her husband that the analysis is very upsetting and that any change in her attitudes or behavior should be attributed to that fact. Too many of the divorces which have followed the psychoanalysis of married persons have strongly indicated a lack of competence in the therapist in dealing with the transference.

The transference stage opens the door to the effective use of active therapy. The patient is then capable of exerting a degree of effort in different directions which would have been utterly impossible for him earlier in the treatment. It is only through the use of active therapy during this period that the course of the treatment can be kept moving forward. Without its use, the treatment might well drift on over a period of years, which has happened unnecessarily often in the short history of psychoanalytic therapy. Eight or ten months is an adequate period of time for the successful treatment of the average run of psychoneurotic or early psychotic patients. Many patients will make satisfactory and permanent readjustments (recoveries) in five or six months of three hourly visits weekly.

Very few rules even of a general nature can be given for the use of active therapy in connection with the transference. The active therapy used will depend on the particular patient. The therapist must be careful not to ask more of the patient than the patient is capable of at the time. On the other hand, the influence with which the transference endows the therapist should be used to keep the patient motivated near the limits of his affective tolerance and adaptability.

THE PROBLEM OF PLATEAUS

A *plateau* is any appreciable *period of time in the course of treament during which the patient shows no signs of improvement.* One or more plateaus occur in most courses of treatment. The first is likely to appear after six weeks or two months of treatment and coincidental with a marked decrease in the severity of the pa-

tient's symptoms. It is as if the patient were inclined to let matters rest. He is unable to remember his dreams, he can think of nothing to say, he appears to be at a standstill.

A second plateau occurs in the case of many patients midway in the transference period. Instead of letting the transference run its natural course, the patient appears reluctant or unable to give free rein to his thoughts and feelings about the therapist. He comes to a stop when his thoughts and feelings tend to become too intimate to be tolerated, when they tend to detract too much from his sense of self-sufficiency, or when he is unable to resolve or rationalize them satisfactorily. In connection with a plateau at this point in the treatment there is often a regressive movement to some extent in the transference feelings. In other words the patient retracts (represses) a part of his interest in the therapist. He goes back, as it were, to a more tolerable (comfortable) degree of feeling toward the therapist. He then unwittingly tries to maintain only that degree of interest.

With some patients a plateau occurs near the end of the treatment. The therapist encounters a peculiar resistance in the patient to becoming completely well. Such a phase is usually characterized by fleeting returns of symptoms, a tendency to manufacture new symptoms, or doubts that a complete recovery will be possible.

When a plateau has existed for a few weeks it becomes the responsibility of the therapist to take active measures to disrupt it. In the case of a plateau early in the treatment, active therapy should be used. All or most affective outlets which the patient has should be blocked, as has already been discussed in the section on the use of active therapy.

When the plateau occurs during the transference stage, the only recourse the therapist has is to insist that the patient retrieve and verbally express marginally conscious thoughts and feelings. Always, of course, in such cases, the therapist should do all he can by way of explanations and generalizations to help the patient to tolerate the transference.

A plateau near the end of the treatment usually indicates a reluctance on the part of the patient to resume his former relationships and responsibilities. These matters may have to do with his spouse, his parents, his work, or with some other situational aspect of his life. The psychotherapist not only may but should seek to bring about

any sort of change in the patient's circumstances that is ethically legitimate and to the patient's advantage. As an illustration of the extreme to which the therapist may go in this respect, the writer once in his experience insisted that a patient's spouse grant the patient a divorce. The two were badly mismated and there were no children. The patient could not possibly have become adjusted within the circumstances of his marriage.

A plateau is always a problem for the therapist, not for the patient. The therapist should make every reasonable effort to disturb the equanimity of the patient once there is little doubt that the patient's subjective effort to achieve a complete adjustment has come to a stop.

EDUCATIVE AND RE-EDUCATIVE THERAPY

In a broad sense all psychotherapeutic procedures might be reduced to the matters of the *education* and *re-education* of the patient. These terms are being used here, however, in a much narrower sense. Educative therapy in the very beginning of the treatment is strictly in order with some patients. A young pharmacist who had been married six years had never completed the sexual act with his wife but was entirely ignorant of the fact. He had not known that any penetration was involved in sexual intercourse. A young man of twenty-nine believed that all respectable women were innately and strongly averse to sex. A surprising number of young men think that women urinate through the vagina. A highly intelligent college student was surprised to learn that women have sexual organs. He had thought that babies were born by way of a rupturing of the abdomen.

Many young people take it for granted that their aspirations to personal success should be unlimited. They are utterly ignorant of the nature of psychic integration and the necessity of a balance of motives. Relatively few persons realize that it is quite natural to hate a cruel parent, that incest barriers are acquired and not innate, that small children are capable of sexual interests and sexual responses (orgasms), or that selfishness or self-interest is normally half the meaning of the individual's life. Early in the treatment the therapist should take care to see that his patient has or acquires a workable understanding of the basic psychobiological character of human life.

Re-educative therapy is more likely to be indicated during the latter part of the treatment than at any other time. During the process of recovering from a functional nervous disorder many old attitudes, sentiments, feeling habits, and convictions become radically altered or dissolved. This may leave the patient more or less devoid of specific affective orientations toward self and others, toward responsibilities, work, and various other aspects of his life. It is in this connection, with this situation, that re-educative therapy finds its proper place. The patient may be definitely in need of help from the therapist in acquiring new interests, developing new attitudes, and in establishing other subjective guides to his efforts. The role of the therapist becomes that of counselor. He offers suggestions, helps the patient to evaluate new interests and opportunities, and gives moral support to the patient's endeavors.

CONCLUDING THE TREATMENT

Ending the treatment too abruptly may be as bad for the patient as letting it drag out unduly. The therapist should bear in mind that, with the disappearance of symptoms or a marked decrease in their severity, the patient's ability to meet the problems of reality has increased correspondingly, irrespective of what the patient may have to say about the matter. This increased ability should be put to use as it arises. If this is done, the termination of the treatment will be easier for all concerned.

If the patient has been coming, say, three times weekly for one hour each visit, the consultations should be reduced to once weekly during the last month or two of the treatment. This not only aids materially in dissolving the transference, it also provides an easier transition for the patient from his dependence on the therapeutic situation to a satisfying participation in the everyday affairs of his life.

In the case of the patient who has manifested an ability to deal satisfactorily with the problems of his life but who nevertheless insists on continuing the treatment indefinitely, a further attempt to dissolve the transference should be made. If this proves ineffective, the therapist should firmly dismiss him. The patient may be told that after six months or a year the matter of further treatment will be discussed if there appears to be any reason for it at that time.

Part Two

SOME PSYCHOTIC AND CLOSELY RELATED DISORDERS

CHAPTER 2

Early Schizophrenic Reactions

SCHIZOPHRENIA, the most common of the psychoses, has received considerable attention and study in the past and calls for still more in the future. Far more remains to be learned about it than is yet known. Theories of its etiology vary from those which place chief emphasis on a hereditary diathesis to those which find its roots in maladjustive or vicious habit formation in early childhood. The present interest, however, is neither in the etiological intricacies of the disorder nor in its chronic form; but, rather, in making understandable certain psychotherapeutic procedures which have shown some promise when used with cases showing *early* schizophrenic reactions.

It is important that the reader distinguish the type of reaction to be discussed in this chapter from those of the manifestly schizoid personality, on the one hand, and from those of the chronic schizophrenic patient, on the other. In the case of the former, the individual's reactions, however peculiar and pointless they may be, leave him with an appreciable capacity for a workable contact with reality. He continues to manage his life, even though poorly. Moreover, his maladjustive reactions can be traced back over a long period of time. If his reactions have become increasingly maladjustive, this has been a gradual and not a sudden change. If a psychotic episode has occurred, these same reactions can be traced beyond the episode.

The chronic schizophrenic patient's reactions comprise an estrangement from reality and denote at least a functional loss of capacity for self-management. However varied his reactions or symptoms may be, all in all they are definitely stereotyped and fixed. The patient is obviously not in any sort of intimate affective contact

with his human surroundings. Any affective responses he makes to other persons are utterly shallow, without intensity.

Between the very first appearance of symptoms and the chronic stage, there is an appreciable period of time. This is the *prodromal* phase of the disorder. Particularly significant of this phase is the fact that the patient possesses some insight at times and consciously fights the encroachment of his symptoms. He tries to ignore them or to push them aside, as it were, and to maintain a rational and affective contact with his surroundings. During this early phase of the disorder, psychotherapy is the most proper and promising form of treatment. Through its immediate and energetie application, a large percentage of patients, particularly those whose reactions are predominantly of the paranoid or the catatonic variety, could undoubtedly be returned to sanity and ensured a permanent psychosocial adjustment. In the absence of proper psychological management at this time, the patient is fairly certain to become chronic and incurable. Shock therapies should not be used, or if they are, but mildly and in connection with psychotherapy. Their highly questionable value is better left for the most part to experimental research with the chronic case.

There is no type of patient in whose case more tact and discernment by the therapist are necessary during the first two or three visits than the early schizophrenic. One or two injudicious remarks, a too solicitous attitude, or some other seemingly slight inadvertency may preclude the very possibility of the therapist's helping the patient. That this is true and why will be made clear later.

From the moment the therapist discerns that the condition is even possibly one of early schizophrenia he should adopt and consistently carry through a *calm, impersonal,* and *noncommittal* manner. If the patient makes impulsive advances, the therapist should become a little more cool rather than more friendly. If the patient expresses delusional ideas, the therapist should neither agree nor disagree. If the patient behaves in a silly or childish manner, he should nevertheless be treated as an intelligent and mature adult. If the patient is negativistic and refuses to talk, only very little pressure should be brought to bear to make him speak.

The symptoms of early schizophrenia must be seen above all else as *inner, unwitting but energetic attempts to break, remove, or*

destroy affective contact with reality. Or, more specifically stated, during the prodromal stage the patient is unwittingly renouncing or repressing those feelings toward his environment which possess the greatest intensity. Such feelings usually relate to children, spouse, parents, siblings, sweetheart, or vocational goals. Along with this withdrawal the patient makes no effective effort to redirect his interests toward other reality goals. Thus, if a schizophrenic youth is effecting a withdrawal of his interest in a young woman with whom he has fallen in love, he will not become interested in some other woman, as is ordinarily the case with the young man who is adjusted. The affective withdrawal of the schizophrenic patient is primarily subjective and is due to subjective factors. It is subrational and unwitting but nevertheless it must be seen as subserving a purpose. It is pointed at the goal of affective isolation. The patient is doing unwittingly and subjectively what the hermit does with conscious intent and objectively.

During the prodromal phase of the disorder, then, the patient's psychic energies are divided and directed toward two disparate goals. *On the one hand he is trying to withdraw from affective participation in the major aspects of his world of reality; on the other hand he is trying to retain affective contact with this reality*. Anyone who would try to help one of these patients must constantly bear in mind this deep-seated and antagonistic duality of motivation.

Behavior which is queer, odd, strange, often seemingly devoid of any meaning, is common to these patients. Such behavior may follow any one of numerous patterns, but it always expresses or results from the tendency to withdraw emotionally from reality. In one case there is silly giggling for no apparent reason; in a second, the patient stares in a fixed, blank manner at the opposite wall or at anyone who talks to him; in a third, there is continuous mechanical-like, stereotyped behavior; in still a fourth, the patient makes impulsive, child-like, affectionate but short-lived advances to the visitor. Odd and peculiar behavior may comprise the chief symptoms in the prodromal period or it may be accompanied or displaced by symptoms of a more specific character.

Frequently the patient is mute and negativistic (inaccessible). Some patients refuse to eat or talk; they may assume a fixed posture and maintain it over long periods of time. A patient may isolate himself in his room or hide under the bed or in the basement. Some appear

to hear someone talking to them (auditory hallucinations) or to see persons or objects where none exists (visual hallucinations). In many cases the patient thinks other persons are talking about him, usually in a disparaging manner (ideas of reference), or that somone has a hypnotic influence over him (ideas of influence). Again, a patient may repeat everything that is said to him (echolalia) or imitate the acts of those nearest him (echopraxia). He may believe he is not constructed properly physically (somatopsychic delusion) or believe his mind is dissolving or leaving his body (autopsychic delusion) or that he is not his mother's child, or that his own child is not his (allopsychic delusion).

Although this is by no means a complete list of the symptoms found in early schizophrenia, it is sufficient to indicate the character and variety to be found. But irrespective of how weird or phantastic or apparently meaningless the symptoms may be, as long as they have not become firmly fixed or crystallized and as long as the patient manifests a definite effort to remain in affective contact with reality, he should not be regarded as a hopeless case for psychotherapy.

As soon as a diagnosis of incipient or early schizophrenia has been made the therapist should take time to get clearly in mind the known and theoretical facts concerning this disorder and to plan his procedure in accordance with these facts. First to bear in mind are the basic characteristics of the schizoid personality as outlined in the preceding chapter. Namely, the patient is emotionally inhibited and inarticulate; psychically, he is poorly integrated, his interests and attitudes tend to live independent existences; he is lacking in affective tolerance, that is, he does not easily resolve his daily affective tensions. In addition to this, in the case of the schizoid person who develops schizophrenia, the existence of repressions or complexes should be taken for granted.

Whatever the external factors or situation may be, from a strictly subjective point of view *the precipitating cause of schizophrenia is always an overcharged interest or emotional problem.* This may consist of or relate to a romantic attachment, childbirth, a contemplated undertaking, disturbing factors in his place of work, or some other emotionally stimulating event or situation. In some cases it would appear that manifest schizophrenic reactions result

from nothing more tangible than social-sexual drives reaching a strength which is beyond the patient's tolerance.

The patient is unable to tolerate the new interest or emotional problem. He is unable, in other words, either to endure his affective tensions or to vent them in an overt manner which is in keeping with his own needs and meets the demands of reality. Being unable either to endure or to express, he unwittingly takes the step which spells schizophrenia. Possibly it would be more correct to say that his inner dilemma initiates a process which supports the development of schizophrenia, for in no other type of personality disorder does there appear to be less active effort exerted by the patient, consciously or subconsciously. Whether or no, simultaneously with the first appearance of symptoms *a part of the psychic energy (affective tension) takes an introverted and regressive direction.* This fact can be discerned in every case of early schizophrenia. With the birth of her first child, a young woman began to manifest schizophrenic symptoms. She expressed a "fear" that if she permitted herself to go to sleep she would become paralyzed and would not then be able to take care of her baby. A switch of attention from her baby to herself is obvious in this symptom. Likewise, the regressive element is obvious. She was afraid she would become paralyzed, helpless like an infant, and then, of course, have to be taken care of herself.

The regressive flow of the psychic energy activates the early, infantile patterns of interests and feelings (complexes or repressions). Unless the psychotic crisis is very sudden and severe, bringing about an immediate shattering of the mental organization, resistance to the repressed, childish interests will divert the expression or manifestation of them to patterns which are definitely symbolic and symptomatic. Accordingly, the symptoms may appear phantastic and meaningless.

The assumption that the symptoms are expressions of a regressive flow of energy, becoming manifest through fragmental patterns of the implicit activity of early childhood, seems to explain the fact that the affective character of the precipitating problem may be radically different from the affectivity belonging to the symptoms. A heterosexual interest, for instance, may be the precipitating emotional problem but be followed by symptoms of a distinctly homosexual significance. Or, an exaggerated concern about her children in

a schizoid woman may leave in its wake the symptoms of the hebephrenic, emphasizing complete irresponsibility and unconcern.

With the basic nature of the disorder in mind, the specific aims or goals of the treatment will immediately become apparent. First, *the introverted and regressive trend of affective reactions must be halted and reversed.* Otherwise, childish patterns of feeling and interest will become fully reinvested with psychic energy, elaborated and built into a world of phantasy, firmly established as a result of the withdrawal of the energic support of adult and realistic interests, and unalterable. In other words, once the infantile patterns have become invested with the psychic energy of the patient, the patient is inaccessible to psychological treatment. His adult patterns of thought and feeling are no longer energized and he is therefore irresponsive to an adult level of approach. His childish patterns have become introverted to a pathological degree and he is therefore similarly inapproachable on a childish level.

Secondly, *it is necessary to bring about a decrease or diminution of the overcharged interest which is causing the patient to withdraw his attention and interest from the world of reality.*

In the third place, *the patient must be trained to be more articulate in his affective responses.*

Fourthly, *he may need to be helped to realize the importance of maintaining a reasonable variety of interests.* His interests tend to become too concentrated and, therefore, too few; and, being too few, they tend even more to become too concentrated.

Finally, *the patient must be taught how to maintain a workable emotional distance between himself and other persons,* particularly those in whom he is most interested. Some persons can get much closer emotionally to family, friends, and associates than other persons can without loss of inner efficiency and stability. Here is a husband, for instance, who works more efficiently during his wife's absence from home than when she is with him. He is very devoted to her and spending a large part of each twenty-four hours in her presence pulls too heavily on his affective tolerance. Here is a son who cannot even read a book to himself in his father's presence. He has become too close to his father emotionally. On the other hand, here is a woman who responds with genuine feeling to nearly everyone she meets without inner disturbance or loss of personal efficiency. The

schizoid personality tends to respond more intensely, to get closer emotionally, to others than he is able to tolerate.

An essentially "passive" procedure should be used during the first few consultations.* From one to four of these *preparatory* visits should be had with the patient. During these visits nothing should be attempted beyond the establishment of a mild rapport. If the patient divulges intimate thoughts and feelings in an outburst of confidence, as occasionally happens, the therapist should offer no interpretations or analysis of this material at this time. Rather, he should pass over it lightly, perhaps remarking that such mental preoccupations are of wide occurrence. If the patient is reluctant to talk or refuses to do so, he should not be pressed. If the therapist finds it necessary to do most of the talking himself, he should confine his remarks to impersonal topics with only an occasional question, and this never concerning some intimate aspect of the patient's life. If the patient appears perplexed or impatient with these seemingly purposeless talks, he should be told that it takes time for two persons to become acquainted and that one of the best ways to do so is to converse about matters in which all intelligent individuals are interested.

There are two purposes in these preparatory visits. First, the therapist needs time to get acquainted with his patient, a patient who may tax his understanding to the utmost, and to arrive at an inference regarding the nature of the patient's more serious conflicts. A patient of this type needs time to come to feel that his therapist is not a threat to his already disturbed emotional integrity. A serious mistake will be made if the therapist uses these preliminary visits to try to lead up gradually to the patient's emotional problems. Actually, it is impossible to approach the inner conflict of an early or incipient schizophrenic patient gradually. If such an attempt is made, the patient will be sure to sense the "direction of the wind" and will make a further *affective* withdrawal. The therapist will then have lost his opportunity to help the patient.

The *approach to the patient's subjective problems must be made suddenly*, but with quiet determination and perseverance. *This step*

* See also the writer's articles: "Psychic Shock Treatment For Early Schizophrenia" and "The Treatment of an Early Case of Schizophrenia by the Psychic Shock Method." *Am. J. Orthopsychiat.*, Vol. XIV, No. 2, April, 1944, and Vol. XV, No. 2, April 1945.

is the most critical of the entire procedure. On its success or failure largely depends the success or failure of the treatment. If the therapist has no definite idea of the exact character of the patient's complexes, it is safest to assume the existence of a nuclear complex of a sexual nature in a broad sense. The writer has never worked with a schizophrenic patient who did not have such a complex.

At the very beginning of this visit, the first to follow the preparatory visits, the patient should be told that up to a certain point the causes of his nervousness or troubles are understood. He should then be assured in the most firm and convincing manner that during childhood he had thoughts, feelings, or experiences of a sexual character which produced a lasting effect on him. He should then be ordered to recall and relate these matters.

If the patient recoils from this sudden and blunt approach, or if he seeks to end the visit, the therapist may be fairly certain that he is on the right path. In any case he must not relax in his determination and perseverance. If the patient at first refuses to answer or denies early sexual interests or experiences, there is no choice but to ignore the silence or denials and to resort to direct questions. Any method from persuasion to commands—but never threats—may be employed. If there was a drinking father or uncle or older sibling in the home when the patient was small, careful inquiries should be made concerning the actions of such person when drinking. If sleeping quarters were crowded, this fact suggests a line for questioning. Silence or inability to remember can sometimes be favorably affected by a simple question as to how and when the patient learned the facts of sex and reproduction.

If prolonged questioning fails to gain responses from the patient and to elicit relevant material, there is nothing left to do but go into a frank and lucid discussion of the whole field of human sexuality. Sex should be discussed in its natural, biological aspects in particular. With many schizophrenic patients, sex is a very narrow and overpersonalized issue. The patient's feelings and attitudes toward sex are in need of being "depersonalized." This can be done only if sex is portrayed in its broad, universal, and racial significance.

The discussion should include the frequency and variety of sexual interests and experiences in childhood. The point should be emphasized that thousands of persons develop nervous disorders, or otherwise become maladjusted, simply because they failed to ac-

quire a comprehensive and workable understanding of sexual facts in early life. And, in the case of the unmarried patient, the complete normality of conscious sexual thoughts, feelings, and desires should be stressed. The schizoid personality frequently turns his back on all matters of a sexual nature, having failed to bring into harmony the physical and emotional (spiritual) aspects. Finally, the matter of masturbation should be mentioned, with emphasis on its almost universal occurrence. The therapist should not be afraid of shocking the patient. In fact, the patient *needs to be shocked* out of his introverted and regressive rut.

This visit should be prolonged, if necessary, till every possible effort has been made to uncover early sexual interests and activities. Whatever is brought to light should be thoroughly discussed, with the patient's recounting every detail that he can recall. A single experience, or perhaps only some early interest in sex or curiosity about the matter, may be obtainable. But even this may be sufficient for the immediate purpose. However trivial it may appear, it should be discussed fully, particularly in relation to the situational background in which it occurred.

Although this visit may drag out for two hours or more, it should be continued if possible till the patient is again in as good rapport with the therapist as at the beginning of the visit, assuming considerable resistance has been aroused during the consultation. If the nuclear complex or latent interest, with which the regressive preoccupation has been concerned, has been brought to light, the patient will give unmistakable signs of this in his more relaxed and less withdrawn manner. On the other hand, as long as there is no evidence of any inner change of a favorable kind, the questioning, probing, and discussion of sexual matters should be continued. Although the writer has never had occasion to prolong this particular visit beyond about two hours, theoretically four or six or eight hours might be required with some patients, patients who are not entirely inaccessible but who appear to be incapable of cooperating to begin with.

If the therapist is essentially successful during the visit under discussion, at least a good part of the regressive excitations will be checked and reversed in direction. This inner change in the patient will be clearly manifest during the succeeding visits. There will be an immediate decrease in the severity and/or variety of the symp-

tomatic content. The symptoms may disappear completely within a few days. The overcharged interest or emotional problem (load) which precipitated psychotic reactions will tend to become re-enhanced. A very strong transference may develop rapidly.

In most cases the next two or three visits should be devoted mainly to re-examinations and discussions of childhood, erotic (including narcissistic) interests and attitudes. This will tend to ensure against a repetition of the tendency to regressive preoccupations. Hypothetically, the regression in the first place is in part due to the "pull" of the complexes or latent interests. With the dissolving of these, adult patterns of response regain their lost priority.

Next, the therapist should work rapidly to bring about a diminution of the overcharged interest or the significance of the emotional problem. Thus, if the patient is a mother who became emotionally overinvested in her children, she should now be required to discuss her children freely and to take a more objective attitude towards them in doing so. Here, again, the therapist may need to be extremely firm and persevering. The patient must be induced to give up a part of her emotional investment. She can succeed in doing this only if her children, or whatever the fact or object of her excessive interest is, is altered within her own feelings and rational perspectives. In case the fact of excessive interest is children, for instance, the patient must be helped to accept and tolerate the idea that her children are actually endowed with no more importance or significance than millions of other children. She must be helped to realize that her overinvestment in them is in part an expression of her own narcissism (self-interest),* operating by means of an over-identification of herself with them. Finally, the therapist should emphasize the fact that an *overinvestment* of attention to a fact is detrimental not only to the person who overinvests but to the fact as well, wherein, of course, the fact is another person or persons.

When the treatment has progressed to the place where there is no longer any recurrence of symptoms and the points discussed so far have been thoroughly dealt with, the patient can usually be in-

* Whether this is actually true or not makes little difference since the therapeutic purpose is to divert a part of her affective energy from her children to other matters. The fact of her psychosis has shown that she is incapable of tolerating the concentration of interest or concern that has existed.

duced to extend his scope of activities. This matter can be handled in connection with teaching the patient the necessity of maintaining a comfortable and workable emotional distance between himself and other persons, family members in particular. These two matters naturally dovetail inasmuch as the greater the number of interests a person has, the less strong or intense any one of them is. In this connection it is well to give thought to C. G. Jung's lucid discourses on the mind as a closed energic system. The mother who has been too engrossed in her children needs more outside interests and activities; the man who has been too absorbed by his work needs a hobby or a change of work; the youth who became disturbed as a result of an infatuation with a member of the opposite sex needs to associate with a number of persons of opposite sex.

The transference relationship often becomes very strong and unwieldy with schizophrenic patients. The patient tends to become helplessly and painfully fixated on the therapist. This in turn conduces to a *new* regressive trend and the reappearance of symptoms. The symptoms may be distinctly different from those which existed originally, more fleeting or unstable and related in one way or another to the therapist.

In managing the transference of a schizophrenic patient the therapist must firmly and steadfastly practice what he preaches. In other words he must rigidly maintain a considerable emotional distance between himself and the patient. As the patient "approaches" he must "withdraw" accordingly. Merely friendly gestures or expressions which would be wholly innocuous with a psychoneurotic patient or even possess some slight positive value might immediately become loaded with an alarming import for the schizophrenic patient.

If the therapist can succeed in keeping the transference at a fairly even intensity, just within the patient's limits of affective tolerance, for a period of several weeks, the patient will acquire added ability to tolerate (endure) emotional tensions. And there is nothing the schizoid personality needs as much as more ability of this type. If on the other hand, the transference becomes so strong that new symptoms begin to appear, the therapist should bluntly and minutely analyze the transference feelings immediately. In connection with doing this it may be necessary to minimize the patient's emotional investment in the therapist, even to ridicule it

mildly. As a part of the patient's interest in the therapist is withdrawn, efforts should be made to direct this to semipersonal ends, such as, for instance, gaining a fuller understanding of the wide variety and significance of human attachments. Usually, one may begin to introduce active therapy at this point. This should follow the principle of having the patient extend the range of his activities and interests.

The last part of the treatment properly consists of such educative and re-educative procedures as are indicated.

Following the first few weeks of treatment, three visits weekly, properly spaced, is the best schedule for most patients. Later, the visits may be reduced to one or two each week. The complete course of treatment can ordinarily be concluded in from four to ten months with a patient of good intelligence.

TREATMENT OF A CASE OF EARLY SCHIZOPHRENIA*

An unmarried woman in her early thirties consulted me about her brother, Harold E. On the previous day Harold had left his place of work in the middle of the afternoon and without a word to anyone had gone home. On arriving there he had taken a pair of his trousers and cut the legs off above the knees. He then scalloped the abbreviated legs of the trousers. After fully undressing he put on the trousers and went to bed. He refused to talk to any member of his family or to eat. The family became very much alarmed and upset.

Inasmuch as Harold had remained quiet, showing no signs of restlessness or inclinations to violence, I decided to get as much information from the sister then and there as I could. Harold was the youngest of a family of four, and at this time had just passed twenty. A brother, eldest of the four, was married and living in another part of the state. Neither sister was married. The elder of the two, my informant, was employed by a business concern and lived at home. The other sister who was five years Harold's senior was employed in a

* In giving this case and those in the succeeding chapters, I necessarily do so in a very sketchy manner. The main purpose is to bring out only such points as may be of particular interest or significance to the reader.

The first person is used because it seems more effective in the presentation of this kind of material.

distant town. The parents were both living. They were in their middle fifties.

All members of the family were reported to be in good physical health and none had ever suffered from a prolonged or serious illness, except that both parents were more or less neurotic at times. The parents were poorly educated. Harold and his siblings had completed high school.

Till the two girls began contributing, the family had always been in very poor economic circumstances. Both parents were socially maladjusted to an extreme. These two facts had combined to create a most inadequate and unwholesome childhood environment for Harold and his siblings. They had never had playmates at their home and but few friends of any kind. The mother had been a lifelong chronic complainer and hypersensitive to her poor social-economic status. She was afflicted with strong perfectionist strivings. Her attitudes and constant complaining had instilled strong feelings of personal and social inferiority in all of her children. Harold's brother and sisters had partly compensated for these feelings through the development of markedly aggressive tendencies (overreactions). Harold had not. Early in his married life, Harold's father developed neurasthenic complaints, perhaps largely as a defense against his wife's complaining and emotional outbursts.

My informant stated that Harold's health had always been good. He had always been very shy and retiring socially. She could not recall his ever having had friends of either sex visit him at home and believed he had never had a single date with a girl.

After finishing high school he had worked here and there, never holding a job very long. He spent his Sundays fishing, usually alone, and much time caring for a small aquarium of tropical fish which he had at home. At the time of his mental disturbance he was employed at a lunch counter and soda fountain, which position he had held for several months. My informant declared that he was well liked by his employer. She believed he was generally liked but that his company was not sought by others because of his extreme shyness and social inadequacies.

She knew of no unusual experiences which Harold had had and informed me that this was the first time he had ever behaved in a peculiar manner. She knew nothing of his personal ambitions, if he had any. She had always thought of him as well adjusted within his

limited sphere of activities and interests. She had assumed that he was not really interested in girls and that he was not strongly motivated in any direction. He was invariably pleasant and agreeable albeit in a shy and diffident manner.

With the onset of the psychic disturbance, Harold had isolated himself as completely as possible and had seemingly lost interest in everything. My informant stated that he simply lay in bed, apparently in a deep preoccupation or partial stupor, giving no attention whatever to his surroundings. I instructed her to tell her parents to leave the patient entirely alone, and made arrangements to visit him later the same day.

When I visited Harold's home, the house was as quiet as a morgue. His parents had taken my instructions almost too literally. They moved about with extreme caution as if they feared a slight sound might prove disastrous to the patient. Such was decidedly not the best atmosphere. They were told to go about their affairs exactly as if there were nothing seriously wrong; that they were to talk in a normal tone of voice, not in whispers, but to avoid discussing the patient. Above all else they were not to hover about the patient or to talk to him unless he showed an inclination to talk. In case the patient did talk, they were not to discuss his personal problems with him under any circumstance. Inasmuch as I had already learned from the sister that it would be all but impossible financially to have Harold removed from the family circle for treatment, these instructions were emphasized. The parents were told that everything might depend upon their compliance.

As I entered Harold's room he glanced up and smiled in a childish, embarrassed manner. I asked in a casual, offhand way if he were ill. He mumbled, "No, I guess not." I explained that his family felt he was not feeling very well and had asked me to call. He made no comment. I remarked briefly on the frequency of human ailments. I then mentioned, still casually, that young people seem to have more problems than their parents and grandparents did because of the increasing complexity of society. I then inquired lightly if he was worrying about something. Again he mumbled, "No, I guess not." I asked if he had any aches or pains. I received the same answer.

Harold had not looked at me except for the brief glance when I first entered his room. He appeared lost in some deep preoccupation. He was obviously disinclined to engage in conversation. I suggested

that he might feel like coming to my office the following morning for a talk, saying that if he wanted to accompany his sister on her way to work she would be able to show him the location of my office. Then remarking that I saw no indication of anything terribly wrong, I left him. I had not been in his room more than ten minutes.

Harold came to my office with his sister the next morning without need of persuasion. He accepted the proffered chair and smiled in a self-conscious manner. During this and the next visit he often smiled for no apparent reason. Most of the time he kept his eyes on the floor. But despite his seeming preoccupation he gave some evidence of listening to what I said.

For the most part he readily answered the rather impersonal questions which I asked but always with "Yes, I guess so" or "No, I guess not." At times he appeared puzzled or confused, glancing about the room in a perplexed way.

I ignored his mannerisms and peculiarities and, assuming the attitude of a person who likes to talk even though his listener is not very attentive, I launched into an hour-long discussion of various topics. I talked of education, sociology, psychology, and anthropology, holding throughout to the matter of differences, as opposed to similarities. I emphasized in particular the differences among human beings in all conceivable respects. I pointed out that personalities differ; that one person has one kind of problem, another a different kind; that one person likes group activities whereas another does not; that the appropriate pattern of life for one person could never possibly fit the needs of any other person.

When Harold came in the following day for his second visit, I continued to talk along impersonal lines. Most of my talk was about the biological and physiological aspects of sex. I stressed the fact that any individual is only one half of a biological unit and is therefore naturally drawn toward a member of the opposite sex. I tried to present sex as the most *impersonal* of all meanings in human life, as merely a concession of the individual to the race.

At the end of this visit I decided to make an energetic effort to arrive at the cause of my patient's preoccupation, to get at the nature of the complexes which had induced him to cut off his trousers and isolate himself from reality. Before doing this I gathered two additional bits of information. By visiting the lunch counter where Harold had been working, I observed that the place catered chiefly

to unmarried working girls and youngish women and that only young men were employed behind the counter. An incessant flow of flirtatious banter across the counter appeared to be an inherent characteristic of the place. When I imagined the very handsome but shy and inarticulate Harold as a daily recipient of the undisguised overtures of the female patrons, there seemed little question but what he had become overstimulated. He had become overstimulated but was incapable of doing anything about it, except to withdraw from the situation and repress his overcharged feelings.

The other bit of information was obtained from Harold's sister during a further discussion of his case. She recalled that between infancy and the age of six or seven Harold shared a bed with his younger sister, the sister who was five years his senior. Although she knew of no traumatic experiences which might have resulted from this arrangement, the fact itself was loaded with possibilities.

On his third visit to my office I immediately took up the matter of my patient's personal problems. I said to him, "Now that we have become fairly well acquainted with each other, Harold, I want to know what is worrying you." He appeared startled for a moment, then dropping his glance to the floor, mumbled, "Oh, nothing, I guess."

"But I know there is," I insisted, "and so do you. Your behavior has not been normal for the past few days. Come on now, let's go straight into the matter and figure out what the trouble is."

"Nothing, I guess."

"I know better," I replied. "One doesn't walk away from his work without a word to anyone and go home and go to bed and refuse to talk and refuse to eat unless something is wrong. I want to know what's wrong. What is it?"

Harold remained silent, looking at the floor. Not wishing to give him time to become more resistive, I immediately broached what I believed to be his subjective problem. "Harold, your worry or trouble or distress or problem or whatever one might call it has to do with girls or sex, doesn't it?" I made the question broad in the hope of forcing an affirmative reply. After a prolonged pause, Harold muttered, "Yes, I guess so."

"Fine!" I exclaimed. "Now we are beginning to get somewhere. Don't be afraid of these matters. Let's go right into them and see just what is wrong. The only way to overcome a difficulty is to face

it frankly and try to understand it. Now tell me exactly what is bothering you."

"Oh, I don't know."

Further questioning and probing elicited nothing more. I, therefore, proceeded to discuss sex and sexual relationships frankly and concisely. I emphasized such facts as: the existence and continuation of the race depends on the sexual act; sexual thoughts and interests are a natural and normal part of the mental content of every man and woman; sexual problems are very common to the lives of both sexes; as a result of childhood influences many persons acquire distorted ideas and feelings about sexual matters; since incest taboos demand that we rule out or renounce sexual interests in parents and siblings, there is often a tendency to rule them out in relation to all other persons as well; every adult should fully understand the facts of sex, for only then is he in a position to manage his sexual thoughts and desires in an adjustive manner; that the sexual structure of the two sexes is homologous, the differences being matters, primarily, of differences in development; and, finally, complete frankness with oneself concerning all thoughts and feelings whatever is the cornerstone of mental health and emotional stability. In discussing the sexual structure of the two sexes I mentioned the various organs and their functions and gave both the scientific and the more common vulgar names of each.

I had talked for more than an hour. Harold appeared to be a little less disturbed but still resistive. He had glanced up at me occasionally while I was talking, chiefly when I was mentioning matters of sexual structure. I was afraid to dismiss him for I was certain I would never be able to get into rapport with him again if I did. I had not yet succeeded in obtaining any sort of concrete expression from him concerning the cause or nature of his disturbance. There was nothing to do but resort to more questioning.

I asked if he was interested in some particular girl. He shook his head. I asked if he had been mistreated by some girl, if some girl had been rushing him, if he had offended some girl and was worrying about it, if his mother or sister had been nagging him, if he was worrying about masturbation. . . .

I was asking such questions and receiving shakes of the head when he muttered, "I guess it's me."

"Just what do you mean, it's you?"

"Oh, I don't know."

"You mean there is something wrong with you?"

"I guess so."

"Is it physical or mental?"

"Physical, I guess."

"You mean you have some kind of disease?"

After hesitating Harold replied, "No, not that, I guess."

"Then you mean you are deformed in some way, not made right?"

"Yes, I guess so."

"You really mean, don't you, Harold, that there is something wrong with your sexual organs?"

"Yes."

For the first time since I had met him, Harold gave an unequivocal answer to a question. He looked up at me and appeared relieved at having finally stated the nature of his worry.

Ideas of structural, sexual inadequacies are not uncommon among schizophrenic patients. I was sure Harold's idea was pure delusion. Had any anomaly existed his sister almost certainly would have known about it. To be sure the matter could have been easily checked by an examination but I felt that such would be unwise at the time. It is well to bear in mind that a patient's delusion serves a purpose, that it comprises an anchor for his emotional distress, and that to try to break it down suddenly may have serious results. In the schizophrenic patient, further regression, loss of rapport, and additional symptom-formation may result. The fact to which the belief relates may be minimized somewhat but the validity of the belief should not be refuted; neither need it be overtly accepted by the therapist. "Anything of that sort," I told him, "couldn't very well be of extreme significance. You are perhaps making it out to be much more serious than it really is."

Harold's delusional idea that he was sexually malformed pointed almost conclusively to a history of childhood worry or concern about the same fact or similar facts. That the two siblings nearest to him in age were both sisters and older than he, that he slept with the younger one till he was six or seven and that she was his chief playmate, that his father was shy and retiring while his mother was complaining and self-assertive within the home, all suggested an early home environment which was conducive to his acquiring ideas of personal deficiency, inadequacy, or incompleteness. If such feelings

of personal inadequacy somehow became associated with the matter of sexual structure, he would, then, have developed a complex of sexual inferiority. It seemed more than probable that some such complex was the psychic factor (pattern) which was being reactivated by the regressive movement of his psychic energy. Consciously, there was an idea that he was not made right; subconsciously, there certainly existed the original complex of thoughts and feelings which now engendered the conscious idea. The next step, therefore, was to bring this complex into consciousness, that is, induce or force the patient to recall the original disturbing elements.

But the session had been long and tiring and inasmuch as Harold appeared to be somewhat relieved and less intensely preoccupied, I made a few remarks about variations in sexual structure among persons of the same sex and dismissed him till the following day. I thereby made a mistake. He went directly home and to bed, again having no word for anyone and refusing to eat. He remained in such a condition for the next two days, ignoring his sister's requests to come to my office. I thought it best not to visit him yet. I had his sister tell him on the morning of the third day that I had something interesting to tell him. He dressed and came along with her to my office.

I had no intention of delaying matters any longer. I again made an abrupt and determined approach. I told him there was something I wished to tell him but that before doing so there were certain additional facts which I needed to know and that I wanted him to tell me about these facts. I went on to explain that he had certain childhood experiences, thoughts, feelings, worries, and beliefs in relation to sex. I reminded him that till he was six or seven he had slept with his younger sister and suggested that he had had some sexual experiences in connection with that. I directed him to let his thoughts drift back, to try to open his mind to any thought that might come, and to tell me the first idea that came to him.

For a few moments Harold looked at me in a half-perplexed, half-preoccupied way. Then I noticed what appeared to be surprise and fear or apprehension come into his face. He glanced uneasily about the room and then at the floor. He appeared anxious and embarrassed. I was positive some disturbing recollection had come to his mind. I immediately began to *persuade, cajole, demand;* and bit by bit I

secured a fairly complete report of certain childhood experiences and the accompanying emotional reactions.

When Harold was five and six his younger sister repeatedly engaged in sexual play with him. It was hardly play for Harold, however. She rationalized the reason and responsibility for these activities, pretending that she was engaging in them entirely for his pleasure and in return for things of a different sort which he had done for her during the day. She strongly admonished him not to mention these acts to anyone. He recalled that he had felt inadequate, could not remember having derived any pleasure from the activities, and was fairly certain that his sister had expressed disappointment and dissatisfaction with him. (His sister, incidentally, had been large for her age whereas he had been small for his.) He further recalled that after he stopped sleeping with his sister, her manner toward him appeared to undergo a marked change. She seemed to avoid the slightest physical contact with him of any kind.

Harold was noticeably distressed during this visit. I attributed this in part to a feeling that he was betraying confidences but still more to the recollection of facts which had been very disturbing and confusing to him as a child. I discussed both of these points in detail. I encouraged him to try to take a more objective attitude toward these childish matters. I had him recall all of the details possible: the position of the furniture in the bedroom, the location of doors and windows, what his sister had said, what his exact feelings had been, the exact character and extent of the sexual acts, etc.

When I dismissed him at the end of this visit I was confident his nuclear complex had been brought to light. He seemed to be in better contact with his surroundings and in satisfactory rapport.

Harold sent word by his sister the next day that he was not feeling well and would not come to the office. On the following morning he came by himself and of his own accord. The change in his appearance was almost startling. He was carefully groomed, his smile was frank and friendly and, although his manner was quiet and reserved, he appeared at ease and in normal contact with his surroundings. His stilted awkwardness, his morbid preoccupation, his silly smile, his guarded attitude, and evasiveness were gone. His first remark was to ask how much money he owed for his visits. He went on to say that he would like to continue but wished to know what the treatment would cost.

From then on he made rapid and steady progress toward a satisfactory adjustment. His past experiences, feelings, and attitudes were thoroughly analyzed as were also those of his present life. At the end of three months of three one-hour visits weekly, Harold and I decided that he should try to secure some college training despite his lack of funds at the time. His intelligence quotient of 112 was not so high but I had discovered plenty of dormant ambition. He went to work at once in his brother's business which was near the college he planned to attend.

During the two years following the course of therapy, Harold came to me at irregular intervals for a total of eight or ten visits. These were made in connection with problems of social and sexual adjustment and our discussions were along the line of educative therapy.

With the outbreak of the last war, Harold left college and enlisted in the Marine Corps. He saw active duty in several major engagements in the Pacific and attained the highest enlisted grade possible well in advance of his separation from the service with the cessation of hostilities. At the time of this writing he is married and the father of two children. Although quiet and reserved and not given to making public speeches, he is a friendly and substantial member of his community. I had the pleasure of dining at his home a year ago. There has been no recurrence of maladjustive or psychotic reactions during the eleven years since his treatment.

Harold had grown up under the influence of older and aggressive sisters, a frustrated and exacting mother, an essentially negative father, and a much older brother, who, incidentally, left the family home soon after Harold's birth. Accordingly, as a child he had very little opportunity to achieve helpful and supporting identifications with members of his own sex or in any other way to acquire feelings of equality and competence in his relations to the opposite sex. He arrived at adulthood with deeply rooted feelings of personal inadequacy toward girls, particularly in respect to any physically intimate relationship with them. That these feelings largely resulted from his early sexual experiences with his younger sister can hardly be questioned.

These early sexual experiences were not entirely negative in value, however, for Harold. In the first place, he had always been fond of

this sister and all in all she had been protective and motherly toward him. Thus, he had always felt unafraid and secure in her presence. In the second place, although he was unable to recall the fact, one may assume that he was more or less erotically stimulated by his sister's efforts to obtain gratification through using him as her sexual partner. Bearing these various points in mind, one may surmise that Harold's early sexual complex was compounded of at least the following elements: erotic sensations and feelings, feelings of personal inadequacy, mild feelings of guilt along with feelings of security while with his sister, feelings of loyalty and affection for his sister, and some sort of uncertainty, confusion, or perplexity concerning the whole matter of these relations and activities.

Upon having his masculinity challenged and his erotic tendencies aroused by the remarks and actions of the young women in his place of work, Harold was suddenly in a dilemma. His deep feelings of inadequacy precluded any positive and forward line of response, implicit or overt. His erotic excitations were accordingly diverted, assumed a regressive direction and reactivated the childhood patterns. This brought forth his old ideas of physical inadequacy, appearing in consciousness as a conviction (delusion) that he was sexually incomplete or malformed. The protection and security associated with his early sexual acts perhaps strongly conduced to the regressive flow of libido.

The act of cutting off the legs of his pants was expressive of his flight from the psychosexual problems of adult life and his inclination to return to the irresponsibilities of the small boy in short pants. Scalloping the shortened legs of the trousers was perhaps indicative of a vague longing for the protective sister with her ruffled dress or scalloped panties.

CHAPTER 3

Manic-Depressive Reactions

MANIC-DEPRESSIVE REACTIONS have long held second place in frequency among the psychotic categories. Although spontaneous recoveries are common during the early history of the disorder, it assumes an added seriousness due to the tendency to recurrence of attacks. Moreover, with each succeeding attack or episode, the disturbance tends to last longer and to be more severe and the remissions to be shorter. Many cases become chronic after a time and incurable.

If used during the milder phases or during periods of remission, psychotherapy holds much promise as a method of treatment. There is ample clinical evidence that its proper use will prevent future recurrences of the disorder in many cases.

The manic-depressive patient rarely seeks professional help of his own accord. If he is in a manic phase, he does not feel the need of help; if he is in a depressed phase, he lacks the initiative and self-concern to seek help; during a normal phase, following one or several attacks, he is almost certain to believe that he will never suffer another attack under any circumstances.

There is little danger of the patient's talking too much or of the therapist's talking too much during the initial visits. Some care should be taken, however, to keep one's remarks within the range of talk set by the patient. No effort as such should be made to cheer the depressed patient or to temper the elated patient. Such efforts have a tendency to aggravate rather than decrease the mood.

Manic-depressive reactions are fundamentally affective reactions, either of elation and exaggerated feelings of self-sufficiency (mania) or of despondency and marked feelings of self-negation (depression).

One patient may manifest one of these moods, another patient the other, or the two moods may alternate in the same patient.

Except in certain atypical cases, *the patient's other symptoms are strictly in keeping with the character and intensity of his mood, his affectivity*. If his mood is one of marked elation, he will not attend closely to what is said or look carefully at what is before him (distractability, inattention), and this will result in inaccurate impressions (imperception). This in turn results in his inability a few minutes later to recall what he heard or saw (anterograde amnesia). His extreme elation and positive self-feeling lead to abnormally exaggerated ideas of his own importance (delusions), resulting further in faulty estimates of his true relationship to his surroundings and to other persons (impaired judgment). Typically, he is overtalkative and overactive (psychomotor acceleration). He is very assertive and wants to dominate the situation and be the center of attention. He becomes impatient, may become violent, if he is crossed or thwarted. He wants to reform his community or he is going to write the American masterpiece or whip Joe Louis. If the patient is a woman, most of her talk is about sex. Her manner is flirtatious or even bold and inviting. She dances, laughs, sings, and exposes herself without concern. And along with this elation or gaiety, in either sex, one may occasionally glimpse a dark despondency underneath.

If the patient is of the depressed type, an opposite picture prevails in all fundamental respects. Attention is hard to arouse; speech and movement are slow and labored. The patient condemns himself as worthless and sees his future as hopeless and empty. He is submissive, or simply indifferent to his surroundings. If his despondency is deep, he usually harbors delusional ideas of his own impending death. And, occasionally, one may catch short flashes of hope or elation breaking through the despondency.

There is little or no danger in giving psychological tests to the manic-depressive patient early in the treatment. If the mood is not too pronounced, there may be something to be gained, in fact, by doing so. Since the manic patient is certain not to do as well as he thinks he should, the results of his tests, particularly intelligence tests, sometimes have a deflating effect on his overworked egoistic propensities.

Psychologically viewed, any given instance of manic-depressive psychosis is essentially one of two ways of reacting to inner and outer difficulties: either the patient takes flight from certain subjective and environmental problems into an imaginary ascendancy or superiority to all problems (manic phase), or he becomes whipped and helpless and succumbs to his problems (depressed phase). Why one patient reacts one way while another reacts the other way, or why the same patient reacts in one way one time and in the other way another time, are among the many questions concerning the psychoses awaiting further study.

The subjective cause or problem which leads to manic-depressive reactions, the writer believes, is essentially the same in every case. *During the early years of his life the patient effected or brought about an intolerably restricted range of thought and feeling concerning such basic matters as sex, religion, morality, and personal ambition.* Whether this results from early environmental influences in the main, or whether it is chiefly due to some innate peculiarity of psychic make-up, the writer is willing to leave to others. From the standpoint of psychotherapy it is more important to understand the nature and implications of this restricted range of mental activity than to know its origin. The pre-manic-depressive person is life's most genuine conservative. He thinks "darn" when he should think "damn," she thinks "marriage" when she should think "sex," he thinks "ambition" when he should think "egoism," and when he is inclined to think "hate" he thinks "dislike" instead.

Although this extreme and rigid restriction of mental freedom in the pre-manic-depressive or cyclothymic personality is self-imposed, it is not felt to be such by the person himself. Whereas it constitutes a strict obedience to exacting personal ideals, to the person himself it is essentially nothing more or less than a normal compliance with the demands of *objective* reality. This fact naturally and inevitably results from the normally extroverted orientation of the cyclothymic personality. He is totally unaware that his range of thought and feeling is unduly restricted or foreshortened. He is oblivious of the crying need which he has for a more extended range. He is like the lady of a past day who never questioned the wisdom or sanity of binding her waist to near the vanishing point.

It seems hardly necessary to point out the psychic strain, the

inner frustration, which a markedly restricted range imposes. Mentally, the human individual functions normally and efficiently, to the extent of his actual endowments, only when functioning freely and as an entirety. To think and feel only within an abbreviated range would be comparable, it seems, to doing the same physically, that is, to making only half movements instead of complete movements: to taking half steps instead of full steps, to lifting one's arm but half way when the inclination or need was to lift it all the way. To be restricted to stilted, half movements physically would sooner or later create an unbearable need for a good full-bodied stretch. A manic-depressive manic episode, whatever else, is certainly a good emotional stretch.

The subjective and basic cause of manic-depressive psychosis, then, is an *unwitting, self-effected confinement or restriction of the range or scope of conscious mental activity to a dangerous and often unsupportable degree.* The precipitating cause may be any event or change which vigorously conduces to a marked extension of the established conscious range. Sudden and unexpected success or good fortune may have this effect. More commonly, however, the exciting cause consists of a frustrating occurrence.

The natural way of reacting in the face of frustration is to put forth greater effort. This in turn tends to call into play the total response capacities of the individual. His perceiving, thinking, feeling, and particularly his imaginative tendencies become strongly stimulated. As this occurs, his narrow barriers are disrupted (in the case of the manic episode) and consciousness is invaded by a host of thoughts and impulses which are so radical and foreign to his old and accepted mental processes that the two cannot possibly blend or become integrated. The pathways of the old are usurped by the new, resulting in a manic symptomatology.

The steps leading to a depressive episode are different in one essential respect. Strong resistance is alerted by the threat of the powerfully activated tendencies which lie beyond the established range; that is, such tendencies as, when erupting into consciousness, comprise the mental content of a manic attack. The intense resistance leads to a still further narrowing of the range. In fact, this range now becomes restricted to a pathological degree and maintained by an incessant self-bombardment with thoughts of sinfulness, worthlessness, and futility. The woman patient, for instance,

who harbors ideas of sexual sins in the past and who heaps abuse and condemnation on her own head, is thereby blocking or holding in subjugation underlying tendencies to entertain positive and, from the standpoint of her narrow personal ideals, insufferably objectionable sexual propensities. This reversal and still further negation of natural interests and impulses inevitably accentuate her depression and sense of helplessness through the intensification of the inner frustration. In her dilemma and the darkness of her utter lack of self-understanding, suicide may seem to be the only answer.

Brief reference to a few illustrative cases may help to clarify some of the points which have been mentioned. Upon returning from the funeral of her grandmother, a young married woman was sharply criticized by her husband for using the money necessary for the trip. She was tired, she had questioned the propriety of using the money herself, her husband's criticism aggravated her already existing tendency to self-criticism, she was unable to tolerate the idea that she had behaved improperly; her restricted thought and feeling range was inadequate to a satisfactory resolution of her emotional disturbance. She developed a manic psychosis during which she declared her husband could go to hell, jump in a deep lake, and many worse things. Had she possessed more affective tolerance in the first place she could have "blown off" the necessary amount of "steam" and avoided going to a hospital. A young woman's fiancé left for a foreign country in connection with his work to be gone for two years. At the end of that time he was to return and they were to be married. She tended very strongly to feel that he should marry her at the time and take her with him. She would not or could not frankly and consciously entertain such a thought, however, much less express it. She held herself rigidly—without realizing it, of course—to complete loyalty to his wishes. But her frustration and disappointment were more than she could withstand. She developed a manic psychosis and became very destructive.

As pointed out before, even the personal ideals of the cyclothymic personality exist more as something out in space, in accordance with which he seeks to live, rather than as something within and of his own creation. This fact explains certain peculiarities about him. He is deplorably ignorant and unanalytical of his own affective needs. He is unaware of the rejected and more potent range of his affective capacities. He has a far wider tolerance for the thoughts and feelings

and interests of other persons than for his own. In his normal state a certain young man was a model of modesty and conventional conservatism. When he went into a manic psychosis he had whipped Joe Louis, he was going to make a million dollars shortly, he was, in brief, the most capable and unusual young man in existence. No effort of the imagination is required to discern the sharp discrepancy within his total mental make-up which such a person presents. And, from a strict psychological view, he is only slightly more normal (for him) in his normal state than in his manic state.

A certain woman in her early thirties, unmarried, has had a number of manic attacks. She loses all modesty and is completely dominated by her sexual interests. In her normal state she is almost painfully modest, unselfish, self-effacing, and much interested in religion and art. Even the word "sex," although spoken by a doctor and in private consultation, brings a slow blush to her face. Her rigid, narrow personal ideals preclude any thoughts about sex till such time as she may be properly married and then, of course, only in connection with her husband.

The specific aims of the therapy with the manic-depressive patient should include the following: In order to render the patient stable and capable of dealing with his affective problems, it is necessary that his conscious and accepted range of mental activity be greatly extended; in order to accomplish this, his insight or self-understanding must be increased, and his affective tolerance must be increased. The whole procedure with this type of patient is essentially a matter of educative and re-educative therapy. Ordinarily, he has few or no complexes, quirks, distorted or perverted tendencies, and the like to be exposed and resolved.

The manic-depressive patient must be taught to the end of becoming more discerning and analytical of his own subjective processes. He has to achieve a greater introspective capacity. Usually, he conforms all too easily to the mental picture he has of himself, albeit this picture belongs, as it were, to objective reality. A youngish married woman who was treated by the writer during a moderately severe manic phase had never smoked a cigarette or drunk a cocktail prior to her treatment. The significant point was not that she had never done these things; rather, it was the fact that she had never *thought* of doing these things. They simply did not belong to her

narrowed conception of *her* pattern of life. Therefore, she had never even *thought* of doing them.

The patient must be gradually brought to accept the fact that to think freely and to feel freely are basic to stability and adjustment. He needs to be fully informed of the natural scope and extent of mental processes. He is a victim of the medieval notion that unkind thoughts and selfish desires are reprehensible and degrading. He must be helped to erect a sharp line of demarcation between implicit activity, on the one hand, and overt action, on the other, instead of identifying the former with the latter. Actions have to be regulated and controlled; thoughts, feelings, and desires should be freely entertained and examined. They often belong to the many imperfections of the human being. Ruling them out or suppressing them does not actually change one's basic character but it does conduce to mental illness or instability. The patient must be made to realize that it is far better to be an ordinary man or woman with health and efficiency than it is to be a sick saint consciously and a sinner "extraconsciously."

Affective tolerance can be rapidly increased in this type of patient if he can be brought to accept complete self-frankness as a personal ideal. The goal of seeing and understanding everything about oneself is infinitely superior to that of seeing and admitting only that which is commendable. Time and effort alone are required to convince any intelligent patient of this fact.

With an appreciable increase in insight and affective tolerance, the directive therapy which has been employed can be carried further. Nondirective therapy or classical psychoanalytic procedure might well never be productive of positive results with the manic-depressive patient. The patient will not go beyond his narrow range of thought and feeling of his own accord, assuming he is being treated during a fairly normal period. He must be gradually but firmly pushed beyond this range. He has to be urged to think more freely about such matters as sex, personal aspirations, religion, love, hate, greed, spite, jealousy, etc., etc.

In urging the patient beyond his previous, conservative limits of mental activity, a manic episode may be precipitated or, less likely, a depressed phase. In the case of the former, the treatment should be continued as before unless the patient becomes so maniacal as to render psychotherapy impossible for the time being. In case a de-

pressed phase should ensue, or become definitely more pronounced, the therapist should go back and repeat his earlier educative procedures. Depressive reactions usually indicate that the patient has not yet acquired sufficient insight and affective tolerance to endure the needed extension of his mental range.

Due to the natural psychic flexibility of this type of patient, the transference does not usually present difficulties. It should be utilized to help bring about the necessary greater scope of conscious mental activity. In other words, the therapist uses the influence which the transference relationship gives him to induce the patient to enter more deeply into the self-forbidden realm of thought and desire.

The treatment should be brought to a gradual conclusion. The therapist should make sure that the patient has become irrevocably wedded to his new insight into his affective and dynamic make-up. Also, he should make sure that the patient has fully renounced his former narrow personal ideals and that he has acquired sufficient affective tolerance to meet any thought, feeling, or desire which he might have without undue disturbance.

TREATMENT OF A CASE OF MANIC-DEPRESSIVE PSYCHOSIS*

Ethel A., an unmarried woman of forty, came to see me only after being strongly urged to do so by her physician. She had been discharged approximately a year earlier from a well-known private sanitarium where she had been diagnosed as and treated for a manic-depressive psychosis over a period of three months. She had apparently been fully recovered from her illness at the time of her discharge. She came to me because she feared a relapse.

Ethel's family history was essentially negative in all respects. Her mother was several years deceased; her father was living and in good health except that he was becoming somewhat feeble mentally. She had a brother five years her senior, a sister three years her senior, and a second brother two years her junior, all married. Her siblings were progressive, well-adjusted members of their communities. There had been no serious or prolonged illness in the family, except her mother's

* I give this particular case, not because it was classical but rather because of the atypical features which it presented.

illness and death. The social, economic, and educational levels of the family had always been a high average.

No decided peculiarities of parents or siblings had existed. Her early family life had been congenial but there had been very little demonstration of affection between parents or between parents and children. The family atmosphere had been friendly but never warm. Her parents had always been reserved toward each other and toward their children.

Ethel's own history during childhood and adolescence was also essentially negative. She had enjoyed good health, had been large and robust for her size, and had developed into a large, buxom, well-formed woman. She had had playmates of both sexes but could not recall ever having had any extremely close friends. Following pubescence she had but few associations with the opposite sex. For one of her extroverted orientation, she was unusually shy and reserved.

Her strongest attachments during childhood were to her father and younger brother. Although both had been more or less repressed, neither had been of sufficient strength to constitute a troublesome complex as such. Her attachment to her father was essentially that of obedience to unquestioned authority; that to her brother was primarily maternalistic in character. Both attachments were undoubtedly conducive to her effecting a narrow mental range.

After completing college, Ethel became a high school teacher. She was capable and conscientious in her work and, in as far as I could gather, well liked by her associates, students, and her superiors. She formed fairly close friendships with her feminine colleagues, with one in particular, but remained reserved around men. She did not actively avoid men; apparently she appeared cold and prudish and was therefore left pretty much to herself. She kept in contact with all members of her family, through letters and summer visits, and contributed liberally to her father's support.

Ethel's life continued along conservative and uneventful lines till she was thirty-six. She then became enamored of an aggressive young man who had been one of her students and was several years her junior. Oddly enough (!) after a few months of close but largely surreptitious companionship she entered into a sexual affair with him. This fact is of importance as it largely paved the way for her psychotic disturbance later. But I want to interrupt briefly at this

point my account of the course of events which led to psychotic reactions and to mention other and more specific characteristics of Ethel's affective make-up.

Perhaps largely as a result of the reserved, undemonstrative atmosphere of her childhood home, Ethel had early effected a foreshortening of the range of her natural emotional responsiveness. She had excluded the higher notes, as it were, of the scale of her affective range. She had arrived at and accepted an unworkably narrow concept of the kind of person she should be, of the kind and extent of the conduct which she should permit in herself, of the type of thought and intensity of feeling that were permissible in herself. That she did all of this unwittingly and without reflection, understanding, or insight does not alter the facts. What she actually did, in all probability, was merely to copy and impose upon herself the restricted range of responsiveness which prevailed in her own childhood home. The result was that as a woman she was painfully intolerant of a normal range within herself. Moreover, this restricted range comprised for her her complete self. All capacity for broader, deeper, and fuller responses had been strongly suppressed.

Ethel naturally selected her moral and social values and developed attitudes and thought and feeling habits in accordance with this limited range of mental activity. This meant, to illustrate, that although she could tolerate unselfish feelings in herself, she could not be impulsively generous; although she could tolerate a measure of dislike for a person, hatred must never be felt; although she could overlook small mistakes and slight misdeeds, no significant error or false step must ever be made; although she could permit herself to fall in love, certain rigidly conventional circumstances must pertain. In short, although kind and unselfish toward others in a reserved way, Ethel was a most orthodox and prudish woman concerning herself. She could readily overlook mistakes and weaknesses in others which she would have found utterly abhorrent in herself.

If all this is true, the reader may well ask, how could Ethel ever have entered into an illicit sexual affair? The answer is fairly simple. The aggressiveness of her lover together with the intensity of her own unacknowledged emotions and desires rendered her powerless to do otherwise. She never did condone her actions or attempt to rationalize a justification of them as far as I learned. What she did and tried

to do about the matter will become clear as I go on to sketch my treatment of her.

Ethel was tense and guarded during her first few visits. She seemed determined, however, to make an honest effort to cooperate. She requested that I should not discuss her with members of her family. I readily assured her I would not. She said she was ready to tell me everything she could about herself. Obviously enough, she hoped this would not be necessary.

The first six weeks, three one-hour visits weekly, were devoted to psychological testing, securing a family and personal history and reviewing her psychological development during childhood. I then proceeded to a detailed discussion of her former illness. In connection with this her past romantic affair came to light. She was extremely reluctant to discuss the relationship which had existed between her and her former student. It was only through perseverance and hours of persuasion and reasoning that I induced her to supply the finer details. But Ethel did not appear merely reluctant; often when she was asked some pointed question concerning the relationship, an almost total blocking of her mental processes would occur. She seemed able to recall the more intense moments of her experience with her lover only with the greatest effort. This fact indicated her pressing need of far greater affective tolerance.

After Ethel's romance had lasted nearly three years, her friend moved to another part of the country. They corresponded regularly and he visited her infrequently. Then, quite unexpectedly she learned that he had married. She tried desperately to condone what she tended strongly to feel was utter disloyalty on his part. She tried just as desperately not to feel like a jilted, immoral woman. She flung herself into her work with renewed vigor and determination. But, within two months of her former lover's marriage, Ethel's closest woman friend, a fellow-teacher, died suddenly. This added loss was more than Ethel could bear. She still gamely tried to carry on with her work but strange and disturbing ideas began to assail her. The conviction began to grow that the high school principal had sexual designs on her, despite the fact that he was married, a highly respected man in the community, and much older than she. For a time she fought this ever-recurring conviction but gradually it became so strong she ceased to question it. In addition to this she

thought at times that persons were listening at her door, watching her on the street, and spying on her in general. She became overactive, sleepless, and generally disturbed. When a doctor was called in to see her, she believed he had immoral designs on her. She was taken to a sanitarium. This was approximately three months after the marriage of her former lover.

At the sanitarium Ethel's symptoms became more severe and more varied. At one time she believed she saw her former sweetheart approaching the hospital. This proved to be an illusion, a gross error of perception, not a hallucination. At another time she believed she was to marry her father. At still another, she believed that her father had turned black "like a Negro" and that she and her former lover were on the way to becoming black themselves. She had transient, delusional ideas that lights were being turned on her, that spies had been placed in the hospital to watch her movements, etc. For the first two months there was extreme psychomotor activity and mental disturbance. Early in the third month she began to improve rapidly. She was discharged at the end of the third month.

The reader will observe that Ethel did not run the course of a typical manic-depressive manic episode. There was little or no pure elation or euphoria although there was excessive psychomotor activity. Some of her ideas had a distinct paranoid coloring and she was in an incessant state of acute inner conflict throughout her illness. The reason for this last fact appears simple enough but worth mentioning. The sentiments, attitudes, and ideals in accordance with which Ethel had always sought to think, feel, and conduct herself were too strong to give way completely in the face of the upheaval of her long-suppressed desires for sex, greater personal freedom and self-sufficiency. Therefore, a true elation with feelings of self-sufficiency was rendered impossible and an intense inner conflict was the inevitable result. This conflict brought about a distortion of her mental processes and lent a bizarre aspect to her symptoms. In a more classical case of a manic psychosis the conscious and acceptable range of mental activity becomes submerged and the formerly rejected part of the range holds unobstructed sway. This results in elation, feelings of self-sufficiency, and abandonment to all impulses.

When Ethel first came to me, no pronounced symptoms were in evidence. She complained, nevertheless, that the same thoughts and

feelings which she had during her illness were beginning to appear in shadowy form and with increasing frequency. She was in fear of a second attack of the psychosis and there seemed to be just cause for her concern.

At the end of a couple of months I had completed my study of her personal history, including her love affair and her illness. The origin and character of her mental disturbance appeared fairly clear and understandable. Certain therapeutic objectives were clearly indicated. First, she was badly in need of a considerable extension of her conscious mental range, particularly in relation to sexual matters and personal freedom. It was obvious that she had never brought her affective relationship to her lover into any sort of harmony or even juxtaposition with her consciously accepted interests and ideals. Rather, it had existed essentially as a separate psychic system, utterly incompatible with her accepted way of life. She told me that during their hours together a sort of "fog" seemed to settle about them, shutting everything else out. They never talked of her work, for instance, or her friends or her daily activities. When not with him an entirely different set of interests and feelings prevailed. The two, like oil and water, refused to mix. It was evident, then, that the two must become harmonized and integrated if she were to be stable and adjusted in the future.

An integration of disparate attitudes tends to occur if they are thought about freely and evaluated in relation to each other. When brought together in this way, they have a mutually modifying influence. Accordingly, I had Ethel discuss her past reactions to her lover in detail and repeatedly, and always in the light—which I endeavored to supply—of their universality and psychobiological significance, on the one hand, and the crippling effect of a too narrow perspective on one's justifiable activity, on the other.

In connection with the procedure as just outlined, it was of the greatest importance that Ethel be helped to acquire more affective tolerance, my second objective. Whereas a patient may be able to think freely and to admit various desires, interests, wishes, impulses, etc., into consciousness while in the presence and with the moral support of the therapist, he may abruptly cease doing so the moment he is by himself and on his own. He uses the guidance and insistence of the therapist as an excuse for the mental content that comes to mind.

But genuine affective tolerance always consists of nothing less than one's ability to tolerate any content which comes to mind without recourse to external support, excuse, or rationalization. The quickest and most certain way of increasing affective tolerance, to my knowledge, is not so much by minimizing the reprehensible character of the rejected material, as it becomes fully conscious, but by minimizing the soundness and morality of too lofty personal ideals and aspirations. In other words, in psychoanalytic terms, affective tolerance is increased primarily through reducing the higher and more exacting claims of the Super-ego.

I explained to Ethel that she did not really want to be a wholly correct, perfect, irreproachable person at all times and in all ways. I pointed out to her that she had narrowed the range of her mental functioning to the point of rendering herself unstable and inefficient. I mentioned the mentally restricted, intolerant, self-devoted spinster as an example of too exalted and unworkable personal ideals. I assured her that she really wanted to be only a fairly self-respecting and efficient woman, friendly and generous toward others but never slavish or self-effacing, and reserved or affectionate, depending largely on the circumstances of the moment and her true relationship to those present. I did my best to make her understand and to accept the fact without reservation that all of us must tolerate the slag along with the metal in our personal (subjective) lives if we are to be unencumbered by inner walls and barriers to the freedom of our mental processes. I took the stand that to aspire to personal perfection in general is frustrating and unworkable. I explained that such an aspiration is a striving to be God-like and a denial of one's mortal limitations. And I took care to point out to her that she was a product of millions of years of evolution, that this great period of time has given to each of us an inherent mental constitution, and that to live *reasonably in accordance* with this constitution is a moral obligation of the highest order.

My third objective was to make Ethel more analytical and discerning of her own implicit processes. Thoughts are clearly defined phenomena as compared to feelings and attitudes. These latter are often vague and difficult to express verbally. Moreover, if unwelcome to accepted personal ideals, they may exist with only a marginal degree of consciousness or be entirely subconscious as such. This

is particularly true of persons of extroverted personality. But with effort and practice anyone can become more aware and cognizant of the way in which he actually feels about this or that, of his attitudes, desires, ambitions, aversions. In helping a person to become more self-discerning and analytical, it is necessary to insist continually upon concise and precise verbalizations.

My final objective in the treatment was education and re-education along the lines of natural psychobiological tendencies and dispositions, normal obligations to other persons, one's natural right to frank self-interest, psychosexual differences between men and women, and, in particular, the all-importance of mental freedom and self-honesty to mental health and efficiency. This aspect of the treatment was interspersed, of course, throughout the course of visits.

At the end of about ten weeks a transference was distinctly in evidence. Ethel's old values and standards were still too strong and rigid, however, to let her become frankly interested in a married man. So, she became interested in the man's work. For several weeks she was a mental hygiene enthusiast. She became hypomanic and incessantly active. She talked mental hygiene to her physician, to her relations and friends, and to anyone else who would listen. She saw a crying need of mental hygiene on all sides.

Some of her former symptoms reappeared during this time. She believed that some of the tenants in the apartment building where she lived were spying on her and making noises to keep her awake nights. One day she told me that her house keys and some of her underwear had been stolen. Anyone who is familiar with symbolism in neurotic and psychotic symptoms will readily recognize the sexual implications of these ideas. In resisting the transference, or the stronger sexual motivation which it tended to arouse, she achieved the belief, symbolically expressed, that there could (must) be no such thing in her life as sexual relations—the keys and underwear had vanished. At the same time, of course, the disappearance of the keys and underwear together probably symbolized sexual activity.

I went to Ethel's apartment and made a pretense of searching for the keys. After I had been there a few minutes I asked her abruptly, "Where did you put those keys?" In a purely automatic manner she whirled toward the kitchen door, then immediately turned back

toward me and repeated her statements that the keys had been stolen and that she had looked everywhere for them. I walked into the kitchen and after a few minutes of searching I found the keys on a hook obscured from view. I told her she would perhaps find the missing underwear soon and left.

Although there was strong resistance to the transference, she nevertheless tolerated it to a degree that kept her from reverting to her old interest in her former lover and, though she was living at this time with her father, her mental disturbances never related to him. Occasionally she would miss an appointment with me. Usually she would make up for this by coming to my office two or three times the following day even though I had little or no time to talk to her. I never reprimanded her for missing an appointment, feeling that she was enduring as much affective tension and disturbance as she could. Infrequently she suspected that I was trying to gain an unwholesome influence over her. I assured her that besides liking her as a friend I had no interest in her other than helping her to make a satisfactory adjustment.

Throughout this time I insisted that she try to think with complete freedom and to open her mind to any feelings, desires, or wishes that might appear. I made her discuss all aspects of sex with me and made her go over her experiences with her former lover repeatedly. I used the influence which the transference gave me with her in every way I could to achieve fully the various objectives which have been mentioned.

Toward the end of the fourth month of treatment, Ethel began to grow more calm. The change occurred rapidly and she was soon able to discuss freely any matter whatever, and without apparent resistance or inner disturbance. The treatment was continued to a total of six months. From my standpoint, the last two months were devoted primarily to the end of establishing as firmly as possible the extension of her range of mental activity. For her, these two months consisted of much reiteration of material already gone over and of increasing her knowledge of psychology, sociology, and biology.

She felt that she could never be thoroughly interested in teaching again, so it was decided that she should take up a new vocation. She spent approximately a year in securing the necessary training and has been regularly employed since, that is, during the last nine years. There has been no return of mental disturbance.

Little remains to be added to the interpretation already given of this case provided the reader bears in mind that it was cited as an atypical and not as a typical example of manic-depressive reactions. Although predominantly manic-depressive in character, some of the symptoms had a distinctly paranoid cast.

I should like to mention, incidentally, that Ethel's delusional ideas about her father did not imply, in my judgment, the existence of an Oedipus complex of disturbing strength. Rather, they indicated early ego-identifications with him along moral lines. Even the idea of marrying him was more an expression, I believed, of her efforts to keep his moral teachings alive in her own thoughts than of a desire to gain a sexual partner. Her father, a strict man of German extraction, had always been the mentor and judge of all things moral in her childhood home.

CHAPTER 4

Early Paranoic Trends

BEFORE DISCUSSING early paranoic trends, it is important that the reader know exactly what distinctions the writer is making in the more or less ambiguous and controversial field of paranoic and paranoid trends, reactions, conditions, and psychoses. In respect to the psychoses, he follows the distinctions which have been clearly stated by Strecker and Ebaugh.* In regard to paranoic and paranoid trends, reactions, and conditions, he is employing the term "paranoic" in designation of noticeably exaggerated *suspicions*, *asocial thoughts* and *feelings*, *self-reference*, and *psychic rigidity* in the *absence* of loss of contact with reality, loss of affectivity, and loss of intellectual acuity. He would speak of "paranoid" trends, etc., on the other hand, when the mental content is chiefly paranoic in character but is associated with an *appreciably diminished affective contact with reality*. Paranoid trends are frequently accompanied by other symptomatic tendencies whereas paranoic trends are not. Finally, paranoid ideas are usually more farfetched and bizarre than paranoic thoughts. A couple of brief examples may help to clarify the distinctions which are being made.

A young man of twenty-nine recently told the writer that there was a certain change which was needed in all Christian religions, if these religions were to endure and serve their purposes. He went on to say that he believed he was the only person who understood the needed change and who could bring it about. When questioned he reluctantly admitted that he would not be willing to take an oath that he was the only person living who possessed this understanding.

* *Clinical Psychiatry* by E. A. Strecker and F. G. Ebaugh. The Blakiston Company, Philadelphia, 4th ed., 1935, p. 428.

This young man was obviously in normal contact with his surroundings and there was no indication of affective loss. No other symptomatic tendencies could be elicited. Had the occasion arisen, the writer would have felt fairly safe in diagnosing this young man as a case of paranoic trends.

A few years ago a young man of twenty-five came to the writer, not for help but for the writer's opinion in respect to a certain matter. He said that he possessed a very unusual chemical combination in his brain and that this endowed him with mental capacities of a superiority that had been known only twice before in the history of mankind, once in Frederick the Great and the other time in Napoleon Bonaparte. In view of his unusual abilities he wanted to know if the writer did not think it his obligation to take over the presidency of the United States and let the President take over his job and live in his room. This young man walked back and forth across the office as he talked, gave no sign of listening when the writer spoke, and seemed all but oblivious of his immediate surroundings. He repeatedly reached back with one hand and pressed his buttocks, apparently quite unaware of doing so. When pointedly questioned, he appeared to have difficulty in concentrating on the content of the questions sufficiently to give intelligible answers. The writer would have ventured a diagnosis in this case of early schizophrenia, paranoid reaction type.

The first of these young men attempted to account for his unique "understanding" in terms of his own particular experiences and training, which he believed to have been unusual. In other words, he sought to rationalize his claim to distinction. The second young man would offer no sort of explanation or reason for possessing his exceptional chemical combination. He would not even suggest that a parent had been peculiar or brilliant or outstanding and that he had likely inherited his uniqueness. This tendency to rationalize is perhaps always to be found in paranoic trends and is probably never present in an appreciable degree in paranoid trends.

The present interest is with paranoic trends as just defined. The writer is of the opinion that such trends always precede manifest paranoia, namely, permanent, systematized (rationalized) delusional formation without definite loss of affective contact with reality. At the same time he does not hold that such trends are always

precursory of paranoia. In some cases, for reasons which can only be inferred, the trends appear to became fixed, stationary. The individual then continues on through life as what one might call a "paranoic personality." As far as the present discussion is concerned, however, it seems best to think of these trends as comprising an early state or phase of paranoia and to examine them in relation to that well-known disorder.

Paranoic trends or reactions are strictly of endogenous origin. No type of maladjustive reaction is less dependent on existing situational factors. And, although much remains to be learned about the genesis of paranoia, the development of a typical case can be roughly sketched. Early in life the individual acquires a homosexual and, often, an inverted sexual orientation.* Subsequent to this but still during the pre-teen age, he strongly represses his homosexual tendencies and interests. At the same time he develops and rigidly maintains such attitudes and personal goals as are diametrically opposed to, or decidedly sublimative of, his repressed tendencies. Then, because of the constant pressure of his repressed impulses, he is unable to achieve a genuine identification with members of his own sex. Since his libidinal drives are partly or wholly directed to his own sex, he is incapable of making a workable and satisfying adjustment to persons of opposite sex. These two facts force him into a narrow, confining, and too personal perspective on all of his associations with other individuals. He is not able to develop and maintain an interest in either sex which is normal in kind and adequate in degree. Since his repressed tendencies would be utterly obnoxious to his conscious and accepted system of personal values, he stolidly refuses to perceive or recognize their existence. Holding an antithetical relationship to his conscious ideals, they generate feelings of guilt and moral depravity; and because they comprise a constant threat to his self-esteem and moral integrity, and being thoroughly unaware of their subjective origin, he projects them onto others. He then feels that other persons, particularly members of his own sex, are suspicious of him, unfriendly toward him, or persecuting him. In some cases wherein the patient has tried particularly hard to make a normal psychosocial adjustment, the homosexual tendencies become projected onto some person of like sex. He then thinks that this person has improper sexual designs on him.

* The origin of homosexual tendencies will be discussed in Chap. 20.

The writer has never become well acquainted with a case of manifest paranoic reactions in whom evidence of repressed homosexual inclinations could not be discerned. Once a diagnosis of paranoic reactions is fairly certain, a subconscious homosexual orientation should be taken for granted. In this connection, the more intelligent the patient is, the less apparent his abnormal tendencies will be. Also, to the extent that he has succeeded in sublimating these proclivities, the less obvious they are.

Inasmuch as the patient is utterly intolerant of his repressed desires, and since he usually lacks psychic flexibility to a normal degree, the first step in therapy is *preparatory*. The patient's perspective on personal relationships must be broadened and his psychic rigidity (affective intolerance) softened. "Insight," with all the significance the word has acquired in the field of psychotherapy, has no greater relevance in any other type of case. There is great danger, however, in proceeding too rapidly. This type of patient *cannot tolerate* a sudden exposure of his subconscious interests.

The second objective, of course, is the complete exposure and examination of the patient's homosexual propensities. But in doing this the therapist must persistently endeavor *to lead the patient into making a discovery of these propensities by himself.* In no instance should their existence be *forced* on the patient's awareness.

If these two objectives are successfully accomplished, there remains little else to be done other than such educative or reeducative therapy as may be indicated in the particular case.

The therapist should anticipate spending several months of about three visits weekly in gaining his first objective. And, in the very beginning, in order to establish a workable basis, he should try to induce the patient, not to relinquish, but to lay aside, any suspicions or half-formed delusional beliefs for the duration of the treatment. The patient can usually be persuaded to do this if it is made clear to him that if others treat him in a peculiar manner it must have something to do with the way in which he treats them; and that until he has been thoroughly studied and analyzed as a personality no light can possibly be shed on the matter.

Although a nondirective line of procedure should be used in as far as possible during the first part of the treatment, the therapist will usually have to give more or less direction to the patient's lines of

thought. The one topic which should never be investigated during this part of the treatment is that of homosexuality. Most any other subject can be safely discussed.

The crippling and narrow personal perspective of the patient and the psychic rigidity can be altered through a detailed revival and minute analysis of the attitudes, interests, and experiences of childhood, particularly during the period of four to eight. The patient should be encouraged to recall this part of his life to the fullest possible extent in his thoughts and *feelings*. The mere recollection of childhood events is not sufficient. The therapist should insist that the patient recapture the affective reactions that accompanied them. To illustrate:

A patient was recounting a seemingly trivial incident of childhood. "I don't know why this comes to my mind but I recall that my father brought me a bottle of soda water one day when I was quite small."

"Just how old were you at the time?"

"About five, I think."

"Well, why do you recall this particular incident? What was there about it that caused it to become deeply impressed on your mind?"

"Nothing, so far as I know. I just remember it. That's all there was to it. He merely brought me a bottle of soda water."

"No. There was something that made the act very significant to you. For some reason or other you were deeply impressed by your father's action. Otherwise you would not be able to recall it now. I want you to take a few minutes and let yourself drift back to that particular time in your childhood. Perhaps you can visualize yourself at play. Exactly what you were doing at the time should come to your mind. Perhaps. . . ."

"Oh yes, I recall now that I was on the porch. It seems I was sitting down. Maybe I had been ill."

"Good. Now let your father approach you again in your imagination with the bottle of soda water. Then tell me what thoughts or impressions come to your mind."

After a few seconds the patient began to smile. "You know, I remember now that I was very pleased and I felt very friendly toward my father." Then he came abruptly out of his brief retrospection. "It now vaguely seems to me that I was very fond of my father at that age. I didn't think I ever had cared about him."

In this brief illustration the point of therapeutic significance was not so much the patient's recalling the incident as it was his reliving it. By doing that he discovered quite by himself that he had once been fond of his father, a fact which he theretofore had strongly denied. And the return to his integration of *conscious* interests and attitudes of this long repressed affectionate capacity toward a member of his own sex tended to increase his tolerance for friendliness toward men and to temper his psychic rigidity.

Long before the analysis of childhood material is completed, a masculine-feminine, psychic duality will have become apparent. This matter must be pointed out and fully explained to the patient, but only in keeping with a properly prepared background of understanding. This part of the procedure may be somewhat as follows:

"My understanding of your psychic development and your present mental organization is becoming clear. I know the source of your problems, why you are dissatisfied and do not get along with other persons better than you do. You have become caught in the same psychic net in which thousands find themselves. The net was woven largely by yourself, as a result of childhood ignorance and misunderstanding. In order to release yourself from it you have to gain a clear understanding of certain facts about the mental lives of human beings. This understanding together with plenty of determination should help you to a much more efficient and satisfying life. I am going to explain some matters. I want you to listen closely.

"There is a widespread notion or belief, which is utterly false and absurd, that men should be 100 per cent masculine in their interests, attitudes, and overt behavior and that women should be 100 per cent feminine in theirs. You will find that this notion is particularly prevalent among the more ignorant and among children. As you know, silly jokes are often heard about the "sissy" man or the mannish woman. And many intelligent and capable persons are morbidly afraid of being thought effeminate or masculine, as the case may be. Because of such a fear many lean over backward and act unnatural and absurd. Thus, the man who is afraid he will be thought effeminate because he likes interpretive dancing or cannot help admiring fine lacework may affect a coarseness of manner or use profane language, even though it jars on his own sensibilities. While, for the same reason, the woman who would rather break a bronco than manipu-

late a knitting needle may affect many frills in her dress and a lisp in her speech. . . .

"There is absolutely no sharp line of demarcation between men and women in regard to psychic constitution. In fact, there is no line at all. There never was, strictly speaking, and never will be. For that matter, there is no really sharp line between the sexes in regard to physical structure. The person who produces sperm is a man; the person who produces ova is a woman. All other facts are of secondary significance only. It is important that you understand and fully appreciate these facts. . . .

"In respect to mental constitution and in respect to physical structure and development too, there is the greatest overlapping of the two sexes. This overlapping is not only natural, it is of the greatest conceivable benefit to the race. If it did not exist, if the sexes were clearly demarcated in all respects, there could be no community of real understanding between them. . . .

"Yet, as I have said, many persons fight against certain of their own traits and inclinations because they feel that these attributes tend to identify or align them with the opposite sex instead of with their own. They feel this way because they were reared in an environment which was saturated with erroneous, conventional views and criteria. And now the question arises as to what persons do who have strong drives and tastes which properly belong to the opposite sex from the standpoint of society. Do all such persons live lives of inner conflict and lowered personal efficiency?

"Such persons fall into three classes. First, there is the person who gives free and frank expression to these—let us call them—*cross-identifications.* They cause him no inner conflict simply because his attitude toward them is natural and rational. He can do interpretive dancing one day and break a bronco the next without feeling inconsistent or that his behavior is odd. While dancing, he does not feel that his behavior is effeminate, and while breaking the bronco, he does not soar to ecstatic feelings of masculinity. . . .

"The person who belongs to the second class is painfully conscious of his cross-identifications or, perhaps more often, he is rigidly guarded against performing any act which would indicate such identifications. He unceasingly fights against any feelings or propensities which he feels normally belong to the opposite sex. Usually he overcompensates for his cross-identifications by affecting just the op-

posite in speech and manner. His efficiency is lowered and his life is far from satisfying. . . .

"Finally, there is the person who has long since rejected and repressed his cross-identifications. They exist in him *subconsciously*, as a complex. He is no longer aware of them except, possibly, for fleeting moments now and then. He does not and cannot permit himself to become frankly aware of them. He has built up so much inner resistance to experiencing and recognizing such attitudes and inclinations that he is firmly convinced of their nonexistence in himself. He is aware only of the uneasiness, of the personal dissatisfaction and frustration and the self-preoccupation which they produce whenever they are activated or aroused. For as soon as they are aroused they encounter the strong resistance which has been developed against them, and the resulting conflict is experienced in the form of the symptomatic pain and distress which I mentioned. . . .

"You belong to this last class of persons. There is no question whatever but what you have strong cross-identifications. But way back in your childhood you became ashamed of these, of this feeling of identity with the opposite sex. Accordingly, you rejected and repressed everything about yourself which you felt was in any way effeminate. You then proceeded to emphasize in manner and speech all capacities which you regarded as distinctly masculine. . . ."

A line of procedure to be followed in making the patient familiar with cross-identifications and their significance has been merely indicated. Every point which has been mentioned should be fully elaborated and explained. Full emphasis should be placed on the fact that the more intermediate psychic type, the person who is neither extremely masculine nor feminine, not only has stood foremost in the ranks of the *great* in human history, but has many advantages over the more extreme type in most walks of life. His advantages lie in the broader perspective and fuller understanding of human relationships and human affairs which his more varied ego-identifications afford him.

The therapist should substantiate his diagnosis of repressed cross-identifications in terms of the information secured from the analysis of the patient's past history. This should be done as convincingly as possible, for it is of the greatest importance that the patient accept the diagnosis and interpretations which are made at this point

Otherwise the therapist may find that he is unable to lead the patient to a discovery of the repressed homosexual tendencies later.

The patient's symptoms should now be translated as fully as possible into the inevitable effects produced by the conflict between his cross-identifications and his conscious attitudes and ideals. The more completely this can be done, the nearer the patient will be to that degree of tolerance which is necessary to the recognition and acknowledgment of his repressed tendencies; for the cross-identifications and the homosexual inclinations are intrinsically of the same order and tolerance for the former is a decided step in the direction of tolerance for the latter. Moreover, a part of the patient's symptomatic tension is usually an expression or result of *inverted* tendencies, as distinguishable from his narrower and more deeply repressed *homosexual* tendencies. Once he has tolerance for the first, he is rid of part of his tension and in a better position to confront the latter problem.

"Now that you understand the significance of your cross-identifications, you should be more able to understand your troubles. Your feelings of uneasiness and suspicion when around certain persons of your own sex are not due, you see, entirely to their actions; they result largely from your own rejected submissive inclinations toward *those* persons. Your subconscious tendencies to submit arouse a violent masculine protest. This protest takes the form of a suspicious and guarded attitude toward the other person or persons. Instead of being clearly and frankly aware of your repressed passive or submissive tendencies, you unwittingly experience or interpret them as a demanding or unfriendly attitude in others toward you. When you are around members of the opposite sex, on the other hand, your repressed cross-identifications tend to *align* you with them. This, likewise, arouses a masculine protest, with the result that you carefully maintain a safe *emotional distance*. . . ."

The most important point in the therapy has yet to be dealt with. This, as already mentioned, is helping to bring about and coping with the emergence into the patient's consciousness of his homosexual tendencies.

The various matters which have been mentioned in relation to cross-identifications should be discussed pro and con till the repressed factors finally make their appearance.

Distinctly negative elements usually appear in the transference

relationship with the paranoic patient. If these elements become too strong the treatment will be terminated by the patient. Thus, one young man after less than two months of treatment became firmly convinced that the writer had sexual designs on him. No amount of reasoning to the contrary could alter his conviction. Another young man when asked concerning his knowledge of homosexuality became immediately hostile and ceased his visits. No particular effort should be made to keep the patient whose transference feelings become markedly suspicious and unfriendly, unless the therapist would invite possibly serious trouble for himself.

Negative elements in the transference can be handled most effectively by a rigidly impersonal and blunt denial and dismissal of the suspicions or other negative feelings which the patient expresses. Under no conditions must the therapist permit himself to be placed on the defensive. A defensive or even an argumentative attitude only encourages the patient's negative feelings.

The patient's dreams should be preserved in written form from the beginning of the treatment. None expressing homosexual tendencies will have been interpreted, of course, till the patient himself has become aware of them. When this point is reached the therapist will want to muster all the material he can which is in substantiation of the existence of the tendencies, for with his first glimpse of them the patient may be strongly inclined to discount or even to reject them outright Once the patient has discerned and admitted homosexual thoughts, interests, or feelings, the therapist should leave no stone unturned in his efforts to force them *fully* and *clearly* into the other's consciousness.

The treatment is not properly completed till the formerly repressed material has become dissolved, sublimated, or integrated with heterosexual interests, and this inner readjustment has been firmly established. This is a matter of re-educative and supportive therapy.

TREATMENT OF A CASE OF EARLY PARANOIC TRENDS

George Y. came in of his own accord. The reason he gave for seeking professional help was excessive drinking. He said he went on binges but did not drink otherwise or have any desire to do so. He

thought his drinking was not only jeopardizing his marriage but was threatening his future success.

George was a slender man of good appearance, very courteous and seemingly friendly. He seemed to be entirely willing that I should talk to his wife and mother about his drinking and his conduct in general. He appeared almost anxious that I learn as much about him as I could from the two women. Since there was no apparent reason for his excessive drinking, I took my time to secure as much information as I could from his wife and mother.

George was the only child of educated and refined parents who had always been somewhat above the average socially and economically. His father, who had been dead nine years, had been a professional man, extremely well liked in the small city where he had practiced, according to my information. His mother was a rationally orientated, matter-of-fact woman in her late sixties. She married late and was nearing forty when George was born. I gathered that she had been fond of her son, to be sure, but had never been demonstrative toward him. She made no secret of the fact that she felt wholly undeserving of the shame and humiliation which George's drinking had caused her. She spoke more warmly of her son's wife than she did of her son. But toward both and their married relationship she displayed an unyielding practical attitude which never left her even when she wept.

George's wife was an attractive and educated woman. She was very much like his mother in some respects, particularly in her undemonstrativeness. She appeared to be reasonably tolerant, though, and for years had endured her husband's drinking without undue complaint. They had been married for seven years and although she had been very desirous of children they had been unable to have any.

George was thirty years old. He had always enjoyed good physical health. He had taken a higher degree in a professional field and, like his father, had engaged in private practice.

I learned from my patient that as a child his home atmosphere had always been quiet and undisturbed but very "chilling," to give his own expression. This had been due, he believed, to his mother's unremitting reserve and practical-mindedness about all things. He felt that his father's natural spontaneity and friendliness had been constantly held in check by his mother's distaste for any sort of emotional display.

George had playmates of both sexes during childhood but had never had what he regarded as a really close friend. Although he mixed easily he always, at least from an early age, maintained a certain emotional distance or reserve. As a man, he had generally been considered "good company" by his acquaintances. No one seemingly ever acquired a genuinely strong friendship for him except his parents. I later concluded that this applied to his wife as well as others. And it was understandable. Underneath George's gracious and hospitable manner one could detect a definite coldness and an ever-present egocentricity. I later learned that he could pay court to a woman with enviable finesse and yet leave her feeling that something had been definitely lacking. He could be outwardly very friendly toward a man and still leave the person feeling that he had been merely *used* to while away an idle hour.

Since his marriage George had earned a fair income but had freely dissipated it in gambling, drinking, and meaningless affairs with women. His father-in-law had repeatedly been called upon to help with George's expenses.

George had drunk considerably since his college days but after his marriage his drinking had increased and two or three times he had been obliged to spend a few weeks in a hospital as a result of drinking. He and his wife had been estranged most of the two years just preceding his first visit to me. However mild her interest was in him, she was strongly desirous of having her own home and was ready to return to him the moment he gave up liquor. She was still loath to seek a permanent separation. George was entirely willing to seek professional help when his father-in-law agreed to take care of the fees.

I devoted the first three months to a painstaking study of his past life, particularly the period of his early childhood. George was very cooperative and as we sorted and evaluated his early affective experiences, the weighty but very different influences which his two parents exerted on his emotional development assumed major importance.

The treatment had not progressed far, incidentally, before the basic nature of George's maladjustment began to appear. Evidence of repressed homosexual tendencies not only showed frequently in his dreams, but such tendencies were strongly indicated by certain early attitudes and feelings which he recalled.

George was unable to remember ever having felt affectionate or sympathetic toward his mother. He did recall, however, that his father punished him on several occasions for his lack of deference and respect for her. During one such time he actually fought his father when the latter started to punish him. He was only ten or eleven at the time. He said he had always felt, since his earliest recollections, that his father demanded a degree of courtesy and consideration toward his mother which her cold and exacting attitude did not merit.

He believed that his emotional estrangement from his mother reached its climax in an incident when he was about seven years old. She reprimanded him in her usual harsh manner for a small infraction of her commands. He had replied with considerable warmth that he was not guilty of her charge. Without stopping to investigate the matter, she contradicted him and proceeded to reprimand him severely for lying. When his father returned home, George was punished at his mother's insistence for disobeying her and then lying. George declared to me with some heat, when relating the incident, that he had actually not been guilty of the act, that a boy playmate was at fault. He went on to say that he had never felt very friendly toward his mother following this incident. I gathered from the way he talked that he had been hurt most by the fact that his father had sided with his mother instead of with him. It is probable that his father was afraid to do otherwise.

George felt very friendly and close to his father throughout his childhood. He recalled the keen pleasure which was his when his father played with him or took him to town or on one of his short trips into the country. And he recalled that these events were particularly enjoyable if his mother was not along. Most of his early memories were of being with his father. As I listened to him and observed the obvious signs of pleasure with which he recounted various early associations with his father, I got the impression of a little girl who was frankly and intensely fond of her father. For George was unable to recall a single instance of dislike or hostility, or even of competitive play with his father. True, he deeply resented his father's punishing him at his mother's behest, but the reason for this was obvious enough and tended to bespeak his affection for his father rather than otherwise.

As the analysis progressed and these childhood feelings and atti-

tudes were recalled and subjected to careful scrutiny, the patient's present feelings began to come into clearer relief. Thus, he remarked one day that he was not sure he really cared for his wife or that he wanted to go on through life with her. After reflecting for a moment he added that he did not believe he had ever been interested in any woman, except sexually. In this latter respect, he went on to say, he preferred certain perverted acts to normal relations. (His wife had already told me that whenever George was drinking he insisted on *coitus per anus.*)

Then his attitude toward his father-in-law began to come into prominence. He said he hated him with considerable fervor and often thought of ways in which he could make him suffer and also, incidentally, force upon him a realization and admission of his (George's) unusual superiority. He had been severely critized by his father-in-law for his extravagance. This, perhaps, tended to revive the old bitterness caused by his father's punishments. On the other hand, inasmuch as he said he had originally been very fond of his father-in-law, I attributed a part of his animosity to the resistance aroused by his repressed homosexual orientation.

It was during this same time, after about three months of treatment, that negative elements in a developing transference relationship began to appear. George declared that his living quarters had been entered and ransacked. He said this had happened twice within the past week. He decided that before mentioning the matter to me he would "set a trap" for the intruder. Hence, following the first occurrence, he had arranged all of his clothing and toilet articles just so and sprinkled talcum powder lightly here and there. He thought the intruder must have suspected a trap for the second time things had been only slightly disturbed. Nevertheless he was convinced his premises had been entered twice. He looked pointedly at me and said he had no doubt as to whom the person was. "If you are thinking of me," I replied, "you are barking up the wrong tree. In the first place, I haven't the slightest interest in any of your personal possessions whatever they may be; and, in the second place, I happen to be too busy to find time to snoop in other persons' homes, even though I had an inclination to do so." His suspicions of me seemed to waver. He said it could, of course, be his father-in-law.

A day or two later George remarked that he had drunk no liquor during the last three months. He said he was fully aware that some-

one was checking on his drinking and he supposed I was the party. He wanted to know how far professional privileges extended in my work. He had tried to be so casual in his remarks I could not help laughing. I told him perhaps his wife was checking on his conduct, although I knew she was not and knew he knew it. No one, of course, was checking on him. Neither had anyone entered his apartment during his absence. I told him everything would come to light in due time and turned the talk to other matters. He continued to harbor his suspicions for some time but they did not noticeably interfere with the progress of the treatment.

By this time a number of facts had become fairly clear to George, as well as to myself. The only real affectionate attachment he had ever had was to his father. This was still very much alive in him as indicated by the frequency with which his father appeared in his dreams, always in the role of close friend and companion. Toward his mother he had only negative feelings. When around her he felt oppressed and dominated. In his dreams he was sometimes in open rebellion against her wishes and demands. He had very little affection for his wife and was utterly inconsiderate of her, except when she was ill. At such times he suddenly felt dominant and master of the situation and became very solicitous. His usually repressed, sympathetic tendencies could come to expression at such times simply because his masculine ego was securely in command. Otherwise he was consistently cold and never hesitated to utilize her to his own ends in any manner he could.

George's affective attitudes toward other men were interesting and significant. He actually *tended* to feel very friendly toward them. But his friendliness became automatically projected with the result that he felt that others were definitely friendly toward him. With the projection of his friendliness he was left, as it were, with very little real feeling toward others. (Only feelings which are essentially repressed are projected. Since they are repressed they are not adjustively operative, of course, as conscious, acceptable feelings are.) From this it followed in turn that although George had a childlike trust in other men, they invariably learned that they could not trust him. In fact, he could take advantage of another's trust with an indifference which could be explained only by an utter lack of regard. Yet, inconsistently—consistently enough, psychologically—if another man took advantage of George even mildly, he

would feel completely outraged, brood about it for weeks, and plot revenge.

Around women George would have felt at a distinct disadvantage had he not always armed himself with the polite and gracious manner which he had developed during childhood at his father's insistence. This manner not only concealed his true attitudes from women, it served as a very effective weapon in disarming them of any tendencies to dominate him. He suspected every woman of having such tendencies. His Don Juanian propensities were primarily an expression of his sense of ego-insecurity in relation to women, not of sexual drives as such. Seducing women temporarily gave him a sense of personal prowess and masculine supremacy.

George was very ambitious. His egoistic motives, however, were not definitely orientated. He simply wanted *to be*. And he very much wanted a short cut to being. When sober, his gracious and rather modest manner tended to belie his deep craving for great personal distinction. When drinking, I learned, he presented a different picture. Although he remained courteous enough, he was quietly but incessantly boastful. He boasted chiefly of his great intellectual powers and his success with women. His drinking tended to inhibit or dull his painful feelings of personal and masculine inadequacy and release his pent-up craving for self-sufficiency.

At the end of the first three months I believed the patient had been prepared to examine himself and his personal problems in terms of a masculine-feminine, psychic duality. I told him it would be our purpose to consider these matters from a point of view I had not yet introduced, and went on to a thorough discussion of the conventional distinctions between masculinity and femininity. Instead of encountering resistance, for which I was prepared, I met with a very interested and receptive attitude. For the next six weeks we discussed the feminine in the man and the masculine in the woman and reviewed his childhood development from this new perspective.

I emphasized the basic difference between attachments rooted in ego-identifications with other persons, on the one hand, and attachments rooted in unselfish interests in others, on the other hand. I then proceeded to point out that cross-identifications, comprising a type of ego-identifications, tend to align or identify one with the opposite sex; whereas sexual, affectionate, sympathetic, and suggestible interests in members of the opposite sex normally place

one's energies at their disposal. I explained that in his case, however, his mother's cool and undemonstrative attitude had strongly deflected his unselfish interests toward his father who, in his warm friendliness, had been a satisfying recipient. This had induced a rivalry with his mother for his father's attention and interest and had forced him into making ego-identifications with her. These cross-identifications he later renounced and repressed.

George proved to be an apt pupil. He immediately became aware of his tendency to assume an attitude of rivalry around women and that he usually sought to resolve the issue by seducing them, thereby demonstrating his superiority and his masculinity. His unwitting projection of his feminine tendencies onto women made of them an ever-existing threat to the security of his masculine integrity and self-sufficiency. A quick seduction of the woman of the moment appealed to him as the best solution.

George volunteered additional examples of his feminine interests. He said he was inclined to putter around the house and have everything in order and neat as his mother had always done. He became aware that he usually fought this tendency, though, and kept his own room as disorderly as possible. He came to see this as a masculine protest against the feminine patterns which he had copied from his mother. He also liked "frills" and lacework and sometimes secretly admired them. But he openly scoffed at such things, in his quiet, sarcastic way, and he married a woman who favored tailored clothes and severe lines in her dress. Although he actually disliked loud or vulgar talk in either sex, he often affected obscenity with a casual swagger.

I encouraged George to differentiate his interests in terms of masculinity-femininity to the most hairsplitting extent in an effort to bring his homosexual tendencies into his consciousness. I requested him to detail his thoughts and feelings in connection with his sexual intimacies. He said that during sexual relations, he always felt detached and impersonal, except when he indulged in *coitus per anus*. He then experienced a definite excitement. He declared that he preferred slender women, that he was not interested in their breasts, and that their buttocks were their most appealing feature.

His dreams had become increasingly indicative of repressed homosexual tendencies during our detailed discussions of psychical hermaphrodism. Then, after about five months of visits, he brought in a

dream in which he was in bed with a man. His wife was standing a few feet from the bed, looking at him reproachfully but without disgust or contempt. He felt in his dream that he was not treating his wife fairly and *that he had permitted the man to usurp her rightful place.* Nevertheless, he was reluctant to ask the man to move and was wondering if his wife would be very angry, when the dream faded out.

George had become fully convinced of the subjective validity and significance of dreams during the course of treatment. He looked at me for a few seconds and then said, "Hell, that looks as if I'm a homosexual subconsciously." I complimented him on his courage and discernment and told him that he was entirely correct.

Therapy was continued for another six weeks, during which we discussed homosexuality and sexual inversion from all angles. George showed more irritation than shock at his discovery that he had homosexual tendencies. He rapidly lost much of his gracious manner. He said his wife was not the type of woman he wanted to spend the rest of his life with. She reciprocated his sentiments and they secured a divorce. At the end of the treatment he appeared to be easily in command of the matter of drinking, seemed more thoughtful and reflective, and expressed a determination to make something more worth-while of his life.

About two years after the course of treatment, George paid me a brief social visit while passing through the city in which I lived. He made no reference to our former relationship and neither did I. He mentioned a change of plans in his work, remarking that he had never been genuinely interested in his profession. He laughingly said he was still enjoying his single state. He appeared entirely normal and unaffected in his speech and manner. I have not heard from him during the last seven years.

In a case of this kind one can never be sure, of course, that he is dealing with an early phase of paranoia. At the same time there is nothing known about the early or prodromal period of paranoia and the symptomatic reactions which commonly exist at that time that would seem to preclude benefit from psychotherapy. Unfortunately, not many of these cases seek help of any kind till they have become incapable of frank self-examination and, therefore, inaccessible to psychological treatment.

A few further remarks are in order concerning George's almost intense hatred of his father-in-law who, despite his reprimands, had befriended him many times. Repressed homosexual tendencies engender self-hatred and self-contempt. These feelings then tend to be projected onto the person or persons toward whom the homosexual tendencies are directed. But George had been too genuinely *fond* of his father ever to turn against him. But his father-in-law, by becoming a partial father surrogate, made such projection possible.

CHAPTER 5

Involutional-Melancholic Reactions

PSYCHOTIC REACTIONS of a melancholic type, occurring during the climacteric or menopause, characterize approximately 2 per cent of first admissions to mental hospitals. Such conditions are more common to women than to men, the ratio being about three to two. Roughly speaking, about a third of these patients recover, a third commit suicide or die of intercurrent diseases, and a third become chronic and stationary. In those cases who recover the disorder runs a course of a few months to three or four years. The disorder usually occurs in women during the late forties or early fifties and in men during the late fifties or early sixties.

The menopause is normally characterized by certain and various glandular, physiological, and anatomical changes. The only *psychological* changes which can safely be said to be normal are some diminution in sexual drive, an increase in self-interest, and perhaps a relative loss of psychic flexibility. Unhappily, however, many women and some men regard this period as an anticlimax in their lives. Superstitions, ignorance, and faulty teaching have made of this period of life a time to be dreaded by millions of persons. Consequently many persons are inflexibly bent on having their difficulties when they reach the menopause whether or no.

The more common symptoms of early involutional melancholia include intense *physical restlessness*, often reaching *agitation*, *acute mental depression* and *emotional despondency*, *apprehension*, *anxiety*, *self-accusations* and *condemnations*, *nihilistic delusions*, and *tendencies to suicide.*

The mental depression with its paucity of ideational content

and the despondency are perhaps the most common symptoms. If the patient talks, one soon discovers that the talk consists of little else than an endless repetition of the same phrases and sentences. And if an attempt is made to divert the patient's thinking to new channels, the patient appears to have great difficulty in initiating and sustaining the new line of thought. The despondency may vary from a dull emotional ache to agonizing despair.

The tendencies to self-accusation, self-condemnation, and self-negation are among the most significant and psychologically revealing of the symptoms. These may vary in intensity or degree from condemnation for some trivial past act to convictions of complete depravity and feelings of unfitness to live. The extent of the self-condemnation is a measure of the intensity of the inner conflict and the severity of the psychosis.

Most of these patients have a sort of insight. At least they know there is something wrong with themselves. They know, of course, that they are wretchedly unhappy, intensely restless, unable to sustain a line of thought unrelated to themselves. They fail utterly, however, to discern the true significance and causes of their symptoms. In this more strict sense they have no insight.

Involutional melancholia is *the* frustration psychosis. Symptomatologically, it *results from and expresses a desperate effort to hold in check a violent surge of self-interest, egoism, selfishness, personal ambition in its narrowest sense.* Its peculiar symptoms, most of which are centered about the principle of self-negation, become understandable only when seen in this light.

Everyone is familiar with self-reproach in the normal person who has behaved in a selfish or shameful manner. The psychology of it is clear. The self-reproach arises from injured self-esteem or a violation of friendliness toward others or both. The self-reproach (self-condemnation) of the melancholic patient is not so simply explained. The psychology is deeper and a clear understanding of it is essential to effective therapy.

Much becomes clear about involutional-melancholic reactions when one carefully studies the life history of such a patient. The writer believes that most of the facts to be mentioned, taken from an actual case, will be found to hold true of any fairly typical patient of this class. During the early years of life self-esteem and personal

ambition become overdeveloped. This results not by way of compensations for feelings of inferiority but as a consequence of home influences acting directly upon a certain arrangement of personality and temperamental characteristics. These include a keen alertness to the presence and actions of other persons, a somewhat extroverted orientation, a rather intense affective make-up, and strong motivation. Repeatedly, one will learn that as a child the patient tended to be singled out in the family group and highly and consistently commended for such virtues as industry, kindliness, unselfishness, honesty, conscientiousness, and, in many cases, even saintliness. This encourages, even forces, the child's self-interest or egoistic propensities into highly socialized and *normally* unselfish patterns of behavior. He is unwittingly tricked at an early age into accepting a *life-plan* (Alfred Adler) which makes no room for a frank expression of self-interest. But unselfish behavior as such cannot possibly serve as an adequate medium for the expression of self-interest. A too completely unselfish orientation in word and action leaves the individual slavishly dependent on a constant flow of praise and laudation by others for a satisfying feeling of his own completeness and worth-whileness. Of a *genuine* feeling of self-sufficiency, such a person has little or none. Self-sufficiency comes from a relative independence of others, never from any kind of complete dependence on them.

The kind of life-plan which has been described may seem entirely satisfactory to the person. Indeed he neither knows nor conceives of any other life-plan for himself. The time must come, however, when others (children) will cease to need him and/or he no longer has the energy and endurance to maintain a constant, close, and helpful contact with others. This means, psychologically, that the source of his egoistic satisfaction—always a day-to-day matter—slips from him. His old way of life, oversocialized and underindividualized, can no longer support his subjective needs. He becomes tormented by acute feelings of personal loss, loss to his previously socially fed and therefore never substantial sense of his own individuality. These feelings of loss, or impending loss, set off a violent thrust of his frustrated egoistic propensities. There is a strong tendency to a complete renunciation of his former mode of life and an unqualified demand for recognition, self-sufficiency, and personal distinction. This egoistic thrust is met by the most violent resistance.

It never comes clearly into consciousness and is not definitely revealed by the patient's symptoms. In meeting the egoistic propensities, which point toward a maniacal abandon, the feelings of loss are elaborated and utilized. So, far from declaring a complete self-sufficiency as the maniacal patient does, the melancholic patient heaps abuse and condemnation on himself. The intense conflict between the egoistic drives and the resistance creates pronounced psychomotor tension and restlessness. The patient's despondency is a reflection of his helplessness. He is a victim of the utter incompatibility which exists between naked egoistic cravings and his lifelong, highly socialized ideals. If the egoistic thrust becomes strong enough to threaten to usurp the voluntary mental and motor functions, suicidal attempts are inevitable.

In following this brief account of the genesis of involutional melancholia, it is important to bear in mind the early overdevelopment of self-esteem and self-interest. The involutional melancholiac is and has always been a too self-centered person. But, as pointed out, he has always looked to the appreciation and commendation of others for gratification of his egoistic needs. With the onset of the involutional period his attention becomes focused more on himself. He then fails to find adequate support for self-esteem simply because he has always depended too much on others for it.

With the character and significance of the patient's inner problems and mental conflict in mind, the specific aims of any therapeutic procedure are clearly indicated. Harmony must be established between the strongly rejected egoistic propensities and the highly socialized and selflessly conceived thoughts, sentiments, attitudes, and habits which formerly dominated the patient's conscious orientation. Tolerance for a narrower and franker expression of self-interest must be developed; this rejected self-interest and desire for self-importance must be brought within the patient's insight and understanding.

It should be clear why efforts to cheer, console, encourage, or to unduly distract this type of patient's attention from himself should be kept to a minimum. The patient is desperately fighting to block the encroachment of intense, narrow egoistic aspirations. He is fighting, if not to preserve his lifelong personal identity, at least against becoming a type of person who would be abhorrent to him.

To belittle his symptoms is to belittle the gravity of his inner problems and to align oneself with the very egoistic forces which he is trying to hold in check. The patient should be removed from the family circle if possible, for the same reasons, and visits by family members made only very infrequently.

The therapist should gain as much information as possible about the patient's past life from family members and friends. This information, particularly concerning the early years of life, should be carefully organized before it is discussed with the patient. It should contain definite evidence of strong, early self-esteem and self-interest. Such evidence is often contained in reports that when a child the patient was tidy, honest, conscientious, loyal, unselfish, and considerate of others and well liked by his teachers; that he developed desirable social patterns early in life and usually considered the other person before himself; he never let others down; he accepted his social obligations without complaint, even at considerable personal sacrifice. One will learn further that throughout his life the patient has been modest and reserved in speaking of his own accomplishments.

Some of these bits of information can be obtained from the patient himself in many cases if tactfully undertaken. Others can be secured only from family members or friends. When all possible information about the patient's past life since early childhood has been collected and arranged, an attempt to expose the underlying demand for self-importance and recognition and the gnawing sense of personal frustration is in order. This attempt should be carried out in a persistent and systematic manner. Coincidentally with it, the patient's old devotion to unselfish and oversocialized ideals and goals must be materially lessened.

The two objectives are accomplished, in the main, by persistent reinterpretations or retranslations of the causes of his illness which the patient himself gives. Some of the things which the patient says about himself may, in certain cases, be ignored; nothing that he says about himself should be denied. If he expresses nihilistic delusions, for instance, the therapist may see fit to ignore this; if he says he is guilty of some past sin, on the other hand, this should be neither ignored nor denied but reinterpreted.

The melancholic patient is extremely prone to interpret his present feelings in terms of past actions. He feels guilty, beaten,

tried, and convicted. He accounts for this by recalling some past act, usually of a trivial character, or simply by postulating a past life of selfishness or wickedness. Actually, his present feelings are due to his present inner conflict, as has been explained. The *tremendous significance* which he attributes to some past, trivial act is understandable and justifiable once it is viewed in relation to its true cause. Through a sort of displacement his conviction of worthlessness or sinfulness is attributed to a past act instead of to his present unrecognized greed for personal distinction, perfection, or power. The therapist must undo this displacement and help the patient to bring into consciousness his repressed egoistic propensities.

Only a *would-be* godly person can find himself so wanting as to heap the condemnation on his own head that is found in involutional melancholia. Patiently and painstakingly the therapist has to bring about a realization of this fact by the patient. The capacity for true unselfishness in human beings is definitely limited. This fact should be stressed. Selfless goals and ideals may, therefore, easily be carried too far. One not only has a right to a good measure of frank self-interest, but it is essential to individual adjustment. One may do for others out of friendliness and sympathy or as a means of enhancing one's own self-esteem. As to which is the reason may make little difference to others but it may make a great deal of difference to the person himself. Efforts made on "behalf" of others in order to enhance one's own self-esteem are invalid and therefore unhealthy and maladjustive expressions of self-interest or egoism. The patient's past interests, personal ideals, and acts should be carefully analyzed and discussed in the light of these facts.

In his efforts to expose the repressed egoistic propensities, the therapist must bear in mind that the patient can tolerate them only to the extent that his lifelong conviction of the exclusive value of unselfishness is weakened. He not only has to be shown the basic value of selfishness in personal adjustment but along with this the limitations on the value of unselfishness in this respect. From the standpoint of personal adjustment, efficiency, and happiness there would be no choice between a completely selfish person and a completely unselfish person, could such persons exist.

Any dreams which can be obtained will point to the nature of the inner conflict and support in general the interpretation of the illness which has been given. The therapist should make full use of such

dreams. In doing this it is important to emphasize the fact to the patient that his dreams are his own constructions or creations and that what they say, he is saying about himself. The therapist, it will be pointed out, only interprets the dreams and says back to the patient what the patient has said about himself.

Occupational therapy should be introduced, along with the psychotherapy, if and when the patient becomes less restless. Care should be taken not to try *to force* the patient into occupational therapy. Attention cannot be forced or feelings coerced. The moment the therapist drifts or relapses into the old fallacy of "will power," "free will," or "freedom of choice," he has ceased to be a psychotherapist.

There is always more or less danger of precipitating suicidal tendencies, if these are not already present, in exposing the repressed egoistic drives.

There is also the danger in permitting the patient to return to his family too soon or in letting him have family visitors even after he has shown marked improvement. The patient not only has to make an inner readjustment, but some time is required for this readjustment to become stabilized.

TREATMENT OF A CASE OF INVOLUTIONAL MELANCHOLIA*

I was asked by her husband and one of her sons to see Mrs. N. at her home. Before making the call I secured some information about her. She was forty-nine years old, and had been ill three months. I was told she was very despondent, accused herself of wrongdoing, disparaged herself, and was extremely restless, particularly during the night. She talked very little, even to members of the family, and resented visitors and doctors. The two men were very anxious for me to visit the patient immediately so I put off getting more information till later.

I found Mrs. N. sitting with her hands clenched in her lap in an uncushioned rocking chair. She sat very straight and appeared tense

* The reader who is familiar with my textbook in abnormal psychology will note certain interesting and striking similarities between this case and one I gave in the text. *An Introduction to Abnormal Psychology*, 2d ed., The Macmillan Company, New York, 1937.

and rigid. Except for a single quick glance as I entered the room, she gave me no attention, staring straight ahead and never altering her position in the slightest. Her face was lined and set. She appeared ten or fifteen years beyond her age. She replied to my questions briefly, sometimes irrelevantly, and rarely shifted her glance in my direction.

"How are you feeling, Mrs. N.?"

"I don't feel."

"Just what do you mean when you say you don't feel?"

"I don't feel. I have no feeling left. It is gone."

"Do you eat well?"

"I have no taste. Everything is the same."

"You can distinguish between the taste of sugar, say, and a pickle, can't you, Mrs. N.?"

"Nothing has any taste; my taste is gone."

"Do you sleep well?"

"I don't sleep."

"Do you have any pains?"

"My feeling is gone."

"Is any other member of your family affected in the way you are?"

"My daughter is getting like me. She is losing everything." Further questions brought forth statements from Mrs. N. that she had lost all capacities and functions. She had no sensations, no feelings, no thoughts, no digestion, no circulation; she was just a dead, wooden image of what she had been, and her daughter was becoming exactly like her.

"Do you know what has brought about these changes in you, Mrs. N.?"

"Certainly."

"Do you want to tell me?" She did not answer and since members of the family were present I did not press her.

Although Mrs. N. was opposed to any form of treatment, declaring that no one could help her, I drew up a schedule of three visits weekly at her home. Husband and son believed it would be all but impossible to get her to my office regularly due to her extreme resistance to being moved or otherwise complying with anyone's wishes. The family was against having her committed to the state hospital or even having her placed in a private sanitarium. There had been no

manifest suicidal tendencies but I warned the family against the possibility of such.

I made a careful list of the patient's symptoms during the first visit. Despondency was present but liberally colored by irritability, resentment, and negativism. There was mental retardation, an apparent paucity of mental content, and a tendency to verbal repetition. The patient was reported to be restless to the point of agitation during the night. Throughout the day she sat with her hands tightly clenched in her lap (a symptomatic renunciation of her former excessive activities), tense and rigid. Nihilistic delusions were pronounced. Convictions of past sins and wickedness and a marked tendency to self-disparagement were prominent. A diagnosis of involutional melancholia appeared well confirmed by the symptoms.

I secured a fairly complete case history from the patient, her husband, a brother, and one of her sons. There was considerable information which I did not get till much later, when the patient supplied it herself.

Both parents were deceased. They had lived to a good age and had died of natural causes. She had two brothers, both older than she, and no sisters. The health of her parents and siblings had always been good except for infrequent and temporary ailments. The parents had received eighth grade educations, the brothers, high school. The social and economic level of the family had been a good average. The mother was described as having been quiet and even-tempered and somewhat self-effacing. The father had been more dynamic, aggressive, and socially inclined. Both brothers, who were married and fairly successful, were said to be more like their mother in temperament and personality. There was no history of nervous or mental disorder in the family.

Mrs. N.'s home life during childhood had been pleasant and congenial throughout. There had been little or no family friction and she had always got along with her parents and brothers extremely well. She had enjoyed good physical health. She received a high school education and secretarial training. For three years prior to her marriage at the age of twenty-one, she worked in a private office.

I was told that Mrs. N. was socially very active and agreeable as a child. She had many playmates and friends of both sexes over whom she easily exercised a friendly leadership. She achieved this position among her friends through her intellectual keenness, her dynamic

personality, her kindly and gracious manner, and her early devotion to fairness and justice. She was exceptionally well liked.

I was led to assume that in her family circle, too, she occupied a rather unique position from an early age. Her brothers were very devoted to her and her parents were very proud of her. She was a kind and harmonizing spirit in the family group. She appeared to derive a distinct pleasure from doing things for others and making them happy. While still very young she became one in whom to confide, one to turn to for sympathy or advice. She was freely and constantly praised for her virtues.

There was little change in her attitudes and patterns of behavior as she grew older, except that she became more strongly wedded to her ideal of service and devotion to others and, undoubtedly, increasingly dependent on the praise and esteem of others. In high school she was one of the leaders and possibly the most popular girl in her class. Instead of becoming strongly attached to only two or three schoolmates, she seemingly liked all of them. *She perhaps felt the need, however vaguely, of the recognition and esteem of all of them.* Always friendly and impartial, she won the friendliness and respect of her fellow students. Moreover, she easily struck a happy medium between her social activities and her studies. She was not only extremely popular socially, she was among the highest ranking students in scholarship.

Mrs. N. kept steadily on with her social activities after her marriage. These had gradually assumed a more serious character. She did not make social activity an end in itself; she was very little interested in social clubs in the lighter sense. Rather, she joined and took an active part in service clubs. She won high praise from the community for her unremitting efforts on behalf of social welfare and improvement. She also won the *dependence* of others and their *expectations* of her *continued devotion* to their needs. Naturally, she was regarded as a fine, unselfish, and self-sacrificing person; and her untiring enslavement to the needs of others came to be taken more and more for granted. Year after year she went on, completely dominated in thought and action by the Frankenstein of service to others which she had built up.

Mrs. N.'s husband was a man of phlegmatic temperament, lacking both her dynamic qualities and keenness of intellect. She had three children by him, two sons and one daughter. Her sons were

healthy and intelligent and made good adjustments in their adult lives. Her daughter became hopelessly crippled and badly deformed as a result of early infantile paralysis. This daughter had always lived at home, being capable of doing scarcely anything. The family was in rather modest circumstances.

Mrs. N. had had no previous attacks of nervous or mental disorder. Her illness had come on suddenly and had progressed rapidly for the first month. Since then it had remained essentially as it was when I first saw her.

The changes in her attitudes toward her family and her community activities could not have been more marked. She showed no interest whatever in anyone or anything except herself. She sat day after day in a painful, egocentric state of preoccupation.

At the end of four visits I had secured all the information I could for the time being. Partly through inference and partly on the basis of definite information which I had gathered, I was able to gain a fairly clear picture of my patient's past temperament and personality and the course of her psychic development. With my fifth visit I commenced psychotherapy proper.

My first task was to help my patient to recall and recognize the early existence of exaggerated self-interest, to understand the course which this interest had taken through her life and the part it was playing in her present disturbance. She was very uncommunicative and, therefore, I had to do most of the talking. Nondirective therapy is usually out of the question, of course, with patients of this class. Many therapists feel thwarted with patients who will not talk. This is often unjustified, however, for although the patient will not talk or will talk only to the extent of giving monosyllabic answers to questions, he still may be a good listener and this despite the fact that he may seem to be wholly preoccupied with his own thoughts and inattentive to his surroundings. The involutional-melancholic patient is frequently far more observant than he appears to be.

I explained to Mrs. N. that an individual normally—aside from interests in food, shelter, etc.—has two major sets of interests in life, that one set of interests is in other persons and their welfare and the other is in oneself, that is, in one's security, equality, attainments, and personal enhancement. I went on to explain that due to various influences early in life, either of these two sets might readily become

exaggerated or overdeveloped at the expense of the other. I pointed out that a child can be encouraged to overdevelop affectionate, sympathetic, and sexual interests in others or he can be shunted in the direction of an excessive interest in himself. I asked her if she could not recall that early in life she came to be very proud, self-admiring, and self-interested. "My mind is gone," she replied. "I can't remember anything." But I had observed a telltale flutter of her eyelids. I continued with my explanations and questioning.

I pointed out and explained in great detail, freely using analogies and illustrations, that self-interest may be expressed frankly and directly, or it may become diverted to socialized, that is, normally unselfish, patterns of thought and action. The latter tends to happen if the child learns early that if he behaves unselfishly toward others he will be praised and sought after. And he learns this quickly, particularly if he is extroverted and socially inclined and if the attention and praise are generous. I pointed out to her that she had had no sisters to compete with for the attention and laudation of the members of her family; that her father was naturally very fond and proud of his only daughter and freely showed his devotion; that her mother was quiet and somewhat self-effacing; that her brothers were both older than she and were always ready to give liberal commendation in exchange for being waited on or listened to.

It was necessary to go to particular pains in making clear the fact that a selfish motive may be expressed by way of a seemingly unselfish thought or action pattern, a fact which even too many psychologists overlook in the interpretation of human behavior. Although Mrs. N. gave signs of resenting my talk along this line, I felt sure she could not help applying it to herself.

I assured my patient that she not only had developed an exaggerated degree of self-interest in childhood but that she had gone on to camouflage it with seemingly unselfish and socialized patterns of behavior. I explained that her lifelong devotion to the needs of others had been maintained more on her own account than on behalf of those she served. Her self-interest, egoism, had been invested early in the ideas or ideals of service to others. Hence, in order to maintain the fiction of her own perfection, she was forced to make service to others the main theme of her life. And inasmuch as her inner demand of self-perfection was so strong, she had necessarily been slavish in her attention to others' needs.

As evidence of the selfish motivation of her "unselfish" community activities, I pointed to the fact that she had not let her daughter's crippled condition and crying need for help deflect her from her outside activities. I reminded her that she might have devoted herself unreservedly to helping her daughter to develop such capacities and potentialities as remained unimpaired by her infirmity. She had not done this, however. She could not forego the recognition and commendation of the outer group. I likened her to the overburdened bishop who neglects his own family for his flock, because his flock is larger and he gets more praise for his efforts and recognition of his worth than he would get from his family.

As further evidence of her enduring self-interest, I directed her attention to the fact that she had always kept her thoughts and conduct on such an irreproachable plane that now, in her present misery and need of self-deflation, the worst thing of which she could accuse herself was some relatively trivial improper act. She would rather magnify such an act out of all proportion, I explained to her, than face the really significant fact of her profound egoism, her unacknowledged craving to be perfect.

Should the reader feel that to talk to an already depressed and very unhappy patient in the manner which I have indicated is unpsychological or poor therapy, I would point out that in all of his work the psychotherapist takes over the role of the patient's resistance to his repressed interests or desires. Mrs. N. condemned herself for an insignificant act; I merely endeavored to direct her attention to the real cause of her self-condemnation, namely, to her repressed self-interest.

As still further evidence of her exaggerated self-interest and the spurious nature of her past unselfish conduct, I mentioned her present, complete self-preoccupation with its accompanying indifference to the welfare of anyone else. Only a most extravagant self-interest, I told her, could distract her attention from all else and keep it incessantly on herself.

After eight or ten visits during which I talked along these lines, Mrs. N. became increasingly resentful of my visits. She would noticeably stiffen at my approach and gaze at the opposite wall as if strongly determined to be uninfluenced by what I said. But all this indicated that she was being affected by my attack upon her egoistic propensities and that my remarks were beginning to sink deeper

than her self-condemnation. I continued along this line for several more visits, insisting throughout that she acknowledge or refute my statements. Thus:

"You do recall that as a child of five or six you were very proud and satisfied with yourself, don't you?"

"I have no memory. I can recall nothing."

"But even though you have no memory, you know that that was true, don't you?"

"How can I know it was true if I have no memory?"

"Because your belief in your own perfection became a living conviction with you, deeply embedded in the very fiber of your being. Because you never questioned this perfection till recently. Because you recognize that your present feelings of wickedness and selfishness are in sharp contrast to your former feelings about yourself. That is so, isn't it?"

"It must be if you say so."

Usually I would get no nearer to an admission of my contentions than this. But even this constituted a partial admission on her part inasmuch as it was a refusal to continue the argument. At times I deliberately led her into self-contradictions in an effort to break through her stubborn resistance.

"But you haven't always been selfish and wicked, have you Mrs. N.?"

"Yes, all my life."

"But you just said that you had no memory left and did not know how you were as a child."

Then she would become still more rigid and refuse to answer.

Mrs. N. had told me that on the day her illness began, she had refused to answer her doorbell, having glanced through the window and recognized a woman who often came to her for sympathy and help. Her refusal was a sharply discordant note in her lifelong subservience to the needs of others. And it was her refusal to help another person, Mrs. N. said, that had condemned her to eternal misery and the loss of all of her functions.

I explained to Mrs. N. that her refusal had been the expression of a sudden and unguarded declaration of her formerly camouflaged egoism or self-interest; it had been a proclamation of her complete independence and self-sufficiency, of her aspiration to Godliness; in essence, an announcement that she could do as she pleased, for she

could do no wrong, being a perfect and God-like individual. It had been an avowal of her superiority to all moral codes. This was the inner significance with which her act had been suddenly invested. Her profound, egoistic propensities, I further explained, had abruptly become divorced from their previous, tempering alignment with ideals of unselfishness. The freed egoistic cravings, becoming invested in or expressed by the act, lent it a terrible and sinister significance. She immediately began fighting her released, egoistic propensities with self-condemnation and self-negation.

I repeatedly explained to Mrs. N. just why she had needed to condemn herself for this simple and trivial act with such vehemence. Since her ignoring her caller had been motivated solely by egoism or self-interest, in doing so, she had caught a glimpse, as it were, of such a reservoir of egoistic lust that she had been terrified. Saint and humanitarian that she had always believed herself to be, she now found a devil in her own inner sanctum. Inside was a vociferous and incessant clamoring for direct and bold self-expression, unmitigated by any regard for the wishes or needs of others. In order to block this powerful demand for self-acclaim she clenched her hands and steadfastly manufactured thoughts of her worthlessness and emptiness.

Attacks on Mrs. N.'s exalted ideals of unselfishness were made now and then along with the procedure which has been mentioned. I obtained a ready admission from her, almost a declaration, that service to others is the only positive value in life. I pointed out that such a point of view is absurd, unworkable, and unnatural. An individual can be of no greater service to others than he is to himself; for his worth to others is but a measure of the uniqueness or individuality which he has acquired and expresses. A mere slave, I told her, does not really serve others; rather, he encourages others to become dependent, slothful, and unproductive. But one acquires his own particular uniqueness only by a normally free expression of self-interest, of his individualizing tendencies, not through the adoption of patterns of thought and action offered him by others, and never through a *camouflaged* expression of basic propensities. I explained again to Mrs. N. that inasmuch as she had always sought to be wholly unselfish in her thoughts and feelings as well as in her conduct and to comply fully with the wishes and needs of the group and with purely conventional standards, she had inevitably arrived at a point of com-

plete egoistic frustration. Her egoistic propensities were now demanding complete right of way and were therefore coming into violent conflict with her lifelong, rigidly sustained social ideals.

My purpose was not to convince Mrs. N. of any undesirability of unselfish ideals as such, but to lessen markedly the exalted value which she had always accorded to such ideals. Accordingly, I tried to force her to see that her exaggerated ideals of unselfishness were, in fact, largely a product of her lifelong, camouflaged self-interest. I reminded her that there was no doubt that she had become self-adoring and too interested in herself as a child. Her exaggerated self-interest became diverted to the goals, ostensibly, of unselfish endeavor. In other words, she had set out early in life to become a perfect individual and had chosen, as her path to this end, complete unselfishness toward others.

She did not take kindly to this line of reasoning. She was tense and resentful but showed more inclination to "fight back" than she had formerly. And although she incessantly heaped condemnation on herself, she tended to limit this to the act of not answering the doorbell. True, she repeatedly accused herself of lifelong selfishness but this was little more than lip service. She plainly showed that she did not like to have another person say that she had always been selfish, and she was extremely reluctant to recognize the disguised, self-interest back of her previous "unselfish" behavior. But it was only when she began to tolerate this fact that she began to improve.

At the end of about three months Mrs. N. was definitely improved, though far from well. She appeared less tense at my approach and occasionally her hands lay unclenched in her lap. I had reviewed her childhood development and the course of her mental life a number of times. One day she quietly remarked that she guessed she had always wanted to think too much of herself and others to think too highly of her. This was the most matter-of-fact and candid statement she had uttered about herself.

As Mrs. N. became less tense, began to sleep better, condemned herself less frequently, and grew less resistant to talking, she appeared to become increasingly concerned about her daughter's welfare. I foresaw her growing concern about her daughter's crippled condition as an obstacle which I would be unable to remove or to help her to resolve. In other words, I was afraid she would come to the point of anchoring her own right to self-interest to her daugh-

ter's unchanging (unchangeable) condition. That is, she would tolerate personal freedom in herself only to the extent that her daughter could enjoy an equivalent measure of personal freedom. In view of this fact and inasmuch as one of the state institutions had just inaugurated a service for voluntary patients, I induced her husband and sons to help me to persuade her to go to the hospital as a voluntary patient. She consented, partly, I think, in order to be rid of me and my unpleasant talks. The only specific treatment given her there was whatever occupational therapy she could be induced to engage in, which reportedly was very little.

Mrs. N. was dismissed from the hospital at the end of two months as fully recovered. During the next two years there was no recurrence of her illness; nor did she attempt, during that time, to resume her former social welfare activities. For the last six years I have had no opportunity to secure any firsthand information concerning her mental status.

Although Mrs. N. adopted a faulty and one-sided life plan when still a child, her daughter's early and continued illness was not overlooked as a contributing causative factor of probable great significance. It was rarely mentioned during the treatment, lest suicidal reactions be precipitated. But it had constituted a direct and profound challenge to Mrs. N.'s unselfish capacities and, therefore, must have added considerably to the inner strain due to her largely suppressed unselfish and camouflaged selfish motivations. That this was so seemed to be indicated by her declarations that her daughter was becoming just like her, that is, a victim of the mother's wickedness (selfishness) and by the fact that as she began to improve, her attention turned increasingly to her daughter, not to her former social activities.

CHAPTER 6

Psychopathic Reactions

THE CONDITION known as constitutional psychopathic inferiority, or more simply as psychopathic personality, is of undetermined frequency and unknown origin. Hospital statistics are useless in arriving at its frequency since only a few of these cases are ever committed to hospitals. They are more likely to be found in jails and penitentiaries. Most of them, however, are perhaps to be found in neither place but are moving freely about, albeit, along the more shady avenues of human intercourse.

The psychopathic personality will usually make a very good first impression. He will appear frank, friendly, and in full command of his destiny. If he lies, and he perhaps will, it will be without the flutter of an eyelid. If permitted to talk freely, he may gradually assume the attitude of doing the therapist a favor by talking to him.

This is one of the most difficult of all conditions to diagnose. *Unless a fairly conclusive case history is at hand, only a gradual elimination of all other possibilities will bring one to a correct and certain conclusion.*

It is more appropriate to think and speak of clinical forms or varieties than of symptoms in relation to psychopathic reactions. In every case the symptomatology has profound social significance. In fact, if it were not for this, psychotherapy would be very little interested in the problem, for, as a group, psychopathic personalities are not among the world's mental sufferers and seldom seek help of their own volition. The more common varieties include *pathological liars, swindlers, thieves, forgers, impostors, quacks, alcoholics, drug addicts, prostitutes,* and *sexual perverts.* These dif-

ferent forms are not, of course, mutually exclusive. The swindler, for instance, can hardly help being a good liar at the same time. On the other hand there is the pathological liar who does not make a practice of swindling.

Thus far, the psychopathic personality could be more accurately described as the sociopathic personality. All persons who fall in the categories which have been mentioned, however, are not psychopathic personalities. The type of person being considered here is unquestionably a true psychological case even though he is not too well understood and usually proves incurable. The best clinical evidence supports the view that *the psychopathic personality is inherently deficient in those capacities*, other than intelligence, *which support the development of truly moral and social sentiments.* The most basic and enduring moral and social sentiments are rooted in the individual's unselfish, affective capacities. A marked deficiency in these inevitably results in a lack of any genuine concern for others. This in turn precludes a sense of responsibility to other persons. Briefly summarized then, we have a person who is genuinely *cold toward others, unreliable, inconstant, self-centered,* and *unstable.* He is relatively incapable of profiting from experience simply because experience for him is so devoid of any affective quality other than the selfish impulse of the moment. He is incapable of sustaining any course of conduct which does not provide constant nourishment to his egocentricity. Lacking those qualities mentioned and having neither a past to uphold nor a future to achieve, he is unstable and the ready victim of any impulse of the present.

The psychopathic personality will usually make scores well within the normal range on tests of neurotic tendencies, emotional adjustment, social adjustment, etc. He is prone to answer such tests in accordance with his understanding of what constitutes normal or acceptable human values and conduct rather than in keeping with his own personal characteristics. A free association test more than any other will tend to reveal whatever affective capacity the patient may possess. Reference to intelligence test scores will aid in evaluating the extent of the personality defects once a diagnosis of psychopathic reactions has been made. The higher the intelligence, the more indicative the maladjustive or antisocial conduct is of deficiency in the affective sphere.

The case history is the most important and reliable instrument of diagnosis. The early history is usually negative, except for an absence of strong friendships or affectionate attachments, which fact can sometimes be established through parents or older siblings. Once psychopathic personality is suspected, the therapist should look searchingly for any possible evidence of early affectionate attachments, particularly to younger siblings or pets. In doing this, however, there is always more or less danger of mistaking possessive (egoistically supported) attachments for those of a truly affectionate (selfless) character.

The history from the age of ten or twelve on should be investigated carefully for evidence of asocial and antisocial conduct. The psychopathic personality is often an easy mixer. Unless the patient has run afoul of the law on one or more occasions, this part of the history too may appear negative. Needless to say, any infringement of the law or of moral standards should be examined closely with regard to motivation and provocation.

There are still other data, usually obtainable, which help in making a diagnosis and in estimating the individual's capacity for selfless interests. The therapist should inquire as to the exact age at which personality, moral, or affective deficiencies first became apparent. The individual who became a habitual liar, thief, truant, or other moral or social misfit at the age of six or eight is a far less promising case, other things equal, than the person in whom such tendencies did not appear till the teens or later. Similarly, the patient whose parents were inferior and who came from an inadequate home cannot be directly compared with the patient whose parents were superior and who came from a good home.

As soon as the therapist is reasonably certain of a diagnosis of psychopathic personality he should weigh whatever evidence he has of any capacity in the patient for selfless interests. If he is without such evidence after he has studiously examined the case history and other data on the patient, he will perhaps lose less sleep during the succeeding months if he dismisses the patient then and there. The writer knows of no type of patient who can induce so much painful frustration in a psychotherapist as a psychopath.

The following case, for instance, was believed to be incurable and was dismissed after a few visits. No evidence whatever was obtained

of any selfless interest at any time during his life. Part of a conversation between him and the writer was essentially as given below. The patient was a man of high intelligence, twenty-three years old, married three years, and the father of one child. He came of a good family. He had never held a job for more than a few weeks either before or following his marriage. He was a pathological liar. At times he did not appear to be sure himself when he was recounting actual events and when he was merely imagining them. When detected in obvious lies he did not manifest the slightest shame. Rather, he immediately told another lie.

"Have you ever been genuinely fond of another person?"

"Yes, certainly."

"Of whom?"

"Why, of my parents and brothers and sisters and wife and child."

"I mean have you ever loved another person?"

"Of course."

"Those persons you just mentioned?"

"Yes."

"Are you in love with your wife?"

"Certainly. Why would I have married her if I hadn't been?"

"Very well, let's stop for a moment and examine your exact feelings for your wife. Describe to me exactly how you feel at a moment when you could spontaneously tell her you love her."

"I want to be near her I guess. Perhaps I feel like kissing her. I want her to kiss me."

"A lot of men would like to kiss every pretty girl they see. Does that mean they are in love with them?"

He appeared puzzled for a moment, then replied, "But I don't want to kiss every pretty girl I see."

"Now I want to ask you another question. You see we are merely trying to get together on this matter of love or affection. You complained to me the other day that you had caught cold because your wife was absent from home and you had no one to keep your feet covered during the night. So I want to ask: Does it seem to you, you love your wife more when you are sick or when you are well?"

"I guess I love her more when I am sick."

"When you say you love your wife you really mean you feel a need of her, don't you?"

"Well, aren't they the same thing?"

"No, I'm afraid they aren't. Haven't you ever in your life experienced a feeling of tenderness for someone, a feeling that you would like to do something for him just to make him happy and see him smile?"

The patient looked at me as a child might to whom one were trying to explain the fourth dimension.

Assuming, on the other hand, there is evidence of some degree of capacity for selfless interests and a course of treatment is to be undertaken, then the specific aim of the treatment is already rigidly determined. There is no real substitute in human life for unselfish effort and interest. The only possibility which the therapist usually has, then, of helping the patient is through the thorough awakening of whatever capacity there is for selfless interests and the bringing of this capacity into integration with the patient's other mental capacities.

There is very little place in the treatment of the psychopathic personality for nondirective therapy. One is not dealing with a case of repressions or complexes as such. The procedure must be initiated and sustained by the therapist. The central purpose is to discover and awaken any dormant capacity for unselfish effort. To the extent that such capacity can be brought to the fore, it is the further responsibility of the therapist to see that the patient makes use of it. "When you go home this evening take your wife a bunch of flowers. If she faints at the unexpectedness of such treatment, don't call a doctor, just throw a little cold water in her face. Ask her now and then how she feels, how she would like to spend the evening, if she would like you to take her out to dinner. And in asking these questions, *listen to what she says.* Begin to treat your wife as if you liked and appreciated her, and let's see what the results are. This is sort of an experiment which we are going to carry out and we want to do it thoroughly so put everything you have into it." Or: "Now the next time you give a party try to think of the party's being for your guests, not for yourself. Try to see that everyone has a good time and see what effect it has on your feelings. Try to hold in check your tendencies to be at the center of things. Hold yourself in the background more than is your wont. Also, try to put a little sincerity into your actions; don't just act a part. This is an experiment. Let us see what it reveals."

Inasmuch as the psychopathic person has relatively little affective

capacity, he is not used to relying on what he has for satisfaction in his daily life. In fact, he may long since have pushed aside or suppressed whatever capacity of this sort he actually possesses. Moreover, should being friendly or mildly affectionate or otherwise unselfish lead him into frustration, disappointment, or other painful experience, he is capable of repressing his selfless propensities immediately. He is capable of doing this simply because he does not have much to repress. He stands in sharp contrast in this respect to the normal young woman, say, who is jilted and vows never to look at another man as long as she lives, only to fall in love again in a few months. A psychopathic young woman of high intelligence, married and the mother of two children, had never shown signs of maladjustment till she discovered that her husband had been unfaithful to her. She thereupon immediately became utterly cold toward her husband, almost completely indifferent to her children, and readily turned to semiprostitution. She continued to live with her husband and manifested little or no feeling of any sort toward the woman with whom he had been intimate. It is easily conceivable that she would have lived an outwardly normal life had not her *weak,* selfless propensities readily permitted egoistic frustration and humiliation. Such cases are not infrequent but are always puzzling to relations and friends.

The patient's unselfish capacities should be held up to him as personal assets of the highest order; not in a moral or ethical sense but with the assurance that they have an unrecognized potency for enhancing the satisfaction of his day-to-day life. Every psychopathic personality craves the recognition and admiration of other persons. The therapist should make every effort to convince him that only through the utilization of his selfless propensities can he possibly obtain this desired attention.

A transference relationship to the therapist of normal strength naturally will not occur. The therapist must accordingly take care not to ask more of the patient at any time during the treatment than the patient is capable of. Needless to say, full use should be made of any degree of transference that appears. There is no better exercise for unselfishness than being unselfish.

Particularly in the case of the unmarried patient one should look into the home situation. Parents have often become utterly distrustful of his dependability and show it. This should be corrected.

The patient cannot be expected to make any improvement as long as he is kept on the defensive. The parents should be instructed to appear to place confidence in him whether they feel it or not. The same reasoning applies to spouse, of course, in the case of the married patient.

Finally, the patient's fitness for his occupation—assuming he has one—should be considered. No person of this type should occupy a position of heavy responsibility; nor should his work entail much drain on his selfless capacities. A white-collar, routine sort of work is best.

TREATMENT OF A CASE OF PSYCHOPATHIC PERSONALITY

Lawrence R., a man of thirty, married eight years and the father of four children, was brought to me by his mother and wife for intensive psychotherapy. He was on parole from a state hospital. At the hospital he had been diagnosed as psychopathic but not insane.

The patient's father had died of natural causes two years previously. His mother was in good health. There was one brother, twenty-one, and two sisters, nineteen and twenty-three respectively. Aside from the patient there was no history of nervous or mental disorders in the family. The family had always been above average educationally, socially, and economically, and had consistently held a prominent position in the community. I gathered that the home atmosphere had always been friendly and dignified.

Lawrence had always enjoyed good health. He had completed two years of college but had never liked school and had been only a mediocre student despite an I.Q. rating of 117 on a standard intelligence test. His family had always regarded him as well adjusted till the last two and one-half years. Following his marriage he had secured a good white-collar position in a business which his father controlled. He appeared to get along well with his associates but this may have been largely because of his father's position in the firm.

I was unable to uncover any strong interests or attachments in childhood. Lawrence's mother told me that he had been an average sort of child except for a lack of perseverance and industry. On several occasions she had given him money to work for higher grades

in school. His grades had not changed materially. Twice he had wandered away from home when very young and got lost. She believed he had been less obedient than her other children but seemingly out of thoughtlessness rather than from any open defiance of her wishes. He had never been an affectionate child. His brother and sisters felt they had never understood him very well.

No strong interests or attachments had appeared during pubescence or adult life. He had no particular preference in regard to vocation other than that it should be work of the white-collar variety and not strenuous or too exacting. He was definitely shy of manual labor of any kind. His interest in the opposite sex had always been mild. As far as I was ever able to learn his chief reason for marrying was to add to his prestige in the community in which he lived and, of course, to have someone to wait on him. Only a married man, in his eyes, could be a really prominent member of the community.

The business concern for which Lawrence had worked was located in a small town. He had taken an active part in the affairs of this community. He has been on various committees at different times and had apparently been liked and respected.

Within a few months of his father's death Lawrence was accused of stealing ten dollars from the cash register by his superior and was dismissed. He stoutly denied having taken the money. Although he was not prosecuted he was out of a job. He then began to reveal his psychopathic make-up. He immediately took to gambling. When his small savings were exhausted he began forging checks. He did these things in the same small community in which he had lived for years and where he had served on committees and been something of a community leader. His mother redeemed his checks but soon came to believe he was suffering from some mental ailment and had him committed to a state hospital. At the end of six months the superintendent of the hospital requested Lawrence's mother to take her son out on parole. He had manifested no psychotic symptoms and the hospital was overcrowded. The patient returned to his own family, who still lived in the community where he had worked. Shortly after his return home he again commenced forging checks, always signing his wife's name. He continued to do this till he was brought to me more than a year later. For a time his mother had continued to redeem the checks, then she stopped. He was not pros-

ecuted, perhaps because no check was written for more than twenty-five dollars and because of the high esteem in which Lawrence's wife was held.

When he was unable to cash any more checks in the town where he lived, Lawrence moved with his family to a larger city some twenty miles distant. Here he was successful in cashing small checks for several months. When he could no longer do so he took to searching about for the money which his mother sent to his wife periodically for the support of his family. Many times he succeeded in finding it despite his wife's best efforts at concealment. He would help himself to the money, taking as much as twenty dollars, say, from a total of twenty-five on hand, although he knew several days were required to get more money from his mother who was living several hundred miles away.

On different occasions Lawrence took the last money his wife had in order to make the trip to his mother's home for more money. If there was sufficient money he would go by airplane. This would cost him twelve dollars. Thus he would spend twelve dollars to fly to his mother's home and ask for twenty-five dollars from her. Of this he would spend five or six on a return bus fare home. He also pawned nearly everything in his own home except the furniture, bedding, and cooking utensils.

After his dismissal from the hospital Lawrence did little or no gambling. He spent the money which he obtained in the various ways mentioned to buy drinks for the loungers in the beer parlors. Nothing seemed to give him such a feeling of self-importance as buying the drinks for the crowd. It made little difference to him whether the persons knew him or not. He would actually take the last dollar of grocery money from his own children in order to buy beer for strangers. During the two years or more since the loss of his position he had made no effort to secure employment.

After listening to the story of his maladjustive and antisocial activity, I had little hope of being able to help him and accepted him as a patient only at the earnest pleading of his wife and mother, both of whom had been driven to the point of desperation. I began by making a detailed study of the patient's childhood history, largely in the hope of discovering some evidence of dormant affective capacity. At the end of six weeks I had found very little evidence of such. Although decidedly gregarious in his behavior, always

seeking group situations, he had perhaps never felt genuinely friendly, sympathetic, or affectionate toward anyone.

I decided to try to make use of his gregarious propensities. If he was utterly dependent on the presence and recognition of others for any positive sense or feeling of his own I-ness, as he seemed to be, this fact had certain theoretical possibilities. Possibly he could be induced to conform to the standards and ways of others in order to assure himself of their recognition and esteem.

I devoted a considerable amount of time to the discussion of such matters as the interdependence of individuals and groups in modern society, of the necessity of the individual's complying with established laws and conventions irrespective of his own inclinations, and the compensation to the individual who complies in the form of community respect and esteem. I emphasized the fact that the person who refuses to comply inevitably becomes ostracized and held in contempt. I assured Lawrence that, if they knew of the situation of his wife and family, many of the persons for whom he bought beer would refuse to drink with him. Still others would continue to drink his beer but would not want to be seen with him among their own friends. I pointed to the immeasurable power which the community holds over the individual and the utter futility of trying to resist or combat it.

Perhaps I should point out that Lawrence was still on parole from the hospital and that this fact together with the fact that his mother and wife both declared that everything was in my hands and left to my judgment gave me a considerable leverage. If this had not been the case, it is doubtful if he would have kept his appointments.

Among his responses to a free association test, the responses to three words in particular stood out. These words were "fear," "disgrace," and "failure." His response words were not atypical but his reaction time was very long. This indicated a mental blocking and a tendency to recoil from the meaning of the words. It suggested further that he had been keenly distressed over the loss of his position and the recognition and respect of his community. Careful questioning and study clearly established that his distress had not been on account of his mother or wife or children; he had suffered no remorse or self-reproach at having brought hardship and disgrace on them; rather, he had suffered in the sense that the miser does who is forced to part with his money. His narrow self-esteem, his I-ness, had

been wounded by the loss of the recognition which his community had formerly accorded him. This showed that his selfish or egoistic aspirations and his daily feeling of his own importance were intimately bound up with and dependent on community recognition and esteem. This insatiable desire for the recognition and acclaim of others is not an uncommon characteristic of psychopaths and stood out as the only promising feature of Lawrence's case.

It had become apparent, then, that although my patient did not possess the unselfish capacity to make an adjustment on behalf of mother and family, or the moral strength to do it out of a sense of fairness or decency, he might be induced to make the effort on behalf of his own pronounced self-interest. Buying beer for groups of men and in this manner being the "big shot" of the moment was decidedly second choice with him to enjoying the esteem and recognition of more important citizens.

For the next two months, having worked with him for two, I tried in every way I could to picture community recognition in its most alluring colors. I repeatedly reminded Lawrence of his intellectual and educational assets, and pictured to him the kind of figure he would present if he could succeed in discarding his maladjustive and socially estranging ways and make a sustained and determined effort in the opposite direction. I avoided moralizing. I permitted a bit of swagger to creep into the picture we drew of him as he walked to his office in the morning, casually passing the time of day with the town's leading citizens.

This procedure seemed to prove even more effective than I had dared to hope. Lawrence became increasingly restless and dissatisfied with his present way of life. For a time he became more irresponsible than ever. He missed two or three appointments. He flew to his mother's home for money and then did not go near her when he arrived.

When I thought the "psychological moment" had come, I told him I had a plan whereby he could largely re-establish himself in the eyes of the community and go on from there to being somebody. I explained that I would obtain the money from his mother but that he would have to go around in person and redeem the forged checks which were still outstanding. They amounted in all to about two hundred dollars. None was for more than fifteen dollars. He was very

loath to do this. I admitted to him it would take some grit but it would go far toward restoring his standing in the eyes of the men he had cheated. He finally consented and redeemed the checks. His mother was uneasy and wished me to go with him but I stoutly refused.

Readily acting on my suggestion, Lawrence then wrote to one of the leading officials of the firm for which he had worked. At my instructions he fully admitted his two years of maladjustive and shameful conduct but stated that he believed that he had been greatly helped and would like to get back to work. The official, who had long known Lawrence's parents and siblings, replied in a friendly and encouraging vein. He wrote that there were no positions open in his firm but gave permission to give his name as a reference and suggested a similar company in another state.

Lawrence declared that he was very desirous of visiting this company in person. I thought it best to let him make the trip and had his mother supply him with the necessary money. I told him he would not need to come to me any longer provided he secured employment. At the end of a few days I received word from him that he had obtained a position, and two weeks later he sent for his wife and children.

I did not believe that Lawrence would ever come to know a normal degree of selfless interest in his wife and children or that he would be able to adjust to severe frustrations. At the same time I felt that if he got most of the "breaks" he might be able to go along as an acceptable member of his community and provide financial support for his family. I was further of the opinion that there was little or nothing more that I could do for him in any case.

Approximately three years after the conclusion of Lawrence's visits to me I received a lengthy letter from his wife. She stated that her husband still held the same position, worked regularly, and apparently got along well with his fellow employees. Her specific reason for writing to me, she went on to say, was that recently Lawrence had taken to demanding that she practice fellatio with him. This caused her such keen mental distress that she was considering a divorce, but decided to write me for advice before taking any action. I felt unable to advise her in the matter, particularly from a

distance and by letter, and suggested that she consult some competent psychologist or psychiatrist near her home. I never learned the outcome of the difficulty.

This new trait in Lawrence definitely pointed up his basic psychopathy and pronounced lack of affective tolerance. Such demands as he made on his wife are perhaps always more egoistically than sexually motivated. Compliance in his behavior with the ordinary demands of the community in which he lived and worked left his egoistic cravings unsatisfied. Hence, in his unfeeling and inconsiderate way, he sought to utilize his wife to enhance his own sense of importance.

CHAPTER 7

Hypochondriacal Reactions

THE WORD "hypochondriacal" means morbid concern about one's health in the absence of physical causes for such concern. Hypochondriacal reactions are found in the symptomatology of various psychotic and psychoneurotic disorders. Occasionally, however, such reactions essentially comprise the symptom-complex. The present chapter is concerned only with cases of the latter type. Where such reactions constitute only a secondary symptom of a disorder, treatment is governed by the basic character of the illness.

Hypochondriacal reactions vary from *vague but continuous preoccupations with matters of physical health to solid convictions of incurable diseases.* When the conviction assumes the inflexibility of a permanent delusion, little or nothing can be done. But in many cases the patient is only incessantly worried lest he injure his health. In such cases a great deal may be accomplished.

The case history will usually reveal one of the following conditions as having existed during childhood: the patient was chronically ill and was encouraged to use his illness to gain attention and concessions from others; the patient became physically ill because of, in connection with, or immediately following an acute emotional disturbance at some time during his developmental history; a parent or older sibling was chronically ill and/or a chronic complainer during the patient's early childhood; one or both parents manifested excessive concern about their children's health.

In addition to one or more of the conditions mentioned or some

equivalent circumstance, the history will show evidence of over-identifications, marked emotional dependence, and exaggerated submissive tendencies. Overidentifications are of particular significance, the other two factors often being but the results of them.

Every child tends to identify himself with various meanings or attributes of his environment. This process is an entirely natural and important aspect of his psychic development. Inasmuch as this process is an active striving toward or to possess or to be like, he tends to identify himself with attributes which appeal to him and are potent in getting and holding his attention. The little boy normally identifies himself with his father or, perhaps, an older brother. His father's size, strength, knowledge, abilities, etc. appeal to him. He wants to possess these attributes, to incorporate them within his own identity or make-up. But the father's various attributes are consolidated or incorporated within the single identity of "father." The boy reacts to his father as to a single entity, not as to his many distinct attributes or qualiies. This fact is of tremendous significance. It means that the child is unwittingly led to identify himself with his father's negative as well as with his positive attributes. "Like father, like son" is a tersely cogent expression of this fact. As time goes on the boy's identifications tend to be extended to other boys and men, but in the beginning the process of identification tends to relate to and be largely determined or guided by some one person in his immediate family.

A moment's reflection will make it obvious that the child inevitably comes under the influence of the person with whom he identifies himself in proportion to the strength of the identification. For one cannot seek to become like another person without placing himself in a postition of subordination to that person. What the person says and does, thinks and feels comprise first-order influences in the daily life of the individual who is making the identification. If the identifying process is unusually concentrated and sustained over a considerable period of time, *an overidentification will result.*

An overidentification is a bondage, an enslavement. It distorts and frustrates inner freedom and individualizing tendencies. It imposes on the individual the personality pattern of another. It blocks the attainment of a normal degree of self-sufficiency, restricting it to a subordinate relationship to some one person, a single group, or to some one concept or meaning. Morn as it is of the more unwitting

and affective levels of mental activity, it comprises an emotional complex within the individual's psychic organization, exerting a tremendous influence on his daily thoughts, feelings, and attitudes.

With increasing maturity, an overidentification with another person comes to be felt as the frustrating agency which it actually is. A strong inner protest develops. There is an urgently felt need to break free from the mental bondage imposed by the identification. But the individual concerned tends to see the person with whom he is overidentified as the frustrating and interfering agency instead of the complex within himself.

There are perhaps cases of hypochondriacal reactions wherein the patient suffered from prolonged chronic illness as a child, received a great deal of assistance and attention because of this, failed for the same reason to mature emotionally, but did not develop overidentifications. Other than for this type of early history the writer believes that overidentifications enter into the genesis of all cases of hypochondriacal reactions. It seems extremely doubtful, for instance, that mere association with a chronically ill or complaining parent would conduce to the development of hypochondriacal tendencies in the absence of a strong identification with that parent. *The psychology of hypochondriacal reactions, then, is essentially that of overidentifications coupled with the idea of physical illness, in a person who is seriously lacking in feelings of self-sufficiency, independence, and personal competence.*

Whatever the genesis of the hypochondria in the patient at hand, the specific and major aim of the therapy is to divert the patient's attention from himself and the idea of illness and to direct it to the world of objective reality and to more satisfying ways of acquiring and maintaining a sense of his own identity. The patient has become enslaved by the idea of physical illness. He depends on this chiefly for his sense of his own identity and uses it as an excuse for not undertaking more in life.

The treatment of hypochondriacal reactions naturally falls into two parts. The first part of the treatment consists of a thorough analysis of the genesis of the disorder; the second part comprises a re-educative procedure in regard to subjective processes, personal relationships, and purposes in human life. The second part often requires a considerable period of time.

The interrelationship of mental and physical factors in good health and ill health should be clearly explained to the patient in the beginning of the treatment. At first he may be very skeptical of this if not openly resentful and antagonistic. Accordingly, the therapist may need to emphasize the fact that mental factors are as genuinely causative in our daily well-being as physical factors; that a mental factor in the nature of a desire, an aversion, a constant direction of attention, or a partially or wholly repressed interest or attitude may produce symptoms of a purely physical character; and that illness which results from mental factors is just as serious and genuine as that which results from physical agencies. It should be further stressed that one is no more responsible for illness which results from mental factors than he is for an attack of diphtheria or smallpox. He should be helped to recognize the fallacy which exists in the universal tendency to minimize the seriousness of illness which results from mental causes. In helping the patient to acquire a workable orientation, it is sometimes useful to mention the generally recognized role of mental factors in such purely physical conditions as stomach ulcers, spastic colitis, functional blindness and paralyses, hay fever, and a host of other conditions. At no time should the patient's illness or his belief in his susceptibility to illness be refuted.

As soon as a workable degree of rapport has been established and the patient's cooperation secured, a painstaking analysis of the genesis of the hypochondria should be commenced immediately. This requires, of course, going back to the earliest years of the patient's life. As rapidly as the therapist can discern the particular course of the development of the disorder, he should explain it fully to the patient. If an early identification with an ill or complaining parent is brought to light, for instance, the whole process and significance of identifications should be explained forthwith. The patient must be made to see that by adopting such a parent as the pattern for his own psychic development, he unwittingly and inevitably incorporated within the meaning of self the idea of physical illness or a susceptibility to such. The identification with the parent should be explored in all directions. The greater the number of similarities which can be established between the patient and the parent or person with whom he early identified himself, the more convincingly the idea of illness can be brought within the province of identification. Established habits of implicit and overt activity should be

explored for such similarities, as should likes and dislikes, mannerisms, peculiarities of speech, walking, coughing, sneezing, combing the hair, etc., etc.

If, on the other hand, there is a history of childhood illness, the exact bearing which this had on the patient's personality development should be worked out in detail. If there is evidence to support this, the patient must be helped to understand just how his early life gradually became organized about the idea of illness; how this interfered with his erecting other personal values and meanings; and how his illness came to stand as the *nucleus of his selfness.*

In the case of the patient who developed hypochondriacal reactions in the absence of a history of early illness or illness of family members, the etiology, the writer believes, is rather unique. The illustrative case at the end of the chapter presents this type of patient.

It will be gathered from what has been said that the first part of the treatment consists largely of directive therapy. A free association or nondirective procedure would perhaps never elicit most of the relevant material in the hypochondriacal patient. Because of the strong inner protest which exists against his overidentification, the facts of the identification tend to appear only in a negative or distorted form. Similarly, the patient who suffered from early chronic illness is prone to recall only the unhappy side of his illness, not the use he made of it in gaining attention and enhancing his sense of personal identity.

The patient's symptoms will not usually have disappeared with the conclusion of the first phase of the treatment. Hypochondriacal preoccupations are very tenacious, constituting as they do a watchfulness over an inadequate sense of self-sufficiency and a guard against the encroachment or influence of other persons. The second phase of the treatment, the re-educative and educative therapy, must be carried out painstakingly and systematically. The patient must be made to understand fully the basic importance to individual adjustment of an adequate feeling of self-sufficiency and personal competence. The lack of such instills fear and uneasiness and tends to rivet the attention to self. This interferes still further with efforts to deal effectively with the environment. Any individual who is kept from putting forth a normal degree of effort because of unrecognized but deeply rooted feelings of inadequacy, sooner or later

becomes painfully aware of his failure to lead a progressive and active life. His egoism, personal pride, self-esteem then *demands* a sufficient reason (excuse) for his failure. The ceaseless preoccupations with ideas of illness or a pronounced susceptibility to such are put forth and sustained as *the* excuse (defense mechanism).

Cases illustrating essentially the same psychological principles but presenting different symptomatologies may be freely used in the explanations given the patient. A young woman was very ambitious to become a pianist. She actually felt inadequate, however, to reach her goal. Perhaps she seriously doubted that she had the necessary musical talent; perhaps she just felt inadequate as a young woman. In any case she either did not recognize or could not admit to herself her feelings of inadequacy. Following an ear infection, she suffered from (acquired) akoasms. This symptom became very fixed and constituted an absolute barrier in her eyes to going ahead with her musical education. A certain young man became interested in a certain young woman. They became engaged. The young man felt utterly inadequate to meet the responsibilities of marriage. Because he was not able to admit this fact to himself he did not recognize it. He developed a functional paralysis of the right arm. He then ended the engagement, despite the girl's protests, telling her he could not permit her to marry a man with a useless arm.

Active therapy should be introduced as early as feasible and used as fully as possible. The extent to which it can be employed will depend, first, on the degree to which a transference has developed and, second, on the weakening of the self-preoccupation. These patients are too self-centered and oversensitized to the influence of other persons to develop transferences easily. There is danger, therefore, in the therapist's overestimating his influence with the patient. It is better to err on the side of asking the patient to do too little than too much. The active therapy may consist of almost anything which requires the patient to attend to objective facts and to make some sort of constructive effort in connection with them.

In the use of active therapy little or nothing should be left to the judgment of the patient. Thus, if he is requested to risk heart failure by helping his wife with her housework, specific tasks should be stipulated and he should be instructed to attempt nothing beyond the activities mentioned. Any inclination on his part to do more than has been asked and thereby impress or surprise the therapist or

". . . just to try myself out" must be strongly countermanded by the therapist. The reason for this is that if the patient overreacts against or away from his symptomatic preoccupation with himself, a relapse accompanied by an increase in the rigidity of his hypochondriacal tendencies is certain to occur.

Temporary relapses with this type of patient are to be expected no matter how judiciously the therapist is conducting the treatment. If the therapy is proving effective, the relapses will decrease in frequency and duration and following each one the patient will be capable of longer periods of constructive effort.

The writer believes it is doubtful if well-established hypochondriacal ideas are ever completely eliminated. This makes little difference, however, if the force (motivational strength) back of them can be diverted. Even in the most successful cases the idea tends to persist, constituting a sort of psychic shell or shadow of its former vitality. "I expect to drop dead any day but I don't let that stand in my way any longer."

TREATMENT OF A CASE OF CHRONIC HYPOCHONDRIA*

Jacob T., a man of thirty-nine, possessing the outward appearance of perfect physical health, came for help of his own volition. His principal symptoms were a pathological fear of fatigue or of overexerting himself and a firm conviction that he was a victim of lead poisoning. He had been to many specialists and had tried innumerable treatments without results. He stated frankly enough that no specialist had been able to detect signs of lead poisoning. Negative reports had not weakened his conviction. The lead poisoning dated, he believed, from the age of sixteen, when he last worked in his father's small-town newspaper establishment.

I secured a case history from the patient himself, having no opportunity to contact a relative. Jacob had only one sibling, a sister who was several years his junior. Both parents were deceased, apparently from natural causes, but had lived to fairly ripe ages. His sister was married and in good health. I was unable to obtain any

*I have selected this particular case because I believe it illustrates in an unusually clear manner the role of overidentifications in the genesis of certain cases of hypochondriacal reactions.

history of chronic childhood illness in the patient or chronic illness in either parent.

Jacob's father had been the owner and editor of the one newspaper in a small Midwestern town. The educational, social and economic levels of the family had been above the average for the community. I was able to learn of no outstanding peculiarities of parent or sibling except that the father had apparently been an unusually dominant member within the family group and had perhaps not been too honest and conscientious in his treatment of the members of his family. The home atmosphere had always been congenial, largely as a result, I inferred, of the mother's pleasant and submissive disposition.

Jacob stated that he had been strong and healthy throughout his childhood. He believed he had some of the more common children's diseases but had never been ill over a prolonged period of time. He became ill at the age of sixteen and had never recovered, which facts will be discussed in detail shortly. He had been above average as a student in school without excessive effort and had graduated from high school at the age of sixteen.

Although he had known nearly every person in the community and came into frequent contact with many of them in connection with helping his father in the latter's printing shop, Jacob's early social life had been narrow in the usual sense of the term. He had always been serious-minded and had not cared much for social activities as such. Following the onset of his illness his social life had been almost nil. At the time of his visit to me he was maintaining no social contacts whatever. Since leaving home at the age of seventeen he had supported himself without difficulty as a typesetter. I gathered that he was unusually efficient in his work and had never experienced difficulty in obtaining part-time employment, which was the only kind he would accept.

As I inquired into Jacob's early history, particularly his early attachments and interests, one fact stood out far beyond all others. This was an early overidentification with his father. From his earliest recollection to the onset of his illness when he was sixteen, his father had been his model in all things. This fact was supported by numerous early memories. And even when still only eight or ten years old, his identification became extended to include his father's field of work. When about ten he began to help his father regularly in the

printing shop after school hours, on Saturdays, and during the summer months. He was not paid for his work and declared that he had never wanted or expected to be paid.

By the age of twelve or thirteen Jacob was setting type, soliciting subscriptions, delivering orders of printed material, gathering news items, and in fact participating in all aspects of the enterprise except composing and writing captions and editorials. During these years he became increasingly bound up in his relationship to his father and their mutual work. This automatically excluded other interests and social activities. Also, his overidentification with his father *left him dependent on this relationship alone for a sense of personal identity, a normal feeling of self-sufficiency and self-esteem.* In his sense of personal identity he and his father were inseparable. He was simply a branch of the trunk, which was his father. His father was an unimpeachable judge in all matters, and Jacob was part and parcel of the judge, and, therefore, never questioned the judge's judgments. Moreover, the judge was kindly and very appreciative of Jacob's help, which meant that Jacob held his own efforts in very high esteem. In addition to all this, of all the youngsters in the community, Jacob was first to the news, closest to the great world all about, the world which his father and he depicted in the headlines of *their* newspaper. He was the publisher's son and the publisher's dependable right hand and he undoubtedly felt himself admired and envied on all sides.

When Jacob was fourteen or fifteen his father voluntarily promised to send him through college as soon as he finished high school, in appreciation of the loyal help which he had given. As my patient told me about this it seemed obvious that he had regarded this promise not in the light of its monetary value or as assuring the enhancement of his own future but rather as an avowal of esteem and appreciation. Not many boys went to college from this town. That his father should promise to send him to college could only mean that his father was deeply appreciative of the help he had given through the years. At the age of fifteen such a promise meant everything to Jacob. He had measured up to his father's expectations; he and his father were indeed of an identity in their work, their interests, their perspectives, their understanding.

Jacob recalled that following his father's promise to send him to college he worked harder than ever to meet the demands of the

printing shop and to be a worthy assistant to his father. In discussing the matter with me, he was sure that he had not looked forward to going to college and although his recollections were probably more or less confused and distorted by the deep bitterness which he still felt toward his father, he was sure that he would have preferred to remain with his father in the shop.

Everything went along smoothly till Jacob had finished high school. He stated that one day shortly after his graduation he inadvertently overheard his parents discussing the matter of his going to college. He said he heard his father tell his mother that he had never had any intention of sending Jacob to college, that he had mentioned the matter merely to keep him interested in the work at the shop. To say that Jacob's world crashed about his ears is scarcely an exaggeration. His father's remark constituted a sharp renunciation and a flat denial of everything that his overidentification with his father had comprised. The tree had turned about suddenly and sawed off its branch, denying any real need of it, any genuine kinship to it.

There was no way in which I could make certain, of course, that Jacob's father had been as deceitfully brutal as Jacob alleged. There is a very definite possibility that his father had only said that he was not financially able to send his son to college or that it would have to be postponed or that he was not certain that Jacob would like college. There is this possibility for the simple reason that, as an overidentified child approaches maturity, a strong inner protest against the identification begins to develop. As already explained, this is because an overidentification chokes self-initiative and suppresses freedom of thought, feeling, and action. If the protest is strong, a relatively innocent remark or act by the person with whom the identification exists may be misinterpreted or immediately exaggerated out of all proportion.

At any rate Jacob became tremendously upset emotionally and very ill. In fact, he was sent away to an aunt to rest and recuperate. He recalled that during the first week with his aunt he wept much of the time. He was unable to sleep and had very little appetite. He felt worn out and utterly debilitated. "*Then I began to realize that I had suffered lead poisoning in my father's printing shop.*" After a few weeks he returned home but did not feel well. Although he made an attempt to resume his work in his father's shop, his in-

terest was gone. After a few months he left home and never returned.

In case it is not entirely clear, I want to direct the reader's attention to the exact manner in which Jacob fought against his overidentification after his father's remark had rendered it useless and intolerable. He had somehow learned of the possibility of lead poisoning in printing shops. His acute emotional disturbance was naturally accompanied by physiological malfunctioning, endocrine unbalance, and autointoxication. He suffered from indigestion, aches and pains, and extreme lassitude. These purely temporary symptoms naturally brought his attention more or less to himself. Under his pressing need to free himself from his father emotionally, he undoubtedly paid more attention to his bodily ailments than he otherwise would have done. And the more attention he paid the more acute his aches and pains were. He began to cast about for an explanation of his physical distress, never having been ill since he was a child. The idea of lead poisoning crossed his mind, born, no doubt, of his feeling that his father had gravely mistreated him. He immediately clutched this idea to him as a drowning man would a lifesaver. The idea at once fulfilled four urgent needs: it accounted for his physical ailments; it enabled him to condemn his father for having been negligent of, if not indifferent to, his (Jacob's) health and welfare, thereby serving as a justification for renouncing his attachment to his father; it served as an effective disguise of the feelings of helplessness which assailed him the moment he was no longer able to rely on his identification with his father for a sense of his own competence and self-sufficiency; finally, it enabled him to keep his attention on himself and his own needs and thereby to exclude the possibility of his ever again coming unduly under the influence of another person. The idea of lead poisoning was therefore nursed by his feelings of inadequacy and developed into a firm conviction of physical illness.

With the development of his hypochondria, Jacob's attitude toward his family and work underwent a radical change. He grew extremely bitter toward his father and indifferent toward his mother and sister. Although he tried desperately to renounce or dissolve his identification with his father, it persisted as an inseparable part of himself. In fact, it held him rigidly to his previous type of work. In endeavoring to suppress his identification he inevitably suppressed

most of his drive to action. He went about his part-time work with a lackadaisical spirit and spent the rest of his time in a state of dejection, frustration, and self-pity.

Jacob was six feet tall, weighed one hundred and eighty pounds, and of a deep, ruddy complexion. At the time of his first visit he was working three days each week and resting four. He explained that he was afraid to work more than this lest he become overfatigued and endanger his health. When questioned about his social activities he stated that he engaged in none, out of consideration for his health. He blamed the specialists to whom he had gone for not having found evidence of lead poisoning. When I reminded him that I worked only along psychological lines, he said he would like to try my treatment nevertheless.

For the first few visits, devoted to a study of his early history, Jacob was very cooperative. He was very interested in the facts of ego-identifications and appeared to grasp them without difficulty. As soon as I began to lead up to the matter of his own overidentification with his father, however, he manifested sharp resistance. He accepted the causative role of mental (emotional) factors in various types of physical afflictions, as I explained these matters to him. But when I suggested that his own "poor health" could be the result of emotional factors and subconscious attitudes, I again met with the strongest resistance. I hurt his feelings severely when I asked why he had gone on working in printing shops since he believed he had already been poisoned and was, therefore, already oversensitized to such conditions. He grew sulky and muttered that it was the only kind of work he knew.

For two months I tried in various ways to induce Jacob to accept at least tentatively the proposition that psychic factors were at the roots of his difficulty and to cooperate with me in following through such a line of study of his case. He stubbornly refused to admit the slightest possibility of a functional etiology. At the end of two months he discontinued the treatment, complaining that it was fatiguing him excessively. It seems probable that had he sought proper psychotherapeutic help twenty years earlier the results might well have been favorable.

Part Three

PSYCHONEUROTIC REACTIONS

CHAPTER 8

Neurasthenic Neurosis

NEURASTHENIC complaints are so common the sufferer can rarely get anyone to listen to him for long, even a doctor. They have come to be taken largely for granted. The patent medicine industry vigorously endeavors to supply answers to the neurasthenic's problems, with much profit to itself.

One must not confuse neurasthenic reactions with normal fatigue sensations which result from overwork, insufficient rest, and an excessive pace of life. The former type of reaction is primarily of psychological origin, the latter of physiological.

Clinical evidence offers some support for a division of neurasthenic patients into two groups: a psychogenic and a constitutional class. In the latter, the symptoms are supposedly rooted to an appreciable degree in a constitutional weakness and susceptibility to fatigue and exhaustion. The two groups are not sharply demarcated and there are perhaps always mental determinants, even in the most extreme case in the constitutional class. At the same time, the more pronounced the constitutional factors are, the less the help that can be expected from psychotherapy. Only a thorough study of the patient and his history will enable the therapist to estimate the relative significance of the two types of etiological factors. Only the predominantly psychogenic variation of the disorder will be considered here.

The most common symptoms and complaints are *fatigue*, *headaches*, *backaches* and *pains*, *visceral pains* and *disturbances*, *sleeplessness*, an *erratic appetite*, *worry*, *moodiness*, *self-preoccupation*, *intense sexual cravings* and *preoccupations*, *irritability*, *feelings* of

inferiority, and *compensatory* and *defensive devices* of various kinds. The patient's *attitude toward his symptoms* is always a point to be carefully examined in differential diagnosis. His attitude is possessive. Although he will complain bitterly about his symptoms, he nevertheless treats them as if they were assets instead of liabilities. This attitude immediately becomes manifest if one belittles his symptoms or tells him he is not as badly off as he thinks or even, in some cases, if one merely assures him that he can be helped. A patient of this type, a young woman, once became very angry at the writer solely because he would not agree that she was the most nervous person he had ever met. This peculiar attitude is always present in the neurasthenic patient. In fact, it might properly be regarded as a basic symptom of this disorder. The most excellent reasons for it always exist, as will be brought out shortly.

The person who develops a typical neurasthenic neurosis is *definitely introverted* and *emotionally saturated.* He has overdeveloped submissive tendencies toward his responsibilities, obligations, and other persons. His submissive tendencies appear to be rooted in his emotional intensity rather than in suggestibility as such. He is prone to the development of excessively strong affectionate and sympathetic attachments. He tends to be exceedingly loyal and conscientious. There is an indefinable affective softness about him of which he tends to become the victim. In terms of C. G. Jung's classification of personalities, he is the introverted, feeling type.

Because of the characteristics which have been mentioned, and perhaps others still unrecognized, the pre-neurasthenic tends to become completely dominated by his environment, by the demands made on him by family, work, community, etc. He cannot help meeting these demands with too much seriousness, too much affective intensity, and, therefore, with too much neglect of himself. When the demands become too excessive, or when he exceeds his affective tolerance in trying to meet them, an inner revolt begins to occur. This revolt is initiated and supported by the heretofore rejected egoistic propensities. The first step, seemingly, *is a diversion of attention and interest from the environment*, to a large extent. The second step *is the focusing of attention and interest* (*concern*) *on self.* These two steps are probably rendered possible by fatigue sensations and other physical disturbances, resulting from

his excessive emotional output in compliance with environmental demands, and by the further fact that the individual is naturally introverted and therefore unusually capable of attending to subjective factors.

The relief and security from the pulls of the environment which this accentuated introversion of attention gives is enthusiastically welcomed *egoistically* and jealously guarded. Through it the individual has effected a marked weakening of the affective pulls of his environment; he has achieved some degree of freedom in this sense; he has retrieved his sense of personal identity, a sense of his own individual existence apart from his environment, albeit, an unsatisfactory and symptomatically supported one.

Inasmuch as the partial (essentially complete in very severe cases) immunity which he has achieved to environmental demands is solely dependent on continuous self-attention, and self-attention in turn is dependent on something about himself to which he may *conscientiously* attend, the fatigue, aches and pains, originally the result of overexertion or physical illness, become rapidly intensified, elaborated, and firmly established. The exact psychic mechanisms whereby this *modus operandi* is brought about are not known or understood in detail and with certainty. The symptoms are undoubtedly kept alive and in the foreground of consciousness through a constant preoccupation with them. The preoccupation is maintained, apparently, by an underlying and basic need to remain relatively immune to the demands of the environment. This need results from the fact, as has been explained, that the pre-neurasthenic tends to overrespond affectively to environmental demands.

Although the neurasthenic patient's symptomatic pattern becomes established or fixed in the sense that it changes but little from day to day, it never becomes fixed in the sense of being independent of the patient's conscious attention to it, as many psychoneurotic patterns do. In other words it has to be constantly nourished and maintained. This fact seems to show conclusively that the patient's subservient tendencies toward his environment are not repressed but only pushed aside, and kept aside only by the device of constant self-attention. This interpretation of the relationship existing between the egoistic and selfless propensities is supported by various facts which can be easily demonstrated. All neurasthenic patients feel better, for instance, in the evening than in the morn-

ing. Feeling that they should participate more actively in the affairs of their environment, they are more in need of their symptomatic protection against the environment in the morning (the beginning of the day's activities) than in the evening (the end of the day's activities). Similarly, they often lose their symptoms later in life, in the absence of treatment, that is, when it is *too late* to do all of the things they felt they should do and age neutralizes the demands of the environment. If one appeals to a neurasthenic patient to make more effort despite his fatigue, the appeal will have the effect of intensifying his fatigue or other symptoms. If one succeeds in diverting the patient's attention from himself and getting him momentarily interested in impersonal matters, the patient will complain of an intensification of his symptoms with the return of his attention to himself.

In keeping his attention on himself all of the time, the patient automatically blocks his emotional outlet toward his environment. He becomes emotionally surcharged; he becomes locked within his own little inner world. This breeds feelings of frustration, despondency, and discouragement. Because of his emotional tension and because to feel rested would interfere with his symptomatic way of life, he sleeps poorly. Careful inquiry will often reveal that the patient actually fights sleep. He may report, for instance, that the moment he drops off to sleep he awakens with a start. He apparently experiences exactly the same sudden dozing and sudden awakening that the very sleepy person does who is trying hard for some good reason to remain awake. The neurasthenic patient's basic mental set is to remain ill. He does not want to sleep because he does not want to feel rested; he does not want to feel rested because he does not want to engage actively in the problems and affairs of his environment; he does not want to do this because he feels incompetent to do it; he does not feel competent to do it because once he turns his attention to his environment it exerts an intolerably heavy pull on his affective capacities, tending to rob him of any sense of volition and independent existence.

The main objectives of the treatment of this type of patient are indicated by the obvious nature of the subjective problems. The patient is normally introverted and must be taught how to live in accordance with his introverted orientation. The patient is emo-

tionally intense and tends to overrespond to other persons and to his everyday problems, much to his own detriment. He has to be taught how to correct this and to maintain a workable affective relationship to his objective world. The whole course of treatment is essentially one of educative and re-educative therapy. The patient has to be taken in hand and taught how to live.

The patient should be given full opportunity during the first few consultations to describe his symptoms and express his feelings freely and completely. Following this, psychological tests may be given at the discretion of the therapist. As in all cases, a complete and detailed case history should be obtained before psychotherapy proper is begun.

In helping an introverted person to accept and live reasonably in conformity with his introverted orientation and tendencies, a detailed explanation of introversion-extroversion is usually necessary. Despite the contentions of certain authorities (?) to the contrary, introversion as such has nothing to do with selfishness or unselfishness. It is true, on the other hand, that we live in an age of extroverted values. The basic theme in American philosophy is sell yourself to the other person, put yourself across; and not too much attention is paid to the means whereby this is done. The order of the day appears to be to go places and do things. Where or what is of secondary consideration. Verbalization holds a dominant position in comparison with thinking. A neat way of expressing an old thought receives more acclaim than a new thought. Due contemplation and reflection on subjective values are left for the most part to a perspiring clergy, many of whom are swept along by the extroverted tide.

Introversion-extroversion appears to be a linear variant of hereditary origin. The introverted person cannot become genuinely extroverted, even if this were desirable. Trying to be extroverted, particularly in the eyes of others, only conduces to feelings of failure, frustration, and acute self-consciousness in the introverted individual. He can, on the other hand, be helped to understand, accept, and express himself in accordance with his own inherent make-up. In helping him to do this the first step is to correct any faulty ideas he may have to the effect that introversion is synonymous with personal deficiency or inadequacy. He must be encouraged to have confidence in his own, subjectively colored values and perspectives.

He should be helped to understand the fundamental importance to satisfaction and efficiency in life of the acceptance of one's own personal uniqueness. The profound, psychological truth of the saying "One man's meat is another man's poison" cannot be too strongly impressed upon him.

The neurasthenic patient, being introverted, will be materially helped once he has come to see that if one has nothing to say, silence is proper; that extroverted persons are doing ample lip service in the world; that for him (the patient) it is better and more natural to have a few close friends than an army of acquaintances; and that only harmony between feeling and action can ensure basic and enduring satisfaction.

When the introverted person has been induced to accept his shyness of group situations, his natural reticence, his tendencies to reflection and self-examination and an ever appreciable degree of consciousness of himself, he will have become socially and emotionally much better adjusted. For, once he has accepted himself essentially as he is, he will no longer be put to the task of trying to behave in a manner which is unnatural to him. The person who is nervous before an audience, for instance, will not be half as nervous if he will not try to conceal his nervousness from the audience. Keeping one eye on oneself, in an effort to conceal one's feelings, while keeping the other eye on the attitudes and reactions of others, subjects the mental functioning of anyone to a severe and tiring strain. Accordingly, it follows that once the introverted person understands fully that it is not his calling to keep pace with others in mere time-consuming group conversations, to set out to ". . . make friends and influence people," to put his personality over, to go to church because he does not like to, to maintain many interests and a large circle of friends, *he will actually participate more freely in social affairs and group activities.* And when he learns how little genuine substance there really is in the garrulity of his extroverted acquaintances, any feelings of inferiority and acute self-consciousness which have resulted from comparing himself with extroverted persons will largely disappear.

The pre-neurasthenic patient has a tendency to overrespond emotionally, the second basic respect in which a correction is always needed. He meets his obligations and responsibilities with too much affective tension. It lowers his efficiency and conduces to mental

fatigue. This tendency to overrespond is apparently inherent and therefore cannot be directly altered. But the intensity with which an individual responds to a given situation or fact not only depends on his inherent capacity for emotional response, it depends also on the exact significance which the situation has for him. Thus, two men of equal affective capacity will not respond with equal intensity to the same woman, she being the sweetheart of one and a comparative stranger to the other. Their responses are not equal because, obviously, the woman does not have the same meaning or significance for them. Herein lies the key to the most effective means of reducing the intensity of the patient's affective responses. The patient's affective capacity cannot be altered but the *significance of his everyday problems and situations can usually be altered* or, in some cases, he can effect a change in the nature of his daily problems and activities greatly to his own advantage.

If the patient takes (or took) his work too seriously, for instance, if he met its demands with a debilitating affective tension, then the therapist's task is either to bring about a change in the patient's perspective toward his work or induce him to change to a less demanding type of work. In the case of the first, the patient must be brought to the point of viewing his work as less important than he had felt it to be. This may be accomplished in either of two ways or by a combination of the two. He may be helped to acquire one or two additional interests, which will proportionately lessen the intensity of his concern about his work; or he may be helped to acquire a broader and less personal perspective toward his work and his relationship to it.

If one wishes an introverted patient to acquire a new interest, speech and argument should be kept to a minimum and activity expressive of the interest to be developed should be initiated as soon as possible. The strongly introverted person imagines doing this or that with such vividness he is prone to exhaust the merits and pleasures of the activity without actually engaging in it. Accordingly, if the therapist wishes his patient to take up golfing, for instance, as a corrective and an antidote to an excessive preoccupation with office work, he should not hold forth at great length on the value and pleasure of golfing but insist that the patient procure clubs and balls and go to the links forthwith. In short, the therapist must short-circuit the patient's exaggerated proclivity to deal with con-

templated activities *implicitly* to the exclusion of dealing with them *overtly*. The neurasthenic woman who *tends* to be emotionally enslaved by her family cares can sometimes be induced to take up some outside activity which is remote in character from those at home.

In most cases of neurasthenia, however, a change in perspective or attitude toward family or work or some other feature of the daily life must be effected before the patient is receptive to other interests or activities. No effort should be made to bring about such a change till a transference of appreciable strength has developed. The influence which the transference gives the therapist with the patient can then be utilized to force the patient to examine more critically and impersonally those features of his environment to which his responses tend to be too saturated or intense. Through a critical and detailed analysis of these features, they can be robbed of a part of their power over the patient. For example: A certain strongly introverted, emotionally saturated woman gradually became completely enslaved by the demands and expectations of her husband and children. Finally, with the loss of her baby (precipitating cause), she developed a serious neurasthenic condition. Her husband was very extroverted, extremely active, impatient, demanding, selfish, and extremely egocentric. But because he was usually pleasant and talkative and habitually used the pronoun "we" instead of "I" in speaking of *his* aims, intentions, etc., she had utterly failed to see him in his true light. She had always felt that she was somehow included with him in his narrow, inordinate personal ambitions and, hence, had never discerned his basically egocentric and domineering mode of life. Until her illness she had unhesitatingly tried to comply with his requests and demands irrespective of what personal sacrifices this entailed. As his true motives, interests, and attitudes were closely scrutinized, during her treatment, she became increasingly indifferent to his expectations of her. His demands of her naturally became intensified as her indifference increased and he soon revealed himself fully as the thoroughly self-centered person he was. This change alone in her perspective toward her husband had a markedly salutary effect. With her growing indifference to his incessant demands, her preoccupation with her symptoms automatically decreased.

All neurasthenic patients suffer from feelings of personal inade-

quacy. They usually compensate for this by way of daydreams. In their daydreams they reach the heights of competence and achievement which are so far beyond their actual attainments or even their abilities that the latter seem empty and meaningless by comparison. The patient should be instructed to stop daydreaming. Along with this the patient's subjective assets should be searched out and brought into the foreground of conscious inspection and evaluation.

With the advent of the symptomatically intensified attention to and preoccupation with subjective factors, the patient's capacity for fortitude, perserverance, effort, and sustained attention to objective facts is submerged. This must be gradually resurrected and put to work. The patient has to be taught that he need not be a complete victim of his symptoms any more than a victim of the claims of his environment.

The transference relationship may become emotionally saturated and very dependent in character. As the treatment comes to an end the patient may have to be *forced* to learn that he can get along without the visits to the therapist just as he learned to get along without his pills or sedatives or extra hours of sleep in the morning.

Incidentally, the therapist should not demand admissions of improvement from the patient. Some neurasthenic patients will continue to complain about their fatigue and aches and pains almost as much as they ever did, even after they are taking a normally active part in the everyday affairs of life. Seemingly, such patients feel they need to keep their symptomatic means of defense near at hand in case some aspect of objective reality should again threaten their emotional independence and self-sufficiency.

TREATMENT OF A CASE OF NEURASTHENIA

Alice S. was a smallish, unmarried woman of twenty-seven. She was physically well developed and would have been fairly attractive had it not been for the forlorn, introspective, and woebegone expression of her face. Her gait was slow and labored and when she sat down she lost all semblance of posture.

Although Alice came for help of her own volition, she was reticent and defensive and apparently skeptical of any benefit to be derived

from psychotherapy. Nevertheless she agreed to give the treatment a trial and a schedule of hours was arranged.

The complaints and symptoms which she mentioned were neurasthenic throughout. She stated that she was always tired, had no energy, and was finding it increasingly difficult to go on with life at all. She suffered from headaches, eyestrain, and backaches. She slept very poorly. She worried constantly about her work, fearing that she was not doing it competently. She worried continuously about her mother, feeling that her mother's life had been unduly sacrificing. (This later proved to be a symptomatic worry, engendered by a feeling of guilt because of the patient's strong psychosexual interest in her father.) Most of the time she felt despondent and was unduly concerned about her future. She complained that she had become very irritable and that lights, noises, and any change in her physical environment distressed her. When alone she was lonely and when with others the strain of keeping up a conversation was more than she could bear. She could not engage in amusements of any sort because of her aches and fatigue. Happiness in others made her more miserable, by comparison with her own lot, whereas she was utterly unable to endure the suffering of others if in her own presence. She felt that her condition was practically hopeless and looked with cheerless mien to the future.

In view of the patient's obvious acute self-consciousness, defensive attitude, and apparent hypersensitivity, psychological testing was postponed till such a time as might appear more appropriate. Similarly, no close examination of her complaints and symptoms was made at this time. After she had enumerated them she was advised of the necessity of supplying a detailed history of her life. The next four or five consultations were taken up with obtaining the history.

Alice had one brother, two years her senior, and one sister, two years her junior, deceased a few months prior to the time of which I write. Her brother was married and well adjusted. Her sister had been a normal and well-adjusted girl. The patient's parents were living and in good health. They were persons of little education but seemingly intelligent, industrious, and economically successful. Although they had never been very active socially, they were well liked and good solid citizens of their community. She believed that her mother had always been somewhat "high-strung" but there was no record of nervous or mental disorder in Alice's immediate family

or close relatives. The home atmosphere had always been congenial but quiet.

As a child, Alice had enjoyed good health but had been emotionally intense and sensitive to the reactions of other persons. In regard to her early interests and attitudes, certain significant points came to light. At an early age she developed a very strong affectionate attachment to her father. She recalled following him about the farm when she was four or five years of age, and she had always felt closer to him than to her mother. Her father was a quiet, introverted person and although they spent many hours together during her childhood, she was sure that much of this time was spent in silence. This early attachment, which endured, perhaps had much to do with Alice's later lack of normal interest in members of the opposite sex; and this of course added to her load of affective tensions. In her childhood she assumed and maintained a distinctly maternalistic attitude toward her sister. Instead of coming into rivalry with her sister, who was attractive and socially adaptable, she hid behind her maternal attitude and sought compensation for her lack of social equality through an overidealization of her father, a symptomatic sympathy for her mother, and the development of homely virtues within the family orbit. This all led, naturally enough, to feelings of personal inferiority, to a degree.

Alice had no very close friends, outside of her family, during her childhood. She was generally liked, however, as far as she could recall, and was consistently above average in her grades at school. No early traumatic experiences could be uncovered.

After completing high school, Alice spent four years at a small college. While there she was generally liked but not sought after. Her teachers commended her for her industry and high grades. Upon graduating she secured a position teaching.

Teaching school was apparently the precipitating cause of Alice's neurotic disturbances. In the light of her personality and temperamental characteristics, her old interests, attachments, and orientations, and her relative lack of experience in dealing with the demands and expectations of other persons, this was not difficult to understand. In the manner of a strongly introverted person with feelings of personal and social inferiority, she had looked forward to teaching as a fulfillment of her long unrequited personal aspirations. In daydream and phantasy she had imbued the position of schoolteacher

with a glamor which that noble profession has never in reality possessed. She had pictured the principal of the school (an imaginary father surrogate) as a handsome and discerning sort of person who would inevitably become enamored by her intellectual and spiritual superiority. Her pupils would be affectionate, obedient, and readily responsive to her instruction.

She became rapidly disillusioned. The principal was unattractive, undiscerning of superiority among his teachers, and "very much married." Many of her pupils were disrespectful, disobedient, and dull. Teaching school, she soon learned, was monotonous, exacting, and full of frustrations. The demands which the pupils made upon the energies of the teacher seemed to be unlimited. Her work contained but few of the ingredients necessary to a balanced emotional life. It seemed to be all give and no take. It provided little or no outlet, on the one hand, for her pent-up social-sexual propensities and, on the other, it threatened to rob her of the meager feelings of independence and self-sufficiency which she possessed.

Since Alice was introverted, conscientious, and emotionally intense and possessed only very few established interests, she inevitably overexerted herself in an attempt to meet fully the demands of her work and at the same time to glean from it some of the satisfactions she craved. She overresponded. She gave to her work all of her thought, feeling, and attention. She took it with an increasing and debilitating seriousness. But the more she threw herself into her work, the more frustrated and empty-handed she felt; for she was desperately seeking for minerals in an ore that the ore did not contain.

Alice soon came to feel tired and beaten. Her work was constantly on her mind. Her sleep became light and frequently disturbed and her appetite grew poor. She suffered from increasingly frequent headaches, fatigue, and irritability. By the middle of the school year she was beginning to question her ability to do her work properly; and in questioning her fitness for her work and her actual competence she became increasingly aware of her aches and pains, fatigue, inability to sleep, irritability in the schoolroom, difficulty in sustaining her attention, and her tendency to shun the presence of other adults. As time went on her attention shifted more and more from her work and the world about her to her symptoms and herself. Thus she gradually became a victim of chronic neurasthenia. She

regained a part of her former vitality, courage, and emotional stability during her summer vacations; but each year of teaching brought her nearer to complete helplessness and, as I have said, when she came to me she felt she could not possibly endure another year of teaching, although she had contracted to do so.

At the end of a month I gave her a number of psychological tests. She revealed a superior degree of intelligence, as I had expected. On the free association test her responses were extremely personal and frequently delayed, particularly to those words referring to meanings or situations involving fear, sex, morality, success, failure, and family. On various personality inventories which I gave her, she made very high (unfavorable) scores on psychoneurotic tendencies, emotional instability, and social and vocational maladjustment.

With the completion of the testing I settled down to a searching analysis of my patient's feelings toward each member of her family, her attitudes toward her own success or failure in life, and her responses to her vocational duties. During the next two months her symptomatic sympathy for her mother largely disappeared and her partially suppressed interest in her father became more evident. That she was excessively devoted to her father was conclusively shown by the frequency and character of her dreams about him. Once she had become convinced that dreams are valid indicators of one's most genuine—though unacknowledged—desires and interests, she was forced to recognize and, under my insistence, to scrutinize closely her intense regard for her father. She finally saw and fully admitted that she had developed a strong Oedipus attachment during early childhood; and that in accordance with this her brother and sister had been invested with the significance of her own children. Her mother had all but been left out in the cold; hence her exaggerated sympathy for her.

At the end of the three months of summer vacation Alice's emoitonal fixation on her family members had been largely dissolved and a strong transference had developed. She had given up her emotional bondage to her family, her father in particular, only to acquire a similar one to her therapist. She could not see where her situation in life had been much improved. But the therapist, not the patient, is the one who must recognize the great value of the influence with the patient which the transference gives him and utilize it to advantage. By means of it the patient's attention can be directed to

almost any goal and his energies marshaled for any reasonable undertaking.

Although Alice did not want to do any more teaching, I insisted that she keep her contract with the school board. I did this because I believed it would be to her advantage in the end, knowing, as I did, that she was an extremely conscientious person. Moreover, I do not believe in breaking contracts just because it is hard to meet them. I permitted her, however, to look forward to giving up teaching altogether at the end of the following school year. I reminded her that the distance was not so great but what she would be able to see me infrequently during the year and I assured her that between us we would be able to keep her symptoms sufficiently in check to make it possible for her to carry on her work.

During the three months of treatment I had also fully explained the origin and significance of introversion-extroversion, the problem of emotional distance and the results of overreactions, and the respective roles of selfish and selfless motivation in human life. She had been a cooperative and intelligent patient. Her realization that frank selfishness is as important to personal adjustment as unselfishness, that to think of oneself is as essential as to think of others, had a noticeably salutary effect. She appeared relieved when she became convinced that she had a perfect right to think of her own welfare and satisfaction in life. She appeared to fully grasp my explanations to the effect that her symptoms were essentially defenses against the encroaching demands of her environment. At any rate her symptoms had become far less severe, her headaches and much of her fatigue having disappeared completely, and she was no longer always in the focus of her own consciousness.

Alice made six visits to my office during the school year. Her symptoms had become more severe again but she was capable of taking a more objective attitude toward them. By June I had become thoroughly convinced that she should give up teaching. I was afraid she would never be able to stop overresponding to the incessant demands of a roomful of youngsters; I saw little opportunity for her to meet and establish friendships with unmarried men.

She was again placed on a schedule of three visits weekly. At the end of a month her symptoms had almost completely disappeared. The material already covered the previous summer had been rehashed, her somewhat stale self-understanding had been re-

freshened and brought up to date. She now stood as an emotionally intense young woman, very personal in her orientation toward all facts that interested her, with good insight into her personal peculiarities and needs but without established social patterns and friends of suitable age of opposite sex, and without a satisfactory vocation. She was decidedly not a subject for prolonged psychotherapy.

During the next two months, the last of her treatment, I worked with two specific ends in view. In the first place I tried to teach Alice how to effect and maintain a workable emotional distance between herself and other persons, her work, the claims of objective reality in general. In the second place I undertook to help her to decide on a more suitable vocation.

Any person who is prone to become dominated by his environment because of a tendency to comply fully with all of its demands can do much to prevent such domination once he understands all of the relevant facts. The mother who is dominated by the demands of her spoiled child will be in a position to take corrective measures only when she fully understands that her subservience to the child's whims is not good for the child, is unfair to herself and others, and that a worn-out mother cannot be a competent mother at best. Similarly, the person who takes his vocational responsibilities with too much seriousness is unwittingly attributing too much importance to his work, and indirectly to himself.

Another means of increasing emotional distance, that is, rendering affective responses less personal and intense, is by distributing the affective responses of the patient among a greater number of facts (stimuli). Alice was instructed to go to more places where people gathered to do things. She was told that any pleasure she might derive or distress she might suffer were beside the point. Needless to say, she soon wanted to mix with others more for the mere pleasure of being with others, having come to realize fully that she was not called upon to push herself or try to outtalk the other person. As I said before, Alice was not unduly shy around others before her nervousness. Rather, she had never looked on social activity as an end in itself where she was concerned.

I had decided that Alice should take up some type of work in which she would have to meet people and deal with them but in a much less intimate manner than is required of a grade schoolteacher.

We discussed various vocations and finally decided that she should go to college and secure a degree in home economics, planning to obtain a position with some electrical appliance company. She left at the end of the summer and obtained her degree in eighteen months. She almost immediately secured a position demonstrating electrical kitchen appliances on her return.

I saw Alice about two years after she had taken up her new line of work, nearly four years after treatment. She liked her work, engaged in more social activities than she ever had, had remained free of neurotic complaints, and was apparently getting as much satisfaction from life as any woman in her early thirties with no husband in view has a right to expect.

CHAPTER 9

Neurotic Anxiety Reactions

In time of war or other widespread catastrophes millions of persons suffer from daily anxiety. Anxiety is a normal reaction to impending danger. In times of peace and security, on the other hand, thousands of persons experience constant or frequently recurring periods of anxiety to a degree that is utterly foreign to the experience of the emotionally adjusted person. This is neurotic or subjectively determined anxiety. It occurs in the absence of observable cause, the cause being within the individual himself.

The patient may or may not attribute his anxiety to a specific cause. One will declare that he is constantly anxious lest his heart stop beating, although he has been repeatedly assured that his heart is in perfect condition. Another will complain that he is painfully anxious for no reason at all. The anxiety may appear suddenly, the patient being completely unable to predict its occurrence. Or some seemingly insignificant event may precipitate it. A young man entered a restaurant to eat lunch. When his soup was brought he noticed the waiter had neglected to bring him a napkin. He had a momentary inclination to demand a napkin and to chide the waiter for his oversight. But he was immediately "seized with terror" and, snatching his hat, rushed from the building.

Neurotic anxiety is not to be confused with timidity or fear of unfamiliar situations, a characteristic of many persons. A young man who complained that he seldom had a moment of complete relief from anxiety was riding one day with a friend in a truck. They collided with an automobile. His friend and one person in the automobile were seriously injured. The patient was very surprised afterward when he recalled that he had not experienced the slightest anxiety or fear.

In addition to anxiety neurotics as such there is a sizable group of individuals, not discussed in this book and only infrequently appearing in the office of the psychotherapist, who are cases of potential anxiety neurosis. They do not actually suffer from anxiety symptoms or develop anxiety equivalents, as discussed in the next chapter, simply because they live unobtrusively behind the curtain of human affairs. Among them are retiring bachelors, spinsters, and other types of hermits. Were they to step forward onto the stage of active human enterprise or be pushed forward, they would rapidly become victims of neurotic anxiety. Many did when they were ushered into the armed services during the last war. They developed symptoms of neurotic anxiety even before they left the shores of their own country. But in times of peace and if left alone they live within the barren but secure shelters which they have constructed from rationalizations, excuses, time-consuming hobbies, and esoteric interests. They may even mix freely with other persons but on a purely superficial level. There is little or no affective participation.

Feelings of anxiety comprise the chief symptom, of course, in this class of patients. Various associated symptoms, symptomatic reactions, and complaints are also usually present. Among these are *acute self-consciousness* and *feelings of personal inadequacy whenever the situation calls for assertive or aggressive action, fear and defensive attitudes when around members of the opposite sex, feelings of uncertainty and apprehension concerning all future undertakings, inability to maintain a strong interest, a tendency to accept vocational positions far beneath the abilities possessed, periods of mild despondency, self-pity, egoistic daydreams, and fear dreams at night.*

As one becomes better acquainted with the patient, other personality and temperamental characteristics will come to light. The patient is emotionally guarded and only superficially responsive. His usually gracious manner lacks the ring of sincerity. His interests and attachments lack depth. He is continuously preoccupied with his relationships to other persons. He is obtuse to the needs and rights of others. He is emotionally infantile and childishly intolerant of rivals and competitors. If he is married he is inclined to be emotion-

ally dependent on his spouse and very possessive and demanding in his attitudes.

Neurotic anxiety results from *the patient's relative lack of a feeling of self-sufficiency in the face of his assertive, aggressive, sexual, and other positive tendencies.* His lack of a feeling of self-sufficiency is the result in turn of his relative lack of positive ego-identifications. He failed to acquire positive personal meanings, attitudes, and orientations during his childhood development.

In regard to the very important matter of early ego-identifications, any one of three courses may be followed, generally speaking. Because of environmental influences and circumstances the child may make negative ego-identifications. That is, he may assign to himself inferior attributes, attributes which he feels to be inferior to those possessed by other persons in general. Such attributes may be physical, social, racial, religious, intellectual, or something else. Ego-identifications of this type ensure feelings of personal inferiority, an inferiority complex, in adult life. The individual's sense of personal identity incorporates a preponderance of negative (inferior) personal meanings. Obviously, such ego-identifications tend to block assertive and aggressive tendencies, albeit, such tendencies may become unduly pronounced as a result of compensatory efforts.

Early environmental influences may conduce to the acquisition of positive ego-identifications. Such identifications provide a basis for normal feelings of self-sufficiency and support assertive and aggressive tendencies.

Finally, early environmental influences and circumstances may all but prevent the child from making any ego-identifications, from acquiring with any serviceable degree of conviction and permanence any personal meanings whatever. One circumstance, at least, which is very conducive to this type of development, or lack of development, is constant dissension and quarreling between the parents and in connection with which the child is constantly used as a weapon by each against the other. Such a continuing circumstance forces the child to align himself definitely with one parent or the other or leaves him to be buffeted about. If he fails to take sides early, and he usually does, he finds himself accepted or rejected, praised or criticized, the object of undue attention or ignored, all depending on the

use which each parent sees fit to make of him at the moment. Thus the child is unable to acquire a firm and enduring sense of his own personal identity (a consolidation of one's accepted personal characteristics and meanings). A child in such a situation is actually unable to arrive at any genuine conception of just who and what he is. He grows up without a definite orientation toward himself or others. He remains burdened with uncertainties, doubts, and misgivings. With the approach of physical and intellectual maturity, anxiety appears as inevitably as hair on the face or a swelling of the bosom.

What am I? What am I supposed to be? What shall I try to become? How should I treat my superiors, my inferiors, my equals? How should I behave toward persons of opposite sex? What are my personal abilities and assets? What kind of work should I try next? How far should I try to go in my career? What do others think of me? These and many other similar questions are among those which the person who suffers from neurotic anxiety is constantly asking himself. He is never able to give himself a satisfactory answer for he is always doubtful of the correctness of any answer that comes to his mind.

Neurotic anxiety results, then, from an individual's coming face to face with the responsibilities, undertakings, and demands of adult life but who lacks established attitudes, convictions, and orientations which would enable him to meet these problems in a direct, energetic, and sustained manner. The person who is markedly lacking in positive ego-identifications is without inner guides to effort and assurance of competence. Having always depended on parents or other family members for guidance, his own resourcefulness is dormant and untried. He is not afraid of failure, as many have contended, but of losing sight of himself. His sense of personal identity is so meager, his feelings of personal security and self-sufficiency so insubstantial, that mere self-preservation as a psychic entity is his first and major concern. He cannot afford to become strongly interested in another person lest his flimsily constructed I-ness become dissolved completely in the identity of the other.

Many writers have contended that the person who suffers from neurotic anxiety is not afraid of environmental agencies but of his own impulses to action. It is important that the truth of such contentions be recognized and kept in mind in working with this kind of patient. Obviously, if the patient were not egged on by his own innate

propensities to participate in human affairs, there would be no reason for anxiety. Accordingly, as is often clinically observed, the stronger the urge to activity becomes, the more intense is the anxiety which accompanies it.

The primary aim of the treatment in the anxiety neurotic is the development of ego-identifications. There is no substitute. Normal feelings of self-sufficiency rest upon such positive capacities as the individual has definitely attributed to or discovered within himself. As long as these remain dormant or seriously questioned mere self-preservation and personal security in all respects remain the prime, if not the sole, considerations of the patient.

The first step in the therapy, following psychological testing and history taking, is a thorough explanation to the patient of his position and his needs. There is very little danger of offending him or of arousing undue resistance by speaking frankly. In making this explanation the patient's anxiety itself should be carefully distinguished from the rest of his symptoms or symptomatic reactions. The anxiety is a direct result, as has been explained, of the extreme disparity which exists between the strength of his positive drives to action and the substantiality of his feelings of self-sufficiency. His other symptoms or symptomatic reactions, on the other hand, are precautionary and defensive constructions. They consist of rationalizations, subterfuges, attention-diverting devices, and various obstacles placed in the way of constructive effort.

The patient will usually understand and accept the origin of his anxiety when this is explained to him. When his symptomatic devices are picked apart, however, and their true significance revealed, he will manifest resistance and often uneasiness. This part of the procedure should be accomplished with thoroughness. The patient must be left without a symptomatic leg to stand on, aside from his anxiety itself. If he belittles members of the opposite sex, for instance, he must be made to realize and admit that he does so in order to conceal his fear of them from himself and others, to subdue his natural inclinations toward them, and to save face; if he argues that washing dishes in a restaurant is really better experience for him than holding a clerical position he must be made to admit that fear of assuming responsibilities is dictating his thinking; if he quakes with apprehension when his boss is unusually friendly, he must be

helped to understand that it is not because his boss is seeking to gain an unfair advantage but because his friendliness is an invitation and an inducement to him to forget himself and be friendly too.

As the patient's rationalizations and other safeguarding devices give way under the persistent scrutiny and analysis made by the therapist, a dependent transference will develop. This opens the way for the use of active therapy. No anxiety neurotic could ever be divested of his anxiety in the office of the therapist. New and sustained effort on the part of the patient to come closer to the various aspects of his environment and to adjust to them is imperative. The influence which the transference gives the therapist with the patient must be used to the fullest extent to force the latter to this. Substantial ego-identifications can be acquired only through close emotional contact with reality.

Considerable care should be taken not to insist that the patient undertake anything that is too far beyond his present level of adjustment. If he is holding a position, for instance, which is decidedly below his intelligence and training, the therapist should insist that he seek a *somewhat* better position. And when the patient takes a step forward, secures a more responsible and exacting position, *he should be firmly held at this new level of effort till he has made a thorough adjustment to the demands of the new situation.* He may then be pushed forward again.

The writer has never known a case of anxiety neurosis who was not maladjusted to the opposite sex, although many such persons rationalize their maladjustments and believe that their responses in this respect are exactly in line with their basic motives and interests. A young man of twenty-one had never had a date with a girl. He met with a small group of male companions of like characteristics more or less regularly to drink beer and disparage women. Although he was of superior intelligence and fair education he nevertheless had achieved a wholly ridiculous but considerable pride in his woman-hating fervor. On the other hand he made innumerable abortive efforts to meet and associate with girls. He would take pains to encounter some young woman on her way home from work. Walking along beside her, he would engage her in light and often childishly absurd repartee. Upon arriving with her at her home, he would make face-saving and circuitous hints at a date. "You know, by gosh, one of these days I'm going to date you up." Or, "I guess you would be

pretty surprised if I dragged you off to a show one of these nights, wouldn't you?"

It is not surprising that the anxiety neurotic is not usually very popular with the opposite sex. He is like a timid child who wants to enjoy swimming but is afraid of getting wet. He yearns for closer contact with others but he is afraid to invest just a reasonable measure of genuine feeling in his relationship to them. His meager sense of personal security leaves him afraid of their possible influence over him. Accordingly, he carefully maintains a safe emotional distance from other persons.

Again, as in the matter of the patient's vocational adjustment, he must be started at his present level of social adequacy, or just slightly beyond it. If he is avoiding members of the opposite sex, the therapist should insist that he associate with them, but only with those (to begin with) around whom he does not feel too uneasy. In other words, instead of encouraging him to vie with others for the attention of the person of his choice, the therapist should insist that he seek dates with members of the opposite sex who are far less appealing and attractive to him; and that he continue to associate with such persons till he is at ease and unguarded when with them. He may then seek companionship with persons who are somewhat more appealing to him, and so on till he becomes fairly adjusted socially to his equals. In the beginning the young man just mentioned was instructed to take out girls who were so unattractive that he protested strongly against being seen with them by his male acquaintances. But it was only after he had done this over a period of time that he was capable of making frank and direct advances to more attractive girls.

The therapist should be watchful lest the patient become fixated at a level of social adjustment which is considerably below his actual potentialities. He must be egged on from one level to the next till he is making a genuine effort to adjust at a level which is commensurate with his personal assets.

Full use should be made of the patient's daydreams and night dreams. The daydream content is of value as an indication of the level of personal accomplishment to which the patient aspires and the distance between this and his present level of adjustment. Also, the daydreams indicate those spheres in life in which the patient feels least competent and the level of his emotional maturity in respect

to them. In his daydreams, is the patient usually with members of his own sex or the opposite sex? Do his daydreams give him imaginary equality with others, superiority, or great power and influence over them? Do his daydreams involve competitive activities or does success come to him without even trying? Do they remind one of the imaginary exploits of a ten-year-old or are they concerned with reasonable achievements? Do they usually include family members, indicating that the patient has not outgrown his nesting habits, or are they about others?

As soon as the therapist has sufficient influence with the patient to make the request effective, he should ask that all daydreaming be stopped. In the first place, excessive daydreaming renders reality dull and uninteresting and, in the second place, it uses up time and psychic energy which the maladjusted person can ill-afford to dissipate.

The night dreams of anxiety patients are fairly typical. For the most part they are dreams of fear, failure, and indecision. They are often vague, highly symbolical, and rambling. They frequently follow a long and tedious course only to fade out gradually like mist before a rising sun, instead of coming to some definite end or conclusion. All in all they present a fairly accurate picture of the patient's fear-throttled impulses to action, lack of specific orientations, and ever-present uncertainties. If one thinks of dreams as implicit attempts during sleep to gain ends, solve personal problems, fulfill desires, then the effect on the anxiety patient of his dreams can only be to encourage his already exaggerated degree of caution. For dreams of fear, failure, and uncertainty produce corresponding moods, and these moods carry over into waking life.

The dreams and daydreams of the patient are of most value to the therapist as an aid, when interpreted, in helping the patient to gain a full understanding of the exact nature of his subjective difficulties. The more clearly he comes to see his essentially negative way of life, the more intolerant he tends to become of it and desirous of making a radical change. In the interpretation of his dreams, therefore, the greatest possible emphasis should be placed on their neutralizing and negating effect on positive effort.

About a year's time, three visits weekly, is usually necessary to help the chronically anxious patient to reach the point where he can go along without further guidance and support. In most cases it is

best to bring the treatment to a gradual close, reducing the frequency of visits toward the end.

TREATMENT OF A CASE OF CHRONIC ANXIETY REACTIONS

Emil B. was a healthy, well-formed, good-looking man of thirty; college educated, married six years, no children. There was a droop to his square shoulders and he did not swing his arms freely as he walked. His walk struck me as an invitation to others to take no notice of him. He was polite, extremely shy, and appeared to be acutely self-conscious. He came to me with the request to be psychoanalyzed. He was frank enough in his speech but often uncertain and indefinite.

When I asked for his complaints and symptoms, Emil mentioned periods of anxiety, self-consciousness and uneasiness around others, preoccupation with his early home life, marital dissatisfaction, inability to maintain interest in a given line of work, daydreams of a phantastic nature, fear of women, occasional cold sweats at night, and difficulty in making up his mind about anything.

During the first few consultations I gave him various psychological tests. He was eager to take these and showed a childlike interest in his scores. On standard intelligence tests he made an I.Q. rating of 125–130. He was very proud of his scores when their relative significance was explained to him and immediately asked me to give the same tests to his wife. Then he at once expressed uneasiness lest she do better than he had. On introverted-extroverted inventories he made an introverted centile score of 99, which I believed was more indicative of his load of anxiety than of his true position on the scale. He made the same centile scores on inventories of emotional adjustment, neurotic tendencies, etc., that is, he scored in the lowest centile of adjustment. His responses to a free association test were frequently delayed, often personal, and all in all typical of those of the anxiety patient. On vocational interest questionnaires he indicated a decided preference for creative lines of work, such as writing, art, music, and inventions.

When he first came to me Emil held an appointive position with a government agency. His work consisted in part of clerical duties

and in part of collecting and compiling historical data pertaining to the part of the country in which he worked. He drew a fair salary but contributed nothing to the support of his wife who lived in a nearby town with her parents. He had no close friends of either sex and when not working spent most of the time in his room or at the public library.

Emil's complaints and symptoms were not of recent or of sudden occurrence. His anxiety neurosis was the gradual and inevitable culmination of extreme emotional maladjustment since early childhood. His whole course of psychic development had become markedly skewed early in life and thereafter notably lacking in various essentials. And although he had gotten along after a fashion during his developmental period, upon reaching adulthood he had become increasingly unable to adjust. His marriage undoubtedly hastened the outward manifestations of his personal weaknesses.

He was fairly efficient in his work but he carried an excessive burden of affective tension. He performed his duties under a turbulent bombardment of doubts, fears, and preoccupations. According to him, he was repeatedly on the verge of a complete inner collapse. The presence of women in his place of work was a particularly grave source of discomfiture.

Emil's parents were moderately successful farmers, uneducated but industrious and persevering. They were not happily mated, however, and this fact had been extremely instrumental in Emil's faulty emotional development and later psychoneurosis. Each parent had persistently tried to dominate the other. His mother belittled men, nagged her husband, tried to wear his pants on more than one occasion, pouted, assumed the attitude of a martyr, and made frequent bids for Emil's support in her incessant conflict with his father. His father similarly disparaged women, frequently expressed regrets that he had ever married, strongly advised his son against making the same mistake, refused to quarrel with his wife whenever she particularly wanted to quarrel, and in various other ways contributed liberally to the unwholesome atmosphere of the home. They took turns at threatening to commit suicide; each sought to neutralize the other's influence with the children and to augment his own by whatever means; each professed martyrdom to the other's selfishness; each went about a good part of his time with a dejected and hopeless bearing.

Emil had only one sibling, a sister two years his junior. She identified and aligned herself with her mother at an early age and thereby achieved a position of dominance over Emil, who failed to identify himself to any extent with either parent. He grew up in fear of his sister and in a compensatory effort resorted to phantasies in which he did everything from seducing her to cutting off her ears. His sister, quite unperturbed, continued her early line of development, came to regard men as a necessary evil to woman's fulfillment, married a man whom she could easily dominate, and bore several children.

As a child Emil enjoyed good physical health. His home life was the shaping factor in his maldevelopment. He received so much contradictory instruction and guidance from his parents that he was unable to follow either or to effect an independent course of his own to pursue. He sat on the fence between the warring factions. He was afraid of both parents, or more specifically, he was afraid to join hands with either against the other. The daily dissensions between his parents kept him so busy playing safe by siding with neither and so uncertain of his own just position in the family circle, that he all but failed completely to develop any independent lines of thought and feeling. In other words, he acquired only a very rudimentary and shallow sense of personal identity. He was played back and forth between his parents so constantly he failed to acquire a sense of independent existence as a personality. Inasmuch as his weak identification with his father and men in general was but little stronger than his still weaker identification with his mother and sister, he was left in between, genuinely belonging to neither sex in his own feelings. As a man, he immediately impressed one as being rather effeminate. On further acquaintance he gave the impression not so much of being effeminate as merely neuter. He was not inverted in his sexual interests.

Needless to say, Emil had no close friends or playmates during childhood. He always remained on the fringe of the group or avoided others altogether. As he reached pubescence he became even more shy and substitutd phantasy and daydreams for overt activity to a large extent.

In his school work he was above average throughout. He took no part in extracurricular activities either in high school or college. He associated very little with fellow students. He was regarded as shy, awkward, and unsocial. His teachers encouraged his bookish com-

pensations. Both parents thought he would be a genius and each sought to impress strongly on Emil his own pet admonitions and advice.

He followed up daydreams of being a great artist with various attempts at painting during his early teens. He recalled that he used to experience a painful mixture of ecstasy and fear whenever his mother would insist on his showing his paintings to visitors. His painting career came to a sudden end when a girl acquaintance about his own age forced her way into his attic "studio" and rummaged about despite his agonized protests till she had uncovered his "masterpiece," a not too well-proportioned and variously accentuated female nude.

Emil next turned his attention to writing and dreamed, of course, of writing *the* American novel. But his actual efforts to write were more or less abortive and the results very infantile and sentimental. He became interested in music during his last year in high school and made spasmodic and brief attempts to learn to play different instruments. But, again, he did not persevere to the point of any real accomplishment.

Through college Emil continued to remain apart from others. He majored in English and literature and kept his grades well above average. While completing his fourth year of study, a certain woman student with strong matrimonial inclinations singled him out as desirable and legitimate prey. She was a most unprepossessing person physically but of brilliant mind and forceful character. She operated mostly by moonlight, apparently aware of her physical unattractiveness, and before Emil was fully alert to her intentions he was quite helpless. She brushed aside his defenses and evasions more rapidly than he could erect them. They were married at the close of the school year.

Emil obtained a position teaching in a high school in a small community the following year. He suffered severely from anxiety and self-consciousness while before his students and at faculty meetings. In his own words his life was a daily torment of fear and cold sweats. At the end of three years the school board failed to renew his contract, offering no explicit reasons. Presumably, as he concluded, he had made a too unfavorable impression to be kept on the faculty. He had never taken any part in the discussions at faculty meetings and had been able to maintain very little discipline over his students.

He tried his hand at farming during the next three years, leasing a part of the farm of his wife's father. These years were no happier. His wife was an only child, excessively demanding and domineering. She was more domineering even than Emil's mother had always been. She was very aggressive and decidedly masculine in her manner. She was perhaps afflicted with some glandular unbalance for her mustache notably excelled anything her husband could have grown. She treated Emil as if he were a personal possession. She fussed over him, scolded him, or ridiculed him as her moods dictated. She frankly claimed an intellectual superiority to him and sought to demonstrate it on various occasions, frequently in the presence of others. She was direct, energetic, and persevering. She wrote a novel, for instance, while Emil was talking about writing one.

After three years of farming and living with his in-laws as well as his wife, Emil was desperate. He possessed just enough courage to leave when he learned of a vacant position in a WPA office in a town a hundred miles distant. His wife objected to leaving her parents and he made no attempt to dissuade her. He had been in his new surroundings about six months when he came to see me. He had not visited his wife during the six months and she had visited him but very infrequently. Sex, apparently, was the only interest that ever drew them together. She was too unattractive to get a lover easily and he was too full of fear to seek the company of other women. In keeping with his undecided way of life, he would decide to return to his wife one day and change his mind the next.

At the end of two months of regular visits I was able to summarize Emil's more serious personal deficiencies and problems. He was about as deficient in a sense of personal identity as a sane man of his intelligence could be. He had failed to acquire any strong, positive ego-identifications and accordingly had no definite orientations toward the various aspects of life. He was socially inept. He had developed no social reaction patterns other than mere subservience to the situation of the moment. Naturally, he was obtuse to the less obvious aspects of any social situation. He was unhappily and unsuitably married. He was in continuous disagreement with his parents. He had no friends of either sex. He was selfish and infantile in his feelings and sentiments toward the opposite sex. He was hesitant and indirect in his approach to any problem. He was adept at side-stepping issues and responsibilities.

Among his assets, on the other hand, were superior intelligence, a college education, a good physique, and, seemingly, a genuine desire to make a better adjustment and employ his time and effort to greater advantage.

I shortly became convinced that there was nothing that could be done about Emil's marriage except dissolve it. When I mentioned this to him he appeared terrified at the prospect of approaching his wife with a request for a divorce. Although he had finally become convinced that he could never return to his wife, I could not prevail upon him to make the slightest move in the direction of securing a separation. In order to get the matter settled and out of the way, I sent a request to his wife to call at my office. I succeeded in convincing her of the desirability of a divorce and she obtained one forthwith. Incidentally, she married her father's hired man a few months later.

My next step was to bring Emil into contact on a social level with members of both sexes, particularly with women. I had explained the source of his anxiety and other maladjustive characteristics to him fully. I assured him that a better adjustment and the elimination of his psychoneurotic symptoms would require the greatest possible effort on his part. He showed a strong proclivity to dwell on his past marriage and speculate on his wife's thoughts and actions since their divorce, but I persistently demanded that he turn his attention to the future. He agreed, without enthusiasm, to try to carry out any instructions I gave him. Since his divorce he had become increasingly uneasy around women, no longer having the excuse that he was married for remaining aloof from them.

My persistence won out and some six weeks following his divorce he surprised himself one day by asking a woman acquaintance to go to a movie with him. She was not very attractive or popular and eagerly accepted the invitation. Emil immediately regretted asking her. Her friendliness during their date frightened him. He left her that evening in an abrupt manner, thoroughly convinced that she had designs on his unmarried freedom. He reported that he spent the night in cold sweats. He not only never went out with her again but carefully avoided meeting her on the street. For awhile he had fleeting suspicions that I was secretly determined that he should marry this woman. I ridiculed his suspicions and fears and demanded

that he should not mention the girl again in my presence. I then insisted that he have a date with someone else.

The ice had been broken. For the first time in his life he had made and kept a date with a girl, his former wife always having made what dates they had herself. From then on he made slow but steady progress. He tried valiantly at times to erect unshakable barriers between himself and all members of the opposite sex but in the security of my office we always succeeded in tearing them down. He gradually came to see through his defenses, ruses, and subterfuges as rapidly as his fear erected them. When, for instance, he would suddenly begin to hate women because, perhaps, some girl had given him an inviting smile, he would soon recognize his feelings as fear-sponsored defenses and face-saving devices.

After a little more than a year of therapy, three visits weekly, I moved to a different part of the state. For the next three years I saw Emil infrequently and irregularly. He continued to make slow progress. He associated with both sexes with some degree of ease. At the end of this time he married a dominant type of woman with whom he quarreled frequently. A couple of years after this second marriage he entered the army, at my suggestion, although he could have had himself deferred to help on his father's farm. During his two years in the army he rose to staff sergeant.

At the present time, twelve years since Emil first came to me for help, he and his wife are successfully engaged in a small business of their own. Since the war I have been in sufficiently close touch with him to know that he has been very persistent in his efforts to acquire workable and satisfying ego-identifications, namely, with men in general, his own business and business associates, and the community in which he lives. When he talked to me last, late in 1948, he reported that he and his wife were getting along much better together and that he was otherwise deriving more satisfaction from his daily life than he ever had before.

CHAPTER 10

Some Anxiety-Equivalent Reactions

IN THE LIGHT of our present knowledge it is not possible to give a concise and clinically substantiated etiological-symptomatological classification of the broad field of anxiety and fear reactions. Lists are given below of some of the more common caustive factors and conditions in which they result.

Causes	*Reactions*
Paucity of ego-identifications	Neurotic anxiety reactions, as discussed in the last chapter
Cross-identifications	Anxiety equivalents:
Castration complex	Neurotic dizziness
	Heart palpitations
	Hypertension (muscular)
Repressed fear of castration	Coarse tremors
	Hyperpiesia (increased blood pressure)
	Cold sweats
Repressed hostility	Blushing (excessive)
	Pains in the head
Oedipus complex	Akoasms (subjective auditory sensations)
Repressed fear	Suffocating sensations
	Gastric and abdominal pains
	Priapisms
	Vaginismus
	Stuttering
	Sexual frigidity
	Psychical impotence
Perfectionistic strivings	Anxiety hysteria
Repressed feelings of guilt	Phobias

Neither side of this list is presumed to be complete. And specific cause-effect relationships between the two lists cannot be indicated except in a few instances. Anxiety hysteria never develops, in the opinion of the writer, in the absence of perfectionistic strivings, as such strivings are defined in the next chapter. A syphilophobia perhaps never occurs in the absence of a repressed fear of castration or strong, repressed cross-identifications. Generally speaking, however, any of the causative factors may contribute in a given instance to any of the conditions. Not only this but a given causative factor may bring about opposite symptomatic conditions in two different patients. A good example is wherein a castration complex conduces to a rigid aversion to sex in one woman and to nymphomania in another.

Sexual frigidity and psychical impotence are regarded by the writer as essential anxiety equivalents, in the majority of cases. In view of their social as well as individual significance, however, they will be taken up in separate chapters. Anxiety hysteria and the simple phobias, also, will be discussed independently.

Roughly, there are three classes of anxiety equivalents: cases in which there is no physiological disturbance, actually, but a firmly established and constantly nourished *idea* of such; accelerated, slowed, or otherwise disturbed motor, glandular, or circulatory functions; the suppression or loss of a psychophysical function.

Neurotic dizziness and akoasms are common examples of the first class. Usually, if not always, the symptom initially occurs in connection with or as a symptom of a physical disturbance or illness. The patient recovers from the illness but through a diversion and/or a conversion of neurotic anxiety he retains the symptom as an anxiety equivalent. A potentially neurotic Jewish youth had approached the day when he would be ushered through certain rituals which would declare him then a man: self-sufficient, responsible, and independent. He overate of heavy foods in midafternoon and then lay down and fell asleep. When he awakened he felt nauseated and very dizzy. Seven years later he sought treatment for his neurotic dizziness which he declared had grown gradually worse with the years. A very timid but very ambitious young woman suffered from an infection of her left ear. The infection was accompanied by distressing sounds in the ear. With treatment the physical disorder

disappeared completely, according to a number of prominent specialists, leaving no impairment whatever. Nevertheless, years later she was holding a man's watch to her ear to "deaden the terrible roaring and buzzing."

The second class of equivalents comprises the main body of such ailments. It is to them that the more recent and rather misleading term "psychosomatic complaints" is chiefly applied. Most of the equivalents listed on a previous page come within this group. An actual physiological disturbance is present, brought about and sustained, or at least contributed to, by a diversion of neurotic anxiety and more or less constant attention to the symptom. The onset of these equivalents is usually gradual, though not always; they become more severe and fixed with time and the conscious anxiety with which they were originally associated slowly disappears.

The third group covers certain instances in which there is a loss (suppression) of function. The most common examples are found among cases of psychical impotence and sexual frigidity. Psychologically speaking, the condition is of long standing, having been effected during early childhood, and often appears as a complete surprise to the patient himself in adult life.

Much remains to be learned about the subjective conditions and the psychic mechanisms which give rise to anxiety equivalents. Certain facts, however, have been noted and confirmed by clinical observations. First and most significant, the person who has anxiety equivalents or who is going to develop them *is predisposed to anxiety reactions in the ordinary course of life.* This predisposition not only has to be assumed in any attempt to explain anxiety equivalents, its existence is strongly evidenced by those cases in whom anxiety equivalents alternate with anxiety attacks as such.

Given this predisposition, the second step in the development of an equivalent is the diversion and/or conversion of the anxiety (the nervous energy which would otherwise become manifest to the individual as feelings of anxiety) to some bodily function. The disturbance of the function constitutes the anxiety equivalent.

The drainage and short-circuiting hypotheses provide plausible explanations of how the diversion takes place. Why the diversion takes place and why to one function in one person and to an entirely

different function in another is of the essence of the psychology of anxiety equivalents. There is no category of personality disorders which allows less generalization than this. Only an intensive study of each given case will reveal the patient's need of an ego-defense, the exact nature of the subjective conditions which impose this need, and why the defense (equivalent) became effected through one particular organ or function instead of another.

The predisposition to or cause of anxiety reactions perhaps always exists as a ratio of the strength of the repressed factor to the patient's degree of self-sufficiency. The maladjustive effect of a repressed *fear of castration,* for instance, will depend not only on its own strength but also upon the patient's degree of self-sufficiency in respect to the various modes of human experience and conduct. Thus, in one individual the repressed fear might result in a syphilophobia or a specific aversion to sexual relations as such, otherwise leaving him unencumbered in his social and emotional adjustments. In a second individual, characterized by general emotional immaturity, the same repressed fear could seriously affect all of his social and emotional reactions. In short, the greater the affective tolerance or the emotional competence of the individual, the less the symptomatic effect will be of a repressed factor of given strength. The following brief discussion of some of the more common specific causative factors in anxiety equivalents is given with this always existing ratio or relationship in mind.

Any repressed desire, interest, feeling, or propensity is treated—and would be felt, were the individual to become suddenly conscious of it—as a threat to his ego-security. This observation holds even where the repressed factor is nothing more sinister than affection or sympathy. Nothing, in fact, is ever repressed except on behalf of ego-security or ego-enhancement. Given, then, a person who is emotionally immature and untried and who is not safeguarded by external situations against his natural propensities, one is likely to find neurotic anxiety or tendencies to such. The individual will then suffer from anxiety, develop anxiety equivalents, or, if he is definitely extroverted, renounce the functions or parts which are normally instrumental in an expression of the untested propensity and present a picture of dissociation (conversion hysteria).

Repressed *hostility* or hatred is particularly likely to engender

anxiety in adult life. The individual who develops hostility toward a parent or sibling in childhood usually represses it and then goes on to effect strong defenses in the form of humility, modesty, overconscientiousness, and excessive compliance to the demands of others. He may even develop and rigidly maintain a symptomatic fondness or concern for the very person he hates. The anxiety results from the constant threat which his repressed hatred comprises to his organization of conscious ego-ideals or moral values.

A young college woman frequently suffered from intense attacks of anxiety lest harm had befallen her mother. In order to allay her anxiety she would hurry to the nearest telephone and call her mother to see if she was unharmed. She never became concerned in this manner over her father or brother—her only sibling—to both of whom she was strongly devoted. Her outbursts of anxiety scarcely concealed a strong and not too securely repressed wish that her mother would die and thereby remove herself from the family circle.

Cross-identifications are common factors in neurotic anxiety and, therefore, in the development of anxiety equivalents. Such identifications are instrumental only if they are more or less repressed, unacknowleged, and unaccepted by the individual. Here we are dealing not with a specific repressed factor which constitutes a threat to the patient's ego-organization but rather with two ego-organizations, one masculine and one feminine (conventionally and traditionally evaluated), one eagerly supported and jealously guarded and the other rejected and denied (repressed).

A man with repressed cross-identifications (repressed feminine tendencies) is at a marked disadvantage around members of either sex. When around women his repressed tendencies tend to impose on him an identification with the women. This alerts his conscious masculine identity. The influence which women normally would have with him is augmented by the weight of his repressed tendencies and he accordingly feels insecure and anxious. His inadequately energized masculine identity is pitted against two, as it were, instead of one. He is therefore usually defensive in his reactions to women. His defensive attitude may take the form of coarse, vulgar, sarcastic, or otherwise objectionable behavior. More frequently it simply leads to an avoidance of emotional and, sometimes, physical relationships with the opposite sex.

When around members of his own sex such a man again tends to feel insecure and anxious. This results in part from his insufficiently supported masculine identifications and in part from the pull of his repressed feminine tendencies. The latter impel him to a submissive attitude toward men. He usually shuns frank competition with men and might actually feel that it is not right to try to excel the other fellow. Much of his anxiety may result from this clash between his two sets of ego-values. In Freudian terminology he has a divided Super-ego. His feminine tendencies to yield to the other person are in sharp conflict with his masculine tendencies to excel or dominate.

Repressed cross-identifications in women (repressed masculine strivings) are less likely to contribute to neurotic anxiety. Although such identifications incline them to a dominant and competitive attitude toward men, they can quite easily and unwittingly be expressed through and in accordance with woman's natural reactions to man. The desire to dominate, to whatever degree it might naturally exist in a given woman, is enhanced by whatever repressed masculine tendencies she has. But this desire to dominate is easily converted into a desire to possess. Her desire to possess can then be readily and fully expressed through feminine bids for masculine attention and interest. In fact, even an exaggerated desire in a woman to possess can be expressed or satisfied through ostensibly being possessed, as is clearly illustrated by cases of nymphomania. For that matter the idea that man possesses and woman is possessed in their emotional and physical relations is only one of our many traditional absurdities at best.

In relation to her own sex, a woman with repressed masculine tendencies experiences no particular difficulties. Her repressed tendencies simply render her more or less indifferent to women as friends and companions—her interests in adults being confined chiefly to men, both because she is a woman and because subconsciously she is identified with men.

Repressed masculine tendencies in a woman may conduce to anxiety if her feminine ego-organization is immature, infantile, or if she is unusually inept in giving expression to her feminine tendencies. In such a case the repressed aggressive tendencies tend to impose themselves on the patient's consciousness as a mental image of a brutal or threatening man with whom she feels utterly inadequate

to cope. Unable to give safe and satisfying direction to her female urges, her only hope, as it were, is that the outlawed man in her psychic make-up will move in and take over. Accordingly, she is both horrified and stimulated by any thought or mention of brutality, rape, or unbridled passion of any kind.

Before dismissing the matter of cross-identifications, it may be in order to remind the reader that such identifications do not contribute to personal maladjustment or personality disorders unless they are repressed. The person, man or woman, who does not tend to the extreme of his sex in his identifications (personal values, meanings, orientations) is unquestionably more adjustive and efficient than the he-man or the clinging-vine woman. The whole matter of adjustment depends on whether essentially all of his identifications are accepted by him and utilized or whether part of them are rejected and repressed. The most masculine woman or effeminate man is not necessarily at a disadvantage as long as he is not quarreling with himself about what he is.*

Given the dynamic basis of neurotic anxiety in the form of one or more repressed desires or attitudes impinging on an insecure ego-organization, what determines that an anxiety equivalent will result instead of conscious anxiety as such? Here, one is in the field of speculation. A few facts, however, have been noted and confirmed by clinical observation which shed some light. In the first place, it has long been known that various physiological changes normally accompany anxiety or fear. Some of the more common are increased pulse, circulatory changes producing blanching or blushing, trembling, changes in striped and smooth muscle tonicity, alterations in endocrine functioning, sweating, inhibition of peristaltic movements of the stomach, motor incoordination, muscular spasms, changes in the pitch of the voice, and dryness of the mouth. Now, *any person who tends to suffer from anxiety for no apparent reason and who fights against it will try to direct his attention away from his uneasiness and to something else.* Under such conditions he will be more capable of attending to some conscious accompaniment of his anxiety than to some unrelated fact.

This observation alone goes far in throwing light on the genesis of

* Some of the other factors which were mentioned in the beginning of the chapter as conducive to neurotic anxiety will be discussed later in the book and in connection with conditions to which they are most frequently related.

a number of anxiety equivalents. Since neurotic anxiety is aroused by subjective rather than objective factors, the patient's attention may play about himself instead of becoming directed to facts in his objective environment. His intolerance of his anxiety in the absence of any discernible and justifiable external cause inclines him to welcome any conscious physiological disturbance as a fixation point for his attention. Keeping his attention on the physiological factor not only mitigates his anxiety, it is acceptable to his self-esteem. Whereas feeling anxious for no apparent reason whatever would tend to make one regard himself as weak, childish, or ridiculous, being attentive to and concerned about a too rapid heart beat or a cold perspiration would seem entirely justified. Once such an arrangement of anxiety, physiological disturbance, and direction of attention comes about, repetition and time conduce to an automatic maintenance of the attention in the given direction and to a firm establishment of the physiological disturbance. The initial anxiety decreases as the disturbance becomes firmly fixed in the attention and concern of the patient. One may then properly speak of the disturbance as an anxiety equivalent.

Another set of subjective factors which frequently results in the appearance of an anxiety equivalent has already been mentioned in connection with the definition of the first class of equivalents. The person is already strongly predisposed to neurotic anxiety and in need of defense mechanisms, and then he becomes physically ill. Some symptom of his illness is grasped and maintained, essentially as a persistent idea of physical illness or impairment. The condition which results in the equivalent in such cases is perhaps always in the nature of a strong inner drive toward some goal coming into conflict with intense feelings of personal inadequacy.

Occasionally exigencies in adult life contribute largely to the development of anxiety equivalents. A married woman of thirty-five suffered from frequent spells of an exceedingly rapid pulse. While sitting quietly in a chair or lying on a bed her pulse would reach a rate of 140 or 150 beats per minute. Although little or no primary anxiety accompanied these palpitations, as far as could be ascertained, the patient had become genuinely alarmed about the condition of her heart despite her doctor's assurance that she had no cause for worry.

Years earlier when the patient was seventeen she had given birth

to a son. Her aggressive, domineering mother thought the patient's husband unfit as a father and the patient too young to be a mother and bullied and frightened her into signing away all rights to her child, even before she had seen it. The child was adopted by a couple unknown even by name to the patient.

In a desperate effort to adjust to the situation, the patient largely repressed all thoughts and feelings concerning her child. She later divorced her husband and remarried. She had had no other children by either man. When she was thirty-four she began to suffer from the palpitations. Interestingly and understandably the palpitations did not occur when she was thinking or talking about her "lost" son. Quite unknown to her, it was when she was trying not to think of him (to long for him) that they occurred. Longing for her son tended to arouse to a violent pitch all of the hatred and anger of a robbed mother toward those who had robbed her. This smoldering violence produced intense anxiety which long since had been diverted to excitation of the heart. Needless to say, at the time the child was taken from her, she suffered both from intense anger and fear and an accelerated pulse. She had tried to console herself at the time with the thought that she would do something about the matter as soon as she was strong and on her feet.

The palpitations ceased only when the patient had been encouraged and helped to relive her earlier tragic experience in all its emotional aspects and intensity and, incidentally, when she had become calmly determined to make every effort to learn the whereabouts and situation of her son.

In cases of anxiety equivalents the usual diagnostic and exploratory tests should be given. The results of these are not likely to be very informative, however, or too reliable. Only a thorough and painstaking study of the individual case will establish the chief sources of his converted anxiety, the nature of his predisposition to anxiety disorder.

A nondirective, psychoanalytic therapy is usually the best procedure during the early part of the treatment. With the appearance of a transference of usable strength and when the therapist has become fairly certain of the principal etiological factors involved, more or less active therapy is invariably indicated.

The closest attention should be given to the patient's dreams. They are of the greatest help in arriving at a knowledge of the etiological factors. A young man who suffered from a number of typical equivalents and an extreme shyness of girls dreamed that he went swimming with a girl acquaintance. They swam out for a distance side by side then turned and swam back toward the shore. As they touched bottom and stood up the girl grabbed him and thrust him under the water. In his dream he felt that her intent was to drown him. He awakened very frightened. Although the therapist had already noticed various but inconclusive indications of a repressed fear of castration, this dream confirmed his impressions beyond any reasonable doubt.

A woman patient who complained of periods of depression as well as certain anxiety equivalents recalled during her treatment that when she was four or five she dreamed she saw a man whose penis had been cut away, leaving a vertical gash. A castration complex was thereby verified although there was nothing in her symptoms as such which pointed specifically to such a causative factor. Another woman dreamed that she was putting a piece of meat in the refrigerator when her husband suddenly appeared. She was startled and felt guilty. She wondered in her dream if he had seen what she was doing. Here again we have definite indications of a castration complex (she wanted a piece of meat of her own, a penis) and of strong cross identifications (masculine strivings). She was sexually cold toward her husband (refrigerator). She wished she were a man and therefore had feelings of rivalry toward her husband. She was uneasy lest he had come to discern her true feelings. The same patient later dreamed that she had a penis of her own. This patient complained of headaches, extreme tension in the back of her neck, palpitations of the heart, tremulousness, and periods of weakness.

Three one-hour visits weekly is the best frequency in most cases. Full and concise explanations of the origin and genesis of anxiety equivalents should be given as early in the treatment as the patient shows some ability to turn his attention away from his symptoms and to seek a deeper understanding of his inner problems. The extent to which supportive and re-educative therapy are indicated will vary widely from patient to patient. Supportive therapy should be continued no longer and no more frequently than is necessary. The

therapist should make persistent efforts to substitute active therapy for it.

TREATMENT OF A CASE OF ANXIETY EQUIVALENTS

Leah C. was a smallish, attractive, dark-complexioned woman of thirty-four. Her manner was pleasant but presented a peculiar admixture of assertiveness and uncertainty. In speech she was blunt and sometimes crude. She gave the immediate and general impression of being very determined but uncertain of the proper direction to take, of the correct course of action to pursue. Thus, although her speech was direct and blunt there was a jerkiness about it. She would often stop speaking suddenly as if abruptly brought to question the truth or relevancy of what she was saying.

Leah had been married for thirteen years and was the mother of one child, a boy one year old. She was married to a successful business man of whom she was very fond. He appeared to be equally devoted to her and their marriage had been essentially devoid of conflict. Both were college graduates, industrious, and well liked in their community.

At the time of her first visit Leah mentioned the following symptoms: a fairly constant feeling of being hurried or of a need to hurry, marked psychomotor tension, extreme physical tension when driving a car, frequent dryness of the throat, sensations of tautness in the back of the neck, spells of dizziness, a strong fear of fainting when alone and away from her own home, tremulousness, tremors of the hands, and heart palpitations. In addition to these symptoms, she had never achieved a sexual climax in her relations with her husband during her thirteen years of marriage. In order not to disappoint or distress him, she had kept her husband in complete ignorance of this fact, always acting as if she had obtained full satisfaction. I mention this as indicative of the extent of her subservience to her husband's wishes and expectations.

On her second visit I gave Leah the Otis Test of Mental Ability, the Watson-Fisher Inventory of Affective Tolerance, and my own free association test. She made a converted I.Q. of 104 and a centile score of 23 on the affective tolerance test. She had failed to respond at the end of fifteen seconds to the word "disgust" in the free

association test but otherwise her responses were essentially normal. Her symptoms were so definite and pronounced as to leave little question as to the correct diagnosis so no further tests were given.

Leah was an only child. Both parents were living and in good health at the time of her treatment. Her father, retired, had been a successful business man.

The history taking as such brought out a number of significant and clarifying facts relating to Leah's early home environment. She was unable to recall any demonstrations of affection between her parents during her childhood. On the other hand they did not quarrel or fight. As to their more intimate reactions to her, I give the following recollections which she wrote down and brought in early in the treatment. "I can't recall my parents ever kissing and tucking me in bed at night. I am not sure, but if they kissed me very often, it was Dad and not mother. I can vaguely remember some rough and tussle fights with Dad." Capitalizing the word "dad" but not the word "mother" was strictly symptomatic of the patient's deeper feelings for her father.

Leah's father had wanted a son, not a daughter. He did not accept his disappointment graciously and comply with the facts. Rather, he treated Leah more as if she were a son than a daughter from the time of her birth. He taught her to ride horses, for instance, when she was still small, because he liked horses himself. When she was fourteen or fifteen he had her hurdle racing. She said that every time she approached a barrier she was terribly frightened but that she could not let her father down. Once when she was thrown and injured her father showed little sympathy. He was impatient for her recovery so she could resume her racing. She dreaded the races, yet she was eager to excel, perhaps more on her father's account than her own.

Along with this her father was very much of a prude. She could not recall his ever having mentioned anything of a sexual nature in her presence. Even during her pregnancy after she was married, he never once referred to her condition or mentioned his prospective grandchild. When she was small he was highly intolerant of any childish display of her body, of her tears when she wept, of any bid she made for affection or sympathy. Thus, he not only treated her as if she were a boy or at least sexually neuter, he appeared to disapprove of anything in her that was distinctly feminine.

Leah's mother was a dependent, timid, possessive, self-centered,

and very effeminate woman. Her attitude toward her daughter was coolish, demanding, and critical. Leah could recall that when she was still small her mother frequently reminded her of how much her parents were doing for her and how grateful she should be. This attitude was apparently still very much in evidence at the time of the treatment. All in all her mother was essentially a negative personality in the home, as compared with her father, and Leah never developed any very strong feelings toward her of any kind.

Partly on the basis of her early history and partly in the light of the information gathered from her dreams and other material, the pattern of Leah's psychic development and her present psychic organization (and lack of organization) became unmistakably clear. She acquired an early psychosexual attachment (Oedipus complex) to her father of appreciable strength. The development of this was prematurely blocked, however, by his peculiar attitudes, which I have mentioned, and strong identifications with him (cross-identifications) were effected instead. Under the influence of her father's unwavering guidance and encouragement, Leah's cross-identifications became dominant during middle childhood and pronounced masculine strivings appeared. She acquired a competitive attitude toward boys. Inasmuch as she repressed her feminine tendencies, girls comprised a more or less foreign and uncertain entity in her environment throughout her early life.

Leah also acquired a definite castration complex. She learned of the difference in sexual structure of the two sexes when she was between four and five, seeing a younger boy cousin in the nude at that time. This complex, too, I attributed to the influence of her father, who seemed to reject and frown upon anything feminine. That she should have come to feel that she was somehow deficient, inferior, or incomplete was almost inevitable. Her father was a dominant figure in any situation he entered. He came and went as he pleased. He always appeared certain and forthright in his speech and movements. Her mother on the other hand was often querulous and dissatisfied, frequently appeared uncertain, and remained almost constantly at home.

When Leah was about seventeen she began to renounce and repress her cross-identifications and masculine strivings in a most energetic manner. She was encouraged to do this by the fact that she was sent

away to school and lived in a dormitory among other girls. She was further encouraged to do it by a very important subjective fact. Namely, although she had developed very strong cross-identifications, *these did not include any homosexual tendencies.* Her sexual impulses or desires had remained largely dormant throughout childhood; they had not become directed toward members of her own sex, as frequently happens in cases of pronounced cross-identifications. To the extent that her sexual impulses had ever become directed to any object, her father had been the object. Coincidental with repressing her masculine strivings, Leah had made an equally energetic effort to release and express her feminine tendencies. The repression of her strong masculine strivings mainly provided the basis, of course, for her psychoneurotic reactions later.

Much of the information which I gathered during the first two months I obtained from Leah's dreams. She remembered her dreams well and was very conscientious about writing them down and bringing them to me. In fact, I should mention that she was extremely cooperative throughout the treatment. Her dreams, particularly those during the earlier part of the treatment, clearly indicated her identification with her father, her masculine strivings, a subconscious impression of physical incompleteness and the need of a penis of her own, feelings of inadequacy, and an excessive emotional dependence on her husband. I give a few examples of her early dreams below with interpretative comments of my own in parentheses.

"I dreamed that I was at a pagan ceremony. (An effort to renounce and divorce herself from the excessive conservatism of her parents.) Some tiny men were in a bowl. (An effort to reduce her strong but largely repressed masculine strivings.) It seemed that these people gave me something to sprinkle on these tiny men, after which my troubles would be over. (Her free association with this was sprinkling clothes, which I took to indicate asserting her femininity.)"

"It was dark, yet afternoon, as if a storm were coming up. (Her disturbed and anxious state of mind.) My cleaning woman and I were talking to Mrs. R. (Cleaning woman represented the drab life and mundane tasks which befall the average woman—her early impressions of her mother's day-to-day life perhaps.) Mrs. R. had a lot of new cupboards and sinks to be installed in her kitchen. They were

rather cheap and shoddy. Yet her little boy had a coat of Persian lamb. (Her early conviction of the male's superiority—Persian lamb coat—to the female—shoddy female sex symbols.)"

"I met an old school friend of mine and she said she had divorced her husband for the third time. (Being dominant like the male. 'Third' or 'three' is usually a symbol of male sexuality.) She said, 'Imagine, he says next Wednesday he is going to be a woman yet he knows he can't.' (A subconscious desire, rooted in her repressed masculine strivings, to exchange places with her husband, or at least to reduce him to her own level of inferiority.)"

"My mother and I were shopping in a super-market. (Feminine activity—procuring food, being a housewife, waiting on her husband.) Chum (her dog, a male, representing her masculine strivings) walked by my side, though no one but I could see him. I felt irritable and wished he would stay completely dead or come fully to life. (A wish that she could be frankly dominant and masculine or that she could be completely free of such a desire.) I bought some bananas (penis symbols) but they were stubby (underdeveloped like the clitoris) and overripe (spoiled, unfit)."

"I was applying for some sort of an insurance policy (a longing for a feeling of personal adequacy and security) and had to have a physical examination. The doctor took one look at me and grabbed the phone and said, 'That reject is here.' I asked him why he would not pass me and he said, 'All I have to do is look at you.' I began to shake and begged him to tell me what was wrong. He said, 'You had better take yourself to Dr. Fisher.' I said I already had and he said, 'Fine!' but he didn't look very hopeful. I was very despondent as I walked home. I came to a church and started to enter in search of peace of mind but choir practice was taking place so I did not go in. (This part of the dream clearly reflected her feelings of personal inadequacy and insecurity which resulted from her castration complex, repressed masculine strivings, and lack of a feeling of self-sufficiency as a woman.) I walked on and caught up with two girls and we sort of walked along together but I could tell that they thought it odd of me to walk with them. (Other persons of her sex could not accept her as one of them in a wholehearted manner because she had never been able to accept herself as such.) The two girls finally turned off on another street. I passed a store and a girl came out with a dog on a

leash. The dog was dressed up and had an arrangement of fruit on his back. (A dog always symbolized the male sex or male sexuality, I think, in Leah's dreams. The dress made him humanlike and the fruit perhaps represented 'sexual food'. In other words, a woman with a dog, a penis, was complete and amply provided for in her sexual life.)"

"I was walking down the street and met two men in riding clothes. I looked down and saw that I was in riding clothes too (masculine strivings or identifications, being like the men). I decided to go with them but when we got to the stables it dawned on me that they really did not want me with them. I excused myself and went to a girl's house (an effort to abide by her femininity). It was a funny house. All the rooms were so narrow (inadequate) and I remembered that certain people I knew (her parents) had designed it and it was supposed to be very fine. (The house symbolized a woman's physical make-up). But I still thought it was poorly designed, especially the bedroom (female sexual structure). Then my friend took me into the kitchen to show me some kitchen innovations she had made. I was quite impressed. (The kitchen, too, symbolized femininity or, more exactly, perhaps, a woman's relative position in life. The friend represented Leah's own *feminine* identifications and traits. Thus, Leah was trying hard to find herself and her position in life as a woman acceptable and worthwhile, impressive.)"

"I was in a hospital with my baby. In the next room there was a woman and some doctors who were consulting about an operation on the woman's nose. I walked by the door and looked in. The woman had the biggest nose I have ever seen. (This dream needs to be turned around. A woman with the biggest nose I have ever seen was in a hospital. Doctors were consulting about an operation on the woman's nose. Then I was in the hospital with my baby. The woman's nose was a symbol of a penis and masculine strivings. As a small child Leah came by the impression or conviction that girls and women had lost their sexual organs, were castrated. Knowledge acquired later refuted this early conviction. But the conviction still persisted more or less, subconsciously, supported by strong feelings of personal inadequacy and inferiority. Leah was trying hard to resolve her castration complex with its associated masculine strivings. She took the stand in her dream that she must give up her desire for

masculinity, for a penis—the woman had to have an operation on her nose—and accept her femininity. She reminded herself that she had been or could be partially compensated for the sacrifice by having a baby)."

"My parents were visiting at my home. I was sweeping the floor. I went to another room to work to get away from my father who was watching me. He pulled his chair up to the door and continued to watch. I was very embarrassed. I kept falling down and felt dizzy. (She was having difficulty in functioning as a woman under the eyes of her father, that is, under the disturbing influence of her masculine identifications. She went to another room in an effort to get away from these identifications but of course they went with her, her father followed her.)"

As soon as I had obtained the readily recallable content of Leah's personal history I began to give her lengthy and detailed explanations of the origin and nature of her different complexes and emotional trends. I explained how she came by her masculine identifications, why she later repressed them and why they thereafter created a masculine protest against her role as a woman. She was extremely eager to obtain a complete understanding of herself and her emotional and neurotic problems. I early detected an unusual degree of psychic flexibility about her and therefore, almost from the beginning, I interpreted her dreams as they came along.

Throughout the treatment I followed a freely modified psychoanalytic procedure along with active therapy after the first three months. I regularly secured and made use of her free associations and much use of her dreams but for the first three or four months I did much of the talking myself. At the end of about three months I began to introduce active therapy. The first move I made in this direction was in connection with her failure to have an orgasm in her sexual relations with her husband. After I had explained fully to her how and why her masculine protest prevented her from responding (yielding) completely, as a woman, and how her castration complex (subconscious notion of being defective or mutilated in her sexual anatomy) further interfered with a completeness of response, I ruled out all sexual contacts as such for a period of a month. (During the first six months of her marriage Leah had been able to achieve a climax through manual stimulation of the clitoris by her husband. She had then put a stop to such activity, fearing that her husband

would become displeased if not disgusted with her. Thereafter she had pretended to respond fully during sexual intercourse.)

I employed this bit of active therapy for the purpose of allowing more sexual tension to accumulate in my patient than she customarily had. It has long been my assumption that even when a woman does not reach a climax she nevertheless discharges a considerable amount of libido during the sexual act if she is emotionally more or less responsive to her partner. I believed that the increased sexual tension together with the greater insight which she was rapidly acquiring would enable her to have an orgasm by the end of the stipulated period. Leah's husband complained, quite good-naturedly, about the hard lot of a man married to a neurotic woman but cooperated fully in carrying out my instruction. With the resumption of sexual relations at the end of the month's time, Leah immediately began to have orgasms during normal sexal intercourse for the first time in her life.

This change in Leah's sexual response was followed at once by an appreciable weakening of her other symptoms. They did not disappear, however, for many more months. I continued to interpret and analyze her dreams, free associations, and any chance thoughts or changes in her feelings that she was able to report. I reviewed her psychic development with her many times, always trying to elicit further details about her childhood life.

Leah smoked cigarettes but never, she declared, without a feeling of guilt. She knew that her parents were aware of the fact she smoked but she had never been able to bring herself to do so in their presence. I explained that whatever additional significance her smoking might have, it embodied an unsuccessful or abortive declaration of her independence of them—the feeling of guilt and fear of smoking in their presence, hence abortive or unsuccessful. Leah's parents visited her frequently; and although her father, when displeased by anything Leah might do or say, expressed his displeasure by merely becoming more aloof, her mother was very free in her criticisms of the way Leah managed her home and child. Leah had always submitted with nothing beyond a mild verbal protest against these constant criticisms. The mother's nagging actually went as far as to include complaining about the food Leah served her.

I had become convinced by the end of the seventh month of treatment that Leah would have to assert her independence of her

mother in no uncertain manner if she was ever to become really adjusted and happy. I told her that she was going to have to "tell her mother off, put her in her place" if she wanted to get well. It took me another month to bring her to the point of doing this. I stressed the fact that it was unfair to her husband and child as well as to herself to let her mother or any person come into their home and dominate their private lives. Half good-humoredly, I ridiculed her fear of smoking in her parents' presence. I scolded and taunted her till she wept for letting her self-centered, ignorant mother tell her how to handle her child and where to place this or that piece of furniture.

Leah finally carried out this second bit of active therapy. Her mother had not only obstinately refused to come in and talk to me herself, she had consistently scoffed at Leah and derided her for coming to me for help. Apparently, it was unthinkable to her mother that *her* daughter could possibly need the help of a *psychotherapist.* In taking her mother to task, Leah apparently left no stone unturned. She did not argue or quarrel with her mother; she simply told her with much emphasis that she would no longer tolerate the slightest degree of interference with her domestic or personal affairs. She made it plain that no one was welcome in her home who sought to interfere with her management of it. Her mother left the house, sunk in self-pity and outraged by her daughter's show of ingratitude, but resumed her visits after a couple of months. Leah's husband applauded his wife's spunk.

Most of my patient's original symptoms were still present, though in a much milder form, or appeared only from time to time. She arrived on a plateau and no appreciable progress was made for several more months. A transference of a distinctly friendly and emotionally dependent type was present. She frequently dreamed of becoming separated from or losing her husband. I could not seem to get at or identify *the* factor which was blocking further improvement.

Then, about the middle of the eleventh month of treatment Leah brought in the following dream: "Jack (her husband) and I were in a cabin at Y— (a tourist resort). Jack was injured in some way and had to return home by train (a distance of 150 miles). I was to bring the car home (playing the masculine role). The roads were icy and dangerous (uneasiness in the role she assumed) but I

wanted to get at least as far as B—(a town midway) before dark. Several young women were now with me. I got only as far as N—where I was told the road was blocked (difficulty in following masculine role) and that we would have to go cross-country on foot. I led the way. I followed a power line and it was very difficult going —up and down steep inclines and cliffs (still persisting in the masculine role, which becomes increasingly difficult). Finally we came to an empty river bed (perhaps symbolizing her 'empty femininity' in the dream) with high cliffs on either side and with towerlike electric power installations in the bottom. (In giving her free associations to this part of the dream she mentioned the power installations as 'transformers,' which may or may not have had a specific significance. I interpreted them to mean masculinity or male sex symbols and her own masculine strivings or aspirations. However, they were inactive, the real source of power, the water, her femininity, being absent. This point marked a change in the trend of her dream, the beginning of a switch from the masculine to the feminine role.) I then saw a man whom I know and one of the women with me asked him how his wife and baby were. He said the baby was fine but that his wife was a yellow so-and-so because she would not live with him and look after him and their child as a wife should. (This was a self-delivered slap in the face by the patient for her own masculine aspirations and the neglect of her feminine role in life.) One of the women spoke up and said, 'That's too bad. Look at Leah, she is going to Jack even though she is scared to death on this trip.' (I do not think any sarcasm was intended here. Leah's feminine feelings and interests, which were now beginning to assume the dominant position in determining the course of the dream, were expressed by her woman friend.) There was a lady doctor present and she now treated my fingers which had become torn and raw (turning to her femininity for moral support and the resolution of her castration complex). Then we started out again with me still in the lead. This dry river or canyon situation seemed to be the last obstacle on our trip. In order to get out of the canyon, we had to climb one of the high towers and then step across a space to the level ground at the top of the canyon wall. (Her attention and strivings are suddenly diverted again to the masculine role.) I was simply sick with fear. I climbed to the top but just couldn't get across the gap. Down I came to the bottom of the canyon (intense resistance to her masculine aspira-

tions). I climbed the tower and tried to jump across the gap two or three times but could not make it. I was in despair when suddenly I saw an easier way to do it a few yards down the canyon. Even this way was tricky. I climbed a light wire and onto a wiggly fence. (This was the feminine role in which she felt inadequate and insecure.) Then by putting my foot on a large water faucet (perhaps a male sex symbol or masculinity—but not her masculine strivings which had just met with frustration—which she accepted as necessary external support in her role as a woman) I could swing down (down, to a woman's level in life, not up, to a man's) to the top of the canyon wall. I was just in the act of doing this when the telephone rang and I woke up."

With the help of Leah's free associations I interpreted this dream in line with the comments which I have interspersed. I then said to her, "Can't you see that your dream tells you you cannot be a man, you cannot successfully compete with men, you cannot achieve ends which only men can achieve? Furthermore, in your dream you tell yourself that there is an easier road in life for you, the road of a woman; that all you have to do is to go ahead and be a woman, depending on a man in various respects but not trying to be a man, and then you will be able to reach your ends. In short, all your nervous problems and this constant inner conflict of yours will be solved the moment you give in wholeheartedly and graciously to being just a woman in life."

As I made these points, which I had often made before, Leah began to weep, something she rarely did either in my office or elsewhere. When I asked her why she was weeping she said she did not know unless it was because she suddenly felt so relieved, unburdened.

Following this session Leah's symptoms dissolved rapidly. In fact, within a few days she declared herself free of neurotic symptoms. I explained to her that she had finally really accepted her femininity for the first time since she was old enough to distinguish clearly between the sexes, and that by doing this she was no longer in need of fighting her masculine tendencies, that the two would rapidly become integrated. I cautioned her against trying to act more femininely than she felt at any time or in any situation and to give free rein to any tendencies or interests which she might regard as masculine.

I dismissed Leah at the end of the eleventh month of treatment.

I had seen her only twice weekly during this period of time as my own circumstances prevented more frequent visits. It may be of some interest to the reader that when the affective tolerance test was repeated at the end of the third month of treatment she made a centile score of only 1. A lower score on tests of this type after the first few months of treatment is often obtained and undoubtedly results from the patient's gaining a truer perspective on his thoughts, feelings, and actions, that is, he tends to rationalize less. At the time of her dismissal, Leah made a centile score of 57 on the test.

At the time of this writing, nearly two years following the course of treatment, Leah is living a happy, normal, and active life.

CHAPTER II

Anxiety Hysteria

THERE IS FAR from complete agreement among psychologists and psychiatrists as to just what should be included within the syndrome of anxiety hysteria. Some do not use the category at all in classifying the psychoneuroses. With the present writer, however, it is indispensable.

Anxiety-hysteric reactions in severe cases bear a closer resemblance to psychotic reactions than those of any other psychoneurosis. Often extreme care must be exercised in the matter of diagnosis. The therapist should be careful not to confuse any persistent thoughts or verbalizations with the delusional ideas of the paranoid patient; the violent but subjectively directed emotional reactions with the scattered and undirected outbursts of the epileptic equivalent or manic patient; or the marked emotional infantilism with that of the hebephrenic. In many cases, only an intensive study of the patient's reactions and his history will enable the therapist to recognize the unmistakable pattern of a psychoneurosis instead of that of a psychosis or an unclassifiable condition.

A diagnosis of anxiety hysteria is warranted, in the writer's opinion, only if three certain trends or features or peculiarities exist and at the same time comprise the essential characteristics of the disorder. The first is one or more *conversion symptoms* or psychosomatic complaints. Although any part of the body may presumably be involved, such a symptom most frequently consists of a taut or gripping pain or sensation in the chest, neck, or head. This may be described as pressing, pulling, stretching, squeezing, or twisting. In any case one is left with the impression that it is a matter of extreme tension of some sort.

The second feature is a pronounced *egocentricity* which is hard to

define. Although the patient's attention appears to be extroverted, it is accompanied by a peculiar air of detachment. He reacts to his surroundings but in an unfeeling and unconcerned manner. He is particularly indifferent to the happiness or welfare of family members or friends. As one becomes better acquainted with the egocentricity, he learns that it houses and barely conceals the most exaggerated *perfectionistic strivings.*

The third feature which is always present is marked *emotional infantilism.* The extent of this in severe cases can hardly be put into words. The patient ceaselessly exhibits the querulous and demanding attitude of a spoiled two-year-old infant. But regardless of the efforts of others, he is never appreciative. All those about him must give their undivided attention to his endlessly repeated complaints and whims. He must have sedatives at night which, however, he may take only after childish protests and when the patience of those with him is tried to the breaking point. During the day he insists that he be coddled and humored and that as many persons as possible be with him every moment of the day.

The symptoms proper of anxiety hysteria are fairly varied. The more common include *intense restlessness, impulsive acts, anxious apprehensive feelings, suicidal thoughts and tendencies, emotional outbursts, melodramatic acts and gestures and remarks, tension in the neck and back, pressure sensations in the head and chest, coarse tremors, genitourinary disturbances, and certain phobias. Sleep* is frequently disturbed. The *appetite* may or may not be noticeably affected.

Anxiety hysteria is *the* frustration neurosis. The patient's old habits of thought, feeling, and action are dropped in the face of the inner emergency and he comes to a standstill. In the more extreme cases the intensity of the inner conflict unquestionably creates an emotional pressure or tension which is genuinely agonizing. Many of the symptoms can be understood as direct expressions of this tension. This is true of the pressure sensations, tremors, impulsive acts, emotional outbursts, genitourinary disturbances, and to an extent of the feelings of apprehension. In order to account for certain symptoms, however, and for the egocentricity, infantilism, and the emotional pressure itself, one must go into the causes and genesis of the disorder.

The writer does not wish to state that the causes and development of anxiety hysteria conform to the sketch which he gives here in every case. He is strongly of the opinion, though, that in its broader aspects the same outline holds to the extent that any given condition is essentially one of anxiety hysteria, as distinguished from anxiety neurosis, on the one hand, and conversion hysteria, on the other.

During early childhood (two-six) the patient became strongly interested in and devoted to sensual pleasures, particularly those of a sexual character. While this period lasted he freely engaged in sensually satisfying acts, either implicitly or overtly or both. He then renounced all such acts and strongly repressed all thoughts, feelings, and tendencies relating to them. Coincidental with repressing his inclinations toward sensual acts and pleasures, he undertook far-reaching sublimations and idealizations. In other words, he turned away from the sensual and to the ideational (spiritual). This was the origin of his *perfectionistic strivings.* The fervor with which he effected this inner change partook of the character of a sudden religious conversion.

The reason he made this change was that *his intensity of interest in the sensual was threatening to subordinate his whole course of psychic development to itself.* Repression is always instigated by the relative strength of the interest or desire rather than by its moral character or significance. If this were not the case we could hardly have instances of repressed affection, repressed sympathy, etc. In turning to the ideational, the spiritual, the ideal, he accomplished an effective defense against his sensual propensities, a compensatory medium for his impaired and inadequate self-esteem and a fruitful source of egoistic satisfaction. To be irreproachable, self-sufficient, and perfect within himself, as his childish mind conceived of these matters, became his basic orientation toward his future self. Thereafter he was a good little boy or a good little girl. He had repressed the very essence of his affective responsiveness and, therefore, he was not very warm and affectionate toward parents and siblings. He liked their attentions and caresses since these assured him that he was esteemed by others. He had little of the same to offer in return but, on the other hand, he was dutiful, obedient, honest, and pure-minded. These traits were accorded far more value than their real worth and accordingly his parents never for a mo-

ment saw him as self-centered, self-adoring, and quietly egocentric.

One extreme always invites another in the realm of subjective forces. As the patient arrived at adulthood, it became necessary for him to resort once more to repression in order to meet the everyday demands and situations of life. After he *repressed* his sensual interests in childhood, he *reacted* to an extreme in the opposite direction, that is, in the direction of ego-enhancing values and meanings (perfectionistic strivings). As he advanced into adult life it became necessary for him to largely repress, or at least inhibit, his perfectionistic strivings.

The patient was then left in a precarious subjective condition. He was unable to be frankly self-centered and selfishly idealistic, on the one hand, or to give adequate expression to his strong interest in sensual pleasures and physical facts, on the other. Much of his psychic energy was tied up in his repressions and, therefore, it was only with effort that he could sustain a workable degree of interest in the everyday affairs and activities in which he found it necessary to engage. When he met with frustrations or disappointments, or when one or the other set of repressed interests became overstimulated, or when (because of increasing age and decreasing energy and psychic flexibility) he could no longer withstand the inner strain imposed by his repressions, he developed anxiety hysteria.

Some of the points which have been mentioned were clearly illustrated by the case of Helen V., thirty-four, married eleven years, three miscarriages but still childless. According to her parents she had been the model among their nine children. She had always been obedient, modest, idealistic, and religious from an early age. Helen herself refused to discuss sexual interests or acts of her early childhood. She did state, however, during one of her few cooperative moments, that she had responded to her husband sexually only once, which was on her wedding night. Thereafter sexual intercourse had been painful and revolting. These facts attested to strongly repressed sexual desires and responsiveness just as the fact that she reached a climax on the first night of her marriage attested to an actual capacity to respond. Her initial responsiveness had simply alerted strong narcissistic resistance.

Four years after her marriage and following her first miscarriage Helen developed a pelvic pain. This was an unwitting, symptomatic attempt, engendered by her narcissism, her perfectionistic striv-

ings, her desire to be completely self-sufficient, to preclude further intercourse and pregnancies. She continued to submit to her husband infrequently and to try to bear children solely because she consciously regarded such as an obligation and a necessary feature of a woman's life.

After her third miscarriage, Helen went to bed and remained there, praying for the removal of the pelvic pain. She had been told by her religous advisers that she could not carry a child because she was too wicked. At the end of two months Helen's pain suddenly disappeared. Her mind then immediately became invaded by the most distressing thoughts about God. She could not urinate without the thought coming to her that she was urinating on Him, or drink a glass of water without the thought appearing that she was drinking His blood, or eat without the food's becoming His flesh. Thoughts came to her that she had destroyed all of God's works. Here one sees her theretofore partially repressed narcissism violently breaking through. She had become greater than God, her thoughts told her. She was degrading and punishing Him, because He had removed the pelvic pain and left her undefended against the ego-annihilating force of her sexual cravings.

At times attempts were made to effect a compromise, but always weighted in favor of her narcissistic interests and attitudes. She frequently had thoughts that God was passing through her body. She had still other thoughts but obstinately refused to divulge them, saying they were too terrible. These were perhaps thoughts of having intercourse with God or having babies by Him.

Along with this narcissistic rampage Helen was very infantile and dependent. She showed no concern or sympathy for husband or parents. Someone had to be with her every moment of the day and night. She would take advantage of the slightest opportunity to stage some melodramatic performance. She hacked her legs with a razor blade, not cutting very deeply. She jumped in a river, but perhaps first made sure that her rescuers were near at hand. In any case she was industriously paddling for the bank when her husband and father arrived a few seconds later. She could not tolerate conversation among others, even between her parents, unless it was about her. On retiring for the night her husband always tied one of her ankles to one of his so she could not leave the house and force him to find her.

In those cases in whom a definite phobia exists the symptomatology is usually much simpler. The phobia itself may be the only symptom, the patient otherwise appearing normal and unaffected by subjective disturbances. A woman who had been unable to go even to the corner grocery by herself for twelve years (agoraphobia) was regarded by all her friends as a very normal and well-adjusted person. Surprising as it may seem, she had succeeded in keeping her phobia a secret, even from her own husband. But although the patient with a phobia, belonging to the anxiety hysteria syndrome, presents a very different symptomatic picture from such a case as the young woman just described, careful study will always establish the basic psychological similarity of the two conditions. A principal difference appears to be that in the case of the phobic patient a fear arrangement has been constructed and utilized to hold the exaggerated egoistic aspirations to perfection and self-sufficiency in check. The inner conflict has become somewhat stabilized, anchored. In the case of the other patient the egoistic cravings are relatively free to exert their various disturbing influences. The patient with an agoraphobia feels that if he were to go out on the street by himself he would be sure to behave very much as the other type of patient actually does behave. That is, he would act crazy, make a fool of himself, create a scene, and perhaps get himself locked up. Although the writer has made no check on the matter, he is of the impression that the more intelligent the patient the more likely the condition will have resolved itself into a phobia, the less intelligent the more likely the condition will exist in the chaotic, disorganized form.

Other phobias which usually if not always belong in the anxiety hysteria syndrome include the fear of insanity, fear of high places, fear of closed places, and fear of death or of committing suicide. The agoraphobia, however, is the most perfect example of this class of phobias. It is not difficult to understand its psychological significance. In the first place it is a subjectively enforced renunciation of the desire for *complete* self-sufficiency—the patient cannot go and come by himself. With this renunciation of complete self-sufficiency the patient is left free to be more than normally self-centered. Did anyone ever know a person with an agoraphobia who was not obviously self-centered and perfectionistic in his personal attitudes and behavior? In the second place the phobia comprises an

enforced admission of the need of others. This admission is symptomatic, of course, and it therefore enables the patient to maintain at least shallow friendly and affectionate relations with others and a mild display of sexual interest in the spouse. Thus, the phobia is really a compromise formation and it is undoubtedly due to this fact that the patient becomes fairly stabilized, except for his fear. He is stabilized within his subjectively and symptomatically circumscribed range of personal freedom. If he were forced beyond that, forced to go out alone, he would immediately become unstable and disorganized.

Any of the causal factors mentioned in the last chapter as contributing to the development of anxiety conditions may be found in the early childhood history of the anxiety hysteric with the exception of a paucity of ego-identifications. As already pointed out, the patient has become overidentified with ideas of personal perfection and self-sufficiency. Prior to this he was almost certainly troubled with cross-identifications, a castration complex, feelings of guilt or hatred of parent or sibling. Over and over among women patients one comes across evidence of a castration complex. Among patients of both sexes one often discovers strong cross-identifications. In fact, one comes by the impression that anxiety hysterics as a group barely missed sexual inversion in their psychic development. More or less relevant to this is the further fact that one does not encounter strong, unresolved, positive Oedipus complexes in this class of patients.

The anxiety hysteric is always of a strongly motivated, dynamic make-up. He tends to overrespond. He tends to invest more energy in what he does, implicitly or overtly, than is usually necessary or even desirable. Thus, his early sensual and sexual interests in childhood tend to become too strong; and when he reacts against them by way of repression he overreacts. When he then effects his perfectionistic slant, he similarly carries this to an extreme. As he comes into adulthood and finds it necessary to curtail his devotion to his narrow, personal ideals in order to meet the demands of adult reality, he once more reacts to an extreme. He either represses his perfectionistic preoccupations or he diverts his perfectionistic tendencies to the everyday problems and responsibilities of life. In either case severe inner frustration is the result. Perfectionistic strivings

cannot be expressed in the homely tasks of everyday life. Neither can one extract self-glorification from ordinary duties and responsibilities. Thus, at this point, both the patient's affective responsiveness to others and his egoistic propensities are largely blocked.

There is still another mental characteristic of the anxiety hysteric to be mentioned. This is his psychic *inflexibility* or rigidity. Naturally this varies considerably from patient to patient but it is always present to a noticeable extent. It amounts to an inflexibility of attitudes, sentiments, affective habits. The therapist experiences it as a resistance in the patient to any inner change. Although the patient may acquire considerable insight, this does not affect his symptoms and symptomatic attitudes and feelings to the same degree at all that it does in the case of most other types of patients. Moreover, the patient appears obstinate about accepting his symptoms (particularly those which are narcissistically engendered) as genuine expressions of his own psychodynamics. He has a persistent tendency to "depersonalize" them, to objectify or externalize them as it were.

Psychological testing should be rather thorough with this type of patient. The therapist needs to know first of all what the intelligence level is. Without knowing this he is in a poor position to evaluate the significance and seriousness of the patient's symptoms. The young woman who complained of thoughts that she was urinating on God, that she had destroyed his works, etc. was of mediocre intelligence, an I.Q. of about 85. Such thoughts were fairly well in keeping with her inferior intelligence, her very literal conception of God, her ignorance in general, and lack of education. Similar thoughts perhaps could not exist in a case of anxiety hysteria of superior intelligence. Rather, such thoughts in a patient of superior intelligence, as indicated by tests or past accomplishments, would strongly suggest a psychosis and the immediate need of hospitalization.

Personality inventories are not usually very revealing since the patient is prone to answer in terms of whatever remains of his everyday perspective rather than in terms of his symptomatic attitudes and feelings. As pointed out, he tends to externalize these matters instead of accepting them as expressions of his own motives. But free association tests are of particular value, not only in helping in the

diagnosis but in definitely indicating the nuclear conflicts. Projective techniques also may help to reveal the egocentric slant, conflict with physical desires, the psychic rigidity, and the infantile orientation.

Although this class of patients responds more slowly to treatment than most others in the psychoneurotic group, they are definitely amenable to psychotherapy except in the most severe and less intelligent cases. At the same time no psychoneurotic sufferer exacts so much patience, perseverance, tact, and knowledge of the psychodynamics of personality disorders as the anxiety hysteric. In the more severe cases the patient should be seen five or six times each week for the first few months. During the first two or three months no pressure should be brought to bear on the patient by the therapist other than an insistence on regularity of visits and a frank discussion of feelings and symptoms. Even the patient's early history may not be probed into too deeply during this time if doing so arouses obvious resistance in the patient. Interpretations of dreams and other material should be held in abeyance for the most part till later and otherwise given only after due reflection. The exact time at which the interpretation of a given bit of material should be made for the patient and the precise manner in which it should be presented are among the finer points in psychotherapy in working with any case; with the anxiety hysteric they assume still greater importance. It is better, and safer, to put off interpretations too long than to make them too soon.

The therapist should not try to accomplish too much during this period. He has been successful so far if at the end of two or three months he has acquired a fair understanding of the patient's developmental history and present motivations, if an easy rapport has become established, and if the patient is showing some degree of dependence on him and the therapeutic situation. Parents and siblings should have been advised, if possible, to stop discussing the patient's symptoms and vagaries, to listen to the patient's complaints without showing undue concern, and to be noncommittal in any remarks they might make. If a spouse exists, he should be instructed to assume and try to maintain a genuinely friendly and sympathetic but essentially undemonstrative attitude toward the patient at

all times. Any show of intense feeling toward the patient should be ruled out for all family members.

The therapist should encourage the patient to become dependent on him, and essentially him alone, for understanding, sympathy, and help. One of the most effective ways of keeping the patient from acquiring such an attitude of dependence, incidentally, is by demanding it of him. The therapist should encourage it but not demand it. If his attempts to encourage it become too obvious, he will defeat his own aims. The patient is very narcissistic, aspires to self-sufficiency, and is therefore strongly opposed to coming too much under the influence of anyone. He will do it only gradually and unwittingly.

When the therapist is sure that the dependent attitude has become fairly well established, as manifested by the patient's coming too early for his appointments, trying to prolong the visits, requesting additional visits, or by other obvious indications, more forthright steps may be taken in the therapy. The patient may now be instructed to stop discussing himself and his symptoms with all persons except the therapist. Or he may be instructed to rule out only certain persons in this respect and for the time being. The therapist must try to gauge the patient's affective tolerance and decide how much he may safely demand of him. Certain ones or all of the family members may now be told, *with the patient's knowledge*, that they are to stop all discussions of the patient with himself.

Interpretations of dreams and other material may now be given more freely and fully. When significant material is interpreted, the patient's understanding and acceptance of it should be checked a few days later by asking him to give the interpretation in his own words. If he cannot do so or if he merely repeats the words of the therapist by rote, he either failed to understand the interpretation or he refused to accept it because of the resistance it aroused. The interpretation must then be repeated, in slightly different terms or from a somewhat different point of view if possible, and the patient checked again later. The patient should be closely questioned at the time as to whether or not the interpretation seems correct to him and, if not, why.

If good progress is made the visits can usually be reduced to three each week after a total of five or six months of treatment. As the

patient acquires insight and manifests some genuine ability to examine his narcissistic and perfectionistic propensities and his infantile erotic tendencies with frankness, his dependent attitude toward the therapist will become invested with more mature feelings. Along with this, more active therapy may be introduced. Usually the patient has dropped away from the world of daily events. He may be instructed to read the front page of a daily paper regularly or one of the better weekly news magazines. The therapist is also now in a position to enforce a gradual return to work, responsibilities, and social activities. This may be done in most cases considerably in advance of the complete disappearance of symptoms. This is particularly true when the patient is a housewife.

With the resolving of the conflicts and dissolving of the symptoms a strong transference takes place. This may or may not present the therapist with a delicate problem. Enough of the old desire to be perfect and irreproachable usually remains to keep the patient from losing his (or her) dignity in the therapeutic situation. The influence with the patient which the transference gives the therapist should be used, as in any other case, to enforce adjustive efforts both in the direction of complete insight and in his working and social relations with other persons.

Educative and re-educative therapy have a place during the latter part of the treatment with most of these patients. The most important aim of such procedures is teaching the patient that he has a thoroughly legitimate right to be more selfish and self-centered than he had formerly regarded as strictly normal. The only care which he should always exercise in this respect is to express his egoistic and perfectionistic tendencies in word and action and not in phantasy. Other persons will act as an effective control over these tendencies if they are overtly expressed.

The treatment should be brought to an end gradually. This can be done by interruptions of the treatment, the duration of each interruption being increased, or by decreasing the frequency of the visits to the vanishing point, or by a combination of the two.

TREATMENT OF A CASE OF ANXIETY HYSTERIA

Mary N., thirty-three, married seventeen years and the mother of two sons, fourteen and sixteen years of age, was brought to me by her husband, mother, and brother. She was suffering from an acute and severe anxiety hysteria, as became very clear after two or three visits. She was a smallish woman, near medium height but slender. She appeared haggard, distressed, confused, and preoccupied. She seemed to be struggling with some inner force or pressure. She paced about the room, seemingly unable to remain in one spot more than a few seconds at a time. The family members accompanying her all showed deep concern and closely watched every move she made. I contented myself with taking down names and addresses of the patient and her family members during this initial interview and arranging a schedule of visits. Because of circumstances affecting myself I was able to arrange a schedule of only three visits weekly. Five or six would have been better. It was understood that some member of the family would accompany Mary to my office till such time as I might deem it unnecessary. I explained the extreme importance of punctuality and regularity of visits and also took advantage of the presence of the others at that time to emphasize the necessity of the patient's not discussing with anyone the matters which she and I would discuss till after the treatment was ended.

I devoted the second consultation to recording symptoms, securing data on the onset and duration of the illness, and obtaining what information I could concerning the patient's parents, siblings, husband and children, and her general mode of life prior to her illness. I talked to the patient alone during this visit and all subsequent visits. I began psychological testing with the third consultation.

Some crank in California had predicted that the world would "come to an end" on a certain date. Despite the scarcity of paper at that time, the press gave more or less space to his predictions. Mary, who was already set, of course, for a "psychic explosion" and who was only in need of a spark to light the fuse, became suddenly and violently disturbed on the date mentioned by the crank. Apparently her mind became a turmoil of weird and fearsome thoughts. Thoughts (not true convictions or delusions) that the world was coming to

an end, that she was suspended up in space, that she was losing her mind, that everything was expanding like a balloon, and that she was somehow responsible for these events raced and "twisted and turned" in her mind incessantly. She was extremely tense and restless. She thought repeatedly of committing suicide but experienced no strong impulse in that direction. She repeatedly expressed ideas of death, particularly in regard to herself. If tomorrow was mentioned, she would reply that she would not be alive tomorrow or that she would not exist in any form the next day. She further complained of gripping and expanding sensations in her chest.

The onset of her illness occurred three weeks prior to Mary's first visit to my office. As far as I could learn her symptoms had remained the same during that time except that they had become somewhat refined and stabilized. Thoughts of death and feelings of impending disaster appeared to be with her constantly. She complained continually about the sensations in her chest. She said at times she felt as if her chest were squeezing itself into a little hard knot. Only she would state that it actually was doing this, not that it seemed as if it were. At other times she complained that her chest was expanding tremendously, that something had to get out. She was utterly indifferent to her personal appearance, her hair often looking as if she had not combed it for a week. Her speech was coherent and relevant except for her frequent melodramatic and exaggerated remarks. If asked how her sons were, for instance, she would make some such reply as "I have no sons. They are strangers. Their mother is crazy." All in all she appeared to be mentally confused or dazed. On the street she seemed to notice no one. She walked along by the side of her companion in a mechanical, inattentive, preoccupied manner. Under close questioning, Mary admitted that she slept well. Family members reported that although she ate her meals she appeared indifferent to her food and ate all dishes put before her with the same lack of gusto. With the onset of her illness Mary's mother had taken over her daughter's domestic duties and responsibilities.

On the Otis intelligence test, higher form, Mary made a score of 41 (a converted I.Q. of 99). She made a centile score of 15 on the Watson and Fisher Inventory of Affective Tolerance. On a free association test she gave no response, during a fifteen-second period, to the words "fear," "disgrace," and "guilty," and very delayed responses to the words "ant," "indecent," "sex," "illegitimate,"

"steal," and "naked." The reasons for these delayed responses and lack of responses should become clear as we proceed. At the time the test was given the delay and lack of response simply indicated the words produced an emotional disturbance and a resultant mental blocking. No projective techniques were used.

Mary's earliest memories were of cutting her chin when she was four, of cutting one of her legs while playing around farm machinery at about the same age, of nearly being shot by a careless cousin, and of thinking a falling star had struck and killed a tree. These earliest memories suggested a castration complex in childhood.

After the preliminary consultations were over and a diagnosis of anxiety hysteria seemed fairly certain, I went on to a rather slow but painstaking examination of Mary's childhood life. I permitted her to take up a part of each visit in talking about her symptoms and in voicing weird ideas and being melodramatic. When the matter of sex in childhood was touched on she at first seemed reluctant to discuss the matter. After a little persuasion she launched herself into the subject with such vehemence that I suspected she had been yearning to discuss the matter all the time. Many of the expressions she used are unprintable even in a book on psychotherapy.

Mary had two siblings, a brother three years and a sister eight years her junior. Till she was ten she lived in a large house with her parents, siblings, maternal grandparents, two maternal aunts, and a maternal uncle. Her mother was a virtuous, serious, and hard-working woman. Her father drank, paid attentions to other women, showed only mild affection or concern for his children, and was not very reliable or industrious. He was essentially a negative factor in the home environment. The grandparents were serious, industrious, and proper. The two aunts were high-class prostitutes. The uncle was lacking both in morals and industry. For eight years Mary was the only little girl and one of the only two children among this large group of diverse adult attitudes, activities, and personalities.

Mary stated that from about the age of four to ten she was more fond of her grandmother than her mother. The former humored, petted, and flattered her. Her mother, on the other hand, never compromised with her ideas of how she should handle her daughter and besides she was always very serious and busy. But the outstanding one in the group to Mary was one of the aunts. This aunt was beautiful, always dressed in the height of the prevailing fashion of the

small city in which the family lived, was very fond of Mary, and always kind and generous. She practiced her profession for the most part in the large rambling house in which they all lived, despite the unceasing opposition of Mary's mother and grandparents. Mary frequently slept with this aunt. On a number of such occasions the bed was also occupied by one of the aunt's gentlemen friends (sic). These men who came to the house were always carefully groomed, and were courteous and friendly with Mary. She remembered this aunt as looking like a princess or queen.

Mary's uncle gave her small amounts of money to play with his penis. She was fairly certain that she could recall having taken hold of it a few times. He made no attempt to molest her otherwise. When she was between five and six a boy cousin of sixteen tried to seduce (rape) her. He was not brutal and did not hurt or injure her. He finally gave it up, apparently as a futile undertaking. She was not frightened and offered no resistance. On various occasions Mary engaged in sexual play with little boys and girls in the neighborhood. The play consisted of mutual exposure, examinations, etc. Sexual play with one little girl stood out in her memory. They stimulated each other's genitals with their hands. This had been a thrilling and exciting experience for Mary. She believed it only happened once. Apparently the intensity of pleasure derived aroused resistance which, naturally, soon took the form of moral resistance. (A child can defend himself against his own intensities of desire only by utilizing the ideas which he has been taught.) Mary never told her parents or grandparents about her childhood sexual experiences.

My study of Mary's childhood history left little doubt but that she had made strong identifications with the one aunt whom I have mentioned in particular. She clearly recalled admiring her and wanting to be like her. At the same time she identified herself with her mother and grandmother who, however, embodied essentially the same basic traits and characteristics. Thus she acquired two distinct and disparate sets of ego-identifications. Those acquired through her associations with her aunt pointed to the ends of personal attractiveness, fun and gaiety, personal freedom, and free and easy relations with the opposite sex. Those built up as a result of the influence of mother and grandmother, on the other hand, endowed her with aspirations to modesty, decency, honesty, responsibility, industry, and to an unselfish mode of life in general. As she grew older

Mary largely repressed everything her associations with her aunt had aroused or instilled in her (except for certain rationalized and/or unwitting expressions) and steadfastly thought, felt, and behaved in keeping with the meanings and goals adopted from her mother and grandmother, till the occurrence of her psychoneurosis.

Mary did not develop a positive Oedipus complex. She was perhaps more fond of the women members of the family group than of the men. Her affection was too widely distributed for her to become excessively enamored of any one person. Moreover she was petted, humored, and flattered too much for her affectionate capacity ever to have been fully awakened in childhood.

For the first two months I did not analyze or interpret her dreams and the other material she supplied, except to myself. I encouraged her to discuss her entire life and affective relationships with complete abandonment. In her talk she freely mixed the most obscene references to sex with thinly veiled ideas of personal perfection and omnipotence. And always throughout her talk ideas of her own death or insanity repeatedly appeared.

Mary had always been incapable of attaining a climax in sexual intercourse except through excessive stimulation of the clitoris, according to both her and her husband. And she had practiced fellatio with her husband since early in her marriage, under the guise (rationalization) of wishing to please him. Since she consistently denied any history of masturbation, both of these facts strongly indicated an abnormally strong interest in the male sex organs and therefore a castration complex or cross-identifications or both. And in view of these facts whenever Mary found herself at a loss for something to talk about or was prone to use the whole period in making absurd, melodramatic, and egoistically colored remarks, I quietly directed her attention back to the matter of sex.

Her dreams, many of which she was able to recall and obediently wrote down as soon as she awakened, were concerned for the most part with everyday events and activities throughout the first eight or ten months of the treatment. In fact, she led a fairly normal life in her dreams, far more so than she did in her waking state. This seemed to indicate that with the advent of her psychoneurosis her theretofore conscious attitudes, feelings, and interests became automatically repressed or inhibited to a large extent by the sudden and violent upheaval of her theretofore subconscious attitudes,

interests, and desires. At about the end of the first two months of treatment Mary dreamed that she and a woman friend went to the office of the doctor who had advised the family to bring Mary to me. As she and her friend left the office the friend remarked: "I could perhaps come to like that doctor but I certainly would never fall in love with him." This dream pointed to the beginning of a transference, or at least a tendency in that direction, and very strong resistance to it. Although I had not mentioned a transference to my patient, and did not do so when she gave me the dream, she had heard some mention of such by her husband or mother who had been reading everything they could find on psychoanalysis and psychotherapy. (Later in the treatment she confirmed this.) At about this same time she mentioned the matter of shock therapy. For the next two weeks she seemed to be able to think of nothing but shock therapy when she came to my office. I felt certain at the time that her resistance to a transference and to letting the therapeutic situation become a stronger rival than it already was to her egocentric preoccupations was the dynamic factor back of her incessant thoughts and talk about shock therapy. I was utterly unable to divert her attention to other matters so I finally told her to have the shock therapy and be done with it. I explained the situation to her husband and that further attempts at treatment by me would be useless under the circumstances.

The patient's husband took her to a shock therapy enthusiast in Denver, Colorado, who without bothering about such matters as the patient's history, the psychodynamics of the neurosis, diagnosis, etc. gave her forthwith a full course of electric shock treatments. When the results proved to be negative, and perhaps somewhat worse than negative, he advised her to return home, forget her nervousness and leave doctors alone, particularly psychotherapists.

Mr. N. then came to my office and asked me to resume the treatment. He thought his wife was "cured" of shock therapy. She was and never mentioned it to me again.

I could see no change in Mary on her return except that she complained of drawing, twisting, and expanding sensations in her head. She still mentioned the sensations in her chest but not as frequently as she had formerly. I did not know, and still do not, whether the sensations in her head were in part or wholly attributable to the

shock treatment or whether they appeared because of some other reason.

With the resumption of the treatment Mary was somewhat more cooperative. She seemed to feel that her only possibility of help lay in psychotherapy. I continued for several more months along the same line I had been following, letting her do most of the talking and offering very few explanations or interpretations. I encouraged her to talk freely about her past and present feelings toward her parents, siblings, husband, and children. I persistently directed her attention away from her symptoms and to the matter of sex.

At the time when her illness appeared Mary was working at a notions store. I inquired closely about her work and experiences in the store and her associations with the other employees in a search for a precipitating cause of her neurosis. She admitted frankly when questioned that unknown to the management she had taken various small items from the store. Although the total value of what she had taken was not large, her stealing had a very definite psychological significance for me. It was the first time she had ever strayed from the narrow path of her mother's teachings. This indicated that as her sons became older and required less and less of her attention, her old repressed egocentricity and desires for complete freedom and to do as she pleased (early identifications with her aunt) had slowly inched their way, as it were, to the surface of her conscious life. Taking things which did not belong to her were impulsive, symptomatic expressions of these desires. Of course at the time she had sought to justify (rationalize) her acts in various ways. But like the person who tends to drink to excess and for whom one drink inevitably means going on a binge, so was Mary unable to hold her egoistic craving for personal freedom and abandon in check once she had permitted any genuine and overt expression of it. The crank in California simply suggested a day, sufficiently near, on which Mary would lose control over her repressed desires and land in mental turmoil. I explained these interpretations fully and repeatedly later in the treatment.

About three months after Mary's return for treatment I learned from her mother that my patient was having frequent and peculiar attacks, but only when she and her mother were alone together. Mary had never mentioned these attacks to me, for a very good reason. As reported by her mother, she would suddenly become

rigid and semiconscious and look as if she were going "stark mad." Her mother would become almost terrorized and vigorously apply cold packs and smelling salts and massage her daughter until she (the mother) was exhausted.

I did not believe that these attacks indicated a repressed childhood hatred of the mother as such. Rather, they were outbursts of violent egoistically engendered resentment against the human virtues which the mother represented. Subjectively viewed, they were assaults within Mary by her egoistic demands on her better qualities, the traits and characteristics which she had developed largely through her identifications with her mother.

When I mentioned the attacks to Mary she was reluctant to discuss them. I decided to interpret them for her then and there and to try to force her to understand and accept their meaning. I explained to her that whether she realized it or not her attacks were intentional and that her sole purpose in having them was to distress and dominate her mother, that is, her mother *imago*. She was obviously averse to my explanations and the attacks continued for several more weeks. She then brought in a dream in which she was having a very severe attack. In this attack she was screaming, "acting and looking crazy," tearing off her clothing, and rushing from one room to another. Her mother was completely frantic. But in the dream it had seemed to Mary that she was deliberately staging the attack in order to distress her mother. Thereafter she had no more "fits," as I had persistently called them in discussing them with her.

At the end of seven or eight months I explained the matter of the transference to Mary fully, began interpreting her dreams and other material, including her actions, as thoroughly as I could and introduced active therapy. I explained the dynamics of the transference and that a transference inevitably developed in proportion to and coincidental with improvement. I told her emphatically that she was not supposed to try to develop a transference or to try not to. I emphasized the importance of letting her thoughts and feelings be whatever they tended to be, as I had already done many times before. I repeatedly reminded her that her part of the undertaking consisted of telling me her thoughts and feelings, reporting her dreams, and carrying out any instructions which I gave her. Because of her extreme egoistic bent she, of course, wanted to have much more to do with the matter of her treatment, somehow, than

what I asked. She was strongly opposed to letting matters passively take their course, of letting things just happen to her.

I explained the psychodynamics of the psychoneuroses, and of anxiety hysteria in particular, in as far as I felt she would be able to understand me. With the introduction of active therapy her dreams underwent a definite change. They became more regressive and symbolical. They definitely revealed a castration complex, an inordinate interest in male sexual structure, and an aversion to her own sexual make-up. They expressed strong exhibitionistic tendencies, intense egoistic desires for personal distinction and preeminence, and resentment against all authority. As I said, I now began interpreting her dreams as fully as I could.

The active therapy which I introduced at this time and throughout the remainder of the treatment was too extensive and varied to be mentioned here in detail. I instructed both Mary and her husband to dispense with sexual intimacies altogether for two months, as these had become a matter of frequent complaint with her. Mary had been coming to my office in sloppy slacks and an equally sloppy blouse which was sometimes buttoned and sometimes not. I frankly criticized her personal appearance and instructed her to pay more attention to it. To make the instruction more specific I would tell her to dress as neatly as possible on a certain day, to powder her face, rouge her lips, and comb her hair. On that day I would compliment her on her appearance and then ignore the matter for two or three weeks. Then I would take the matter up with her again.

I had her prepare dinner for her family on certain days, and later, every day, while her mother was still doing most of the work and supervising the household. I had her go to a moving picture once each week with her husband. I outlined a modest reading schedule for her, mostly on current event topics. I had her discuss their school work with her sons, from whom she had become almost completely estranged, and to report the exact conversations to me. I had her do some of the grocery shopping and to make sure occasionally that her boys' ears were clean when they went to school.

I did not introduce all of these measures at once, to be sure, to say nothing of many others which I used later. Whenever I would tell Mary that there was something I wanted her to do and give her one of these instructions she would reply that she was sure that she would not be able to do it but she would try. Actually, she did not

fail to carry out a single instruction, although she would declare that she would be sure to poison her family if she cooked their dinner, act insane if she talked to her boys about their school work, lose her way and wander off if she went to the grocery.

The active therapy produced considerable tension and resistance. For several months she opened each interview with the stock question: "Well, is this thing ever going to develop?" Although I knew what she meant I would nevertheless ask, "What thing?"

"This transference."

"If it doesn't," I would tell her, "we'll just get along without it." She would then want to argue the matter pro and con, but I would insist that she talk about other matters.

One day I told Mary I was going to ask her a question and that I wanted an immediate answer, the first one that popped into her head. Then I asked: "If you could be absolutely anything you wanted, what would you be?" With no hesitation at all she answered, "God's wife." Her answer obviously disturbed her. She had spoken without thinking and despite all I had explained to her about her egocentric and narcissistic orientation she apparently had failed to realize the truly abnormal and exaggerated character of her egoistic aspirations. I never permitted her to forget the answer she gave to my question. Whenever she seemed more egocentric than usual, I would ask her in a serious manner to imagine herself as God's wife. I would then ask if as God's wife she was sometimes slovenly in her appearance, made mistakes in her grammar, used obscene terms, etc.

At the end of a year of treatment Mary had made very noticeable improvement. This was apparent to her family as well as to me. Mary admitted the improvement reluctantly. She still complained about the sensations in her head. Those in her chest had disappeared. Her senseless and melodramatic utterances were much less frequent. She was slowly improving but still holding tenaciously to her egocentric orientation. She complained about not making a transference and yet did everything I asked her to do. In fact, she had already made a strong transference, which became still stronger as time went on.

I continued to elaborate the active therapy, the extent and variety of her activities outside of my office. At about fourteen months I had her begin to renew her friendships and acquaintances. She disliked doing this very much. She was hypersensitive to the so-

licitous inquiries of her friends concerning her health and well-being. Needless to say, many of her former friends were far from tactful in making such inquiries. I told Mary that any time one of her friends or acquaintances became too solicitous concerning her health or state of mind she could tell the person to go to hell or be polite, whichever she felt like doing. This helped her considerably in resuming her former associations and social activities. I never led Mary to feel that she would have to return to her old and altogether too subservient way of life toward family and friends. Her egoistic tendencies were altogether too strong not to require considerable expression. Throughout her marriage till the time of her illness she had catered unduly to her husband's whims and wishes. He had now learned to cater to hers and I told her to keep matters that way to a very reasonable extent. I explained to her that even excessive selfishness was highly preferable to neuroticism.

After sixteen months I had her resume full charge of her home and all of her household duties. At seventeen months I had her return to work at the store, part time, just to convince herself that she could do it. She was now carrying on all of the various activities that she had engaged in before her illness. She looked like a young woman again, was always neat and properly clothed, and showed no tendency to a relapse. I interrupted the treatment for a month to see if she could get along all right and to reduce her dependence on me. I had reduced the frequency of her visits to twice weekly several months earlier.

At the end of the month during which I did not see her I had her come in once each week, telling her when I did so that I would continue for two months and then dismiss her permanently. Perhaps I should state that I continued with my analyses and interpretations to her last visit. She had become fairly adept herself at interpreting her dreams. During the last few months I was pleased to note that she seemed to have no inclination to lose herself in her devotion to her sons and husband and household duties as she had done before.

I have seen Mary infrequently during the last two years. She has looked and acted as if she were emotionally stable and in proper control of her motivations. She has been regularly engaged in outside work during this time as well as taking care of her household duties.

CHAPTER 12

Simple Phobias

PSYCHODYNAMICALLY, there are three distinguishable classes of phobias. One class, identifiable with anxiety hysteria, was mentioned in the last chapter. There are still two other classes or types and these, by comparison, might be called *simple phobias.* In the one, the fact feared was instrumental in arousing strong fear and, according to clinical evidence, feelings of guilt at the same time, at some point in childhood. In the other class, the fact feared owes its potency to some *symbolic* and unrecognized meaning which it has for the patient.

There is no justification for including all strong fears within the category of phobias as some writers do. A mere strongly conditioned fear or one which only reflects general timidity does not constitute a phobia. Thus, a man may have a genuine fear of dogs in general and yet be utterly unafraid of a certain vicious dog once he knows he has its friendship. In the case of the phobia, on the other hand, *repression* is always involved and the fear does not disappear simply as a result of increasing familiarity with the fact feared.

Fears of *knives, guns, snakes, cats, worms, water,* and *human beings* are common examples of simple phobias. In a typical case, *the fear itself is the only genuine symptom.* The degree to which it incapacitates the patient depends largely upon the nature of the fact feared and its frequency of occurrence. A phobia of men, for instance, is a much more severe handicap than a phobia of snakes, for obvious reasons, even though two such cases should be shown to have essentially the same psychological significance.

These phobias are among the simpler personality disorders and the easier to correct. One may be fairly certain to begin with that the patient either suffered a fear-guilt experience in connection with

the fact which he fears, at some time during his developmental period, or that his phobia has some simple symbolic meaning, thereby concealing and at the same time pointing to a repressed desire or interest. The usual psychological tests are in order with this type of patient although they may reveal no more than can be learned in the same amount of time by indirect examination.

There is usually no necessity for spending as much time on history taking as is required with most cases of psychoneurosis. The character of the phobia suggests the lines of inquiry which should be most intensively pursued in the majority of cases.

The person who develops a phobia as a result of a specific fear-guilt experience in childhood represses his memory of the incident. This is fully confirmed by the fact that he is never able to account for the origin of his fear, taken together with the further fact that following proper therapy he is able to recall the incident vividly. The element of fear, on the other hand, is not repressed. In other words when he again encounters a similar fact or situation he again experiences fear. (In this connection perhaps it should be pointed out that actually there is always an appreciable period of time between the original fear experience and the appearance of the phobia.) Just what happens to the feelings of guilt (or shame or self-reproach) is not so clear. In a sense, at least, they certainly become repressed since they are never discernible by the patient in the phobia itself. It is just as certain that they become aroused with each phobic experience for otherwise there is no way in which to account for the development and existence of the phobia. A simple fear experience, unmixed with other feelings, does not result in a phobia. If it did most of us would be victims of this class of personality disorders. One is led to conclude, then, either that through some sort of drainage principle or mechanism the psychic energy which would normally be experienced as feelings of guilt is diverted into the fear pattern, intensifying the fear, or that with each encounter of the fear stimulus the repressed feelings of guilt are subconsciously aroused and that this subconscious activity produces most of the fear which is experienced by the patient. In the latter case the objective fact or situation would merely act to set off the subconscious activity and this in turn would arouse the fear. Either hypothesis would seem to account for the main aspects of the phobia and from the standpoint of psychotherapy it matters little which is favored.

The genesis of the other type of phobia, the one in which the stimulus possesses a symbolic meaning or implication for the patient but which is unrecognized by him, is less simple. Here, the starting point is a strong desire or interest which induces feelings of guilt, shame or self-reproach. Because of its strength and the feelings which it induces, the desire is repressed. As long as it remains dormant the feelings of guilt which are linked with it likewise are dormant. But the arousal of the desire arouses the guilt feelings and these in turn induce fear and apprehension. This desire-guilt-fear arrangement usually becomes established in childhood. At that time the fear is merely fear, fear associated with feelings of guilt. The fear does not constitute a phobia.

After the desire or interest is repressed in childhood it may remain dormant till pubescence or later, when psychophysical maturation adds to its strength, or till some change in the objective environment arouses it to activity.

This resurgence of the repressed desire meets with strong resistance because of the feelings of guilt with which it is inseparably joined. A compromise is now effected in the selection of an object or fact. In other words, the resistance deflects the desire from its true object to a symbolic substitute. But this substitute must at the same time be of such a nature as to permit it to be invested with the idea of danger, because of the fear which the feelings of guilt induce. The object or fact involved in this type of phobia, then, symbolizes both desire and danger. The danger or threat which the desire imposes is always to the patient's system of personal and moral values and not to his physical well-being. Since the patient is unaware both of his desire and the feelings of guilt which a frank expression, or even a conscious recognition, of them would induce, he is prone to think or feel in terms of physical danger.

A sexually repressed young woman had a phobia of electric storms. She had repressed incestuous desires which tended to arouse intense feelings of guilt. The storms symbolized the passion and abandon of a sexual act, which she strongly craved. The associated feelings of guilt induced fear which approached a state of terror. She desired very wrongly and therefore deserved the severest punishment. Hence, she felt she was almost certain to be struck by lightning.

An unmarried man nearing thirty had what amounted to a phobia,

psychologically speaking, namely, that his widowed mother would meet with an accident and be killed. He refused to let her go anywhere without him. He was very ambitious but did not make much money and he was his mother's sole support. She was an insurmountable obstacle in the way of his success, getting married, and leading a normal life of his own. The psychology again is clear and follows the same pattern. His wish that she would be killed tended to arouse intense guilt and, therefore, fear that she would be killed. In this instance there may have been no childhood factors involved other than an excessive devotion to his mother. Accordingly the subjective arrangement of cause and effect was fairly simple. He simply feared the thing he wished for, both because he was genuinely devoted to his mother and because of the wrongful content of the wish.

The strength of the phobia and its insusceptibility to the patient's reasoning and attempts to ignore it are fully accounted for by the subconscious desire, interest, or wish. Since the fear is an egoistic or self-preserving reaction to the desire, the patient is incapable of abolishing it as long as the desire is subconsciously operative and beyond the influence of the patient's thinking and understanding.

The patient's dreams are usually helpful in arriving at a workable understanding of the probable nature of the repressed desire and the identity of its true object or act. For in his dreams the patient is prone to deal with the objective of the desire more frankly than he does through his phobia, or to deal with it in a variety of symbolic manners, or both. Thus the young woman who was mentioned as having a phobia of electric storms did not dream of storms. Rather, her dreams were unmistakably of a sexual and incestuous character, although more or less symbolic.

As soon as the therapist is fairly certain of the nature of the repressed desire or the forgotten experience, he should dispense largely with a nondirective procedure and employ a direct and painstaking questioning method. The patient will stoutly deny any such early experience or early desires or interests of the kind postulated by the therapist, but sheer persistence and insistence by the latter alone will often suffice to break through the resistance. A young woman

who had a phobia of even the slightest physical contact with a member of the opposite sex emphatically declared that she and her father had always remained aloof from each other from the day of her birth. Her dreams indicated otherwise. Through close questioning she was forced to admit that her father was freely demonstrative of his fondness for small children. She went on to contend, however, that toward children of six or seven and older, particularly little girls, he was very aloof. It then seemed fairly certain to the therapist that she had been treated in the same manner by her father. He had perhaps suddenly desisted in his atttentions to her, to which she had formerly responded in keeping with her intense emotional make-up, and left her stranded and yearning. Since her father acted as if any sort of physical intimacy was wrong, she acquired feelings of guilt because of her unrequited longings to be near him. She then repressed her longings and her feelings of guilt. This was all explained fully to her and she was assured that it happened beyond any doubt. She was ordered and commanded to recall her early reactions to her father and his actions toward her. The resistance finally gave way and she had clear recollections of being on his lap, holding to his hand when they went for walks, being kissed by him, etc. She was then instructed to kiss her father, which she had not done, incidentally, since she was a child. She protested strongly against the instruction, declaring that her father would drop dead from shock and that it would perhaps prove fatal to her as well; but after a month of argument and persuasion she embraced her father. The therapist had helped her by suggesting that she take a short vacation and make this an excuse for the embrace. Her phobia of physical contact with men rapidly dissolved and she was happily indifferent to the crowded conditions of the elevators and hallways of the school she was attending.

There is very little left to do in most cases of simple phobias once the early fear experience or the repressed desire has been exposed and its full significance understood by the patient. The patient's adjustment in general has not been severely affected by the phobia.

TREATMENT OF A CASE OF SIMPLE PHOBIA*

Anna P., twenty, was a sophomore in college. She was somewhat above average in intelligence but not brilliant. In her physical appearance she was small, neat, and neither very atractive nor unattractive. She was a quiet, rather shy, and unassuming young woman who came and went without attracting any particular notice or seeming to want to do so. She was serious, conscientious, and polite.

Anna lived alone with her widowed mother, her father having been dead for five years. Her only siblings, two brothers who were respectively five and seven years her senior, had departed from the family home several years previously.

When Anna came to see me she appeared tired, and, during moments of silence or preoccupation, a strained expression would appear in her face. On inquiry I learned that she was carrying a full schedule of work at the university and working part time in the central offices of the school. In addition to this she reported that she did not get sufficient sleep and never felt fully rested.

When asked why she had come to see me she seemed embarrassed and had to be encouraged to state her problem. She then told me that her life was made miserable by a very silly but a very strong fear, over which she had no control whatever. She was deathly afraid, she stated, of a certain knife which was kept in the kitchen at her home. But, she hastily added, it was not only her fear of the knife which troubled her. Every night a sickening fear would assail her that after she and her mother had gone to bed her mother would get up and take this knife and stab her while she slept.

The only protection or defense which Anna had been able to devise was to make absolutely certain that her mother was sound asleep, by surreptitiously listening to her breathing, before she tried to go to sleep herself. Even then, she complained, she was never able to relax fully or to sleep soundly. This explained why she did not get a sufficient amount of sleep and was always tired.

Anna had never told her mother or anyone else about her phobia till she told me. She had never thought of trying to get rid of the knife. The reasons for both should become clear enough later in this

* This case was originally mentioned by me, briefly, in *Auto-Correctivism.*

discussion. Needless to say, she never touched the knife or went nearer to it than she could help. Since her mother kept house, did the cooking and dish washing, Anna had very little difficulty in remaining at a fairly comfortable distance from the object of her phobia. She said that whenever it was lying in view she was unable to help casting frequent glances at it; always doing this in a furtive manner if her mother was present.

I asked my patient to describe the knife as accurately as she could. It was a long, narrow-bladed kitchen knife. There was a rather slight bend in the blade about half an inch from the tip. She said this bend was *the* distinguishing feature of the knife. Although she did not like long-bladed knives, she had no phobia of them. Her phobia was of this one particular knife.

I gave Anna an intelligence test, a personality inventory (the Colgate B2), and a free association test. The latter two suggested complexes and conflicts in relation to sex, an extreme fondness for her deceased father, and some possibly disturbing factor in her affective relationship to her younger brother. After the testing and during the next few interviews I had her tell me everything she could about her parents, siblings, and herself, past and present. She talked freely but told me little that seemed to be of significance till one day when she was telling me about her father. Following a few moments of silence, she musingly remarked, with complete naïveté, "If I could only sit in my father's lap once more I know I would be happy for the rest of my life."

Anna was able to remember many of her dreams. I will mention only two of those which shed considerable light on the origin and psychological significance of her phobia. She dreamed she was clerking in a small grocery store. A middle-aged woman came in the store and bought all of the sweet rolls. Anna was very reluctant to let her have all of the rolls since she wanted some of them for herself, but she did. The woman's name was Mary and she did not like her. In the other dream she was again in the grocery store. A large rat ran along the top of the counter. It had a long, stiff, straight tail, except that the tip was bent slightly downward. The tail slanted slightly upward from the horizontal. In her dream Anna was both frightened and fascinated by the rat, particularly by its tail.

Anna's father had owned and operated a small grocery store. Her mother's first name was Mary. The rolls were of the long, straight

variety, obviously penis symbols in her dream. The meaning of the dream is now self-evident. Her mother had had all of her father in an intimate and sexual way, which fact Anna had strongly resented as a child. In the second dream the rat's tail was almost certainly a penis symbol and, if so, then also was the blade of the knife. The rat appeared in the grocery store. As a child Anna had spent many hours alone with her father in his grocery.

Certain other facts which she told me might be mentioned. Till she was six or seven she slept in a small bed in her parents' bedroom. When her mother would get up in the morning to get breakfast, she would climb into bed with her father. He would cuddle and caress her for a few minutes before getting up himself.

When I asked my patient to tell me all she knew about sex including any sexual experiences of any kind which she had ever had, she earnestly denied that she had ever had any experience of a sexual nature and said she had only the vaguest notions about sex. She said she knew she had never seen a boy's or man's penis and that she had never been around animals except cats. She was even certain that she had never seen a picture or a diagram of a penis.

The information which I had obtained showed beyond doubt that she was wrong, however, and I was now certain of the following facts. She had seen a large boy's or man's penis in the erect state or a picture of such. The bend in the knife blade and the rat's tail and the consequent slope of the tip could only represent the slope of the upper surface of the glans penis. She had a very strong and unresolved Oedipus attachment to her father. She had an appreciably strong dislike or hatred and fear of her mother in childhood and which was now strongly repressed. She had repressed feelings of guilt toward her mother because of her Oedipus attachment to her father. However ignorant she was and had been of sexual matters she had at least known at some time that the sexual act can be easily likened to the act of one person's stabbing another.

I told Anna of my deductions and the reasons for them and insisted that she recall relevant material. I asked her every kind of pointed question I could think of in my attempt to elicit forgotten experiences. I explained that she must have felt her father's penis many times against her legs since many men awaken in the morning with an erection. I quizzed her about her brothers, the younger in particular, and probable past experiences with them of a sexual na-

ture. I assured her that many brothers do not treat younger sisters with due respect. I wheedled, coaxed, and demanded for nearly a month without results. Then one day I was telling her about a dream which a college professor had told to me a few days before, asking me to interpret it for him. It seemed that his older brother was in a deep, dark hole and the professor was trying to rescue him from his plight. Although the brother did not seem to be in danger of his life and had not been injured, the task of rescuing him seemed to be hopeless. I gave the professor an offhand interpretation. I asked if the brother was married. He was. I asked if the dreamer was married. He had never been married. "You must be thinking rather seriously of getting married," I told him. "But there is a deep uneasiness in you about the matter. This uneasiness perhaps goes back to childhood impressions or perhaps childhood fears of the opposite sex. Your brother's being in the hole means that something in you says that when a man gets married he loses his freedom." Then without thinking of other implications which such a remark might have, I added: "A lot of men look upon marriage as getting in a hole."

As I say, I was telling this dream and my interpretation of it (which the professor, incidentally, had confirmed) in connection with explaining to Anna that many men as well as women are sexually repressed and therefore highly sensitive to the physical and emotional intimacies involved in marriage. And, again, I added the last remark, namely, that a lot of men regard marriage as getting in a hole. As I made this remark Anna stiffened suddenly in her chair and gasped, "Oh heavens!" She then went on to relate certain experiences which she had completely forgotten (repressed) till that moment. From the time she was about nine till she was ten both of her parents worked till late in the evening in the store. She stated that nearly every evening during this period of time her younger brother had tried to have sexual relations with her. She recalled that she was always frightened and that she wept and protested but that she did not actively fight him. She remembered not only that she had seen his erect penis many times but that, in fact, it fascinated her and she could not help looking at it. Her brother would become very frustrated and vent his anger in vulgar exclamations, the context of which the reader can easily infer from what has been said. This explains the potency which my essentially casual remark had for reviving her dormant memories.

With the recollection of these experiences with her brother, much of Anna's resistance disappeared, with a corresponding decrease in the strength of her phobia. She immediately began to sleep better and to appear less tired and strained. For awhile I thought the treatment was coming to a rapid close. She did not completely lose her phobia, however, and I was still unable to induce her to handle the kitchen knife. I reviewed her early affective relations to her father with her, and she was able to supply additional details. Nevertheless her phobia still persisted, though with greatly diminished strength.

I discussed her feelings of guilt, earlier flashes of which she was now able to recall, her hatred of her mother, which seemed to have resolved itself into a merely conscious lack of affection for her, and had her recount her experiences with her brother in detail many times. All of this, however, did not eliminate the remainder of her fear. I finally concluded that her fear was being maintained and unwittingly employed as a defense against an exaggeratedly strong interest in sex, specifically in the penis.

I had in my desk at this time a letter opener with a long slender blade. I had used it to pry with at some time or other and the end was slightly, but very noticeably, bent about a half an inch from the end. At the beginning of an interview I engaged Anna in a frank discussion of sexual structure, particularly the male organs. She could not now discuss such matters without some evidence of excitement and when she appeared somewhat tense and stimulated I drew the letter opener from my desk and thrust it across to her. She jerked back quickly as she glanced at it, then suddenly snatched it from my hand and began stroking it gently. She seemed to have become completely oblivious of my presence. I quietly reminded her of her early feelings toward her father, of the frankness of her feelings at that time, of how she liked to be physically close to him and receive his caresses. As I talked to her she slowly lost the eager intensity which she first displayed toward the letter opener. She became more relaxed, and I observed that she was listening to what I was saying. I proceeded to discuss sex pro and con and to emphasize the perfect naturalness of sexual feelings and desires, even in a child and toward a parent. After I had talked for a half-hour, she was leaning back in her chair, idly holding the opener in her hands. I asked her how she felt. She replied that she did not think she would be afraid any more. This interview marked

the end of her phobia. She had finally felt and frankly expressed (abreaction) her strong interest in the penis, although by means of a symbolic or substitute object.

For about five years following the course of psychotherapy, I saw Anna at infrequent intervals. She always appeared well adjusted. During one of our brief talks over this period of time, she voluntarily confided that she had been sexually intimate with a young man without any fear or feelings of guilt. She declared, however, that she had not obtained any pleasure or satisfaction from the experience. I explained that this was not unusual in young women during their first or first several sexual intimacies and spoke a word of caution to her about illicit affairs. I have not seen or heard from her in the past eleven years.

It will be observed that this case conformed to the usual pattern of the second type of simple phobia which was mentioned in the beginning of the chapter. Her desire toward her father became inseparably linked to feelings of guilt, largely in relation to her mother. The feelings of guilt in turn aroused intense fear. The desire, on the one hand, and the feelings of guilt and fear, on the other, settled on a compromise object in the form of a knife. The knife symbolically represented a penis (specifically her father's) and at the same time it represented a possible danger. The possible danger was intensified and rendered more personal by the obsessive idea that her mother would use the knife against her. The feared experience of being stabbed carried the symbolic significance of an act of sexual intercourse but, even more preponderantly, that of being severely punished by her mother for her illicit desire toward her father.

CHAPTER 13

Obsessive-Compulsive Reactions

In view of their basic psychological similarity and significance, obsessive thoughts and compulsive acts can be linked together and treated as a single disorder. In a typical case of obsessional neurosis the patient's mind is invaded by thoughts which the patient himself recognizes to be inappropriate and irrelevant to his present intentions and situation. The thoughts may appear silly and utterly meaningless. In the case of a typical compulsion neurosis, the patient is compelled (impelled) to perform inappropriate and often meaningless acts.

An obsessional neurosis may be seen as an abbreviated or forestalled compulsion neurosis. The reasons for this incompleteness are usually apparent. A young mother is tormented by obsessive thoughts of killing her own child. The thoughts are followed by no action in such a direction because of the violent resistance which they invoke. In fact, action tends to be paralyzed instead of initiated. A young man is obsessed by thoughts that he has an *incurable* skin disease. Since the disease is thought of as incurable there is nothing for him to do about the matter. A woman is obsessed by the idea of going insane. Although she may consult a psychologist or a psychiatrist, the thoughts do not lead to any compulsive type of action.

When obsessive thoughts may become further and more fully expressed in overt action, without arousing too much resistance, a compulsion neurosis results. Then, since tendency may result directly in overt action, related thoughts may be absent, or very fleeting and undetected by the patient, unless the action is blocked by external factors or volitional resistance in the patient. If compulsive acts are blocked by external obstacles, not only is obsessive

thinking intensified but the patient may be thrown into a veritable state of panic.

The thoughts and acts may be of almost any imaginable kind. *Obsessive preoccupation with numbers, particularly the number "three," having to perform trivial acts three times, compulsive hand washing, ritual-like acts in connection with eating, bathing, and going to bed, and obsessive and compulsive preoccupation with dirt* are among the more common examples. Obsessive thoughts may be about a single fact or they may comprise an associative sequence. The compulsive tendency, to think or act, may be concentrated toward a single type of thinking or acting or it may be distributed through all of the individual's thinking and behavior. The tendency may be anywhere from weak to extremely strong. As long as it is not too strong and is widely distributed, it manifests itself more in character traits than in psychoneurotic symptom-formation. Thus the so-called *obsessive character* is prone to niceties, exactitude, scrupulosity, ceremonial acts, etc.

Care should be taken not to confuse obsessive thoughts with delusional ideas. Where the former are almost constant and strongly motivated the distinction is not always immediately apparent. Close questioning of the patient will show, usually, that the validity of the obsessive thought is not accepted, or at least it is seriously doubted, whereas the delusional idea is taken as true. Compulsive acts and the manias are distinguishable in that the latter involve the whole conscious personality and volition and are highly integrated activities, whereas the former are tangent and disparate to the primary motivation and activity of the individual.

Obsessive-compulsive reactions are among the psychologically purest of personality disorders. The therapist need not trouble himself here about the old problem of mind-body relationships, with the why and how of psychosomatic complaints, with the question of where the physical leaves off and the mental takes over. Indeed, he may adopt the comfortable position of the psychical monist without jeopardizing his chances of success with the patient.

Such reactions are among the best examples to be found of expressions or resultants of psychodynamic conflicts outside the province of conscious intent and volition. Whatever the character of the ob-

sessive thoughts or compulsive acts,' the therapist knows to begin with that antagonistic forces are involved. He knows further that the one set of forces comprises unrecognized or repressed impulses, desires, or interests and that the other set is in the nature of active resistance to the first. *The thought or act, then, is a symbolic expression of the desire or interest or of the resistance or of both.*

Obsessive-compulsive reactions might well remind one of coded messages. In order to understand their meaning one must discover their secret or latent meaning. Their manifest meaning may appear essentially meaningless. In other words, they may have no apparent or obvious meaning. There was nothing, for instance, in a certain young man's compulsive acts of buying and throwing away neck scarfs which clearly suggested the nature of the subconscious significance of these acts. There was nothing in another young man's having always to perform certain trivial, everyday acts three times which pointed to the hidden meaning of these acts.

But there is always an understandable connection or relationship between the thought or act and the desire; or between the thought or act and the resistance, whichever the case may be, once all of the facts are known. This relationship or psychological link may become established in various ways. The mere contiguity of two facts in time or space in the experience of the patient may suffice to establish the connection. The verbalizable content of the obsessive thought or act represents the repressed desire or interest by virtue of previous association with it in the patient's experience.

The thought or act may symbolically express desire or resistance on the basis of some element of similarity. This is illustrated by a simple hand washing compulsion wherein the act has the significance of cleansing oneself morally and is an expression of resistance to a masturbatory tendency. The thought or act employed may owe its selection to some conventional or traditional symbolic meaning which it has. Since red has long been associated with blood and therefore with the shedding of blood, obsessive thoughts or compulsive acts in relation to this color may readily express a subconscious death wish toward another person. Finally, a compulsive act may be an exact repetition of an act performed in childhood which resulted in conscious pleasure or gratification, the pleasure element having subsequently been repressed or effectively disguised or obscured by rationalization or resistance.

The primary dynamic processes in this class of disorders are usually specifically sexual or narrowly egoistic in character. The former include anal-erotic fixations and preoccupations, masturbatory tendencies, and strong incestuous interests. The latter include hatred and death wishes toward parent or older siblings of the same sex and exalted aspirations to personal power or distinction. Patients in whom the disturbance is sexual are usually far more responsive to treatment than those in whom it is egoistical.

The primary process, the repressed desire or interest, is infantile and unrefined. It is of the nature of an inner demand rather than a wish or craving, of a tendency to take not to ask. It is an undisciplined desire of a spoiled child of two to six, as was clearly illustrated by the case of a young man of twenty-two, an only child. The primary factor in his case was a strong incestuous interest in his mother. During his early childhood his father was away from home most of the time because of his work. The patient bitterly resented his father's infrequent and irregular visits home and when only four or five vowed to himself that when he became a man he would beat his father to death. He was fondled and petted by his mother and slept with her till he was nine or ten when his father was absent. The parents obtained a divorce when the patient was ten. With the advent of pubescence the patient began to grow hateful and cantankerous toward his mother. His irritability when around her increased till he was unable to remain more than a few minutes in her presence at a time. But he was equally unable to stay away from her. He made a point of getting acquainted with his father's mistress and seducing her. But this did not give the inner relief which the prospect had seemed to promise. In keeping with his obsessive-compulsive mode of life, he then took off abruptly and traveled around the world, making all possible haste during the latter part of the trip to get back to his mother.

This patient's mother possessed three characteristics which in particular would "get on his nerves till he couldn't stand it." She was fat, superstitious, and a Catholic. He criticized her physical appearance, jeered at her superstitions, and ridiculed her religion. At the same time he demanded her undivided interest and affection.

Finally, other troubles began to befall the patient. He declared it seemed to him that he was always "waking up" to find himself painfully infatuated with some fat, superstitious, Catholic girl. These in-

fatuations would develop suddenly, unwittingly and unexpectedly, and always follow the same pattern. For a few days or a week or two at the most he would be lost in his infatuation. It seemed he had to be with the girl every moment of the day, and the night too, if she would permit. His demands on her during this time were exorbitant and incessant. He simply had to possess her completely, physically and emotionally. But whether she submitted to his demands or not seemed to make little difference in one respect for after a few days he would rapidly become intolerably irritated by everything she said or did. Then he would begin "picking her to pieces:" ridiculing, jeering, condemning, and humiliating her in every way he could. In this way he would soon succeed in repressing or withdrawing his obsessive interest in the girl. He would then shuttle back and forth between his mother's home and places where young women were to be found till he "awakened" to find himself in the throes of another infatuation.

In the case just cited it is apparent that there had been little repression, if any, of his early resentment and hostility toward his father. The other side of his Oedipus complex, his excessive interest in his mother, had been partially but insecurely repressed and was constantly threatening to erupt into overt expression, as evidenced by the energetic and violent use he made of his defense mechanisms (resistance). He had considerable insight into his subjective difficulties and clearly remembered being frankly interested in his mother's body as a child. Such partial insight or awareness of the primary dynamic factor is not uncommon in the obsessive-compulsive neuroses.

The patient is always as immature in that aspect of his emotional development to which the primary factor belongs as the primary factor is itself. In many cases, however, the patient has acquired a *superficial* emotional maturity. This fact not only tends to obscure his *actual* immaturity but probably accounts for his tolerance of his partial or vague awareness of the primary desire or interest. His superficial maturity enables him to objectify the manifestations of his emotional infantilism to an extent and by objectifying them to tolerate them. The woman patient who suffers from an obsessive-compulsive neurosis, primarily as a result of strong anal-erotic fixations, but who has married and conforms in *action* to a normal adult sexual pattern, is a case in point. She is frigid, or practically so, but

she possesses a superficial maturity in regard to sex. She goes through the sexual act with her husband, but without warmth or enthusiasm. Nevertheless, the very fact that she conforms, even mechanically, leaves her relatively free to objectify and rationalize her anal-erotic phantasies and preoccupations and to indulge herself in them with surprising abandon.

Free association procedure should be relied on heavily during the early part of the treatment with this type of patient. As the therapist listens to the spontaneous utterances of the patient, his own associations should be loosely governed by the knowledge that anything of significance uttered by the patient may be motivated either by the primary dynamic process or by the resistance to it. In the severe case, where the primary factor is strongly repressed, the patient is prone to talk more in terms of resistance than desire. Also, the content of seemingly very casual remarks should be carefully noted, particularly those following an appreciable period of silence. Such remarks are often loaded with significance. Their seeming unimportance derives from the mutually neutralizing effect of desire and resistance. The young man who had to buy scarfs and throw them away, casually remarked that he was not interested in girls the way other fellows were and never had been. In fact, he was intensely interested in girls sexually, subconsciously, but filled with resistance to the interest. His buying and throwing away scarfs were symbolic expressions of the interest and resistance in turn, which fact became fully revealed during a successful course of psychotherapy. Aside from this, when actually in the presence of a girl, his interest and resistance tended to neutralize each other, leaving him more or less indifferent. Perhaps it should be added that his repressed interest was specifically incestuous and that his resistance, therefore, was of the nature of an intense aversion.

The patient's dreams are often very helpful in establishing the nature of the primary factor or desire. In studying the dreams the therapist should be sure to remain open at all times to indications of the infantile and crude nature of it. Although the patient may be highly educated and intelligent and appear cultured and refined, this psychic element is always infantile, primitive, and undisciplined.

Any *verbal* content in the dreams should be given close attention. It not only often points unmistakably to the character of the pri-

mary dynamic factor in the neurosis but frequently reveals the infantile level of it as well. A young woman who suffered from terrifyingly intense thoughts of killing her own child, dreamed midway of her treatment that the therapist told her she (the patient) was his favorite baby. After this she was no longer in a position to deny her emotional infantilism in relation to men.

Once the nature of the repressed factor has been definitely established and the patient has achieved a transference to an appreciable degree, active therapy should be employed. Without the use of active therapy many cases would prove incurable. It should be used in two respects in particular. The patient should be instructed *to fight his symptoms,* or certain of them, to an extent that is commensurate with his ability in such a direction at the time. Usually it is best to have him fight his symptoms for a time, then to give free vent to them for a period, then resist them again, and so on.

Having the patient actively resist his obsessive thoughts or compulsive acts has the effect of bringing him into a closer and more personal relationship to them. It tends to break down any rationalized or objectified protective barrier which he has erected between the more normal or rational course of his life and the symptomatic course. Moreover, resisting his symptoms, under the instruction and guidance of the therapist, reveals more exactly the strength of the motivation involved and various other details which the patient is certain to have overlooked.

The other principal line of active therapy which should always be employed consists of inducing or forcing the patient *to accept his emotional infantilism as a major characteristic of his personality and to give free nonsymptomatic expression to it in thought, feeling, and,* in as far as possible, *action.* The gap between his actual level of emotional maturity and the much higher, superficial level which he affects cannot be bridged except by growth. He must grow up in that respect in which he is infantile. He cannot do this till he has frankly accepted his infantilism and is willing to let that level of emotional development regulate his spontaneous thoughts and feelings.

A young married woman could not tolerate her husband's being away from her even for an hour or two unless he was at work. She would become panicky and have horrible thoughts of killing her child or killing herself. This resulted not from an old fear or a phobia

but from an infantile demand that her husband remain at her side, be always attentive to her, find no rival interest to his devotion to her even for an hour. But she could not recognize and frankly admit her intense childish resentment at being left alone (neglected), because of the superficial maturity and self-sufficiency which she affected and tried to maintain. Accordingly, the resentment appeared in symptomatic form. It became necessary for her to recognize and accept her childish insatiability for attention and recognition and to express it frankly in order to develop more mature attitudes.

The more severe cases of obsessive-compulsive neurosis require rather extended treatment because of their emotional infantilism and the interference of their superficial maturity. The transference should be taken full advantage of by the therapist in enforcing the active therapy. The latter part of the treatment resolves itself largely into educative and re-educative therapy. The treatment should be brought to a gradual and never to an abrupt termination.

TREATMENT OF A CASE OF OBSESSIVE-COMPULSIVE NEUROSIS

Roy M., twenty-one, high school graduate, was of rather ordinary appearance and average intelligence. He appeared serious, somewhat preoccupied and tense. He came of his own volition for help and talked freely about his difficulties.

Roy had only two siblings, both brothers, one of whom was twenty-four and the other fourteen. I had already had the older brother as a patient and, therefore, was familiar with many facts about the family and the home life. The parents were both living and in good health. They had very little education but were industrious and in moderate economic circumstances.

Roy was a meter reader for a gas company in a large city. His neurotic symptoms interfered with his work to such an extent that he was constantly in fear of losing his job because of his impaired efficiency. There were three principal symptoms besides his worry, tension, etc. He had a "*sitting down*" *compulsion,* which he was completely unable to anticipate. It seemed to him that it always occurred at the most unexpected and inappropriate moments. When he was already far behind in his work, for instance, and was hurrying from one building to the next he would suddenly experience a com-

pulsion to sit down. Its strength was irresistible. He would sit down on the curb till it had passed. Although he had never thought to time its duration, he believed he had to remain seated from one to two minutes. The time always seemed much longer to him. Once while on a crowded elevator he had to sit down, much to the alarm of some of the women passengers. One day his boss sent for him. He felt certain that he was to be reprimanded for not getting more work done. Nevertheless, as he approached his employer's desk his compulsion to sit down assailed him and he hastily drew up a chair and dropped into it.

Often when turning suddenly to cross a street midway in a block he would encounter a lamppost in his path. He would then have to stop and try to decide whether to pass to the right or the left of the post. He stated that, as far as he could tell, it made no difference which side he passed on, as *a severe headache* always immediately followed these experiences.

Thirdly, Roy had to repeat many of the acts he performed in his work. After mounting a ladder and taking a meter reading, for example, he would be returning the ladder to its proper place when he would be halted abruptly by *obsessive doubts* that he had read the meter correctly. He would have to take a second reading and sometimes a third before he could leave the building. After hurrying away through the basement door or the grating in the sidewalk he would again be assailed by doubts, this time that he had closed the door or properly replaced the grating. If he tried to ignore his doubts and continue on his way, terrifying thoughts of someone's falling through the grating and injuring himself or of serious trouble resulting from leaving the door open would force him to retrace his steps.

Roy's father was a quiet, retiring man and exerted very little influence of a positive sort on the emotional development of any of his sons. His mother, on the other hand, was dynamic, assertive, and extremely possessive in her attitude toward her children. She was also a pronounced case of anal-erotic fixations. She habitually accompanied Roy to the toilet and remained with him till he was ready to leave, till he was five, possibly six. When she was unable to remain with him because of some household task, she left the door to the bathroom open. Although she relaxed her vigilance somewhat after Roy was five or six, she repeatedly cautioned him never to flush the

toilet till she had examined and noted the appearance of his feces.

Mrs. M. had shown essentially the same excessive concern about the eliminative functions of her first son, who had come to me with a mixed, anxiety-obsessive, neurosis. He had partly escaped her concern, however, with the appearance of Roy. Roy was regarded as delicate by his mother and was accordingly smothered with an extra amount of attention.

Roy remembered the facts which I have mentioned readily enough in response to pointed questioning by me but he had never associated his sitting down compulsion with sitting on the toilet, with being the object of his mother's undivided attention, as a child. I explained fully to Roy after a few weeks of visits the Freudian conception of the progressive stages of libidinal localization and gratification, presenting it as unquestioned fact. I pointed out to him that he was still in a very infantile stage of his psychosexual development, as a result of his mother's influence in his childhood; that he had never become emotionally weaned from her; that being away from her in his work set up an intense subconscious craving to return to her and to receive her attention and administrations and the other gratifications which originally pertained to the toilet situation.

Roy appeared to understand and accept my explanations and following this phase of the treatment he reported an immediate decrease in the frequency of the sitting down compulsion. But it still occurred and although much less frequent than formerly, it had not lost any of its strength.

In any comparatively pure psychoneurosis the various symptoms are usually, if not always, causally and psychologically related. So instead of trying at that time to completely eliminate his sitting down compulsion I turned my attention to the symptom involving lampposts. Roy stated that his interest in girls was vague, uncertain, and never very strong. He had never had dates with girls. He was aware at different times of genital cravings. These were never intense and as far as he knew, they never became directed toward any particular girl or woman. Inasmuch as he was strongly fixated on his mother in connection with his anal-erotic fixation, I explained that any genital impulses would inevitably tend toward her. Such impulses would immediately be blocked by resistance, leaving him uncertain and unorientated in regard to his genital cravings. For although he could freely include his mother in his erotically moti-

vated concern about his eliminative functions, since she unwittingly and wholeheartedly encouraged such concern, he could not rationalize or otherwise justify his inclusion of her in his preoccupation with his genital excitations.

I believed the lampposts symbolized an erect penis and therefore genital impulses. But he was blocked and without orientation in this sphere of sexual motivation. Accordingly, he was always at a loss as to which side of the lamppost he should pass; that is, what he should do about his genital impulses. His mother had suffered from severe headaches during his childhood. After passing a lamppost his head would ache so severely he would sometimes stop work for the day and go home. I told him his headaches were started by the tension produced by his conflict and uncertainty regarding the matter of genital sexuality but that they were immediately aggravated by an infantile insistence on being home with his mother.

Roy was always attentive to my explanations and thoroughly cooperative throughout the treatment. He did not manifest the usual traits found with anal erotism. He was not obstinate or stingy, he showed no tendency to hoard, and his usually dirty hands denied any undue concern about dirt. But, *he had not repressed* his anal erotism except in respect to his desire to have his mother with him when using the toilet. He had gone on indulging himself freely in anal-erotic phantasies and preoccupation with his bowel movements, with the outspoken encouragement of his mother. In fact, as I learned a little later, he and his mother still regularly took part together in a certain act which was undoubtedly loaded with anal-erotic excitation and gratification. Thus, there was no reason why he should have developed anal-erotic character traits.

I next turned my attention to Roy's compulsive repetitions of different acts, as already mentioned. This was at the end of about three months of visits. These repetitious acts were accompanied by obsessive thoughts of serious difficulties for himself or harm to others. No one, I believe, can be too enslaved by a fixation or dependence on another person without this fact's arousing intense inner resentment or opposition. Because of the dependence which exists, the resentment does not become clearly conscious and understandable to the individual. Rather it takes a symptomatic form. Subconsciously it exists in its simplest form as a wish for the death or removal of the person. Consciously it appears as a fear of causing injury

to another person or of suddenly finding oneself bereft and alone or confronted with insurmountable difficulties.

I explained Roy's repetitious acts and their associated obsessive thoughts and fears in accordance with these assumptions. I explained that he was so fixated and dependent on his mother that he subconsciously rebelled against this dependence. And for good reason, I told him. I pointed out that, in fact, he would never be reasonably independent and self-sufficient until his fixation and dependence were dissolved; that he subconsciously sensed this, as it were, and that subconsciously he confused his *dependence* on his mother with his *mother* and, therefore, in wishing to be rid of his dependence he wished to be rid of his mother. If he left the grating in the sidewalk out of place someone (his mother) might come along and fall through the opening, injuring (killing) himself (herself). But the loss of his mother would leave him in a terrible predicament because of his dependence on her, hence his fear and anxiety.

At the end of four months Roy's psychoneurotic constructions had been markedly weakened, as definitely indicated by a very noticeable improvement in his appearance and manner and by his reports that his symptoms occurred much less frequently than formerly. He was still definitely psychoneurotic, however. Then one day during a break in our talk he casually mentioned his mother's giving him an enema the previous night. I thought I had covered all possible sources of anal-erotic gratification in my direct questions. It had not occurred to me that Mrs. M. might be giving her twenty-one year-old son enemas, and he had never thought to mention the fact—the thought had never come to him while in my office.

The enemas were given regularly every few days and had been for years, in fact, since the age of fourteen or fifteen. I did my best to make him see the utter childishness of letting his mother give him enemas and immediately introduced some active therapy. I insisted on his dispensing with enemas completely. I further instructed him that in case of constipation he should go for three days without doing anything about the matter. He could then take a laxative or consult a physician if he wished.

But Roy did not and had not suffered from constipation. The enemas had been given when he complained of a headache—his mother had always attributed her headaches to faulty elimination. He

did become more tense and irritable for the next few weeks. I continued to discuss, and insisted on his analyzing, his symptoms and various other reactions and attitudes in terms of emotional infantilism and anal erotism. I instructed him to fight his symptoms for a week or two, then to give into them completely, then resist them again if they were still troublesome.

For the next six weeks or two months, that is, to the end of a total of six months of treatment, Roy improved slowly but steadily. The improvement was manifested by a decrease in the strength and frequency of occurrence of all his symptoms. The sitting down compulsion disappeared altogether except for occasional, fleeting tendencies to sit down. Improvement was further indicated by an awakening interest in girls and genital sexuality; by increased efficiency in his work; by more attention to his personal appearance; and, by a rapidly increasing intolerance of his mother's insistence that he pay close attention to his eliminative functions.

At the end of these six months Roy decided to discontinue the treatment, saying he had need of all of his money and he thought he could get along all right by himself. Although I felt the treatment should be prolonged for two or three months I did not urge him to continue. Since I did not hear from him again I finally concluded that he had probably made a fair adjustment.

CHAPTER 14

Conversion Hysteria

HYSTERIC REACTIONS as such, the symptoms of conversion hysteria, were among the first to attract widespread interest to the field of psychogenic disorders. Certainly more has been written about conversion hysteria than any other functional ailment. Much has been learned about its causes and mechanisms and the personality and temperamental characteristics of those who are prone to it. But much still remains to be learned.

Conversion hysteria is not only the most protean of all personality disorders in its symptomatology, it appears on all levels of severity from fleeting and trivial disturbances to those which are completely incapacitating to the individual. The more common symptoms may be conveniently grouped under four headings: *attacks*, *motor symptoms*, *sensory symptoms*, and *mental symptoms*. The principal categories then include, in the same order, *nausea*, *vomiting*, *anorexia*, *hiccupping*, *weeping*, *laughing*, *cataleptic states*, *dream states*, *somnambulisms*, *fugues; incoordination*, *paralyses*, *tics*, *contractures*, *automatic acts; anesthesias*, *paresthesias; amnesia*, *fixed ideas*, *egocentricity*, *suggestibility*, *narrowed consciousness*, and *dual personalities*.

All hysterical symptoms partake of an automatic or dissociative character. That is, they occur or exist quite independently of the patient's thoughts and purposes and in some cases he is not even aware of their existence. The hysterical young woman may weep copiously or laugh uncontrollably for no reason whatever that is known to her. A little girl vomited every time she started for school, yet wept from disappointment at not being able to continue on her way. A young man always held one arm closely against his side when

walking. He did not know that he did this till he was told. A minister forgot his identity and assumed a new name without knowing that he had forgotten his true name and assumed a false one. A young college woman was bathing at the seaside. She swam out for a short distance, returned and rose to her feet to wade ashore. As she stood up both eyes suddenly closed tightly and she could not open them. She became alarmed and called to an aunt who had accompanied her. She was taken to a hospital for observation but for several days her eyes remained closed despite all her efforts. Then, for no apparent reason, her eyes opened, but she was totally blind. She remained this way for several more days when, tossing about, she fell out of bed. As she struck the floor her vision returned fully.

Since the symptoms of conversion hysteria belong to the dissociative variety of neurotic manifestations, they comprise, generally speaking, losses of functions. But one may distinguish at least two degrees of loss in the range of the more common symptoms. There is the complete loss of a function to the conscious ego of the individual, as in the case of an anesthesia or a paralysis. Then there is the symptom which comprises not a loss to the conscious assets of the individual but rather to his volition and self-management. Here we find such symptoms as certain attacks (weeping, vomiting, cataleptic states, etc.), incoordination, contractures, automatic acts, and fixed ideas. In the main, the more completely dissociated the neurotic manifestation is from the patient's awareness and volition, the more serious the case will prove under treatment.

A workable understanding of the significance of hysterical symptoms requires close attention to the temperament and personality characteristics of the persons in whom they are found. Taking only that group of individuals who develop fairly pure conversion hysteria syndromes, one will usually find certain rather definite characteristics. These include marked *psychic flexibility*, *extroverted orientation*, *pronounced deficiency in affective tolerance, a strong bent to give bodily expression to feelings and interests, and a peculiar obtuseness to his own subjective processes.* The patient's psychic flexibility is sometimes remarkable in its various manifestations. Thus, such a patient will often go to bed and dream forthwith about anything that the therapist asks him to. He may develop a new symptom because of an unwitting suggestion made by the therapist. In fact,

his well-known suggestibility must be largely due to this flexibility of his psychic processes. Similarly, his proneness to mental dissociations must have much to do with it. He presents a sharp contrast to the psychic rigidity so often found in anxiety hysteria and always in paranoid conditions. This flexibility is a valuable psychic asset as such and should always be made full, but tactful, use of in treatment.

The *childlike egocentricity* of this type of patient often tends to obscure his genuinely extroverted attention and interest. His extroversion frequently inclines him to externalize his symptoms. He is prone to talk about his attacks as if they were external events affecting him rather than strongly motivated reactions of his own. The young man mentioned in Chapter 1, who suffered from periodic rotatory movements of his head would call out, "Look, this is starting up again!" It never would have occurred to him to say, "Look, I am moving my head again!"

The patient is *deficient in affective tolerance.* A certain aspect of this deficiency has been mentioned by Freudian writers as an inability to sublimate libidinal drives. The deficiency goes much further than this. It renders the patient incapable of enduring or sustaining as well as of resolving (sublimating) his affective tensions. He rejects and represses all such feelings and desires as do not conform nicely to his narrow and unstudied personal ideals or to which circumstances do not permit him to give immediate and free bodily expression. Thus, one very hysterical young woman was free of symptoms as long as her husband was with her and paying attention or making love to her, whereas she could not endure a full day's absence from him without attacks and other obvious signs of dissociation.

The extreme need of some persons to express almost every feeling or impulse in overt action is characteristic of this class of patients, that is, of persons who develop conversion hysteria. They may get fixed ideas and have certain types of phantasies (unconscious phantasies, Freudian) but they do not daydream; they are relatively incapable of substituting implicit activity for overt. This characteristic, unmistakably evidenced by their histories of physical activities, may go far in accounting for the loss and/or automatization of motor and glandular functions following repression of motivation. In other words, motive and overt action appear to be so intimately or inseparably linked that the repression of the former often results

in the suppression, or at least disturbance, of the latter. Both may then become dissociated and occur as an automatism, independently of the main mental organization.

The *obtuseness* found among conversion hysterics to their own subjective processes, particularly their conative and affective processes, is too well known to require any remarks in the way of substantiation, other than to point out that the typical patient is able to mention very few, if any, disturbing feelings or desires either in the past or present.

A proper consideration of these characteristics, which have been enumerated, and an effort to evaluate them in the individual case shed considerable light on the symptoms of conversion hysteria and their underlying or motivational processes. The different characteristics do not operate separately. Rather, they are inextricably interwoven both in their interdependent relationships and in their combined resultant effects on the adjustability of the personality. Some of these relationships, however, appear fairly clear. Thus, the patient's affective intolerance enforces the repression of some desire and along with this the suppression of such physical function as would be expressive of the desire. His weakly integrated mental organization, a consequent, presumably, of his obtuseness to his subjective processes, permits of a dissociation of desire and function from his main psychic system. It must then be an expression of his psychic flexibility which makes it possible for the desire to become displaced to some other physical function as, for instance, in the case of *anorexia nervosa*, carrying with it, its load of resistance.

A careful study of these different characteristics also contributes strong pointers for therapeutic procedure. As long, for instance, as the patient's affective intolerance continues, one could not hope to bring his repressed impulses within his conscious discernment and *keep them there.* Accordingly, in all fairly typical and severe cases, a short course of educative and re-educative therapy is indicated in the beginning of the treatment, as soon as testing and diagnosing are concluded. His affective tolerance must be increased; his alertness to and recognition of his subjective processes must be improved. These ends can be accomplished most quickly and thoroughly through educative procedures. Once the probable nature of the repressed factors has been determined, whether these be es-

sentially sex, fear, or something else, the patient should be fully informed as to what is normal, natural, and healthful in regard to such desires or feelings. He may have what seems to be a fairly adequate intellectual or abstract understanding and acceptance of such matters. It is to be taken for granted, though, that in his feelings he is intolerant, narrow, and naïve.

In carrying out this part of the treatment, the therapist should constantly bear in mind that he is dealing with a person who is actually very unfamiliar not only with his own subjective world of events but with subjective phenomena in general. Descriptions and explanations must, therefore, be painstakingly clear, concise, and pointed. Lengthy explanations of simple facts and involved descriptions of feelings, sensations, and desires only encourage vagueness and meaningless generalizations in the patient. Frequent checks on the patient's understanding should be made by asking him to express in his own words what has been told him by the therapist. Explanations and descriptions by analogy are often very effective with this class of patients.

A brief sketch of this part of the treatment of an actual case will illustrate some of these points. A woman of twenty-eight, married eight years and the mother of one child, came for help because of a chronically recurring sore throat. Her throat would become inflamed and swollen till speech was reduced to a whisper. She suffered considerable distress during these periods. Various physicians had given symptomatic treatment but had found no cause for the condition. One of them finally told her it must be a "nervous sore throat."

Her sore throat was suspected of being a sort of pronounced *globus hystericus* and she was immediately questioned concerning her sexual life. From what she said it was gathered that she was completely frigid and anesthetic sexually and had been from the beginning of her marriage. Not only was this true but on the infrequent occasions when she permitted her husband to be sexually intimate with her, she invariably spent the rest of the night weeping. When asked why she wept and how she felt while weeping, she could only say that she felt terrible. She was asked if she felt embarrassed, degraded, abused, robbed, disgusted, angered, frightened, insulted, or frustrated, in an effort to help her to define her feelings more conscisely. She was not sure. She could only repeat that she felt ter-

rible. Her attitudes toward sex were then probed. She recognized the necessity of sex for reproduction. Otherwise she was skeptical of its necessity. In fact, although she had slept with her husband a number of times before they were married, she kept her virginity till two weeks after they were married. She had never thought or felt that sex was naturally a strong force in human life. When instances of strong interest in sex had been forced on her attention she had simply supposed that there was something wrong with the persons who manifested such interest. Yet, she was not openly opposed to sex; she had nothing in the way of a crusading spirit against sex. Rather, sex simply did not exist for her among her interests or personal values.

Now, for the next ten or twelve interviews from this point, the time was devoted almost exclusively to a discussion by the therapist of sex in its biological, physical, emotional, and sociological aspects. The discussion was carefully kept on the intelligence and educational levels (about normal intelligence and a high school education) of the patient. When it was necessary to use terms which were strange to the patient they were carefully defined and illustrated. When it seemed desirable for any reason to introduce unfamiliar synonyms of terms already known to the patient these were used more or less alternately. Thus, the terms "penis" and "prick" were used alternately, the latter, besides one or two other vulgar terms, being the only one with which the patient was originally familiar. The term "penis" had the value of lending a touch of dignity to the organ for her, while the term "prick" had the value of bringing it more forcibly to her mind. Other pairs of correct-vulgar terms were similarly used.

Descriptions and explanations of sexual facts were presented simply and always as fully illustrated as possible. A single example will suffice. She was told that sexual desire in a woman could be compared to thirst. The analogy was given as follows: "They are both cravings. Thirst is a craving to fill the mouth with water and swallow it. Sexual desire is a craving to have the sexual organs stimulated, to have a penis thrust into the vagina. As the mouthful of cool water passes down the throat intense pleasure is experienced, if one is very thirsty. But immediately a second swallow is craved, and so on till the thirst is quenched. The same is true of the sexual act. The contact of the penis with the vagina gives intense pleasure. But the

pleasure stops with the cessation of movement. Accordingly, repeated thrusts are craved till the orgasm occurs and the craving is satisfied. In both cases we are dealing with tension. Thirst is a tension in the throat produced by dryness. Sexual desire is a tension in the sexual organs produced by the sex hormones, a congestion of blood, etc. You have sexual tension," the explanation continued, "only it is in your throat instead of in your sexual organs. It has become displaced, because of your resistance to sex, from the one part of your body to the other. Your throat becomes congested, swells, and then becomes inflamed and sore. When a woman becomes sexually aroused her sexual organs become congested and swell and, if this condition persists over a considerable period of time, they become inflamed and sore."

By the time this period of educative and re-educative therapy was completed the patient had become properly impressed with the magnitude, strength, and importance of sex. It was more than natural then, when a simple psychoanalytic procedure was begun, that her thoughts would turn to sex. Her comprehension and range of usable terms had been greatly increased, as definitely shown by her answers to check questions. She was able to recall various events since early childhood which had been sexually significant to varying degrees. Moreover, she was able to discern the sexual significance in many of these, which she most certainly never would have been able to do, indeed had she even been able to recall them, in the absence of the course of instruction. At the end of eight months she ceased to suffer from sore throat and was genuinely responsive to her husband for the first time in her life.

The therapist should deliberately direct the patient's thoughts more or less during the remainder of the treatment. To this extent the procedure is scarcely psychoanalytic in a strict sense. If no guidance at all were exercised it is doubtful if the patient would ever recall and report the more significant subjective facts.

Early attitudes and interests, particularly in parents and siblings, should be fully explored and analyzed. An unresolved Oedipus complex is probably found more frequently in conversion hysteria than in any other psychoneurosis. Other unresolved infantile sexual interests are also common.

Where dissociative symptoms exist, a gap or break similarly exists in the motivational organization of the patient. A dynamic unit or

system has become separated from conscious volition and purpose. A reintegration is one of the primary aims of the therapy. In seeking to bring this about, though, extreme care should often be taken and the therapist should make sure that the patient's affective tolerance is sufficient to permit a return of the dissociated interest or desire. Although the dissociated function can often be returned to conscious volition almost immediately by hypnotic suggestion, this should never be done till the therapist is thoroughly familiar with his patient, with the personal and psychological significance to the patient of the dissociated function and with the degree of affective tolerance which exists in regard to these matters. The early and indiscreet use of hypnotic suggestion, in forcing the return of a dissociated function, always results in an increase in the patient's resistance, frequently makes the further use of hypnotic suggestion impossible, lowers the efficacy of other therapeutic procedures, and may even result in suicidal acts.

No attempt should be made to recover the dissociated material, that is, to remove such symptoms as paralyses, contractures, tics, attacks, fixed ideas, etc., early in the treatment. To do so is as crude as it would be for a surgeon to begin a major operation without any examination or preparation of the patient. In many cases there will be few or no symptoms remaining after the patient's affective tolerance has been built up as much as possible, all accessible material has been carefully examined and interpreted, and an appreciable transference has developed. But, if dissociative symptoms still persist, a safe and usually effective method at this point consists of making free use of the patient's psychic flexibility with the patient in the waking state. In short, the therapist may begin to demand that the patient recall, think, feel, or do what is required. In doing this the therapist should assure the patient that he will assume full responsibility for any detrimental consequences to the patient.

Hypnotic suggestion may be used immediately in connection with minor dissociative disturbances provided the therapist is reasonably certain that the disturbance is of minor and not major significance. Thus: A woman whom the writer knew fairly well, having had her husband as a patient, came in because she was unable to speak. She could not even whisper. The mutism was of very recent origin and she had been referred by her physician. Hypnotic suggestion was effective, and she was then asked to discuss fully just

what she was doing and saying, or wanting to say, when she lost her voice. She had been on the verge of "telling a man acquaintance off" but, inasmuch as she and her husband were under financial obligations to him, she had hesitated. She was then unable to speak. She was advised to say at least half of what she might want to say, thereafter, and take the risk of offending. Then she was sent home. On the other hand, when a young woman with astasia-abasia was hypnotized —not by the writer, he is glad to say—and told to walk, she did, for one day. Thereafter she was not hypnotizable by any of her various therapists. Her astasia-abasia was her self-effected safeguard against leaving home and becoming the mistress of a young man of questionable worth but with whom she was infatuated.

The transference in this class of patients is usually characterized by extreme emotional dependence. This in part is a reflection of the psychosexual immaturity which usually exists and in part of the completeness of the emotional response made to the therapist. The immaturity of the patient's attitudes and feelings toward the therapist is often more apparent than real. The patient will be a baby if the therapist will let him. On the other hand he will usually show an appreciable capacity for functioning on a more mature level if this is insisted on.

In helping the patient to resolve the transference and to take over the management of his own life, unrelaxing firmness on the therapist's part is essential. Active therapy should be increased as rapidly as the patient is able to respond to the demands made on him. The frequency of the visits should be reduced gradually. No attempt should be made to dissolve the transference completely. Whatever remains of it after the patient is dismissed will be used by him as moral support in meeting his problems of adjustment.

TREATMENT OF A CASE OF HYSTERIC REACTIONS

Hulda Y., an unmarried woman of twenty-eight, was referred for treatment by the doctors of a medical clinic where she worked. She had been employed as a technician and was very well liked by her employers and associates. She was a tall, slender, slightly stooped girl with delicate features and a shy, uncertain manner. Although obviously timid and, seemingly, painfully self-conscious, her

extroverted orientation was nevertheless apparent. This manifested itself in her quickly checked impulsive gestures, the open, inviting expression of her face, and her ready compliance to the nonhuman, physical aspects of her environment. Thus, when she was asked to be seated, she walked directly to the nearest chair in my consultation room and sat down.*

Hulda had become so "nervous" she was unable to carry on her work. Her principal symptoms were *weeping spells, globus hystericus, somnambulisms, attacks* of *irritability*, and a very *restricted field of mental activity*. This last was her most significant and incapacitating symptom. She had become incapable of carrying on her work because she could not sustain a sufficiently wide range of awareness. She could keep in mind only one thing at a time. This resulted in a degree of "absentmindedness" which rendered her worse than useless to her employers.

On a written intelligence test she made a converted I.Q. of 96. On the "Inventory of Affective Tolerance" she made a centile score of 35. This is essentially a normal score, but in the case of conversion hysteria or other extroverted personalities a misleadingly high score is to be expected. The extroverted personality is too undiscerning of his subjective processes to evaluate his desires and aversions and subjective needs correctly. To the item, for instance, which reads, "I possess self-confidence in my associations with the opposite sex," she marked the answer "Always." The fact of the matter was that Hulda would have been utterly afraid of men in any sort of close association with them. In answering the item she completely overlooked the fact that her self-confidence was due to the safe distance which she carefully maintained from members of the opposite sex, and the further fact that had she lessened this distance she would have lost her self-confidence immediately.

* Conversion hysteria brings on an egocentric manner which is hard to define. It appears to be an acute awareness of self as a focal or orientation point rather than an awareness of self as a system or world of subjective processes, as is the case in a definitely introverted orientation. The two are often confused, both by patients and by therapists. In entering a strange room, for instance, and being merely asked to be seated, a strongly introverted patient will always, I think, hesitate and "size up the situation." He will glance from one chair to another and often ask which chair he should take. I mention this specific example merely as an illustration of diagnostic signs which might be overlooked. To treat an egocentric but extroverted person professionally as if he were introverted would certainly yield the most disappointing results.

She made a few fairly suggestive responses on the free association test. She answered with the word "bad" to the words "naked," "disgrace," "illegitimate," "sin," and "petting." These responses merely suggested immature and overconventionalized attitudes. Her other responses were very conventional and noncommittal.

Hulda's earliest recollections and some past dreams which she reported shed further light on her basic interests and attitudes. She recalled her mother's curling her hair (waiting on her, making her pretty) when she was between three and four. She vividly recalled going about with her father very frequently between the ages of four and seven; of one of her brother's starting to engage in sexual play with her when she was six; of being injured in an accident when she was seven. Between the ages of ten and thirteen she had a repetitive nightmare of being chased by a witch. On the occasion of her sister's marriage, six years prior to Hulda's coming for treatment, she dreamed her sister was killed and cut in pieces (the dangers inherent in marriage, sex, to one's rectitude).

Hulda was the third of four children. She had one sister who was three years her junior and two brothers, respectively four and six years older than she. Her siblings were reportedly well adjusted. Her parents were living and in good health. Her father had had a "nervous breakdown" fifteen years earlier. Her parents, I gathered, were conservative, quiet, and industrious.

According to Hulda, she had always been equally fond of her parents, had admired them equally, been equally obedient to them, and judged them to be of equal intellect, enterprise, emotional responsiveness, and equal in all other respects. Hulda liked the average and equality in all things.

After I had gathered the information which has been indicated so far, I began a course of educative therapy. Except in a purely abstract sense, Hulda was more ignorant of the matter of sex than one would expect to find any normally intelligent girl of twelve to be. She knew of the existence of sex, of course, and that a sexual embrace occurs between husbands and wives, and sometimes between persons who are not husbands and wives. But, on the other hand, she had never had a feeling, sensation or desire within herself which she had recognized or could recognize as sexual. Intellectually, she had long regarded sex as most persons regard an electric light switch, as some-

thing to be turned on when circumstances (outer) warrant, and otherwise as nonexistent.

I explained as fully as I could the significance and various aspects of sex in human life. I continued along this line for about two months, insisting that Hulda keep up with me in my explanations by having her frequently summarize in her own words the points that had been discussed during the previous two or three visits. I gave her a semi-technical book on sex to read and had her give me verbal reports on it.

I explained mental repression and dissociation to her. She readily agreed that she was sexually repressed and declared her desire to have her repressions dissolved. In fact, she manifested an eagerness in this direction. I told her her enthusiasm was about as genuine as that of the little girl who wants to put on her mother's clothes and take over the responsibilities of the home. She thought that such remarks on my part were unkind, but I was trying to break down her "depersonalized" attitude toward the whole matter of sex and her reluctance to accept her femaleness with its full import.

I next went thoroughly into the matter of the Oedipus complex, stressing in particular its sexual components. She did not like the idea of having such a complex and for a while reacted against my talks by spending more time in sleep at home and withdrawing further into her hysterical stupor. I attempted to counteract this by emphasizing the fact that an Oedipus complex allows for a substitute of the parent, that thousands of young women have Oedipus complexes and resolve the matter successfully by falling in love with men who resemble the father, that there is nothing inherently terrible about incestuous attachments, that according to Genesis we all arrived by way of incest, etc.

After approximately two months of explanations and discussions, chiefly about sex, I explained to Hulda that thereafter she was to do most of the talking herself. I emphasized that I did not want her to think up things to say but rather to go ahead and say everything that came to her mind. I was pleased to note that a conscious interest in sex had apparently taken root. I think this was largely due to the fact that I had taken care to explain sex in its broader (biological and sociological) as well as in its narrower (personal) aspects. Almost every time when she came in thereafter she seemed to want to dis-

cuss sex. The matter was still, of course, a completely unexplored field as far as her personal experience was concerned. She appeared to be groping for some sort of realization of sex within herself. But she was still unable to confront the matter of sex frankly. She picked at it as a fastidious woman might a meal that has been served to her on dirty plates.

We continued for another two months with little apparent improvement. She was punctual and otherwise cooperative, but her thoughts and feelings remained pretty much on a superficial level. Her symptoms were less distressing and although she did not appreciate the fact, she was quite content to let good enough alone. In order to force her from the plateau, I eliminated all of her emotional outlets, few and mild as these were. I forbade her to read any fiction, listen to the radio, go to moving pictures, or to accompany her father on his occasional trips out of town. I even instructed her to stop thinking about sex altogether.

Shortly after this Hulda dreamed that she was married. She went with her husband to meet his folks. They did not like her but she overheard them say to each other that they must treat her nicely for her husband's sake. She became very angry and left her husband, returning home in a rainstorm. After arriving home, she was playing cards with a strange girl, her sister, and two strange men. Although it seemed to her she did not understand the game very well she beat the others and won one million dollars. She and her sister then went into a bedroom where her sister was going to hang a picture. As she started to "screw" something into the wall to hang the picture on, the wall gave way completely and crumbled to the floor.

I used this dream to emphasize to Hulda the infantile and maladjustive nature of her attitudes toward the opposite sex. I pointed out that since she felt immature, fearful, and inadequate as a woman, she assumed a defensive and competitive attitude toward men. If she was to have anything to do with them, then she demanded that she win out over them, defeat them, render them inferior to herself. She caricatured her sister, a married woman, in order secretly to scoff at marriage, or any close relationship to a man, of which she was afraid and to which she felt inadequate. I harped on these matters for several visits and until Hulda appeared to be genuinely ashamed of her defenses and subterfuges.

Then she dreamed that she was in a large pit, ten or twelve feet deep. The walls were nearly perpendicular and she was unable to get out. A man then appeared at the edge of the pit and after considerable time and effort helped her to the top. The man was sympathetic but impersonal. After he had rescued her, he casually turned and walked away. A sinister looking man then approached from another direction. Hulda started to run and the man chased her. She awakened frightened.

I complimented Hulda, in connection with this dream, on her strong inner efforts to ignore her childish fears and infantile attitudes toward men and sex and to become a member of womankind (trying to get out of the pit). I explained the transference briefly to her at this point and assured her that I could safely guard her against any untoward consequences of a sudden influx of sexual interest if she would simply obey my instructions irrespective of any desires or feelings she might have. Naturally, I explained that the sinister man was merely a projection or objective representation of her own sexual cravings.

Hulda had now been coming for four and one-half months. From this point on she declared that she felt fine and that her symptoms had completely disappeared, except for two brief recurrences of mild depression and loss of zest.

I asked Hulda to dream of being sexually intimate with a man. I told her I wanted her to introduce as much detail in her dream as possible. She dutifully undertook such a dream that night. She dreamed that when she was ready to go to bed a man was suddenly present in her home. There was nothing very clear about him. He was just a man. She took him with her to her bedroom. They got into bed and the man moved toward her. She then awakened suddenly, standing in the middle of the floor. She felt startled but not very frightened.

She was able to laugh as she told me about this dream during her next visit. She promised that she would do better next time but, incidentally, never did.

At the end of five months and a half the clinic where Hulda had worked became very short of help. Inquiries were made as to whether she could be dismissed, at least for a time, and returned to her former position. Although I would have preferred to have her continue

the treatment a couple of months longer, I readily consented to her leaving with the understanding that if her symptoms began to return she would give up her work and resume the therapy.

I heard from her about a year later to the effect that she felt fine and was associating more with members of both sexes than she had ever done formerly.

CHAPTER 15

Mental Regression

REGRESSION means going back. Mental regression, taken literally, means returning to earlier and less mature modes of thought, feeling, and action. Actually, of course, the individual does not go back in any sense; he simply stops reacting in an adult manner and reacts again in a childish manner. The idea of "going back" merely confuses the issue without throwing any light on what really takes place.

Regressive reactions are found in many different psychogenic disorders. They are so common among maladjustive reactions, in fact, and so significant, as to warrant independent discussion here. Moreover, essentially pure conditions of mental regression, unmixed with other psychotic or psychoneurotic reactions, are not infrequently encountered by the psychotherapist.

Regressive reactions are not to be confused with reactions resulting from mental deterioration in aged persons or with the infantile reactions of individuals who failed to mature emotionally. Regressive reactions are infantile reactions, to be sure, but many infantile reactions are not regressive.

In a simple case of regression *there is no symptomatology in the usual sense.* The patient responds in an infantile manner to one or more of the major aspects of his life, is excessively dependent, and manifests interests which are commensurate with the emotional level at which he exists.

Psychological tests will help to reveal the disparity which exists between the intellectual and emotional levels of the patient. In severe cases of regression this disparity may be so great as to disturb the equanimity of the therapist himself. When a certain young man

had been given a large battery of standard intelligence tests and had made normal scores, the psychologist in charge threw up her hands and exclaimed, "I don't care what he did on the tests, I know this boy is feebleminded!" The "boy" spent most of his time playing with toy trains and crying for his "mama." Emotional adjustment tests and interest and attitude questionnaires may indicate the nature of the patient's inner frustrations and the character of the problems which he is unable to face. A careful history taking, however, and a close study of the circumstances immediately preceding the regression, must be relied on chiefly for an understanding of the why and wherefore of the disorder.

A psychological explanation of regression probably requires the assumption that any person who regresses in a direct and simple manner was *basically* infantile before he regressed. In other words, his adult attitudes, feelings, and inner self-sufficiency had never become substantial; he was like a poorly built house that looked all right and gave no sign of its concealed weaknesses till a strong wind struck it, when its superstructure caved in, leaving only the foundation intact. The case histories of many of these patients appear to support such an interpretation. One will repeatedly find that the patient grew up under the excessive influence of a timid and doting or an aggressive and dominating mother. In the first case, the mother kept the patient too close to her side, preventing his acquiring a normal degree of self-sufficiency through his own self-initiated and trial-and-error reactions to his environment. Instead of responding to his environment energetically and wholeheartedly and thereby establishing himself as a known and proved entity in his own mind, his mother's close supervision and timidity rendered his responses feeble and inconclusive. As he acquired adult feelings and attitudes, these remained relatively untested and therefore unrefined, unexercised, and inherently weak.

In the case of the dominant mother, the patient was overdirected in his activities. She imposed her own patterns of reaction on him. To the extent these fit his needs, or seemed to, he simply adopted them; they were not the result of natural growth processes within himself. If his mother was intelligent and a good judge of proper and adjustive patterns of conduct, the patient may well have thought that he was as well adjusted and subjectively competent and inde-

pendent as he appeared to be outwardly. In fact, as is not infrequently the case, he might have had a somewhat exalted opinion of his own self-sufficiency.

Regression is usually brought on by some new and frustrating or fear-inducing situation. The individual is suddenly thrown on his own resourcefulness, which has never been properly developed, and is forced to draw on his own feelings of self-sufficiency, which are weak, for courage and fortitude. The situation may be the sudden loss of a position, a spouse, a parent, a child, or professional or social standing; or it may be something which embodies a threat of physical injury or death. But whatever its nature, it is always something which suddenly leaves the individual feeling unarmed and helpless.

Whether regression is a *purposely* effected means of escape and protection from an unbearable subjective condition, or simply an *anesthetization* of volition and the higher reaction patterns as a result of the paralyzing effects of fear, is a debatable question. The first assumption not only has some strong evidence in its support; it is the better one to make from the standpoint of psychotherapy. Many persons regress in the face of circumstances which could hardly arouse strong fear. Also, wounded pride or self-esteem, rather than the presence of fear, is prominent in some cases, as when a young woman becomes regressive in her behavior following a frustrated romance.

Assuming that the patient has discarded his higher functions, by means of inhibition or repression or both, rather than that his higher functions have been paralyzed and he has been forced back to a lower (earlier) level of reaction, gives a more promising and wholesome slant to the therapeutic procedure. Although "will not" and "cannot" approach synonymity in the reactions and sought for reactions of maladjusted persons, it is always better to assume that the patient *will not* respond adjustively, unless the facts of the case force the assumption that he *cannot.*

The comfort and security of childhood, the absence of responsibilities and problems, comprise an enticement which lasts throughout the lives of most of us. We like to behave like children occasionally, and do. If behaving like an adult, or trying to, becomes too painful or disturbing, one might go on behaving like a child continuously, *provided one has no firmly established adult attitudes and sentiments.*

Ample time should always be taken to establish a suitable rapport with a patient of this class. It is extremely important that he be made to feel relaxed and at ease in the therapeutic situation. In one respect, at least, the patient is a child. The therapist must win the trust and confidence of the child if he is to be successful.

In some instances it is advisable to remove the patient from his family circle during treatment. This is particularly true if there is a dominant and too domineering parent or spouse.

During the first few weeks of treatment, following the testing and history-taking, the patient should be encouraged to discuss those interests and activities regarding which he has regressed least. If he has regressed in relation to his family responsibilities, he may still be able to talk freely about sports or hobbies or international affairs. If he has regressed in regard to his attitudes and feelings toward the opposite sex, he may still be able to discuss work interests without emotional disturbance. Whatever the subject under discussion, the patient should be encouraged toward the highest level of analytical thought of which he is capable. Whenever opportunity permits, he should be asked for introspective reports and analyses of his own sentiments and feelings. The purpose of these talks is to awaken as fully as possible the patient's sense of personal identity, self-regarding sentiment, in terms of those attitudes and capacities which have been least affected by his regression. He will need all the fortitude and determination he can muster when the therapist seeks to bring him face to face again with the problems from which he retreated. Any direction in which the patient's self-sufficiency can be enhanced will increase his self-assurance to some extent in meeting issues in other directions.

Even during this part of the treatment some active therapy can sometimes be employed to advantage. If the patient has given up essentially all activities, for instance, except eating and sleeping, he may be safely encouraged, persuaded, to engage in some activity for brief periods which is distinctly different from that which was instrumental in bringing on the regression. If responsibilities or exigences in a group situation led to his regressive retreat, he may be induced to take up some nonresponsible activities with single individuals, or to pursue a selected reading course along the line of some past interest. The time spent in active therapy and the va-

riety of the activities followed should be increased as rapidly as the patient's condition permits.

Along with the procedure which has been mentioned thus far or, if necessary, following it, the patient's past interests and activities should be fully recalled and verbalized. This review should be made through detailed discussions. If a psychoanalytic procedure can be used, so much the better; if not, direct questioning and probing must be used. The patient's past should be brought up to the time of the regression, or as near to such time as possible without arousing too much resistance.

Sooner or later the patient's attention and thoughts have to be directed to the precipitating cause of his regression. As to how early in the treatment this can be done or, on the other hand, how much preliminary work along the lines just sketched is necessary, naturally varies widely from patient to patient. If the matter is approached too soon, added resistance will be aroused, the regression will become more marked, and the course of treatment will be retarded if not interrupted altogether. The proper time is a matter for which no sort of definite rule can be laid down. Needless to say, in many cases the patient would never broach the matter of his own volition.

In taking up the precipitating cause (problem, situation) and the attitudes and emotions which were involved, the patient should be given immediate assurance that he will be required only to think about and discuss these matters, not to return to the situation or reassume the problem. Full explanations should be made to the patient that only good can result from his discussing these matters frankly and completely whereas keeping his mind closed to them is doing him immeasurable harm in various ways.

Any amnesia which exists, except in the severest cases, can usually be dissolved through a patient, persistent, and searching approach by the therapist. In his attempt to get to the heart of the matter, that is, the exact nature of the situation which prevailed and the thoughts, feelings, impulses, etc., of the patient at the time, free use should be made of any known or probable associated facts. What led to the patient's being in the situation? Just what had he been doing the previous few hours or days? What kind of situation did he anticipate? Just what had he planned to do in the

situation? How unexpected was the situation? What other unexpected situations had he ever met and how did he react? Was he following his own initiative or the judgment or instructions of someone else? Had he ever found himself in a somewhat similar situation before?

Once the patient is able to discuss the precipitating cause of his neurosis calmly and with good insight into his affective reactions at the time, he is well along the road to recovery. Following this, supportive, active, and re-educative therapy are usually indicated to varying degrees.

TREATMENT OF A CASE OF SIMPLE MENTAL REGRESSION

Carl C., twenty-eight, unmarried, had been completely incapacitated for work for over a year. He was a college graduate and a chemist by profession. He was a little less than six feet tall and of good physical appearance.

Carl was brought to me by his mother. She immediately launched into a scrambled tale of his difficulties. Inasmuch as she had come to my office without an appointment, I made this an excuse for interrupting her flow of words, not being sure that I wanted her to talk freely in the presence of her son at this time. I had no idea what she might be going to say and observing his little-boy-manner as he slumped in his chair I immediately decided against going into his condition in detail with her while he was there. I asked him if it would be all right if I talked to his mother alone later in the day. He nodded his head but did not speak.

Upon Mrs. C.'s return to my office I secured a sketchy but over-all history of the patient and his family. Mrs. C. and her husband were in their early sixties and in good health. Besides Carl there was a daughter and a son, older than the patient by three and five years respectively, both married and reportedly well adjusted. Parents and siblings were all well educated. The socioeconomic level of the family had always been a high average.

My informant was obviously a very dominant personality. She was direct, forceful, energetic, and apparently highly intolerant of human weaknesses. Under quiet and persistent questioning she acknowledged that she had always been the major influence in the

family circle and frankly declared that the responsibility for managing and directing the behavior and development of the children had been fully shifted to her shoulders by her husband. I secretly suspected that she had not waited for any shifting to be done, that she had taken rather complete charge of her children in all matters of her own accord, but saw nothing to be gained by raising the question. She said her husband was quiet and retiring and implied that he was not too strong-willed. I gathered that she felt she had fully and correctly discharged her duties as a mother and regarded her son's condition not only as due to no influence of hers but as tending to reflect a gross lack of appreciation of all she had done for him. She appeared to feel frustrated and rebuffed—in fact, unfairly treated by her son's failure to maintain her high standards of human competence and self-sufficiency. Yet, as she forcibly demonstrated a few months later, she was still demanding that her son submit to her guidance even in small matters.

She stated that the home atmosphere had always been congenial, that she had never tolerated quarreling, and that although neither she nor her husband was very demonstrative, all members of the family had shown genuine affection toward each other.

Carl had been healthy and strong throughout his childhood, and his present ailment was the only serious illness he had ever had. He had always been fond of athletics, a good mixer socially, and average or better in his studies. These various interests and activities had been fully encouraged (and perhaps largely directed) by his mother. After finishing college and prior to his "nervous breakdown" he had been an active alumnus of his school, attending the annual banquets regularly and maintaining close contact with his fraternity brothers.

Mrs. C. stated that Carl had always been more attached to her than to his father but that he had never been unduly affectionate toward anyone. He had appeared to be independent and self-reliant as a child and preferred to be out-of-doors with his playmates to being inside with her. He had been the easiest of her three children to train and manage, and she was always able to reason with him. He was never obstinate and had given her very little trouble. Up to the time of his illness he had always accepted her advice. She had been his confidante, and during his teens and early twenties he had often told her about his girl friends. On two or three occasions she had seen

fit to advise him against further associations with this or that particular girl. To the best of her knowledge he had heeded her in every instance.

Slightly more than a year prior to Carl's first visit to my office he had been keeping company with a certain young woman. For some reason, the exact nature of which I never learned, the girl's father did not seem to approve of Carl. When Carl proposed marriage, the girl refused, stating, or at least implying, that her father would oppose it. Thereupon Carl insisted that she should elope with him. She refused to do this.

This definite rebuff of his intentions and desires brought about sudden and marked changes in Carl's whole pattern of life. He gave up his work and remained at home. He wanted to be constantly with his mother and appeared anxious and uncertain when not in her presence. In fear of making matters worse, Mrs. C. refrained from questioning Carl in too great detail concerning his unhappy romance. When she did mention it he appeared scarcely to know what she was talking about.

The family consulted a doctor, and the doctor recommended a change of surroundings. Mrs. C. took Carl to a seaside resort in a neighboring state. Upon thus being removed from the familiar environment of his home, Carl became still more fearful and dependent on his mother. He refused to sleep in a separate room or even in a separate bed in the same room. To allay his fear and stop his weeping she permitted him to sleep with her. She induced him to play golf with other men during a part of each day, always keeping herself near at hand. The patient's life soon took on a definite routine. During the day he played golf with other men; during the night he slept with his mother. Except when on the golf links he was constantly at her side.

Since no improvement was apparent at the end of three months the same doctor was again consulted and this time recommended a private sanatorium. Carl was keenly distressed at this change. He jumped from a second-floor window but landed on soft turf without injury. He cut his throat and wrists with a razor blade but not deeply enough to sever arteries. After a few weeks he was returned home, still unimproved.

For the next eight or nine months Carl did little but sit around home and play an occasional game of golf. He read the comic strips

and the sports pages of the daily papers. A recent acquaintance of mine who knew Carl and his family recommended my services to them.

I drew up a schedule of three visits weekly and instructed Mrs. C. to accompany Carl to my office till such time as he was willing to come by himself. I explained that my work would be strictly private between me and my patient and that no member of the family was to question him concerning our discussions.

I spent the first six weeks discussing whatever Carl showed a willingness to discuss. I cautiously mentioned the matter of girls once or twice but was met with a blank stare. I usually opened the discussion by asking, "What have you been thinking about since you got up this morning?" or "What is of most interest to you today?" or "What did you do yesterday?" or "Just go ahead and say whatever comes to your mind."

Carl always showed a readiness to discuss sports, particularly in relation to himself. He had been active in athletics since he was a child and I had him review this aspect of his life in detail. He was frankly proud of his past accomplishments and often manifested a boyish enthusiasm when telling of past achievements, a manner which was in sharp contrast to his usual apathy. He talked freely but less spontaneously about fraternity matters, politics, international affairs, etc. He never mentioned women and showed a definite reluctance to talk about work. He had retrieved a toy electric train from the attic at home and spent hours devising new signaling mechanisms, constructing different switching devices, etc. I had him tell me what he knew about electrodynamics, often pushing pencil and paper toward him so he could illustrate his explanations.

Near the end of the first six weeks I attempted some mild active therapy. I asked Carl if he would be willing to attend some of the various lectures which were being given throughout the city on politics, economics, sociology, and various other topics. I hastened to add that I thought it would be better if his mother accompanied him so he would have someone with whom to discuss the subjects of the lectures. He showed no enthusiasm over my suggestion but consented to follow it. I instructed Mrs. C. to try to attend one or two lectures each week with him thereafter.

At the end of two months I still had not broached the matter of women. I had insisted, during the latter part of this time, that Carl

tell me about his past work. He was reluctant to talk about it but did so at my insistence. He talked in a disinterested manner except for fleeting moments when mentioning some profitable suggestion which he had made to his superiors for improving efficiency or increasing output.

He now showed some interest in coming to my office for his appointments, and I believed I could safely take up the matter of the opposite sex and his unhappy romance. I prefaced my approach by pointing out and emphasizing to Carl the fact that thought and feeling, on the one hand, and overt action, on the other, are clearly distinguishable and separable activities; that to think or feel about a matter, however intensely, does not constitute a necessity to do something about it. I pointed out that thought, feeling, and action often become fused, as it were, in one's perspective and treated or regarded as an indivisible unit; and that when this happens, if the individual feels incapable of action in connection with a given problem, he may go to the maladjustive extreme of not permitting himself even to think about the problem. I assured him that this was always a mistake because it interfered with normal freedom of mental activity. I then told him I wanted him to discuss his associations and experiences with girls since an early age. I quickly promised him that I would not try to force or trick him into any overt activity with girls; that I simply wanted him to discuss the matter. I reminded him that our talks were absolutely private and confidential and that there could not possibly be any harm or danger in our discussing anything under the sun.

Carl appeared ill at ease at the mention of girls and more or less blocked in his thinking. At the same time he seemed somewhat reassured by my promise not to try to force him into any overt activity with the opposite sex.

For the next few weeks we moved along slowly. His thoughts about girls seemed labored and his memories vague. I frequently reminded him that our intentions were merely to discuss such matters as women, sex, man-woman relationships, and related matters—merely to discuss them, not to initiate any sort of action. Then, one day while he was disinterestedly telling me about some girls he knew in college, he casually mentioned his diary. He had kept a diary for a number of years prior to his illness. I asked him to bring it when he came for his next consultation. Thereafter, our progress was more

rapid. His diary was replete with details about girls he had dated, his work, fraternity activities, and sport events in which he had engaged or witnessed. It not only provided me with valuable material about his more recent past life but it gave me leads for innumerable questions. He was far more capable of answering specific questions than he was of volunteering information. I led slowly up to his meeting the young woman who precipitated his regression. By the time I had got to this point we had discussed women and sex and marriage pro and con, and when this particular girl was introduced into our discussions, he showed a very satisfying ability to look back on his unhappy experiences.

Ethel—we shall call her—was an only daughter and on the basis of this I suggested that her father was perhaps either narrowly jealous of her suitors or had rather exalted plans for her future or both. I encouraged Carl to mull the whole matter over freely and see if he could hit on any other reason for the father's antagonism to him. Carl did some ruminating aloud, manifesting intense bitterness not only toward the father but the girl as well. I cared little whether we ever discovered the true reason for the antagonism or not; my sole purpose was to get my patient to thinking freely and feeling fully about the events which had affected him so deeply.

I raised the point of Ethel's refusal to elope with Carl and suggested that she was perhaps as strongly attached to her father as he was to her. After this had been fully discussed, Oedipus complexes explained, and numerous examples cited, I turned Carl's attention to his own lifelong submissiveness and childlike obedience to his mother. I felt sure that he would never make a satisfactory recovery and future adjustment till he was again able to confront Ethel, to face the problem from which he had fled by way of his regression. But I was certain that his still existing dependence on his mother stood in the way. I accordingly set about making a short, but probing, analysis of this dependence. I asked him to supply me with every supporting fact or indication of this dependence, both before and after his illness, that he possibly could.

Carl was now thoroughly cooperative and soon began to show some pleasure in supplying evidence of his mother's domination of him. He had been coming to my office alone for several weeks—this was at the end of approximately six months of treatment—although his mother still offered to accompany him each time he left the

house. He began to look about, under my encouragement, for additional ways in which he could assert his independence. He mentioned that his afternoon naps were getting to be a bore. On inquiry I learned that he drank a glass of warm milk and lay down for a couple of hours each afternoon at his mother's insistence. I laughingly ridiculed him for being a panty-waist and told him to give up the milk and naps. He refused to comply with his mother's wishes in this respect the next day and she immediately appeared at my office. She told me I was doing her son more harm than good and demanded that I discontinue the treatment. Naturally, I refused.

From this time on Carl's progress was rapid. I strongly encouraged him to rely on his own judgment in all ordinary matters and gave moral support to his increasing self-confidence in all directions I could. By the end of the seventh month he was becoming somewhat boastful and cocky. I then told him that his future emotional adjustment would not be assured till he had called on his former sweetheart. This had a markedly reducing effect on his feelings of self-sufficiency. I told him he need only call at her home, say hello when she appeared, and then walk away, if he felt that way. At the end of ten days or so he had become unhappily but doggedly determined to make the visit.

Ethel and her family had moved to another city some two hundred miles distant. When Carl came into my office after the trip his compensatory cockiness was absent but also was any evidence of fear or feelings of insecurity. He said he had visited with Ethel for a half-hour, trying during most of that time to discover why she had ever appealed to him in the first place. She had seemed rather simple, unattractive, and boring.

Carl was dismissed in a little less than eight months of treatment. A few months later he married a plain but superior woman whom he had known for some years but had never thought very interesting. He was a very industrious and devoted husband and father till his untimely death several years later from a malignant tumor.

CHAPTER 16

Reactive Depression

A BRIEF indirect psychological examination will usually suffice to distinguish a case of reactive depression from manic-depressive and involutional cases. The reactive patient is responding depressively to some environmental circumstance. He is usually fully aware of this fact and will mention it during his examination. In any case he will not give as the reason of his depression some farfetched or delusional cause.

The principal symptoms encountered are *depression, weeping spells, sleeplessness, loss of appetite, loss of interest in work, mental confusion, and sometimes psychosomatic complaints.* Depression is the basic symptom and the others more or less derive from it.

In all psychogenic disorders subjective determinants are of primary importance. There is this difference, though, between reactive disorders and others: Whereas in the other psychoneuroses some environmental or situational factor may act *merely* as a precipitating cause, and frequently does, in the reactive disorder the situational factor assumes great importance. This does not mean that the person who develops a reactive depression is simply a victim of circumstances; it means rather that he has an Achilles' heel in his psychic make-up. He may meet most of the ordinary exigencies of life with an unwavering resolution and fortitude and then react with intense depression in the face of some particular circumstance which is no less ordinary than life's other problems.

In the writer's opinion the Achilles' heel is usually, if not always, an emotional softness unmixed with pragmatic virtues. It is not sentimentality as such although it might appear to be except under close scrutiny. It is an unselfish affective capacity which has never

become properly integrated with other sentiments and attitudes. It is in the nature of the doting mother's uncritical devotion to her son. Toward all other matters her affective responses may be tempered by judgment and properly aligned with her other interests and feelings.

This emotionality comprises no particular burden or handicap as long as circumstances permit the individual to discharge it freely in his daily life. When circumstances become altered in such a manner as to make it impossible for him to do this, he is blocked in his affective responses, frustrated, and reacts depressively.

A man of the type under discussion had been married to a cold, undemonstrative woman for twenty years. There had been no children. During this period of time he had successfully invested his selfless emotionalism in his work or working situation. His interest in his work was primarily affectionate rather than ambitious or egoistic. Decreasing business necessitated a reduction of the number of workers and he was laid off along with others. He almost immediately went into a deep depression. He was not financially worried or anxious. He did not suffer from feelings of inferiority or feel that he had failed. He did not blame his former employers for reducing the working staff. He did not even think of seeking another position. Rather, he wept much and would talk for hours to anyone who would listen about his former work or, more exactly, about his former working environment. He described the desk at which he had sat for so long and the chair and filing cabinet with all the tenderness with which a bereaved mother might speak of her deceased child. He carried samples of his past work with him and displayed these in the same heartfelt manner. The change wrought in his daily environment by the loss of his position robbed him of the objects on which he had discharged his emotionality for years. His loss was too personal for him to think of replacing it by the simple expedient of securing another position.

Although reactive depressions usually follow in the wake of some change in environmental circumstances which prevents a free discharge of unselfish feeling by the individual, there is at least one other way in which they may be precipitated and sustained. In order to understand this second manner of origin it is necessary to see this type of person as one whose psychic energy is disproportionately directed to unselfish ends. Or, it might make the matter

clearer to say that he is relatively without protection against his own *selfless motives.* He is soft, yielding, unselfish. As a self-sustaining individual in his own right, he is poorly equipped. But as long as he can freely discharge his unselfish tensions he can continue to function efficiently in his mediocrity as an individuality. But once he is prevented from discharging these tensions (affection, sympathy, selfless devotion), his inadequately developed egoistic bent becomes overburdened. He can use his energies on behalf of someone else but not fully in any sense for himself.

This opens the way to a comprehension of this second origin of reactive depressions. The patient's self-interest has been too narrow and unexercised. Accordingly, it tends to impinge on his *unselfish* implicit and overt activities, since these monopolize his available patterns of expression. If the infringement carries too far, he is no longer able to give easy vent to his unselfish motives. He becomes subjectively frustrated, may suffer from vague feelings of guilt, and reacts with depression.

Fairly frequent examples of this second genesis of reactive depressions are encountered among physicians, dentists, ministers, and others who enter vocations in which the demands of other persons upon their time and energies may be without limit and which vocations at the same time offer incentives to high personal distinction. The constant adjunctive egging of the egoistic motives which is inherent in such activities may gradually divert interest and attention from the original aim of selfless effort to the goal of personal distinction. This creates an inner conflict, stifles unselfish devotion to the enterprise at hand, and produces frustration.

The exact therapeutic procedure which is indicated in a case of reactive depression will depend in part on the nature of the sequence of events which led to the disorder, namely, whether they were essentially a change in the patient's environmental circumstances or gradual changes within his own selfless-selfish orientation. But in either case the writer has found that a few explanatory discussions of the naturalness, normality, and necessity of frank self-interest in one's work and human relationships is of great help.

After these discussions the therapist should look to the possibilities of altering the patient's environment or his relationships to his environment, where changes in the environment were princi-

pally instrumental in bringing on the depressive reactions. As to what may be done in any case of this type obviously depends on the particular patient and his circumstances.

Where the depression has been brought on by a gradual awakening of egoistic motivation, brief periods of psychoanalytic and educative therapies are in order. The patient must be helped to discern and recognize the full significance of his egoistic aspirations. Following this he should be helped to a full and frank acceptance of the normality and importance of self-interest, the natural inclination to express and further one's own uniqueness, in the total meaning of human life.

Cases of reactive depression can usually be helped within a few weeks, or not at all. They are not cases for prolonged, intensive, or broad therapeutic procedures.

TREATMENT OF A CASE OF REACTIVE DEPRESSION

Dr. N., a dentist, fifty-two years old, suffered from intense depression, weeping attacks, insomnia, loss of appetite, pains in his left shoulder and arm, and almost a complete loss of zest for life itself. He had been married twenty-six years and had two daughters, nineteen and twelve. He had been estranged from his wife for more than a year and had not been living in the same home for several months. He had started action for a divorce coincidentally with moving to other living quarters, but his wife had contested the action. He was beginning to despair of ever securing a separation, the lawyers for both parties showing little interest in bringing the matter to a decision.

I gave Dr. N. a written intelligence test, a personal adjustment inventory, and a free association test. His score on the intelligence test placed him in the borderline group. Although I had not thought him to be a man of unusual brilliance, in view of his past training and accomplishments his score definitely indicated a serious state of mental blocking and confusion. I was surprised that he was able to carry on his work at all. He was apparently doing so in a purely automatic manner. He fell in the lowest ten per cent on the inventory and was frequently delayed in his responses in the free association test.

When Dr. N. was still an infant he lost his father. His mother remarried when he was twelve and had two sons by her second husband. During the period between the death of his father and his mother's remarriage, he was cared for by his maternal grandmother, a dominant and stern woman who had very definite views concerning most matters. She believed that children should be seen but not heard and although she was kind, she was unrelenting in her disciplinary measures. One of the patient's earliest memories was of being spanked by his grandmother because he had gotten his clothes dirty. Yet he did not recall this period as one of unhappiness and he had never been moody or depressed prior to his present despondency.

He had no siblings prior to his mother's second marriage, and I gathered from his account that he eagerly welcomed the arrival of his half-brothers into the family circle. He stated that he always preferred looking after them to being off with other boys of his own age. They became very fond of him, and he continued to be their close companion and big-brother protector till his schooling took him away from home in his early twenties. Yet I found no evidence of shyness, feelings of inferiority, or social ineptitude in Dr. N. which would have kept him from preferring companions of his own age to his half-brothers. As far as I could discern he had always been very affectionate and protective in his feelings, and his half-brothers simply fit his emotional needs. When he went away to college he immediately formed close friendships both among his instructors and fellow students. Several of these friendships had been kept alive through infrequent personal contacts and regular correspondence up to the time when he came to see me.

In his dental work Dr. N. was known as a very conscientious and painstaking worker. He was reportedly slow but thorough. He seemed to recoil from the idea of giving anything but the best service of which he was capable. For years prior to my meeting him he had been working six full days a week and often seven. Apparently he never refused to go to his office late in the evening to accommodate a patient or at seven or eight in the morning.

When he was twenty-six he married a cold, aggressive woman. Although I never met her I concluded beyond doubt in my own mind that she was a markedly paranoid personality. Shortly after their marriage she began to manifest extreme jealousy of her husband's friends, irrespective of their sex. During their twenty-six years of

marriage, my patient reported, she had succeeded in breaking up most of their closest friendships with other married couples. For a number of years prior to Dr. N.'s attack of depression, he and his wife had practically stopped associating with other persons in any way socially. He said there was no one left for them to associate with, that all of their friends had become estranged due to his wife's unprovoked and vitriolic outbursts. He saw no point in seeking new contacts or trying to make other friends. For years he stated that his life had consisted of little, besides eating, sleeping, and working.

Finally, Dr. N. had decided to seek a permanent and complete separation from his wife, and the custody of his younger daughter. He believed his older daughter had been turned irrevocably against him by her mother. Moreover, he had succeeded in setting aside sufficient money to ensure her a higher education. Inasmuch as she showed no friendliness toward him or any desire to be with him, he saw nothing more that he could do on her behalf.

He placed his case in the hands of an attorney, taking care that his wife was fully informed of his intentions. She secured legal counsel for herself and declared she would not give her husband a divorce under any circumstances. At the same time she stated she was entirely willing that he should live separately from her but asked that she be deeded all their property and guaranteed a liberal monthly payment from his earnings.

Dr. N.'s attorney showed no disposition to take any energetic action on behalf of his client, putting him off with various excuses whenever approached. At the end of two months, even, no court hearing had been held, at least not with Dr. N. present, although he had been paying counsel's fees and a substantial temporary alimony during this time at the instructions of his own lawyer. At the end of this time he went to his lawyer's office, determined to have matters clarified. As he sat in the waiting room he heard loud voices and laughter in the adjoining room. Hearing his own name mentioned he naturally became curious as to the identity of the other occupant of the inner office. When the door finally opened his wife's attorney emerged. Both lawyers were laughing as if at a very funny joke. Dr N. suddenly concluded that his own lawyer was perhaps not looking after his best interests. He began to feel depressed and frustrated. His depression grew steadily worse, and he came to me because of it about two weeks later.

In addition to the information which I have already mentioned, I secured some other pertinent facts from Dr. N. during our first few talks. Despite his years of hard work and good income he was in rather modest circumstances. His wife had often told him to make the money and she would spend it. She apparently had. They owned their home and had a few thousand dollars in savings. Their home, he said, contained many very expensive but useless furnishings. His wife had long been on selective customer lists at the better stores. She liked mink coats and full-time domestic help in their home. After he moved to separate living quarters his wife frequently followed him in a car when he left his office at the close of the day. On several occasions when he had called on married friends to spend the evening, she had sat in her car on the opposite side of the street till he left even when the hour approached midnight. He said that for years past she had accused him of infidelities. He denied any past misconduct with other women. Shortly after he initiated action for a divorce his older daughter borrowed his office keys on a minor pretext. She returned them at the end of an hour or so. A few days later his office was rifled of many papers and records.

On the basis of these facts a diagnosis of reactive depression seemed fully indicated. I had observed no signs of any half-hidden egoistic bent, power motive, or feelings of guilt. I accordingly felt his depression could be interpreted and dealt with in terms of years of frustration, emotional starvation, and his present frustrating and emotionally stifling situation. Since their physical separation his wife had contrived to prevent his visiting his younger daughter. I regarded his loss of this daughter's daily presence in his life as the most specific of the factors which led to his depression.

I talked to Dr. N. a couple of times about the limits to submissiveness and unselfishness which the innate character of human motivation naturally imposes. I stressed the right of the individual to receive as well as give. I told him that in my opinion he had been a sap all his life and that it was time he began to demand his rights. I assured him I would support him in any reasonable manner if he would take more energetic steps toward securing a divorce and, if possible, the custody of his younger daughter. Various acquaintances of his wife had discussed her with me, and I was thoroughly convinced that she was not a proper person to rear any child.

At my suggestion Dr. N. dismissed his lawyer and consulted a bet-

ter known and more aggressive one. This second lawyer said he would push the case to a conclusion with all possible dispatch but that he wanted several good witnesses, particularly to Mrs. N.'s. extravagance and lack of consideration for her husband in other respects. But when Dr. N. called on some of his friends who had long expressed their sympathy for him and their condemnation of his wife for her attitudes and actions, they were loath to appear as witnesses. The women in particular appeared to be uneasy at the prospect of testifying lest Mrs. N. should become vengeful and possibly harm them or their children. It gradually dawned on Dr. N. that he could look to none of his friends for help in his predicament. This was still another blow to his wavering determination to gain his freedom from his wife and start his social life anew.

I was firmly convinced that my patient had every right to a divorce and that he would never regain his self-assurance, competence, and peace of mind till he obtained one. I therefore told him he would have to make up his mind to let his wife have practically all of their property and custody of their younger daughter. I pointed out that most of the harm that his wife could do to the younger daughter had already been done. I reminded him that the court would grant him the privilege of visiting the daughter frequently and that he could watch over her welfare more or less from a distance. As far as the property was concerned, I assured him that he would have no reason to worry about financial matters once his earning capacity was recovered, provided his attorney took care that he was not unduly burdened by payments of alimony and support of the daughter. I instructed him—he was so thoroughly defeated and depressed it was a matter of instructing him, not offering advice or suggestions—to go to his attorney and offer to make these concessions.

Not only Dr. N.'s attorney but his wife's lawyer and the judge became more favorably disposed toward Dr. N.'s action for a divorce in view of his willingness to be more than generous in the property settlement and to relinquish his demand for custody of the child. Mrs. N.'s attorney began to insist that she accept her husband's terms and let him secure a divorce. (I learned indirectly that this lawyer was becoming very intolerant of Mrs. N.'s daily visits to his office and of her ceaseless heated and undignified tirades against her husband.)

I saw Dr. N. twice weekly for several weeks after he had taken the

step which I have just mentioned. After three weeks of this period Mrs. N. was beginning to weaken in her exorbitant demands. Then shortly she capitulated and the divorce was granted.

Dr. N.'s rebound was instantaneous. His despondency disappeared overnight; he immediately began to give more attention to his personal appearance; he rapidly renewed old contacts and friendships; he worked longer hours but said he did not suffer from fatigue. He declared that he intended to see all of the basketball games of the approaching season. He had not been to such a game for several years despite his fondness for them.

Approximately a year following his divorce Dr. N. remarried. A close friend of his, one of my patients, reports that he appears happy and satisfied in his new marriage which, however, is only a few months old at the time of this writing.

Part Four

SOME MALADJUSTIVE PSYCHO-SOCIAL TENDENCIES AND REACTIONS

CHAPTER 17

Suicidal Tendencies

SUICIDAL tendencies are found as symptoms in various psychoneurotic and psychotic conditions. On the other hand they are frequently present where no clearly defined and manifest personality disorder as such exists. It is in such cases that the causes and psychological significance of suicidal acts can be most clearly viewed.

The first two or three consultations with any person who expresses inclinations to commit suicide should be devoted to a study of the probable strength of these inclinations. If all persons who mention such tendencies were to be hospitalized, many more hospitals would be needed. At the same time it is both the therapist's desire and his responsibility to protect those who come to him for help against self-destruction, in as far as possible, whenever such protection is needed or indicated. If there have been past suicidal attempts or if the impulses are strong and their causes cannot be readily discerned and evaluated by the therapist, hospitalization is the safest course.

The causes or motives for suicide have not been too well understood largely, perhaps, because of the literally destructive nature of the act. The consequences of the act, in other words, have often tended to obscure its motive. Although some acts of suicide have the sole aim of destruction, others just as certainly are the expression of a pressing need to preserve.

The writer is of the opinion that all suicidal acts can be understood or interpreted in terms of four broad motives: *to destroy*, *to escape*, *to preserve*, and *to restore*.

There appears to be little question but what hostile impulses or

death wishes toward others may become *inverted*, presumably under the influence of conscience (the Super-ego), and *directed toward self*. A young man had a compulsive tendency each time he shaved to cut his own throat with the razor and, when in a high building, to jump out of a window. During treatment he recalled that when he was four or five his father had severely offended him by ordering him to leave the back yard where he had been enjoying the evening sun with his parents and siblings and to go in the house. He ran up the stairs to the upper floor with the intention of jumping out of the window and killing himself in order to "get even" with his father for mistreating him. He hated his father and was excessively attached to his mother. He recalled further that sometimes when watching his father shave he had wished his father's hand would slip, with disastrous results. When this young man was about twenty-two his father died. When the doctor pronounced his father dead, the patient felt a sharp pain through his back and thought for a moment he had been stabbed by someone behind him.

An overidentification with another person may be instrumental in engendering suicidal impulses. A young man whom the writer believed to have been greatly overidentified with his deceased mother stated that he was certain his mother had committed suicide, although the family had pretended otherwise, and he knew that he would do likewise sooner or later. He did, within a few weeks of the writer's conversation with him.

There is a second and more common way, however, in which an overidentification may be productive of suicidal impulses. An overidentification robs one of ordinary personal freedom and a substantial feeling or sense of one's own distinct and separate personal identity. The overidentified person is emotionally confused with the person with whom he is identified. The loss to himself of his personal identity tends to breed hostility toward the other person. But because of the emotional confusion (identity) with the other person which exists and the sense of guilt which tends to arise, the same hostility may quite easily become directed toward self. A young man suffered from suicidal tendencies and an overidentification with his father. He had hurled a bowl of steaming soup at his father's head and committed other violent acts with little or no apparent provocation. He complained that he was unable to read a book if his father sat in the same room, because of his acute awareness of his father's

presence. He stated that he could not even buy himself a necktie without becoming concerned as to whether or not his father would choose the same tie.

That suicide is sometimes a deliberate *escape* from an unbearable situation has long been recognized. Intolerable pain, enslavement to others, the inability to establish or to live in accordance with one's true identity, and the loss of cherished personal values are among the situations to which man has often preferred death, even at his own hands. No deep or hypothetical psychological principles are involved here. "Give me liberty or give me death!" is the simple declaration of an attitude, shared by many, that the permanent cessation of consciousness of all things is preferable to the continued consciousness of certain intolerable things.

But suicide is not always motivated by destructive drives or by desire to escape from an intolerable situation. In many cases it is a contructive act, in view of its goal, an act which aims to *preserve* or enhance already existing values. A hopelessly invalided mother sees herself as a heavy burden on her only son, who is her sole means of support. She sees herself as a severe handicap to his future happiness and success. He would move forward much more rapidly if he did not have her to support. When she takes her own life in order to lift a burden from her son's shoulders, the goal or objective of her act is to ensure and enhance his future; destruction of herself is merely the means to this end. A man who believes he has come to the end of his earning capacity may take his own life in order to ensure the economic welfare of his family. All life insurance companies take cognizance of suicidal acts of this order.

There is no difficulty to understanding an individual's taking his own life in order to preserve or enhance the life of another. Love remains the strongest force in human nature, at least on occasion. We step into deeper psychology, however, when we turn to the matter of a person's taking his own life in order to preserve some purely personal and subjective value. Yet there is no question but what this frequently happens.

Deep down in the affective make-up of every person there seems to be an implicit assumption of his own immortality. The finiteness of human life is dealt with rationally, not emotionally. Accordingly, what one is or has achieved within himself, he may always be. Thus, if honesty is one of his most basic personal ideals, he may continue to

be honest not only during his lifetime but thereafter as well. Anything, then, either from within or without which jeopardizes his being honest might engender suicidal tendencies.

The encroachment of libidinal and egoistic drives into the province of personal ideals frequently accounts for self-mutilating and self-destroying acts wherein the motive of such acts is to preserve subjective values. A young man, later committed to a mental hospital, partially castrated himself in order to safe-guard his moral integrity against his sexual cravings. A man of sixty who traveled from western Canada to New York for treatment complained that his life was becoming unbearable and that unless he could be helped he would have to commit suicide. He had always regarded himself as moral and upright. He declared that as he walked along the street even little girls of seven or eight would frequently raise their dresses and make other inviting gestures. He felt that there must be something wrong with him or he would not be treated in such a manner. He readily admitted that he was painfully obsessed a good part of his time by thoughts of sex.

Egoistic cravings, too, desires for influence, power, recognition, may become so strong as to overwhelm the individual's mental integrity, his sanity. But, in preference to such a calamity, some individuals will destroy the lust for God-likeness by destroying themselves. In doing so they defeat the inner enemy and preserve to their personal identities, their sameness with their fellow beings and their loyalty to the facts of reality.

Finally, some suicidal acts are aimed at the end of *restoring* something that has been lost. They are acts of atonement or restitution. A young man who felt degraded, that he had lost his moral completeness, because of masturbation, held his hands in a fire till they were so badly burned their use was permanently impaired. The man who has killed another or has been traitorous to his country may take his own life in expiation of his crime and in restoration of at least a portion of his former moral self.

In working with a patient who expresses suicidal tendencies the therapist should take care to treat such tendencies in the same matter-of-fact manner he would any other symptoms. Any alarm or undue concern on his part or any disposition to belittle the tenden-

cies, on the other hand, can lead only to harmful results to the patient.

As long as the causes of the self-destructive impulses are obscure, a simple psychoanalytic procedure is best. The patient's early history along with his dreams and free associations should be painstakingly examined for evidence of repressed cross-identifications, homosexual tendencies, sexual interest in a parent or sibling, hatred of a parent or sibling, feelings of guilt, overidentification with a parent and unresolved narcissistic or egoistic drives. This procedure should be continued till the therapist not only is quite certain of the nature of the disturbing factor but has collected ample evidence in support of its existence.

Once the basic cause is known to the therapist he should carefully evaluate its significance in relation to the patient's psychic needs, affective tolerance, and adjustability. The cause may be something which can safely be revealed to the patient at once. On the other hand it may be something which will inevitably produce an acute emotional disturbance in the patient once he is aware of it. In the latter case it is much better to take too much time than too little in preparing the patient for the necessary insight. A young man with strong suicidal impulses declared that his only real interest in life was to go forth and convert mankind to the true religion, his religion, and, incidentally, a well-known creed. When he was asked, altogether too early in the treatment, if it would be equally agreeable to him if some other person did the converting, he became violently upset and attempted to commit suicide two days later. His interest in converting mankind to his religion pointed unmistakably to a Jesus Christ complex and, therefore, to intensely strong but unrecognized narcissistic drives. Needless to say, several months should have been devoted to preparing him to see and tolerate these drives.

When the causative factor is known the procedure will be modified accordingly. Considerable time should always be spent along the line of educative therapy where the disturbing factor is either of an egoistic or homosexual character before its nature is revealed to the patient. Perhaps the same should be said of repressed sexual attachments to parents. Otherwise the patient may usually be informed of the nature of the disturbing factor without risk and then carried through a course of re-educative and analytical therapy.

A few further words may be in order concerning the strongly identified and therefore emotionally dependent person who has suffered an irreparable loss and then has become troubled by suicidal thoughts and tendencies. Argument, reasoning, and persuasion should be avoided entirely, particularly during the early part of the treatment, and the patient should be required to discuss the lost value over and over, whether it be child, spouse, professional standing, money, or something else. By means of appropriate questions and relevant comments the therapist should seek to broaden or extend the discussions to include more and more details and features of the lost value. The reason for doing this is to help the patient out of the narrow mental groove into which he has gotten himself. For the psychological situation of such a patient is briefly this: He dwells continually on some particular aspect of the lost value because of the personal significance which this aspect had for him. He dwells on it partly in an unwitting effort to keep it alive, to keep it with him, and partly because he feels incapable of turning to other values and interests. Thus his mental activity is concentrated and narrow and therefore fatiguing and frustrating. In his feelings of helplessness and exhaustion suicide comes to mind as an escape. A woman who appeared to be on the verge of suicide because of the loss of her only child, a daughter of sixteen, was a case in point. She dwelt endlessly on her daughter's virtues and great promise. When she mentioned how unusually clever her daughter had been for what seemed the nth time, the therapist pretended to misunderstand the meaning of the term "clever" as she had meant it and asked if she could recall any witticisms or sparkling bits of humor in her daughter. Before she realized it the patient was laughing at some recollection of this sort. She then appeared horrified and remorseful that she should laugh at anything in connection with her deceased daughter. But the ice had been broken and she was encouraged to recount everything of a humorous nature she could recall, being assured that her daughter would rather have her laugh than weep. Later and with due care she was induced to mention some of her daughter's faults and personal peculiarities. Finally, it was possible to make her see that her extreme and prolonged grief over her daughter's death was largely on her own behalf; that she had been strongly identified with her daughter and had therefore looked forward to sharing unduly in the other's anticipated accomplishments; that, in

fact, she had tended to feel bitterly toward her daughter for being let down and frustrated and had reacted against this tendency with an exaggerated loyalty and devotion to the memory of the deceased, with unrecognized self-reproach, and with impulses to kill herself. The discussions partially dissolved her strong identification thereby liberating energy for use in other and new directions, and with the weakening of her identification her suicidal impulses subsided.

With respect to that more prevalent form of excessive emotional dependence, that which results directly from emotional immaturity, the writer is of the opinion that the loss of the supporting object or value never leads to suicide. Suicide is rarely the act of a child; adult perspectives and interests of one kind or another are all but essential to it. The emotionally infantile person lacks such interests and perspectives.

The following case has been chosen because of the unusual light which it sheds on the extreme importance to the adjustment of the individual of a close correspondence between his *conscious* and *subconscious* knowledge and conviction of what and who he is. Till the writer met and undertook to help the young man mentioned below he was unaware that a discrepancy between conscious and subconscious "knowledge" of personal identity could lead to any act as radical as suicide.

TREATMENT OF A CASE OF SUICIDAL REACTIONS

Martin L., an unmarried man of twenty-eight, came to me for help at the insistence of a friend. He was a well-built young man of better than average looks. His manner or bearing was hard to define. He walked at a normal pace, talked in a natural manner, was polite and attentive and yet there was a certain air of unconcern or disinterest. No despondency was apparent, and he denied that he was ever depressed emotionally. He described his state of mind as a feeling or sense of futility.

I inquired during his first visit into his present circumstances. He said he was a licensed dentist and that he had a very good office and good equipment. He went on to add that he was not interested in dentistry or in anything else. He applied himself to his practice only

enough to provide himself with clothes and incidental needs. He lived at home and paid nothing for board and room. He rarely engaged in social activities, had no intimate friends, and had made no effort to keep in touch with his former classmates. He had always been in good physical health.

When I asked Martin about his complaints and symptoms he said he had none other than that life seemed utterly futile and not worth living. He was unable to work up an interest in anything even for a short period. Every day, he said, was exactly like every other day for him, being meaningless and devoid of zest or incentive. He observed that other persons often seemed to be happy but he could see no reason for their happiness. He could not remember being happy himself since he was a child.

Martin stated, or rather admitted, that he had tried to end his life twice. He appeared somewhat ashamed of these acts but appeared to regret that he had not succeeded. My own later inquiries convinced me that these attempts had been quiet, genuine, and undramatic efforts to put an end to his existence. When I asked him the reasons for his gloomy outlook on life he was unable to shed any light on the matter whatever. He could only reiterate that his life was tasteless and meaningless and that he was weary of living.

Martin readily agreed to make no attempts on his life as long as the treatment was in progress. Inasmuch as he appeared to feel that a few more months would make little difference, I accepted him at his word. He was willing to do enough practice to take care of my fees. He asked that I should not mention his coming to me to his parents as he felt it would only add to the dissension at home. He thought his parents would be strongly opposed to psychotherapy.

The tests which I usually gave—intelligence, personal adjustment inventories, and free association tests—gave me no clue to the nature of the disturbing factor in his case. Accordingly, I undertook a thorough-going study of his developmental history, followed by a modified psychoanalytic procedure.

Martin's parents were in their late fifties, in good health, of little education but industrious and moderately successful economically. They were both of foreign birth. They had always been socially active within a limited sphere. Martin believed that neither of them had any unusual personality peculiarities. His mother was the more dynamic and aggressive and had always exerted more influence in

the home environment than his father. There were no siblings. Until Martin was nine years old a maternal aunt had made her home with him and his parents. She had then left for Europe and had not returned.

Martin had never suffered from any chronic illness. His childhood had been happy and he had been pampered a good deal by his aunt. His mother had always been very energetic and exacting but not very demonstrative of her affection. His aunt, as he remembered her, had been submissive and affectionate. During his childhood he had been more fond of her than of his mother in as far as he could recall. I never discovered any evidence, however, of an unusually strong attachment to either woman.

A study of Martin's early interests and activities revealed nothing out of the ordinary. Apparently he had been sociable and agreeable and had mixed freely with other children throughout his development. As far as I could learn he had been a typical child reared in a typical environment and in a typical manner. He could recall no unusual early experiences of intense interests or dislikes.

Pursuing a free association procedure, interspersed at frequent intervals with specific questions and requests for further details, we covered every aspect of his past life that I could bring to mind. I looked into the matter of his foreign parentage; I searched at length for evidence of early sexual interests and subsequent conflict and feelings of guilt; I explored for cross-identifications and overidentifications; I probed for repressed homosexual tendencies; I sought to bring to light some Jesus Christ or Napoleonic complex; I even insisted that he must have met with some severe emotional frustration in his adult life and that he had either forgotten or was concealing it.

At the end of six months, three visits weekly, I had accomplished nothing. Martin was still reluctant to have me discuss his case with his parents and I did not insist, thinking it highly improbable that they would be able to shed any light on the origin of his suicidal tendencies. I repeated the free association test I had given him in the beginning and gave other personality inventories. Nothing yielded any positive suggestions. Beginning all over again, starting with his earliest recollections, I reviewed his past life in detail and also began introducing as much active therapy as possible. I had Martin go out with girls, attend lectures and concerts, mix more

with men and do more reading of current events. He was placidly cooperative but without noticeable benefit.

At the end of another four months I had to admit to myself that my patient was exactly where he had been when we first started the treatment. He had been as cooperative, in his unenthusiastic manner, as I could have desired. He had always been punctual and regular in his visits and had carried out all of my instructions without complaint. He had been able to recall only a few dreams but that, of course, was no fault of his.

In all probability my efforts to help Martin would have continued to prove fruitless had it not been for an incident which occurred at that time. I was sitting alone at my desk one day when Martin's father burst in without even the formality of knocking. He was very angry and very excited. He demanded to know "what in hell" I thought I was doing to his son. I told him I was trying to *undo* something which he or his wife must have done to their son during the latter's childhood, but that I had not discovered yet what it was. Martin had told me that when he was small his father had a habit of kissing him frequently on the mouth in a way that my patient termed "gluttonous." Naturally I had searched for possible harmful consequences of such a practice but had found nothing of significance. Nevertheless, I mentioned this to the irate father and asked if he could think of anything else that I might be interested in knowing. I assured him that he or his wife or both had gravely erred in some respect in rearing their son. I deliberately made my contentions more emphatic than I felt warranted in doing, on the basis of any facts I had, in the hopes of uncovering some clue to the nature of the causative factor in my patient's maladjustment.

My visitor's anger rapidly gave way to anxiety. He paced back and forth a few minutes while I sat waiting. Then he stopped and said there was something he would tell me if I would promise never to tell his son under any circumstances. I then became the angry one, ostensibly. I told him that if he knew of anything that might have a possible bearing on his son's suicidal tendencies, he had to tell me at once and that I would make no promise to keep it a secret till I knew what it was, and that I would then keep it secret or not depending on its significance. After a few moments' hesitation he decided to divulge his information.

The facts were briefly these: When Martin was four and one-half

years old he was legally adopted by due process of court. His adopted parents were a maternal aunt and uncle, namely, my visitor and his wife. Martin's mother was the "aunt" who had lived with him and his "parents" till he was nine and had then gone to Europe. All four parties had been in court at the time of the adoption proceedings. Martin's father was of inferior moral caliber and had deserted his wife and child. Martin's mother had been a kind and affectionate woman but of little fortitude and doubtful moral strength.

The other facts which I will mention were obtained partly from Martin at a later time, and partly from his adopted parents. I told Mr. L., my visitor, that I would give the matter serious thought and let him know later what I had decided to do about the information. During Martin's next visit I questioned him pointedly about the "aunt" who had gone to Europe. He was able to add nothing to what he had already told me, that is, that he could recall having wept for some time when she left. He thought he had soon gotten used to her absence and had all but forgotten her completely.

In a few days I had decided that the best course was to have my patient's adopted parents come to my office and tell Martin in my presence who he was and how he had come to believe that he was their son. This was finally accomplished after vehement refusals and protests and amidst many tears and lamentations. I was interested to observe that Martin showed no surprise whatever when he was informed of his true parentage; neither did he contribute to the tears of the session.

Mrs. L., admitted that from the day of Martin's adoption that she had insisted that he address her as mother and his mother as aunt. She had justified herself in this by pointing out to Martin and to his mother that she was more of a mother to him than his real parent who had behaved foolishly and had shown no ability to rear a child properly.

Thus, from the age of four and one-half to the age of nine, Martin had been in the unhappy predicament of having to address the woman whom he had known as aunt as "mother," and the woman whom he had known as mother as "aunt," and to think and feel accordingly; both women with him daily, eating at the same table, occupying the same apartment. Gradually, under the unremitting insistence of his aunt, ***his knowledge of his true identity became repressed,*** and consciously he came to accept his adopted parents as

his true parents, himself as their son, although he had known differently. At just what age this repression became complete, it would be impossible to say. It probably followed quickly upon his mother's leaving for Europe; for prior to that time she had almost certainly kept his cognizance of her as his mother alive by various surreptitious devices which perhaps only a mother would know how to employ.

Following the disclosure to Martin of his true identity, a surge of interest in his work, social activities, and the movement of life about him in general was immediate. I saw him for only two weeks longer. Incidentally, he expressed no interest in looking up his mother or in changing the pattern of his life in any other respect. Now, years later, he is married, a successful dentist, and, judging from the infrequent communications I have had with him, a happy and well-adjusted man.

In a free association or psychoanalytic procedure, the patient possibly *always* tells the therapist what the source of his trouble is, if the therapist is alert and discerning enough to recognize the information when it is given. Once, about midway in the ten months of analysis, Martin told me in so many words why he had suicidal tendencies but I did not have the gumption to perceive the true significance of what he said. He had reported that his "mother" nagged at him ceaselessly in an effort to get him to devote more time and attention to his profession and to be more active in other respects as well. Sometimes, he said, he would "blow up" at his "mother" and tell her off, whereas for the most part he simply ignored her. I asked him during one of his visits to recall a recent quarrel they had had and to tell me exactly what each had said. He stated that on a recent occasion he had spoken even more harshly than usual. Among other things, he had said to her, "Oh hell, *you're no mother of mine!* All I ever get from you is your damned nagging." But as I say I failed completely to appreciate the genuinely peculiar nature of the remark and to investigate its full significance.

Although decidedly atypical, the case of this young man clearly belongs to the second order of motivation mentioned early in the chapter. His suicidal attempts were efforts to escape from an intolerable feeling of futility. His feeling of futility resulted from the fact that *he* could not initiate or carry out any activity whatsoever. *He*, his *I-ness*, the very essence of his original and true personal

identity, was repressed and subconscious. The young man who came to me for help in the beginning was little more than an automatism, a beaten path of old reaction patterns, a reflex phenomenon, and, incidentally, a striking refutation of the Behavioristic contention that consciousness lends nothing vital to human action and enterprise.

CHAPTER 18

Compulsive Drinking

SEVERAL excellent books and many good articles have been written in recent years on the matter of excessive drinking. Much good therapy, also, has been worked out in relation to it. There is no intention here of trying to cover the many causes and various symptoms of alcoholic addiction. A chapter is being included for the sole purpose of calling attention to such cases as are particularly legitimate problems for the psychotherapist.

Although no too sharp line can be drawn between them, there are two large classes of intemperate drinkers. For purposes of the present discussion, they will be called *habitual drinkers* and *compulsive drinkers.* The latter are psychotherapeutic cases as such; the former are more likely to be benefited by joining Alcoholics Anonymous or by spending a few weeks in a sanitorium where physical exercise and social activities are freely provided.

In order to define the compulsive drinker as concisely as possible, a few remarks about the habitual drinker are necessary. Hundreds of thousands of men and women consume rather large quantities of alcohol daily or weekly. If one takes the norm as a criterion, these persons drink excessively. A large percentage of them get mentally dulled and physically incoordinated weekly or oftener from too much drinking. Many of them enthusiastically plan and zestfully carry out frequent binges, and then tell what wonderful times they had and how terrible they felt afterward. These persons comprise by far the larger class of excessive drinkers in the country today. They take their drinking more or less for granted and their efficiency and happiness are not greatly impaired unless or until they meet with an automobile accident or other misfortune, as a result of

their drinking. They have no intense craving for alcohol as such and they do not regard themselves as addicted to its use. They are essentially right. They are addicted to a rather thoughtless, pleasure-dominated way of life rather than to alcohol itself. The alcohol merely helps them to shed their ordinary worries and cares and lends temporary enhancement to their zest for living.

Included among these habitual drinkers is a certain number of persons who drink to excess periodically in order to escape from the pressure of heavy burdens. A few years ago the writer asked a married man of thirty who had been committed to a state hospital for alcoholism, without psychosis, why he drank so much. After a few moments of reflection the patient answered essentially as follows: "I guess things get me whipped. I have a wife and five children. I am not trained to do anything but common labor and my earnings are only about seventeen dollars a week. That is not enough to buy good food and clothes for my family. We can't even afford to go to a movie once a month. As far ahead as I can see things will be no better. Sometimes I think 'What the hell's the use!' and get drunk."

Widespread excessive habitual drinking is a symptom of a disordered society. It is more of a sociological than a psychological problem. It is rooted in many and diverse factors. Some of the more obvious of these are economic burdens, broken homes, incompatible marriages, interference by in-laws, a general lack of dignity and laxity in discipline within the home, general ignorance of child psychology on the part of parents, too much encouragement of parents to shift their responsibilities for the guidance and welfare of their children to Federal, state, and community agencies, ineffectual enforcement of laws governing drinking by minors, and a deplorable lack of laws and their enforcement covering birth control.

The compulsive drinker, on the other hand, is a distinct psychotherapeutic problem. (Although usually belonging to this class, the person who develops psychotic reactions as a result of alcohol will not be discussed here.) His drinking is not symptomatic of factors within society but rather of factors within his own psychic make-up. Before going into some of the more common causes of this type of drinking, the compulsive nature of it should be clearly noted.

A married man in his middle thirties alternated between periods of excessive drinking and periods during which he would not drink at all but would spend a large percentage of his earnings playing slot

machines. He had been hospitalized twice for drinking, and it seemed to him that if he did not drink he had to play slot machines, and vice versa. No specific reason for his drinking was discovered till he was questioned closely concerning his affective relationship to his parents. At the age of thirty-four, he reluctantly admitted that he had never had the "courage" to smoke a cigarette in the presence of his father. Needless to say his father was self-righteous and uncompromising. But the patient himself was a married man with children. Never having been able to assert a normal degree of independence around his father, he inevitably felt weak and inadequate. There was a compulsive tendency to assert his freedom. Inasmuch as his personal freedom was curtailed in particular by his servile attitude toward his father, his symptomatic assertion of his independence necessarily assumed a form of which his father would have disapproved. Since he drank or played slot machines secretly, as far as his father was concerned, he gained no permanent feeling of relief or independence.

A young woman who was sexually inhibited, if not repressed, to a painful degree, infrequently took a drink. The first drink was always followed by others in rapid succession till she reached a state of intoxication. Almost without exception, following these bouts, she would awaken the next morning in bed with some man. She would feel thoroughly degraded, suffer amnesia for the events of the preceding ten or twelve hours, and continue along her inhibited way of life till the next episode.

A young man of twenty-two, married and the father of one child, asked for help because of periodic binges. He described his tendency to drink at times as persistent, exhausting, and finally overpowering. He would grow gradually more tense over a period of days, lose interest in his work, and become constantly preoccupied with the thought of having a drink. During his sober periods he sought sexual relations with his wife only infrequently, was likely to be partially or completely impotent, and felt guilty afterward. When he was drinking, on the other hand, he was excessively demanding of his wife not only sexually but in all matters, was domineering, and sometimes even brutal.

The distinction which has been drawn here between habitual and compulsive drinkers is purely psychological. Most compulsive drinkers are habitual drinkers, to be sure, in a descriptive sense, but

most habitual drinkers do not belong to the compulsive class. The merely habitual drinker may be reasoned out of his excessive drinking, or give it up in connection with changing his associates or work, or by coming to realize that it is hurting him or others, or by aligning himself with others who are determined to stop drinking or to moderate their drinking. Reasoning with the compulsive drinker about his drinking only tends to intensify the compulsiveness of the practice, as in the case of any other compulsive activity.

Most any kind of complex or repressed interest may lead to compulsive drinking in one type of personality or another. Repressed homosexual and heterosexual interests, cross-identifications, and egoistic tendencies are particularly common, however, to this class of patients. The proper treatment of a case of compulsive drinking is determined, then, by the personality of the patient and the character of the disturbing complex.

The therapist must avoid the temptation to treat the patient's drinking instead of the cause of it. After the drinking has been frankly and fully discussed, the less said about it the better. No attempt to interfere with the patient's drinking should be made other than to demand that he be sober when he comes for his consultations. If the patient insists on immediate relief, he may be referred to a physician for vitamin injections. Otherwise the therapist should take a firm stand that no immediate relief from the addiction is possible.

TREATMENT OF A CASE OF COMPULSIVE DRINKING

Paul H. was thirty-two years old, married three years, father of one child, high school educated, born and reared in eastern Canada. He was a light-complexioned, plumpish person, somewhat introverted but friendly and agreeable. He appeared worried and preoccupied. Smiling, obviously cost him a conscious effort.

Paul stated that he had paid a psychoanalyst twelve hundred dollars, all the money he had, without benefit and had then been abruptly dismissed. He went on to say that he had paid fifty dollars the first visit and twenty-five dollars a visit thereafter. He was told

that it was his own fault that he could not develop a transference. He appeared to regret the loss of his money but did not express any bitterness toward the analyst.

The patient was the middle child in a family of five. Two brothers were his seniors and two sisters were younger than he. His mother, he reported, had been the dominant influence in his childhood home. She was aggressive, dynamic, and industrious. His father was equally industrious but inclined to be shy and retiring both in the home and outside. The home life had been harmonious, the economic level had been average, and the educational status of the parents had been commensurate with that of the better class of people in the community. There was no history of drinking in the family or of neurotic or mental disorders. As far as he knew his brothers and sisters were well adjusted and reasonably successful.

Psychological tests revealed nothing of particular significance except to suggest an inner disturbance about matters of sex. He made a normal intelligence rating and for the most part made good emotional, social, and vocational adjustment scores.

Paul said that he had kept himself about half-drunk for the past two years. At times he became thoroughly intoxicated. He believed he knew why he drank. He had a compulsive tendency to practice cunnilingus with his wife. This desire tended to blend and/or alternate with his craving for alchohol. When he was sober, which was chiefly in the morning, he successfully resisted his "perverted" sexual desire. Trying to resist it over a period of days, however, left him unbearably tense and nervous. After a few drinks it did not matter so much to him what he did. He could then indulge in the act with some degree of abandon.

Thus Paul's drinking made it possible for him to engage in cunnilingus and thereby to reduce his psychomotor tension. Inasmuch as the two acts of drinking and cunnilingus were intimately and, in a sense, causally related, his drinking took on the compulsive force of the sexual act.

His drinking had another significance. At different times Paul felt that the men with whom he associated suspected that he practiced cunnilingus. At such times he was able to continue with his work only by dulling his sensitivity and feelings of guilt with alcohol.

I did not spend much time searching for sexual experiences or

interests in childhood which might have conduced to compulsive sexual practices in adult life. After I had worked up his case history along the usual lines, the nature of his problem seemed fairly obvious. He clearly recalled that his sisters rather than his brothers had been his principal childhood playmates. His father was retiring, and his mother was dominant and assertive. Paul, himself, appeared to be more of the submissive than the assertive or ascendant type. I had his wife come to my office and noticed that she was definitely assertive, dynamic, and assured in her manner. Also, she appeared very neat and clean. She stated without any sign of shame that she liked to practice fellatio with her husband but declared her willingness to forego the practice completely or to do anything else on behalf of her husband's welfare. They appeared genuinely devoted to each other but she was decidedly the dominant personality of the two.

Paul did not become sexually stimulated in the act of cunnilingus. He definitely preferred sexual intercourse as such to fellatio. With these various facts at hand I reasoned that he had developed strong cross-identifications, feminine tendencies, in early childhood. He later renounced these identifications and largely repressed them. Thereafter he endeavored to establish and maintain a distinctly masculine orientation.

Paul did not associate freely with women before his marriage. Hence his marriage had brought him into intimate and daily contact with a woman for the first time in his adult life. This contact tended to stir his repressed feminine tendencies as well as his masculine interests. His wife externalized his repressed tendencies, and although he could resist yielding them a place in his conscious thoughts and feelings, that is, becoming frankly more effeminate, he could not resist subordinating his masculinity to them as externalized by his wife. In other words I interpreted Paul's compulsive acts of cunnilingus as *a subjectively and symptomatically enforced subordination of his masculinity to his own femininity, his feminine identifications.* His wife's delight in practicing fellatio undoubtedly rendered his symptomatic subordination of his masculinity somewhat easier than it otherwise would have been since her action contained an unspoken invitation to him to reciprocate. The real causative factors, however, existed in Paul himself.

For two months, three visits weekly, I discussed sexual interests and acts, identifications, and the natural overlapping of masculinity-

femininity, particularly in the psychic sphere, pro and con. I contended that no principle of morality or personal decency was involved in these "perverted" acts since Paul and his wife were avowedly fond of each other and since the acts had not threatened to displace sexual intercourse. I then drew up a schedule of evenings on which he was to practice cunnilingus *deliberately* and *volitionally*.

The quick results which followed this procedure were a surprise to me as well as to my patient. At the end of three weeks Paul declared that he had not the slightest compulsive desire to perform cunnilingus or to drink. During this time I had, of course, continued with our discussions and had had him introspect closely during the act. Seven or eight years later I received inquiries from him about certain maladjustive behavior tendencies in one of his children. He was thoughtful enough to mention that he had never been troubled any more by compulsive tendencies or any inclination to drink.

A few comments may be in order concerning the efficacy of the active therapy employed, that is, of having Paul practice cunnilingus deliberately and in accordance with a definite schedule. There are at least three understandable reasons why the procedure should have been and was effective. My explanations and discussions had modified his old narrow and rigid conception of masculinity as distinguished from femininity. This tended to increase his tolerance for his feminine identifications. In the second place, the therapist always, presumably, assumes some degree of authority, prestige, and correctness in the eyes of the patient. In my instructing him to perform the act of cunnilingus, I was assuming or at least sharing the moral responsibility for his doing so. Thirdly, by performing the act soberly and deliberately he was forced for the first time to examine his actual feelings about the matter frankly and rationally. This helped to dissolve the unanalyzed "terribleness" with which it had been clothed.

CHAPTER 19

Symptomatic Feelings of Inferiority

IF ALL PERSONS were asked if they ever experience feelings of inferiority, surely the majority of them would answer in the affirmative. This fact, because of the great emphasis which they place on such feelings, leads Adlerians into such faulty and absurd statements as that practically all adults are psychoneurotic. The writer once heard a follower of Alfred Adler's Individual Psychology state that 99 per cent of all adults are psychoneurotic.

Feelings of inferiority are normal affective responses of well-adjusted adults in various situations. If a lone psychologist sitting among a group of physicists is asked to express his opinion of the validity of the atomic theory of matter, he has a perfect and natural right to react with feelings of inferiority. If a college professor were challenged to a bout with the world's heavyweight champion he *should* react with feelings of inferiority.

In short, there are two classes of feelings of inferiority, *symptomatic* and *nonsymptomatic*. Only the former and smaller class is properly classifiable as nonadjustive, affective reactions. Nonsymptomatic feelings of inferiority are not painful or distressing. They comprise mild but permanent ingredients of the daily affective life of every intelligent and normally adjusted adult. Symptomatic feelings, on the other hand, are acutely painful and incapacitating and are one of the most common symptoms of personal maladjustment. The present interest is with this class of feelings only, and during the remainder of the chapter such feelings will be meant whether the qualifying term "symptomatic" is used or not.

The origin and significance of feelings of inferiority are understandable only in relation to self-interest or egoism. Egoism, in-

corporating the meanings or objectives of personal security, equality and superiority, power or distinction, is just as essential as unselfishness to the building and maintenance of civilization. In fact, the capacity for interest in self is perhaps the most important of all human capacities. Lighted and given direction by the gradual development of consciousness of self, this capacity, and not unselfishness, stood us on our hind feet and brought us out of the darkness of the remote past.

Feelings of inferiority develop during the early years of childhood. They are never acquired after the age of twelve or fourteen and only rarely, perhaps, after the age of eight or nine. Whatever the specific cause or causes of their origin they are never more or less than the immediate experiential results of *negative ego-identifications*. In other words the child is forced or led to accept and incorporate within his personal identity meanings of a negative character. A little girl of six had bright red hair and many freckles. She had heard her mother deplore these facts on innumerable occasions. The child was unable to attend school because of her acute feelings of inferiority, her feelings that she was not on a par as an individual with the other children. Her whole sense of personal identity had become centered about these "defects" of complexion.

The various ways in which a child may be led to associate negative meanings with his own identity are too numerous to mention. Suffice it to say that with the exception of obvious physical or mental defects the whole matter of the child's feelings about himself in comparison with others is determined by the attitude toward him of his parents and other close associates. The meanings, characteristics, or level with which he is led to identify himself need not be negative or inferior; in order to acquire an inferiority complex it is necessary only that these meanings be presented to him in a negative light. A dimple, for instance, may be treated in such a manner as to make the child who has one feel somewhat more distinguished than other children or it may be treated in such a way as to make him feel distinctly inferior.

An inferiority complex may come about simply as the result of parents' encouraging too much dependence in the child on themselves. The principle remains the same, however. The child is led into identifying inadequacy with himself. He fails to reach a feeling of equality with other children of his own age because he is kept from

drawing on his natural assets in competitive play and other activities.

Some Freudians have contended that all inferiority complexes in women result from a castration complex in childhood. This is frequently true, but not always. Those instances in which it is true are also cases of early negative ego-identifications. The child is left in ignorance of her physical completeness by the hush-hush attitude of her parents and by the same token is led to believe that there is something wrong or lacking in her physical make-up.

Inferiority feelings in childhood inevitably lead to compensatory efforts. These may take any one of numerous directions. In the case of the strongly introverted child they are certain to follow the line of daydreaming of personal achievement; in the case of the more extroverted child they tend to follow an outward and expansive pattern, namely, becoming attached to as many groups, important movements, or activities in his environment as possible.

Although compensatory efforts may lead, and occasionally have, to unusual attainments, *compensation never effects a cure of feelings of inferiority*. Such efforts, whatever the attainments, do little more than to keep the wolf from the door of the individual's inadequate sense of self-sufficiency from day to day. No permanent relief from the gnawing feelings of inferiority is forthcoming. Unquestionably this results largely from the fact that compensatory striving always skirts the real issue. The little girl who has acquired strong feelings of inferiority because of uncomplimentary remarks about her red hair may become a bookworm and excel as a student. Her superiority as a student does not alter the fact of her red hair, however, or dissolve the feelings of inferiority which developed in connection with her hair color.

The reader should take care to distinguish between the class of persons being discussed here and cases like Gene Neely.* In the latter, one is not dealing with true compensatory activity, as such activity is usually defined, namely, to attain or supply an equivalent. Where an individual makes unusual effort to gain equality or superiority in respect to the very trait or function wherein he feels inferior, the term "overreaction" would be more descriptive of the

* Vaughn, Wayland F., *The Lure of Superiority*, Henry Holt & Co., New York, 1928, pp. 6–7.

facts. In compensatory activity, as the present writer is using the term, the individual always turns his attention away from the trait or capacity or activity in regard to which he feels inferior and to some other trait, capacity, or activity. And, as just pointed out, it is exactly because he does this that he fails to gain relief from his feelings of inferiority irrespective of his attainments in the substitutive direction.

Strong feelings of inferiority in early childhood lead to the erection of lofty goals of superiority. As time goes on the gap between the individual's level of competence and adequacy as he feels it and the level to which he aspires gradually widens. With the advent of pubescence the matter of his self-sufficiency and equality with others becomes an acute issue. He may yield to his feelings of inferiority and become a mere hanger-on of the group, in which case he is not likely to turn to psychotherapy or counseling for help. If definitely introverted, he may retire into isolation and daydream excessively. If somewhat extroverted he may maintain his contacts with others, with others of an inferior social and intellectual caliber, and seek to impress them in one way or another with his superiority; or he may identify himself with (attach himself to) superior persons or groups and compensatorily share their superiority. Any given individual who suffers from feelings of inferiority may, of course, include all four modes of behavior in his repertoire of symptomatic activities.

Those persons who isolate themselves and those who maintain their contacts and seek to impress their associates spend much of their psychic energy in maintaining and enhancing their fiction of superiority. In most cases, fortunately, this sooner or later touches off a strong inner reaction or protest against the exaggerated aspirations to superiority. This reaction is a balancing principle. It is directly opposed to the too loftly and concentrated egoistic aspirations. If it did not occur the individual's psychic energy would gradually become wholly directed toward the goal of superiority, he would lose self-perspective and arrive at a manifest egomania.

Occasionally the protest or defense against the egoistic aspirations takes a very specific form, as in the case of the policeman who had become obsessed wth the idea that his penis was shrinking. Far more frequently, however, it is expressed as self-criticism and an *intensification of the feelings of inferiority*. When the individual

has arrived at this point, namely, when his feelings of inferiority are being intensified and employed to hold his craving for superiority in restraint, we have what is currently called an inferiority complex. The term is a misnomer, of course. The feelings of inferiority do not comprise a complex in a psychiatric or psychoanalytical sense; they comprise defense mechanisms. To the extent that a complex exists, it is a superiority complex, a partially repressed intense craving for personal greatness.

The individual's life is an endless torture, self-inflicted. His partially smothered desires for greatness or influence or recognition are constantly snatching at straws. He cannot be invited to dinner by a friend without becoming agitated by the intensity of his desire to utilize the event to make an enviable impression or appear outstanding. But when the occasion arrives, feelings of inferiority and incompetence pervade his consciousness and he becomes the hapless victim of a conflict between such feelings and his desire to appear superior. He is stilted in his speech and awkward in his gestures. He is perhaps all too keenly aware that he gives the impression of being unapprecative if not unfriendly. On his way home he seeks excuses for his ineptness one moment and bitterly condemns himself the next, and, feeling thoroughly deflated, ends by giving way to a reverie in which he far more than makes up for his recent poor showing.

The proper therapy for persons who suffer from strong feelings of inferiority has already been indicated by what has been said. Ordinarily the treatment falls into several fairly distinct phases. The first thing to be done is to help the patient to understand thoroughly the extent and psychological significance of his aspirations to greatness. The writer has found it helpful to point out to such patients the fact that the race normally, naturally, and legitimately holds a first mortgage on a large part of the individual's energy and ability. One has a moral right to be selfish, but not completely selfish. One has no legitimate right to expect or seek more from life than one gives.

Along with this philosophy of the individual's rightful claims and the rightful claims of others on him, a minute examination and interpretation of the patient's daydreams, night dreams, and egoistically motivated thoughts and acts should be made. The person of

normal intelligence and normal affective capacities cannot tolerate unadulterated self-interest once he perceives it clearly. An understanding of the basic immorality and unhealthfulness of extreme self-interest by the patient tends to alter the inner affective-motivational arrangement. What really happens, perhaps, is that the individual's old craving for superiority and personal completeness is tricked into demanding an investment of interest in others as an essential to its own fulfillment. Once the patient begins to treat others in an unselfish manner, with *their* happiness or welfare in mind rather than *his own* elevation, his unselfish capacities are given a chance to become operative in a non-symptomatic manner. The same principle is found in religious teachings when they hold that if you want to go to heaven, think of others before self. Thinking of others in relation to their wishes and needs inevitably conduces to friendly feelings toward them, and friendliness toward others has a powerful neutralizing effect on self-interest.

The second important aspect of the treatment consists of convincing the patient that he can start "climbing" only from the level of competence where his feelings of inferiority place him, not from the level of his aspirations. This is all-important. This type of patient should never be given "pep talks" or encouraged to undertake anything which is much beyond his feelings of competence.

Once the patient is convinced that he can succeed for the time being only at the low rung of the ladder where his feelings about himself place him, active therapy should be started. A simple illustration will make this part of the procedure plain. A young man of twenty of good intelligence and normal affective potentials felt even more inferior around girls than around members of his own sex. In his daydreams he was seducing the "select" girls of the community with his film-star appeal and astounding them with his physical prowess. In his waking life he was carefully avoiding the same girls on the street. When the time for active therapy came he was instructed to make a date with some girl who was so plain that he was not actually afraid of her. He tended to balk, because of the anticipated humiliation of being seen with her, but the therapist won out. He was kept associating with such girls till he was able of his own accord to ask more attractive girls for a date. In spite of his unprepossessing appearance—he was extremely fat and stalky—in a few months he was quite at ease around any of the girls.

Following the treatment proper, the patient may need supportive therapy at infrequent intervals until he has learned to employ his inherent assets fully along constructive lines.

TREATMENT OF A CASE OF FEELINGS OF INFERIORITY

Bert W. was a blondish, good-looking young man of twenty-one. He was a high school graduate and had spent four years in the navy, two years of which had been in the South Pacific theater. At the time of his first visit to me he was employed in the advertising department of a broadcasting company during part of his time. He spent the remainder of his time in college where he was consistently failing in his subjects because of a lack of application.

As his chief complaints, Bert mentioned acute self-consciousness and feelings of inferiority when around other persons, particularly those of his own age, a persistent tendency to oversleep, and psychical impotence. A little later I learned that he daydreamed habitually and excessively.

On the Otis intelligence test he made a score of 53 (converted I.Q. of 111) and a centile score of 1- on the Watson-Fisher Inventory of Affective Tolerance. Many of his responses were delayed on a free association test.

Bert was the youngest in a family of seven children. The two siblings nearest him in age were both sisters. His youngest sister was six years his senior, hence he was essentially in the position of an only child, surrounded by adults. His parents had never gotten along well together and when he was twelve they became permanently separated. Prior to that, Bert's father had frequently been absent from home for varying periods of time, chiefly as a result of his drinking and constant dissension between him and his wife.

Whatever his father was like, and I was unable to gain a very clear impression of him from Bert's recollections, his mother was extremely dominant in the home, intolerant, and possessive. It appeared that none of her children was very fond of her upon reaching maturity and seldom visited her. On the other hand she had always taken part in various community activities, was very religious, and was apparently highly respected and admired, if not liked, by her many acquaintances.

I gathered that Bert's mother had taken complete possession of him since the time when he was still an infant, and had carefully wedded him to her own line of thought and feeling. She did this, very probably, in compensation for her unhappiness with her husband and the coolness of her other children toward her as they grew older. Bert recalled that his mother usually kept him at home with her while the neighborhood boys went to vacant lots to play baseball and other games. She told him he might get hurt, that she did not want him to associate with nasty boys, etc., etc. She had him sleep with her from the time of his earliest recollections. He still slept with her up to the time when he entered the navy whenever other members of the family were visiting them and sleeping quarters were crowded. She had him bathe with her till he took to avoiding this out of embarrassment. When he came to me he complained that his mother was very indifferent to exposing herself around him although she was always extremely modest when other persons were present. He deeply resented this carelessness or indifference on her part but had never been able to bring himself to take her to task for it. He reluctantly admitted that he had difficulty in keeping his glances from her when she was improperly clothed.

Bert's father had often been harsh and inconsiderate when drinking, and Bert had never developed much friendliness for him. He remembered that he suffered from this lack of closeness between the two of them, particularly whenever schoolmates mentioned their fathers in friendly tones. He also frequently suffered from shame and humiliation because of his father's drunken behavior. He felt that his father was "always letting him down."

Although Bert undoubtedly developed a strong psychosexual attachment to his mother, I believed that this had not been nearly as detrimental to his emotional development as the early negative ego-identifications and feelings of personal inferiority which he acquired. To the extent that he identified himself with his father during his early years of childhood, he inevitably incorporated meanings of incompetence and inadequacy within his own personal identity; for his father was often drunk to the point of being unable to carry on with his work or behave normally in the home.

I might point out here that I did not regard Bert's psychical impotence as a problem in and by itself. I was sure that it was simply a result of his feelings of inferiority since he told me that he had had

no difficulty in being sexually intimate with several native girls in the Pacific. It was only after he had returned home and tried to be intimate with an American girl of good intelligence, appearance, and background that he was impotent, completely so.

He had mentioned the matter of daydreaming and after the testing and history-taking had been more or less completed, I decided to concentrate for awhile on daydream analysis in particular. But first I explained to him as fully as I could the origin of feelings of inferiority, how his, specifically, had resulted from negative identifications with his father, being kept from competitive play with other boys by his mother, and, to an extent, from cross-identifications with his mother. I explained, further, how and why daydreaming becomes established through implicit compensatory efforts to erase or escape from the painful feelings of inadequacy; and, finally, that if the egoistic aspirations to personal greatness, as exemplified by the heights of attainment reached in the daydreams, become too pronounced, the feelings of inferiority are built up to symptomatic proportions and used to neutralize the aspirations.

As is usually the case, Bert was reluctant to admit the actual frequency of his daydreams or the full height to which they soared. In the main he was very cooperative, though, and within a few weeks seemed to be withholding nothing.

His daydreams were both frequent and almost unlimited in their elevation. They were restricted to no one type of achievement. If he listened to a piece of music, he tended to have a daydream in which he greatly excelled the person who had played the selection; if a friend mentioned a book, he was more than likely to drift into a phantasy in which he wrote a much greater book; if he watched an athletic contest, he imagined himself an all-American choice in the same sport; when he was asked to dinner or to a party, which was not frequently, he could not help picturing himself as the lion of the gathering.

Bert and I subjected his daydreams to a painstaking examination as he reported them from visit to visit. When, for instance, he stated that after attending a basketball game he went to bed and lay for some time imagining himself to be the greatest forward of all time, he was immediately asked for details. He was asked to describe his imagined performances in detail, the audiences present, remarks persons made in the way of praise, etc., etc. At times I explained,

and at other times I had him explain, the motivation of his daydreams. In this way he gradually came to distinguish clearly between feelings of inferiority, on the one hand, and aspirations to unusual personal distinction, on the other.

After a few weeks of analysis along this line certain changes began to occur in the thinking and feelings of my patient. He was becoming more moody and dissatisfied in general; he frequently expressed doubt that he was in the kind of work that was best for him; he seemed to have become more acutely aware of his working situation and the other personalities with whom he was associated; he complained more often than before of his mother's efforts to dominate him and direct his behavior. A little later still, he stated that his tendency to daydream was losing its force and spontaneity, that he would often start a daydream only to have it die out or become blocked by an inner resistance or aversion.

I discussed these changes with Bert and explained that they resulted from a diversion of psychic energy. He was becoming more moody because his daydreams, on which he had depended for so long, were losing their flavor; that is, he was losing his taste for daydreaming because he could no longer derive the old satisfaction from this type of activity. Along with this he was becoming more aware of his world of reality and his relationship to it. His mother's domination was becoming an increasing burden because he could no longer escape from it through his daydreams and he could no longer overlook or ignore it to the extent he had formerly done.

When Bert had become so averse to daydreaming that he could no longer indulge in such symptomatic activity even with conscious effort, I turned my attention chiefly to certain lines of active therapy. I insisted, first of all, that he begin to react to other persons in accordance with whatever degree of self-sufficiency he felt at the time, instead of in keeping with the kind of impression he would like to make. I reminded him that his future welfare and success depended on his making a satisfactory adjustment along this line. As an example of my instructions in this connection, I told him he must correct a false impression he had made on a young woman who worked in the same office. This girl had accused him of being a highbrow. He had let her remark go unchallenged, preferring that she have such an opinion of him to knowing that he suffered from shy-

ness and feelings of inferiority. I had him correct her impression by the simple expedient of telling her the true reason for his aloofness.

The second measure of active therapy which I introduced was to have him talk frankly to his mother about his feelings toward her, his subjective reactions to her dominant attitude, and the resentment and embarrassment which her indifference to self-exposure caused him. In connection with this, I instructed him to inform her that he had had intimate sexual relations with young women during his period of military service. I did not insist, however, that he tell her the young women had been native islanders in the Pacific. I also suggested that he discuss his honest feelings and attitudes toward sexual matters with his mother pro and con. I accompanied these instructions and suggestions with an invitation to his mother to come in and talk to me about her son's maladjustments if she wished.

My purpose in having Bert talk to his mother along these lines was to effect a more complete resolution of his Oedipus attachment and subservience to her. He had frequently told me that he often felt constrained and irritable when alone with her. That an Oedipus attachment still existed had become apparent from his dreams; and he was usually unable to oppose openly her wishes.

At the end of two or three weeks I was convinced that Bert had carried out this part of the therapy satisfactorily. He declared that he felt relaxed and at ease when at home and that he had discovered much more understanding and tolerance in his mother than he had dared to expect. She called me for an appointment and came to my office. She was rather pleasant and charming in her manner, but her markedly ascendant attitude was clearly apparent throughout our talk. She was still having difficulty believing that her son had been as maladjusted as he had told her he was and that her early influence on him had been instrumental in his faulty development. I briefly explained Oedipus attachments to her, cross-identifications, and the more common origins of the so-called inferiority complex. By the end of the consultation she appeared to have gained some understanding of the nature and origin of Bert's difficulties and declared herself eager to aid him in making a better adjustment in any way she could. Bert made no further complaints about his mother's attitude toward him after this visit. She had perhaps actually grown

tired of assuming so much responsibility for his welfare and conduct and welcomed my insistence on his being left free to manage his own life.

After he had been coming to me about four months, Bert met a young woman through a mutual friend and rapidly grew interested in her. Although she apparently reciprocated his interest from the beginning, he could not believe for some time that she really liked him. When he finally became convinced at the end of five or six weeks that he had kindled a romantic glow in the young lady, he began to think seriously of marriage. The two of them then discussed the matter with mutual satisfaction. He next wanted me to meet the girl to see if I thought they would be well matched and be able to get along well together.

I found his friend to be definitely assertive or ascendant but to all appearances very well adjusted. She was easy and articulate in her speech and revealed much good common sense. She showed good understanding and appreciation of Bert's social shyness and ineptitudes and was desirous of knowing how she could be of greatest help to him in these connections. After approving of their marriage in my talk with her, I went on to emphasize that she could assist him most *by not running interference for him in social situations*, and by giving him time to work the rough edges off his social deportment.

The two were married approximately two months after their first meeting. Bert continued to come in for consultations for still another month, making seven months in all, two visits weekly. During the last two months I devoted most of my time to evaluating the success he was making in meeting problems in a direct and unaffected manner, to pointing out and analyzing occasional regressions to his old compensatory mode of life, and to encouraging him to cultivate the habit of speaking out more freely when around others without regard for the effect of his words.

After fifteen months of marriage, Bert and his wife are reportedly congenial and well adjusted to each other. They are liked and spoken highly of by their friends and frankly envied by some whose marital ventures have been less gratifying.

CHAPTER 20

Homosexual Tendencies

HOMOSEXUAL TENDENCIES are *tendencies or inclinations to sexual acts with members of one's own sex.* When endeavoring to help persons with such tendencies, it is important that the therapist have various distinctions clearly in mind. In the past, homosexual tendencies have often been confused or identified with sexually inverted tendencies. The two are in no instance identical although they may both be present in the same individual and at the same time. The *latter consist of tendencies to assume the role of the opposite sex in sexual activities.* The man who prefers to have his wife take the more active and aggressive part and assume the upper position in their sexual intimacies is expressing inverted sexual tendences. The man who desires to have another man engage in sexual acts with him and to take the more active and aggressive part in doing so has both inverted and homosexual tendencies.

Homosexual tendencies or acts should not be confused with other so-called perverted interests or practices. Cunnilingus, fellatio, mutual masturbation, inspectionism, exhibitionism, and sadistic and masochistic acts are homosexual in character only when they are carried out between two persons of like sex.

Homosexual tendencies may be conscious and clearly experienced by the individual or they may be repressed and unknown to him. One of the more common effects of repressed homosexual tendencies on the conscious life of the individual who has them has already been discussed in Chapter 4. As to whether or not they always conduce to this same effect to some degree, the writer is unprepared to say. There is little question, however, that as long as such tendencies are

repressed they always induce more or less symptomatic thought and behavior if not symptom-formation as such.

Finally, when existing in a fully conscious state, these tendencies may be expressed in an overt manner with varying degrees of freedom and frequency or they may be rigidly inhibited and any observable manifestation of them held to a minimum. Those persons in whom the tendencies are repressed and those in whom they are conscious but inhibited are the more promising cases for psychotherapy. Comparatively few persons with manifest homosexual tendencies are capable of cooperating sufficiently throughout a course of treatment to be helped.

All clinical evidence yet at hand appears to be in support of the assumption that the libido or sexual energy or sexual desire is not *innately* orientated or directed toward its *natural biological object.* Only on the basis of such an assumption are we able to account at the present time for the high incidence of homosexual tendencies and *acts*, an incidence more or less known to psychotherapists for some time but recently receiving statistical corroboration from the Kinsey studies. If sex were innately directed or governed, deviations, it seems, could not possibly reach such a high incidence.

This assumption, or the absence of it, is of the greatest significance to the therapist in working with persons with homosexual tendencies. If he is not in accord with the opinion expressed here, he can hardly hope to obtain beneficial results. If he is in accord with it, then he must be prepared to make the most exhaustive study of the various conditions and influences which possibly affected the patient early in life.

A fairly large number of subjective and objective conditions encourage homosexual acts; a few subjective conditions conduce to the development of homosexual *tendencies*, that is, to a true homosexual orientation of sexual desire and feeling. In no instance must the therapist make an offhand assumption that because a given person has performed homosexual acts he has homosexual tendencies. A homosexual act may be merely the expression of unrefined and undifferentiated sexual desire. When bulls try to mate with other bulls, one would not conclude that they are *homosexually* motivated but simply that they are *sexually* motivated. When boys engage in sexual acts with each other, one would hardly jump to the conclusion that they are homosexually inclined but merely that they are sexually in-

clined. Until definite patterns of sexual preference and response have become established, sex, like curiosity, is free to go to anything that possesses the qualities to arouse it.

Some of the conditions which encourage homosexual acts in adolescent and adult life but do not necessarily give rise to homosexual tendencies or preferences are the absence of a definite sexual orientation, isolation from the opposite sex, overidealization of the opposite sex, and fear and feelings of inferiority toward members of the opposite sex. All of these factors, except the first, comprise barriers to heterosexual activities and may, therefore, tend to divert the sexual drive to persons of like sex.

A homosexual tendency, on the other hand, as distinguished from an undifferentiated sexual drive and from a diverted heterosexual interest leading to homosexual acts, *is a positive preference for sexual partners of like sex.* The conditions which result in such a tendency appear to be definitely limited in number but they may exist in a variety of combinations. Also, they always exist and are operative early in the individual's life. The principal ones are: positive and negative Oedipus complexes, strong cross-identifications, fear of castration and castration complexes, conditioning of sex along homosexual lines, and unresolved narcissism.

A positive Oedipus attachment is a heterosexual orientation, of course. The absorbing and ego-effacing nature of the attachment, however, and the feelings of guilt which usually become associated with it may lead to a renunciation and repression of it. When this occurs, frank and conscious heterosexual interest has been effaced. Then, depending on many things about the child, including the degree of sexual urgency which he possesses and on the influences about him, a part of his sexual energy may become freed from the heterosexual pattern and erupt into consciousness, taking the most obvious and feasible alternative direction, namely, toward members of his own sex. If this new orientation is not actively interfered with by inner or outer forces for a considerable period of time, then the child will naturally go on to establish a homosexual preference along with his original heterosexual preference. This is perhaps the most common basis of so-called bisexuality.

A negative or inverted Oedipus attachment—wherein the child is psychosexually interested in parent of like sex—conduces directly and inevitably to an enduring homosexual orientation. Because of

inner resistance the attachment may become partially or wholly diverted to a sibling or other person of like sex or it may be repressed, especially its sexual content.

Strong cross-identifications frequently include inverted sexual tendencies. They may or may not include homosexual tendencies, apparently depending largely on the scope or completeness of the identifications. A child may identify with a parent with respect to certain attributes and capacities but not with respect to others. Sex may be included in cross-identifications despite the difference in appearance and structure of the two sexes.

As Freudians have correctly contended, many little boys arrive at the conclusion that girls and women are mutilated and incomplete creatures because they lack penes. This may not only engender a fear in them of suffering a similar fate but it frequently produces a strong aversion to the female genitals. Since all this happens early in the child's life, before any firm sexual orientations have become established, the door is open to the development of sexual interests in the same sex.

Little girls likewise sometimes get the impression that they are physically incomplete because they do not have the organs of the male or, as far as they can discern, anything that is the equivalent. They react in various ways to their inferred lack. One will seek compensation through attaching herself to someone who has a penis, usually father or older brother. A second will repress all interest in sex and sexual structure and grow up frigid and retiring. Still a third will obstinately pretend a physical completeness which she does not actually feel she possesses and, in keeping with her pretense, turn her attention to members of her own sex, quietly ignoring the existence of maleness in human life. She adopts a homosexual orientation as a defense and a protection against her negative self-feelings. Her penis-envy is rigidly repressed.

A homosexual orientation may become established through early conditioning. The conditioning is particularly effective when an affectionate relationship exists between "teacher" and "pupil," when the pupil admires the teacher and when no strong feelings of guilt come into play.

Finally, unresolved narcissism conduces to homosexual tendencies and interests. Self-love can include an object other than self only on the basis of similarity or identity. A narcissistic young woman who

aspires to become a writer may adore another young woman who is already a successful writer. Operating along with this tendency to seek more of self in another is, of course, a positive intolerance of marked unlikeness in another.

Two or more of the conditions which have been mentioned may pertain in any given case. In fact a mixed or multiple causation is the rule rather than the exception in the genesis of homosexual tendencies.

In the person who has repressed homosexual interests, no obvious indication of this may be present. Whatever symptomatology there is, is likely to be mixed, fluctuating, and more or less indefinite. The therapy should proceed along the lines of psychoanalytic inquiry till the nature of the conflict has become known to the therapist through the patient's dreams, free associations, mannerisms, interests and attitudes toward the two sexes, and early history.

Once the therapist is certain that repressed homosexual tendencies exist he should exercise his most considered judgment as to when and how he should make the fact known to the patient. If there is evidence of paranoic trends, the procedure outlined in the chapter dealing with such disturbances should be followed. In the absence of such trends, the therapist need only take care to have built up in the patient a reasonable tolerance for making a frank examination of anything about himself that might be brought to light. A positive transference of appreciable strength usually indicates such a point in the treatment.

If or when the patient is capable of recognizing his homosexual tendencies consciously and admits their presence without evasion or reservations, the tendencies should be discussed in the fullest detail and in the most matter-of-fact manner. Whatever the therapist's own feelings or attitudes toward homosexuality might be, he must not permit any squeamishness to appear in his own manner toward the problem. Under no circumstances should he moralize with the patient.

After the patient has described his thoughts, feelings, desires, and impulses toward members of the same sex two or three times in detail and without hesitation, the tendencies should be dealt with as a symptom and for the most part ignored. From this point on the treatment should consist essentially of uncovering, examining, and interpreting the conditions and influences which brought about the homosexual orientation.

The therapist should make sure that the patient arrives at a clear understanding of the great difference between homosexual and sexually inverted tendencies. In many of these patients the two are blended or consolidated and regarded as one and the same thing. As the patient is helped to make the distinction and to understand the wholly harmless and normal character of inverted tendencies, his emotional burden and the intensity of his conflict are often greatly reduced.

During the latter part of the treatment more or less active therapy is usually indicated. This most often follows heterosexual associations on a social level. In many cases there are very few or no established patterns of an intimately social nature. In other words the boy has never confided in the girl or let her confide in him, or vice versa.

TREATMENT OF A CASE OF HOMOSEXUAL TENDENCIES

Cecil B., a junior college student of twenty, came for help of his own accord. He was of normal physical appearance, showing no tendency to feminine characteristics. He appeared to be deeply troubled but doggedly determined. There was a strained expression on his face, and his manner was at times hesitant despite his obvious efforts to be frank and forthright about his problems.

I asked him to be seated and to tell me in his own words what was troubling him. He sat on the edge of his chair and began by asking if homosexuality was inherited. I told him that it was not, that we inherit no sexual orientation as such. He then wanted to know if it was very common. I replied that it was fairly common both among men and women but that I was not in a position to give exact figures on its incidence. After hesitating a few seconds, he wanted to know what my opinion was of a homosexual person. I assured him that I always evaluated such a person independently of his sexual inclinations, that a homosexual individual might be the finest type of person in spite of his sexual maladjustment. I went on to explain that psychologists are disposed to gauge the moral caliber of a person in terms of his overt actions, not in terms of his subjective processes; that whereas an intelligent adult is to be regarded as responsible for what he does, for him to close his mind to any certain class of thoughts is an act of repression and conduces to emotional maladjust-

ment. He wished to know, finally, if the condition could be cured. I stated that it was remediable in most young persons provided they had the correct kind of help and were thoroughly cooperative. Cecil immediately requested treatment for as long as might be necessary. He then went on to describe his problem.

For the past several months, Cecil stated, he had been "madly infatuated" with a *fellow* student. His friend was distinctly effeminate in appearance and submissive socially. My patient had been the dominant one throughout the relationship. They had engaged in mutual masturbation once or twice a week but in nothing other than this. Cecil said he had been sorely tempted many times to try other forms of stimulation but had succeeded in restraining himself. He felt certain his friend would offer no objections to any kind of act and accordingly he was in constant fear that he would succumb sooner or later to more abnormal practices unless he was speedily helped.

I encouraged him to discuss the matter freely and in detail, including not only the exact character of their overt acts but all of his thoughts and feelings in connection with them as well. There is no need here to mention the details of their physical acts other than to state that the friend was apparently inviting, completely devoid of shame and self-reproach, and very abandoned.

When with his friend, Cecil became almost completely dominated by his attraction to him. He said he lost perspective on everything else. He believed his desires were abnormally intense. When away from him his feelings varied considerably. At times he suffered from disgust and self-reproach. At other times he felt the relationship was beautiful and precious. Sometimes he had an intense longing for an all-embracing emotional union with some other person. Although this longing was occasionally directed toward his friend, more frequently its object was an imaginary person. The imaginary person always remained vague, and although he could not be certain he supposed the sex was male.

When asked if he respected and admired his friend, Cecil was not sure. When he was with him he was so charged with sexual desire he thought there was little room for anything else. When away from him, his friend sometimes seemed repulsive, but such feelings never endured for long. After further reflection Cecil concluded the other was an insatiable sensualist. When I explained narcissism to him

he decided his friend was profoundly narcissistic and desired to be loved and shown attention more than anything else in life.

At this point I gave the usual tests. The results were essentially negative except for strong indications that he was maladjusted—not merely nonadjusted—to members of the opposite sex. These indications appeared in the personality inventories which I gave him and, most particularly, in his delayed and otherwise atypical responses to a free association test, that is, to such words as might imply heterosexual relationships.

Cecil was of Jewish extraction. His parents were of average education, well adjusted socially and economically progressive. He had two sisters who were three and five years respectively his juniors, and one brother who was ten years younger than he. I learned of no significant peculiarities of parents or siblings.

I made a brief and rapid psychological examination of his past history. His earliest recollection was of his mother's bringing him home a toy when he was about four. He recalled having playmates of both sexes when he was a child, his first day at school, something about his early teachers, of being spanked once by his father for mistreating his sisters, and various other of the usual events of childhood. He was unable to recall any sexual experiences during childhood. From about nine to twelve or thirteen there appeared to be a partial memory gap.

The patient's recollection of his mother's bringing him a toy, and that of his father's spanking him, suggested an early sensitivity to his parents' attitudes toward him and possibly a hunger for attention and affection. Inasmuch as he had been dethroned by a sister, and this sister's influence in the family circle had been added to at the end of a couple of years by the birth of a second sister, offered lines for inquiry. When questioned concerning his feelings toward his sisters he stated that he was indifferent to them. Under further and closer questioning he admitted that he avoided them as much as possible. He had not kissed either of his sisters, for instance, for as long as he could remember and thought that to do so would be next to impossible. He was aware of a physical aversion to them but hastened to add that the same was true with respect to all girls. When this line of inquiry produced no more information, I turned to Cecil's dreams.

The dreams, which I had been collecting during the preceding month, mostly fell into three classes. First, he had weird, symbolic

dreams of the sexual organs of both sexes. The organs were distorted, greatly enlarged, mutilated, or diseased. Having explained the origin and significance of dreams in general, I went on to explain to Cecil that his dreams showed beyond question that he was in much conflict and perturbation about sex and sexual structure; that his resistance to interest in sex was so extreme that all of his dream-images assumed distorted, unhealthy, or grotesque forms. This was particularly true, I pointed out, in regard to female sex structure.

A second class of dreams comprised fear-dreams of girls. These were usually very short and often awakened him. He would dream of being in close physical proximity to a girl. The girl was always aggressive and bent on sexual contact.

The third type of dream was the most significant and enlightening. These, too, were of girls but the girls always had penes. I explained that these dreams left no doubt of a basic heterosexual orientation, that libidinal interest was directed toward women and not men in these dreams despite the fact that penes were supplied. And all of this meant that at some time in his life he had been consciously and strongly interested sexually in one or more members of the opposite sex. In view of his adult attitude toward his sisters and the partial memory gap for the years nine to twelve or thirteen, I was certain that one or both of his sisters had once stimulated a strong sexual interest. I pointed these facts out and told Cecil that we must work together to expose these earlier sexual interests which were merely repressed and subconscious. I encouraged him to recall everything he could during the period of the memory gap, hoping to lead from some more or less irrelevant fact to his repressed memories. I employed the principle of free association in various ways—sentence construction using certain words, word-series responses to different stimulus words—but was unable to obtain any positive results.

Cecil had become quite resistant to the procedure. His resistance took the form of skepticism regarding my line of reasoning and interpretations, occasional irritability and mental blocking. I had occasion to remind him frequently that he could lose nothing by continuing to cooperate to the best of his ability. I repeatedly assured him that I was positive there was repressed material to be recovered.

When no observable progress had been made for some time, I instructed him to observe his sisters closely when around them and to

imagine having sexual relations with them. Although he was very loath to do this and I had to give him a lecture on common sense in relation to moral values, he finally agreed. After a few attempts he reported progress in the sense that he experienced less mental blocking when trying to carry out my instructions. I complimented him highly on his success and instructed him to give complete abandon to his thoughts and feelings.

As a result of this last procedure the resistance to the repressed interests gave way and Cecil clearly recalled sexual experiences with both sisters. These experiences occurred when he was nine and ten and consisted of looking, touching, and attempts to have sexual intercourse.

Cecil's interest in his boy friend dissolved rapidly, almost instantaneously, following these disclosures. For awhile he had fleeting desires to make sexual advances toward his sisters. I encouraged him to try hard to sublimate these desires by deliberately being more friendly and affectionate toward them. I also instructed him to have dates with girls, however hard he might have to try to get started. After Cecil had taken two different girls out and appeared to be discovering a genuine interest in the company of the opposite sex, I dismissed him with the request that he report to me at the end of two or three months. When I next saw him he stated that his old homosexual interest seemed like a bad dream. He was going regularly with girls and said he and his sisters were becoming very good friends.

The origin of the homosexual interest in this case is easily understood. At an early age, perhaps with the birth of his first sister or soon thereafter, Cecil came by the impression that girls were incomplete because they lacked penes. This resulted in a certain degree of aversion to physical contact with them. Later, at the age of nine or ten, nevertheless, he became strongly interested in his sisters sexually and expressed this interest in overt behavior. His interest and acts induced intense feelings of guilt. He then repressed his interest. His guilt and aversion sufficed to deflect sexual interest away from all girls as such, but not, significantly, from femininity. His diverted interest, cravings, or desires understandably became directed to an *effeminate* young man, in respect to whom the symptomatic guilt and aversion were not operative.

CHAPTER 21

Psychical Impotence

MOST MEN are sensitive about their sexual prowess. The psychically impotent man is rarely inclined to talk about his trouble freely, and accordingly it is difficult to obtain reliable figures on the incidence of the disorder. Needless to say, the condition is undoubtedly more common than is generally supposed. Many cases are treated medically with little or no benefit while others never come to the attention of either the physician or the psychotherapist. A certain woman had been married thirteen years, had borne two children, but had never experienced sexual intercourse. The birth of her first child deflorated her. Her husband could acquire an erection of sorts and could ejaculate but he had never once made penetration. Neither had ever spoken to anyone about the difficulty till they came to the writer at the wife's insistence. In the case of another couple, the husband protested that the sexual act was vulgar and degrading and that he would have nothing to do with it. They finally separated, at the end of twelve years, the wife still virginal.

Nosologically, all instances of *functional* inability in men to perform the sexual act in a complete and normal manner may be included in a single category. Although some cases of functional or psychical impotence result in biological impotence, whereas others do not, from a psychological point of view there are no clear demarcations among the various forms which the disorder assumes. The same causative factors may result in an inability to ejaculate in one man, for instance, and in premature ejaculations or the absence of an erection in another.

As far as psychotherapy is concerned, however, there are two types of impotence*: that which results from factors which belong

* Hereafter the word "impotence" alone will mean psychical or functional impotence.

to the individual's organization of conscious and known attitudes and values and that which results from more or less repressed, unknown, and subconscious factors. In the case of the first, one is usually confronted with a problem for counseling. Little, nothing, or much may be accomplished, depending on the particular case. A middle-aged man stated that he had gradually become impotent along with his wife's growing indifference to matters of personal cleanliness. He said that she bathed but infrequently and that she did not smell clean. Some relief was obtained for the husband when the writer induced the wife to make greater "sacrifices" on behalf of her spouse's "overdeveloped sense of smell" by bathing more often. Another man gradually became impotent as a result of a long-standing and almost constant feeling of resentment and aversion toward his nagging wife. He could not seem to give up his resentment and she could not forego her nagging so little or nothing was accomplished through counseling.

The majority of impotent men will express some unfavorable feeling or attitude toward the partner or sex itself. This affective reaction may belong to the conscious mental organization as such, or it may be symptomatic of some subconscious factor. In either case the most common examples of it are *fear*, *disgust*, *anger*, *shame* or *guilt*, *contempt*, and *marked feelings of inferiority*. Generally speaking, all of these feelings tend to inhibit the sexual function. The therapist is interested in the source or origin of such feelings. If they are symptomatic, that is, if they derive from some repressed interest or attitude, psychotherapy proper is indicated.

The most common causes of impotence of the symptomatic variety are unresolved *Oedipus complexes*, *castration fears*, and strong *cross-identifications*. The small boy who becomes affectionately and erotically overattached to his mother and then resorts to the simple device of repression, in order to free himself of feelings of frustration and guilt, lays the basis for possible impotence in adult life. In connection with repressing his erotic desires he usually overidealizes his mother. This overidealization is narrow and allows no room for sex. In fact, it is primarily a defense mechanism erected against the repressed erotic inclinations. The idealization tends to include all motherlike women, all respectable women. Upon reach-

ing adulthood he is incapable of bringing frank sexual interest in a woman into harmony with affection, respect, and admiration. And the more respectable (motherlike) the woman is, the greater is his incapacitation.

A man who had been married for five or six years had been utterly incapable of consummating his marriage. He volunteered the remark to the writer one day: "To be sexually intimate with my wife would be almost like being intimate with my own mother—they are so much alike." His wife was a practical sort of woman who desired children. She suggested to her husband that he go out and have some experience with other women, thinking this might give him competence. He followed her suggestion and found that with *prostitutes* he was "as good as any man."

Many men are afflicted in the same way. In the sexual province they vary all the way from complete impotence, as in the case just mentioned, to partial or occasional impotence, as manifested by premature ejaculations or *periods* of complete incompetence.

Subconscious fear of castration is less common but not infrequently encountered. In comparatively few cases this fear gives rise to a syphilophobia. More frequently its effects are less specific and less easily recognized. The patient's dreams are a particularly valuable source of information when a castration fear is involved. A young man dreamed that he went swimming with a girl (symbolizing sexual intercourse). As they rose to their feet after swimming to shore the girl grabbed him and tried to drown him. He awakened very frightened. Another young man frequently dreamed of suffering injury, usually to his legs. In one dream he was in bathing when a sea monster bit him on the thigh. A third young man who had had sexual experiences with a number of women but who had never been able to ejaculate during intercourse, although he had no difficulty if the girl practiced fellatio, hallucinated a cut or opening above the vulva the first time he examined a woman's pelvic region. He had a strong *subconscious* conviction that a woman was a castrated male. A subconscious fear of suffering a like fate suppressed, or became converted into a suppression of, the sexual function to the extent of preventing an orgasm.

Perhaps the most common causative factor in impotence is strong cross-identifications. Such identifications usually include pro-

nounced inverted (not homosexual) tendencies in relation to all intimate human contacts. The man's passive and submissive tendencies tend to outweigh his aggressive tendencies. In the sexual act he is more inclined to submissiveness than dominance. Aggressiveness on his part jars his feminine attitudes, producing in some cases a feeling of guilt or self-reproach. The stronger the cross-identifications are, the weaker is the organization of masculine identifications. In the matter of intimate contacts with a woman, the insecure masculine ego is confronted, as it were, with two antagonists: the femininity of the partner and the femininity of his cross-identifications. Such a man tends to feel inadequate, simply incapable of measuring up to the standards set by his masculine ideals, standards which allow too little latitude to his yielding propensities. His masculine ideals are too narrow and exacting, permitting nothing in himself which remotely borders on femininity. Thus he is intolerant of taking the underneath position, of any submissive tendencies in himself, and, correspondingly, of any show of aggressiveness in his wife.

One must bear in mind that cross-identifications contribute to impotence only if they are rejected and more or less repressed by the individual. The manifestly effeminate man is not subject to impotence because of his feminine tendencies. Such a man, in fact, may even prefer the underneath position and aggressiveness in his wife since these provide an outlet for his feminine tendencies for which he has no intolerance.

The man with repressed feminine tendencies usually marries an aggressive or masculine type of woman, a woman with manifest cross-identifications. Apparently this fact results from his lack of tolerance for his own feminine tendencies and, therefore, for very much femininity in a woman. But marriage to such a woman conduces to impotence rather than to competence. The more aggressive she is in their sexual relations, the more strongly she arouses his repressed feminine tendencies. The more strongly his feminine tendencies are aroused, the more intense the conflict is which ensues between his masculine and feminine or assertive and submissive or normal and inverted motivations. The more intense this conflict is, the more the sexual functon is disturbed.

Many psychically impotent men prefer to believe that their difficulty is due to physical causes. Some of them stoutly maintain

the belief (rationalization) that they have done themselves irreparable damage through excessive sexual output, usually masturbation, at some time earlier in their lives. Although such an attitude is readily recognizable as a defense mechanism and although the history will usually reveal erections when not around women, nocturnal emissions, the ability to attain an orgasm through masturbation, etc., to avoid possible error in diagnosis, the psychotherapist should always require a thorough physical examination.

Partially impotent men, particularly those who are prone to ejaculate prematurely, may be quite unaware of their deficiency. True, out of their egoistic sensitivity they rationalize the facts instead of facing them frankly, and end by believing themselves to be entirely normal or turn about and blame their wives for needing so much time to consummate the act. They remain genuinely ignorant of the true extent of their incapacitation and of its possibly far-reaching effects on their marital happiness. They may visit a psychotherapist for some quite unrelated reason or, not infrequently, the wife visits the therapist because of her own unsatisfactory sex life.

Personal adjustment inventories and free association tests usually indicate the probable causes of the impotence. This is particularly true when Oedipus complexes and strong, repressed cross-identifications are involved. Responses to words relating to sex, women, love, marriage, guilt, etc. tend to be delayed or atypical. The same tests, however, may give no indication of the presence of a subconscious castration fear, even though this fear exists and is so strong as to rule out sexual relations completely. Dreams, rather, are the most immediate and fruitful source of information concerning castration fears.

Following the usual testing and history-taking a freely modified psychoanalytic procedure should be followed. At appropriate times full explanations of the origin and character of the causative factors should be given. Dream interpretation should always be held in abeyance till the therapist has collected enough data to fully support his opinion of the causes of the impotence.

Oedipus complexes and castration fears usually dissolve as they are gradually brought into the patient's conscious recollection and understanding. Cross-identifications present a somewhat different problem.

Identifications do not dissolve easily. Moreover, unless they are too pronounced they become assets to the individual once they are frankly and freely accepted by him. Hence the therapist has the task of increasing the patient's tolerance for his cross-identifications. In most cases this necessitates full, lengthy, and repeated explanations of human sexuality, individual differences, the absence of any sharp distinction between masculinity and femininity, and the great value to mental health and efficiency of giving free expression to all natural and harmless tendencies, whether they are conventionally masculine or feminine in character.

Active therapy can be employed to advantage in the majority of cases at some time during the treatment. This most frequently consists of having the patient refrain from all attempts to engage in sexual intercourse for a period of a month or more. With the blocking of the libidinal outlet, the accumulated tension is productive of clearer recollections and more dreams. Also, it gives the patient a breathing spell, a rest from the whole problem of overt sexual activity, and a better chance to come by a new and more workable orientation.

TREATMENT OF A CASE OF PSYCHICAL IMPOTENCE

Carney H. was forty-one, married twenty years, and the father of three children, all girls. He had a fair education, was prepossessing in appearance, friendly mannered, and had achieved a good measure of success in business. He was definitely extroverted and for many years had been active in community clubs and organizations.

About a year prior to his first visit to me, Carney became completely impotent. He was unable to acquire an erection or to have an orgasm. He came to me at the suggestion of his wife who at the time was just completing a course of psychotherapeutic treatment. Inasmuch as Carney's impotence had been precipitated by knowledge of certain conduct in his wife, a few words about her are in order.

Mrs. H. was an attractive and likable woman who paid close attention to her personal appearance at all times. Like her husband, she had always given considerable time to community and social affairs till a couple of years before coming to me for treatment. At

that time she became infatuated with a married man and became his mistress. The man's wife divorced him. Just before I first met Mrs. H., the man married another woman. Mrs. H. all but collapsed completely from this blow. She lost her appetite, slept poorly, suffered from indigestion and headaches and other symptoms. There is no point here in going into the reasons for Mrs. H.'s blind infatuation and indiscreet conduct other than to mention that they were largely the result of unresolved sexual complexes acquired in childhood. In the main she had always been a highly moral and conventional woman.

Mrs. H.'s affair became widely known in the community. It created a "most deplorable state of affairs," as one of her former friends expressed it. Most of her friends deserted her. In fact, the host of former friends of hers and Carney's became reduced to a single couple, the wife being also one of my patients and the husband a discreet philanderer. Carney became impotent immediately upon learning of his wife's infidelity.

Knowing of Mrs. H.'s indiscretion and knowing that Carney knew about it, I assumed with his first visit, as soon as he had told me about his impotence, that he was suffering from intense resentment toward his wife and from wounded egoism. I expected to be able to build up more tolerance for his wife's past behavior and a more forgiving attitude in a few visits and see him back to normal in his sexual life. I was accordingly rather surprised when he stoutly denied that he had ever experienced the slightest resentment or any other harsh feeling toward his wife. He went on to say that he hated the man concerned with the greatest intensity and that it would give him pleasure to kill him. I explained that he would naturally feel resentful and hurt with his wife and I tried for several visits to obtain an admission of such. I finally became convinced that there was no *conscious* ill feeling toward his wife and settled down to a thoroughgoing psychological study and analysis of Carney.

There is no particular need of going into Carney's early history other than to give a few facts. He grew up largely under the domination and close supervision of an aggressive mother and two older sisters. His only brother was several years his junior. His father was a quiet, retiring sort of man. His sisters were Carney's chief and constant playmates during his early life. I gathered that his mother had strong and manifestly assertive (masculine) tendencies but leaned

to the idea of the superiority of women. Thus, Carney, had early been led to accept the superiority of the opposite sex and in innumerable ways had been encouraged to identify himself with them, that is, strive to be like them. Later, when he arrived at pubescence, he made a desperate and outwardly fairly successful attempt to reject the dominance of the opposite sex and to repress or inhibit his inclinations to submit to their guidance. Along with this he made an equally strong effort to assert and express a masculine self-sufficiency.

Carney had been unfaithful to his wife once. This happened before her infidelity, and he had never told her about it. After about two months of consultations, three visits weekly, I made use of this incident in an effort to expose more fully Carney's cross-identifications, fear of woman's influence, feelings of inferiority to them, and the *fiction* which he had defensively constructed and long nourished *of man's utter superiority to the other sex.* I remained convinced that he harbored intense resentment and bitterness toward his wife but *was unable to let these become conscious without letting those other feelings and attitudes which I have just mentioned become conscious* also. But first, in order to rule out the possibility of a feeling of guilt or self-reproach, as a result of his act of infidelity, I had him tell his wife of the occurrence. He did not mind particularly doing this and she appeared to be undisturbed by it.

The procedure, then, for the next month or five weeks is indicated by the following dialogue, except that during every visit I repeated my conviction that he had repressed strong resentment toward his wife because of her conduct and that I expected him to discern and recognize it.

"If you did not care for this woman, Carney, and had always held marital fidelity up as an ideal, why did you have a sexual experience with her?"

"I hardly know why I did it."

"Oh come, think! Give me an answer."

"Well, heck, she seemed to want me to go with her so bad. She drove up in a car she had just bought and wanted me to take a ride with her and see if I thought she had made a good buy."

"Didn't you know or suspect that she had another reason in mind for asking you to go with her?"

"I had a darn good idea she did."

"Then why did you go?"

"Well, I guess I just sort of hated to refuse her. I didn't like to hurt her feelings."

"Actually, you didn't want to appear to be afraid to go, did you? You couldn't let her know you were afraid of her. You had to maintain your pose as the strong, casual, self-sufficient male, didn't you?"

"Maybe."

"How did you feel just before the sexual act, or, perhaps during it? Were you pleasurably excited? Did you feel at ease? Just how did you feel?"

"Not so good, I guess. I wanted to get it over with and get away from her."

"Did you ejaculate prematurely or have any difficulty in performing the act?"

"Yes, I ejaculated very quickly. I don't think she got much out of it."

"Now think back and tell me if you did not feel that you were being definitely dominated somehow against your will."

After a few moments hesitation Carney replied, "Yes, I guess that is about the way I felt."

"When a woman gets you in a corner, you find it extremely difficult to resist her wishes even though your own are not in accord with hers?"

"A woman never got me in a corner before."

"That brings up another point I want to discuss. As you look back over your past associations with women, is it not true that you have always maintained a safe distance from them? Haven't you carefully avoided intimate emotional and physical contacts with them?"

"I have never cared for the man-chasing type of woman, if that is what you mean."

"I don't want you to carry my meaning quite so far. In any group of men and women there are usually a few women who play up to the men a bit, who tend to become a little more than friendly, who rather welcome a bit of flirtation in a secluded corner. One could hardly call them men-chasers, however. They may be entirely respectable married women but they seek somewhat closer or more intimate emotional relationships with men than their more conserva-

tive sisters. Now, what I wish to know is just what your attitude has been on encountering such women. You are a pretty good-looking fellow and women have certainly played up to you more than once. Have you usually gone along with them for a bit of essentially innocent fun, have you firmly held them at arm's length, or have you run away and sought to avoid them thereafter?"

"I certainly haven't encouraged them. In a sense I suppose I have avoided some of them."

"Why?"

"Because I don't believe in a married woman's making up to other men. It strikes me as cheap. I don't care for such women."

"The woman you had the affair with was married, wasn't she?"

"Yes."

"Surely, then, you didn't approve of her conduct?"

"No."

"Yet you went along with her and did as she wished."

After a few moments and in obvious discomfort Carney muttered that he didn't know why he had given in to her.

"To me it seems obvious," I told him, "that you are very much afraid of women. That is, you are afraid of the influence women have over you once you let them get close enough to exert their influence. Accordingly, you have always tried to maintain a safe distance between you and them. Whenever you have noticed that a woman was showing interest in you, you have avoided her simply because you feel inadequate to deal with a woman's influence with you once you permit enough intimacy for her to express it. And in connection with your feelings of insecurity and inadequacy in emotional relationships to women, certain significant points come to light. In the first place, you have never frankly admitted even to yourself the tremendous influence which a woman can exert on you. Rather, in the second place, you long since built up and have carefully nourished an illusion of man's superiority to woman. Man is strong, rational, self-determined; woman is weak, emotional, easily influenced. That is the fiction you have stoutly maintained. And the only way you could maintain it was by keeping at a safe distance from women; for actually, deep within you, in your innermost convictions, the woman's influence over you is certain to prove stronger than yours over her. This susceptibility to woman's influence is the

result of your cross-identifications. Your repressed but active feminine inclinations tend to join forces with the woman, so to speak, leaving half of you, as it were, pitted against the woman and the other half of yourself. And this brings us to the last and most significant point of all.

"*You cannot accept or tolerate conscious resentment or hostility toward your wife, because of her disloyalty, and maintain your fiction of your own superiority.* To spare your own sensitive masculine ego from hurt, you must continue to see your wife as the weak, emotional, irresponsible woman. We do not ordinarily resent weakness in others. We do not resent the blubbering of an idiot or the awkward movements of a cripple. We do resent unfairness. But only an equal or a superior can be unfair. Now if you will examine your wife's attitudes and conduct without bias, you will have to admit that she has shown a lot of independence, determination, and perseverance. She not only walked unhesitatingly into the affair she had, she unwaveringly pursued it, and she has never expressed regret or self-reproach. True, it was largely the result of childhood sexual experiences and complexes, but, nevertheless, she has manifested no fear, uncertainty, or misgivings. She did not feel dominated as you did in that little affair of yours. She is not overcome with shame. In fact, I am sure she meets former friends with far less embarrassment than you do.

"Moreover," I went on to explain, "you are actually afraid to criticize or condemn a woman. I find proof of that in the fact that you refer to the woman who inveigled you into that meaningless sexual affair as a lady, whereas I gather she is something of a trollop. You grew up under the domination of females who were older and more experienced than you and therefore usually right in your eyes in what they said and did. In your deepest, largely subconscious, convictions, woman is superior to man, and most any woman is superior to you. You have concealed this conviction from yourself, with its pain to your insecure masculine ego, by the erection and maintenance of your fiction of man's superiority.

"Now it is time, Carney, for you to face the facts and frankly recognize and accept your wife's equality with you, superiority, in fact, in all matters of emotional relationships between the sexes. She is not afraid of men, as you are of women. In all of her relationships

to men she has shown an independence, self-reliance, and an abandonment to her emotional cravings which you could not even dream of easily."

After a number of consultations along these lines, Carney grew somewhat despondent and morose. He very gradually and reluctantly recognized and accepted his feelings of inferiority to women. I repeatedly told him that there was every natural reason why he should feel resentment toward his wife and no reason why he should not. I unequivocally stated that the resentment was there and demanded that he detect it. I had forbidden attempts to be sexually intimate with his wife twice for periods of a couple of weeks, hoping by excluding what I believed to be a symptomatic and converted expression of the resentment (his impotence), to create enough inner pressure to bring the resentment into consciousness.

One day when the instruction was not in force and after some three months of consultations, Carney came in a bit excited and exclaimed, "I found it!"

I asked him what he had found.

"That resentment you have been talking about all the time. It went through me like a flash. I started to try to be intimate with my wife and suddenly a wave of bitterness toward her swept over me. For a moment I think I hated her. It was gone in a couple of seconds but it was certainly there."

"Did you go through with the sexual act?"

"No. I no longer had any desire."

"Good! Your lack of inclination simply displaced your former impotence. In other words, the repressed resentment which has been causing your impotence became conscious and operated in a perfectly normal manner instead of in a converted and subconscious form. If you will continue to be entirely frank with yourself about the change in your feelings toward your wife, you will get over the impotence."

During a few more consultations I endeavored to soften Carney's resentment and bitterness toward his wife by pointing out the influence of early experiences and complexes on adult adjustment and conduct. Furthermore, I explained that he did not deserve a lot of credit for his own near-exemplary conduct since it had been more the result of fear than of any lofty sentiments or ideals, and managed to convince him that his wife had been merely infatuated with the

other man rather than genuinely in love. I also reminded him that he had always been a rather poor lover and strongly advised that he show his wife more attention and affection.

Carney was soon able to consummate the sexual act in a normal manner and, according to his wife, with more satisfaction to her than had ever been the case. I was in touch with him infrequently for about two years following the course of therapy. During this time, at least, there was no recurrence of impotence.

CHAPTER 22

Sexual Frigidity

MANY WOMEN are sexually frigid, partially or completely. Some of them are not even cognizant of the fact that they are maladjusted or abnormal in the sexual sphere of their lives. Because they have no positive aversion to the sexual act and are able to conceive, they regard themselves as normal and adjusted. One young woman, married two years, had never experienced an orgasm with her husband. Although she had reached a climax on numerous occasions before her marriage through mutual masturbation with a girl friend, it had not occurred to her that she should experience similar sensations during sexual intercourse. For, as she stated, the two acts were very unlike and, therefore, she supposed the sensations would naturally be very dissimilar.

Many women become frigid after fifteen or twenty years of marriage. In the majority of cases this results in part from the wife's failure to adjust properly to differences with her husband and to his peculiarities as these arise over the years; in part to negative adaptation to her husband, that is, to cataloguing him and taking him for granted; and, in part to her husband's decreasing efforts and proficiency as a lover. Some women think they *should* become frigid, and do, following the menopause.

Although sexual frigidity means, literally, sexual coldness, the problem cannot be dealt with so simply. Frigidity appears in various forms and degrees. As used here the term will apply not only to indifference or aversion to the sexual act but also to failure to achieve an orgasm, with or without conscious erotic craving. Thus, one young woman, married four years and finding nothing in her husband

to complain about except that he was *too affectionate,* decided to get a divorce because she could no longer endure the sexual act. She had been completely frigid in all respects throughout her marriage. Another woman lived in a constant state of emotional turmoil because of her acute aversion to sexual congress. Her husband developed a physical ailment and for two years refrained from sex. He then became better and she developed a manifest anxiety neurosis. Still a third woman suffered from intense sexual craving during most of her waking life and although her husband declared that he had frequently stimulated her in all ways known to him for as long as an hour at a time, she had never experienced an orgasm during the several years of her marriage. She stated that her husband was very exciting to her sexually.

Sometimes frigidity is due to physical causes. A seemingly friendly and affectionate young woman who appeared to be uninhibited and not repressed had never arrived at an orgasm during several years of marriage. The writer referred her to a physician for an examination. An imbedded clitoris was reported and a minor operation performed. Following this she made a satisfactory sexual adjustment without further professional help. Needless to say, the psychotherapist should always make certain that the cause is not physical.

Like impotence, frigidity constitutes far more than a personal problem of the woman concerned. It often results in marital discord, infidelity, broken homes, and injured children. It is a psychosocial problem, and its effects may be passed on to the children in one way or another for generations.

In its variations, frigidity presents problems which cover the whole range of therapeutic effort from simple and brief counseling to the most intensive psychotherapy. When the causes are consciously felt and known to the woman, counseling is usually sufficient to effect the desired change, if the particular circumstances are such as to make a favorable change possible. Where ignorance on the part of either partner is chiefly the cause of the incompatibility, much can usually be accomplished through a few consultations and renewed patience and perseverance on the part of the couple. Nothing was achieved, on the other hand, in the case of a woman who judged herself to be more passionate and responsive than average but who was married to a strongly schizoid man who refused to

bathe. When interviewed he smiled inanely and shrugged his shoulders at his wife's complaints, then gazed abstractedly through a window. He refused to be psychoanalyzed.

Most cases of frigidity fall into one or more of the following categories: inadequate stimulation by the partner; consciously motivated aversion to the partner because of mistreatment, neglect, uncleanliness, etc.; fear of pregnancy; sexual repressions; repressed cross-identifications; and, conscious or subconscious homosexual tendencies.

The first two categories belong to psychological counseling. The third may belong to counseling or to psychotherapy proper. The last three belong to psychotherapy.

Fear of pregnancy may be fully justified and readily understandable in a given case or it may be a rationalization, concealing anything from an unadmitted aversion to the partner to actual repressions. It is a complaint which should always be carefully investigated. One young woman stated that she was frigid because fear of becoming pregnant tied her in a knot and she was afraid to have children because her husband had an uncle and an aunt who had been or were patients in a mental hospital. She was not susceptible to assurance that she was in no more danger of giving birth to a defective child than the average woman. Further study revealed that her fear of pregnancy was a subterfuge for an exaggerated amount of partially repressed self-interest (essentially narcissism, in her case) and that this was the true cause of her frigidity. Exaggerated self-interest in a woman naturally inhibits her desire to have children unless she feels that having children will enhance her own importance. Otherwise her desire for offspring is inhibited by her self-interest because of the demands on her time and attention which children would impose. In this connection it would be interesting to know how many miscarriages are the result of intense but largely repressed self-interest and the disturbing influence of this on natural maternalistic tendencies and functions.

Sexual repression as such, comprised of an unresolved Oedipus complex with its associated feelings of guilt and shame, or resulting from faulty teaching in childhood concerning matters of sex, gives rise to our most classical examples of sexual frigidity. Castration complexes with their resulting feelings of personal inferiority, in-

adequacy and incompleteness also belong in this category. In cases of simple sexual repression there is often a history of excessive interest in sex during the earlier years of life. This should always be looked for. There is every reason to conclude, in view of clinical findings in this field, that any kind of excessively strong interest in childhood which involves relationships to other persons tends by its own strength alone to excite or initiate inner efforts to repress the interest.

Repressed cross-identifications (masculine strivings) make it difficult for a woman to respond normally and fully in her sexual relations. They set up a masculine protest, an opposition to her conforming to the more submissive and passive role of the woman in sex. If they are conscious, however, and an accepted aspect of her motivational organization, they will perhaps lead to nothing more disturbing in her sexual relationships than an unusual degree of assertiveness such as, for instance, that she assume the upper position during coitus. Provided her husband is tolerant of her assertiveness, there is no reason inherent in her masculine orientations that should prevent her from making a satisfactory adjustment. In the case of *repressed* cross-identifications the inner protest usually takes the form of oppressive feelings during intercourse, vague discomfort, abdominal or vaginal cramps, and, of course, the failure to reach a climax.

Homosexual tendencies, latent or manifest, naturally interfere with a heterosexual adjustment. If the tendencies are too pronounced, no heterosexual adjustment may be possible unless the abnormal inclinations can be largely dissolved through psychotherapy and a reorientation of libidinal drives effected. The less extreme case, the bisexual woman, presents two stimulus-reaction sexual patterns instead of one. The libido which is invested in the homosexual tendencies perhaps cannot be discharged through heterosexual activities. Accordingly, periods of intense passion during which she has orgasms tend to alternate with periods of coldness or even aversion to the sexual act. The intense eroticism is probably due to an overreaction in a heterosexual direction as a result of the interference or resistance offered by the homosexual orientation, or to a partial drainage of the homosexual libido into heterosexual channels. With the depletion of the heterosexually orientated libido, only homosexual tendencies are active for a time and this results in a period of frigidity toward the heterosexual partner.

In helping the frigid woman whose problem lies beyond the reach of mere psychological counseling, the usual tests should be given. These will often indicate poor personal adjustment in other than the sexual sphere of life. The manners in which the patient is poorly adjusted or maladjusted will then suggest the proper lines of procedure. Where adjustment in most respects appears to be good, the problem is narrowed accordingly.

Assuming the frigidity is essentially the only complaint, the therapist will pay particular attention to past sexual interests and experiences in the history-taking. At the same time he should not fail to weigh carefully such matters as the early family history; social, economic, and cultural background; intelligence; education; present situation; and the personality, temperamental and physical make-up of the spouse. Although the patient may have been sexually responsive during the early years of her marriage, the therapist should not yet jump to the conclusion that she has lost interest in her husband or that her husband has been unfaithful or otherwise abused her. Repressed homosexual tendencies and other complexes often do not exert a heavy influence on the sexual life till the bloom has faded somewhat from the romance and more or less negative adaptation to the husband has occurred.

A psychoanalytic procedure, modified here and there to fit the particular case, is the most certain and quickest path to beneficial results. In no case is it advisable to try to rush or force a frigid woman into sexual responsiveness. Although one may succeed in doing this, particularly with the more extroverted and psychically flexible patient, he will learn to his regret that the responsiveness not only does not endure but that increased resistance has made its appearance.

The frigid woman's dreams will almost invariably point to the roots of her difficulty. The dreams should be carefully examined and the emotional implications analyzed and discussed. Too much emphasis should not be placed on the orgasm itself. Seemingly, a sexual response in a woman is both broader and more intense *emotionally* than in a man. At any rate, the therapist should be careful not to neglect the emotional factors in favor of the more physical and sensory side of the response.

In many frigid women the emotional life has become divorced from the sexual act. In working to bring about a reintegration of

the two, active therapy can often be used to advantage. This consists in the main of ruling out for periods of time all emotional outlets of a romantic-sexual character. These include such activities as dancing, parties, many movies, reading of romantic fiction, and much of the daily content of the broadcasting companies. Safe vicarious emotional outlets are sought by most emotionally repressed women and by many frigid women in particular. When such activities are barred, the affective energy is blocked, tends to take a regressive direction, and thereby comes into closer relationship to earlier sexual interests as such.

If and when a positive transference appears, success is all but assured, provided the therapist properly manages and utilizes the transference relationship. The patient should be encouraged to let the transference develop freely to its full strength. Although untoward advances by the patient must be dealt with firmly and rebuffed as far as any overt compliance by the therapist is concerned, this should always be done with full explanations and sympathetic understanding. If the married patient reports that thoughts of the therapist intrude whenever her husband makes sexual overtures to her, she should be told that this is a very common and natural feature of the transference and that she is not being disloyal to her spouse by letting such thoughts come to mind.

Once a strong transference exists the therapist is in a position to demand that the patient abandon herself more completely to the sexual embrace, to overlook irritating peculiarities in her husband, to reintroduce any discarded part-patterns of sexual response imagined or acquired in childhood, and to become adjusted through responding wholeheartedly and fully instead of abortively to the situation.

TREATMENT OF A CASE OF SEXUAL FRIGIDITY

Althea N., thirty-six, was a thin and rather unattractive woman. She could become almost but never quite charming during her better moments. She was a college graduate and made a very superior rating on intelligence tests. She had been married for twelve years to a professional man and had had several miscarriages but no children. She was somewhat given to social strivings and had many

acquaintances of both sexes but no really close friends. For one of her intelligence and education, her interests were very restricted, being confined almost entirely to husband, home, and purely social activities.

Althea's complaints were legion and all of them had to do with her husband and marriage. She and her husband did not get along well together and had not since the first two or three years of their marriage. Throughout most of her married life she had been more or less frigid, that is, unable to have an orgasm. She blamed her husband for this just as she blamed him for all of her other dissatisfactions in life. Since he had the reputation of being something of a philanderer, her censorious attitude toward him had some support in objective facts.

But, although Althea expressed numerous complaints and declared that her husband had made a nervous wreck of her, there were no manifest psychoneurotic or psychotic symptoms present. She reacted neurotically at times to her frustrations, having weeping spells, gastric disturbances, loss of appetite, insomnia, headaches, etc., but these were always traceable to quarrels with her husband. She perhaps could have been classified as a case of reactive neurosis of mixed or indefinite type, but in view of the pronounced maladjustive trends which gradually came to light I preferred a diagnosis of adult maladjustment.

Althea was an only child and, incidentally, so was her husband—often a very unhappy combination for marriage. She grew up under a mother with strong perfectionistic strivings and a demanding attitude within the home but who was socially timid; and a quiet and retiring father. Althea became strongly identified with her mother early in life and grew to be very much like her, particularly in her attitudes toward the opposite sex. Because of her lack of attractiveness both in physique and manner she never had many boy friends, and consequently the possessive and exacting attitude toward the opposite sex which she copied from her mother never became appreciably modified. Her more submissive and tender feelings remained dormant and suppressed. She tended to evaluate men rationally, not emotionally. A man was someone who might or might not enhance a woman's life. If attentive, considerate, dependable, and financially successful, he was a highly desirable asset. If he did

not possess these qualities to a marked degree he was a nuisance and a burden at best.

I made several but fruitless attempts to iron out some of the friction between Althea and her husband. He always seemed willing to consult with me and invariably agreed to try to be more attentive and considerate toward his wife. He usually succeeded for two or three days than relapsed into his old pattern of antagonism and neglect. He had very strong cross-identifications. These inclined him to give in too completely to his wife when he did yield to her wishes, and then to switch to the opposite extreme.

I finally gave up trying to bring about more accord in their marriage through consultations with each in turn, and decided to do what I could to help Althea to a better adjustment despite her marital difficulties.

Amorous feelings in a cultured and intelligent woman normally carry with them feelings of friendliness and gracious and submissive inclinations toward a sexual mate, in particular, and other persons in general. So I determined on a thoroughgoing analysis of Althea with special emphasis on her sexual coldness. I believed that if I could resurrect her sexual responsiveness, not necessarily toward her husband but to make it a prominent constituent of her daily affective life, she would not only be more happy and adjusted but more capable of dealing with her marital problems.

Althea was a very difficult person to work with. Whatever submissive feelings and tendencies she may have possessed were rigidly repressed. She was narrow and overpersonalized in all of her attitudes and perspectives. She was highly intolerant or wholly indifferent to any interest or activity which did not belong to her own self-centered scheme of life. The only women she cared to associate with were two or three who were having difficulties with their husbands or men friends. There, she found the only common ground with other women. Her demanding, I have a right to this-and-that, attitude was always dominant.

For several months no appreciable progress was made. Her endless complaints and self-commiseration followed a stereotyped pattern. My procedure was, perhaps, less analytical than critical. I matched Althea's demanding attitude with one of my own. As frequently as she complained of her husband's mistreatment and neglect of her

and the emptiness of her life, I insisted that she recognize and admit her selfish orientation, her coldness toward others, her total lack of interest in anything that did not personally affect her, that her husband had many good qualities, that her basic aim in life was to get before giving, and that she spent much of her time and energy in safeguarding herself against hurt, loss, and disadvantage in all matters. She often wept in my office from a sense of frustration and wounded self-feelings.

Of course I traced her childhood development with her in detail. Her mother's watchful eye had protected her against emotionally traumatic experiences of all kinds. I pointed out that throughout her development she had never had to share anything with another child. All of the toys had been for her, all of the children's clothes that were bought had been solely for her, all of the attention from the parents had been for her, everything for children in her own home had been entirely for her. I insisted that she recognize the fact that just as she had had all of everything in her childhood home environment, she wanted all of everything in her adult home environment. In other words her attitude toward her husband and home was entirely possessive. As an instance of this, when they planned to build a new home, she insisted that her husband's study be off from the kitchen in the rear of the house instead of off from the living room in the front of the house. She simply declared that she would not have a cluttered room (the study) in the front part of *her* home.

At the end of four months of probing, criticizing, coaxing, and picking Althea's attitude to pieces, the only noticeable change was that she was less noisily obstinate and defiant. Her manner was that of a person who says, "Go ahead and say what you want but I can't and won't give in any more than I have."

I began to emphasize—to overemphasize, in fact—the matters of sexual outlet and sexual adjustment. I discussed sex from various angles and had Althea recall her one sexual affair prior to her marriage in all of its details. Certain that her marriage was seeing its last days, I unhesitatingly directed her attention to other men and to the romance that she was missing. (Her husband had already confided to me that he had no intention of continuing in his marriage indefinitely but had agreed to initiate no action for a divorce while his wife was coming for help.) I sought to direct a part of her self-

concern to the sexual and romantic vacuum in her life. I stressed her natural right to a normal emotional and physical relationship with a man and the harm to her of the absence of such.

At the end of nearly six months a mild transference began to make its appearance. This was characterized chiefly by emotional dependence and sexual interest. Along with this she began to talk of securing a divorce. I insisted that a divorce would not help her unless she relinquished her possessive attitude and became more tolerant of the opposite sex. I stubbornly maintained that her whole future happiness and welfare depended on her making these changes, divorce or no divorce.

Not long after this point in the therapy, Althea reported that she had had a most "unusual" experience. She said that during the day before she had been sitting in a chair thinking of nothing in particular and doing nothing when she experienced an orgasm. It was followed in a matter of seconds by two more orgasms. She said she felt as if she were dissolving. From this time on Althea was more tractable and decidedly erotic in her thoughts and feelings. The experience seemed to have been of the nature of an abreaction.

During the next two or three weeks she made halfhearted attempts to reactivate her husband's interest in her sexually. But they had already become too deeply estranged. Her efforts only caused him to withdraw further from her, so she soon desisted.

Althea decided to obtain a divorce. I had her continue with her visits for a couple of months longer, till after the divorce was granted, lest the emotional disturbances inherent in the step she was taking bring about a relapse to her earlier defensive, demanding, and self-protective attitudes. But she went through the process of obtaining a divorce without upset except for a few temporary depressions.

I have no knowledge of how she has been since then, a period of two years, as she moved to a different part of the country. I have no doubt that, at the end of the treatment, she would have been able to respond in an essentially normal manner to any man for whom she had genuinely friendly, though not necessarily romantic, feelings. In the beginning, Althea was affectively dormant to a large extent, or such were my impressions. Neither, I think, was she very intense in her emotional makeup. Such a woman will usually make a good sexual adjustment provided the husband meets with her intellectu-

alized conceptions and ideals. She does not require much warmth and does not have much to give. Accordingly, she is able to repress her emotional responsiveness without too much disturbance to the psychic organization, whereas an emotionally more intense woman would not become frigid so readily or, if she did, acute disturbances in her emotional life would result.

CHAPTER 23

Marital Discord

No problem as broad as this can be more than briefly sketched in a single chapter. Moreover, of course, marital problems as such, are not matters for intensive psychotherapy. On the other hand, no psychotherapist can hope to avoid dealing with marriage problems more or less, as in many cases such problems are intricately bound up with psychoneurotic reactions or other personal maladjustments. This is the somewhat questionable reason for including this chapter in the present book.

Unhappy spouses are always very impatient. Although they may have taken fifteen or twenty years to arrive at an intolerable pitch of disharmony, once they seek professional help they expect an immediate solution of all of their difficulties. Nevertheless, the therapist (or counselor) should never try to help till he is sure that he has the causes of the discord clearly in mind.

In seeking to discover and understand the reasons for the incompatibility, the counselor should insist on concise and complete expressions of complaints. The following are examples of typical but meaningless declarations: "Oh, everything seems to be wrong!" "My husband and I just can't agree on anything." "My husband never shows me any consideration." "My wife nags me all the time."

Intelligence and personal adjustment tests should be given to both parties if possible. Time should be taken to inquire into the educational, economic, and cultural background of both parties and their respective families, the main interests and hobbies of husband and wife, their attitudes toward their children, if any, toward their respective in-laws, and any other matters which might affect their

lives together. Such inquiries should be made in private, for the most part, not with both partners present. The presence of the other spouse often induces a defensive attitude in the one being questioned, inhibits spontaneity of expression, and otherwise interferes with getting at the nature and extent of subjective facts.

Most causes of marital discord can be fitted into one or more of the following categories: *a lack of preparation for marriage; faulty preparation for marriage; disparities in age, intelligence, education, culture, or basic interests;* and *the serious personal maladjustment of one or both partners.* Although these categories overlap in various ways and at many points, for purposes of discussion, they will be regarded as if they were essentially separate and distinct.

Marriage is the one big job in life for which no specific training or apprenticeship is offered. We make little effort to prepare our boys and girls for marriage. We leave success in this very important undertaking largely to wishful thinking and to that highly uncertain and shifting phenomenon of mutual physical attraction between members of the two sexes. Even yet, and in this *enlightened* age, most children are not taught the simpler and more fundamental facts about sex and reproduction. Yet the supplying of such information is only the starting point for instruction in preparation for marriage. Ignorance, not knowledge, of the motivation of human behavior and the psychic and physical mechanisms which subserve it, is the daily companion of most persons. A young man who lived in the center of a large city had been married for six years but had never consummated the sexual act. His wife, still virginal, had become worried because she had not conceived. Neither knew that penetration was involved in normal sexual intercourse. A highly intelligent but uneducated young woman of twenty-three, recently made the startling remark to the writer that a woman becomes pregnant as the result of being kissed by a man. Little wonder the poor girl had carefully avoided "petting parties"!

Lack of preparation for marriage leaves the individual without any definite convictions, perspectives, or attitudes in regard to marriage. Such a person flounders about in a helpless manner. He has no knowledge to guide him in his approach to the numerous problems which arise. His wife's tears over his failure to kiss her good-by on leaving for work either amuse or anger him. No one had ever ex-

plained to him that wives have insatiable appetites for little attentions from their husbands. The burned toast and unturned eggs make him feel abused and unappreciated. That a wife might not know how to cook had never occurred to him. His mother had always seemed to know not only what foods he preferred but exactly the way he liked them cooked. He is serenely unaware, of course, that he hurt his equally blundering wife very deeply by losing himself in a Western thriller on their first evening at home following their honeymoon.

The young married person who received no training or preparation for marriage is a case for educational counseling in the broad field of the relationships of the sexes. Unfortunately most young people who stumble blindly over the rocks along the marriage path never seek expert help with their problems. They are far more likely to confide in an equally unguided friend or relation, often with the result that more harm than good is done.

Many other persons are not merely untrained for marriage, they are actually trained against marriage. Whatever else a close and permanent union between two persons of opposite sex may require, it certainly demands a considerable sacrifice of personal freedom and self-attention on the part of each. Yet numerous parents, mothers in particular, look only to the desired qualities *of* prospective mate for son or daughter, not to desirable qualities *as* prospective mate of son or daughter. In other words, many persons are taught from childhood on to seek a bargain in marriage, in which they expect to receive more than they pay for. Girls are taught sexual virtue, for instance, for the end that they may acquire desirable husbands far more than that they should thereby become desirable wives.

This inculcation of a selfish orientation toward marriage on the individual leads to certain well-defined attitudes or philosophies in respect to marital relationships. The first is that often heard I-am-going-to-live-my-own-life point of view. "Certainly I intend to have children," said a young married woman, "but I'm not going to let them *interfere* with my life." That any normally intelligent young woman can expect to have a husband, much less a child, without interference with her own life only shows how faulty and maladjustive many of the attitudes are which we instill in our young. The young woman just mentioned had a baby, then lost her husband to another woman, then acquired a second husband and another

child, and now appears frankly subservient to the need of more or less unselfishness in marriage. But her first marriage with its accompanying frustrations, turmoil, and final dissolution was a lesson dearly bought.

A second attitude, almost universally held till recent years, which has resulted in innumerable marital failures, is that "I own my wife (or husband)" conception of the marriage relationship. Too many husbands regard their wives primarily as additions to themselves, merely as contributors to their own completeness, and too many wives take corresponding attitudes toward their husbands. The importance of self-enhancement is overtaught both in the home and school; and along with this, respect for the personality and individual rights of the other person is too little stressed. "How to win friends and influence people" is an I-am philosophy. Its popularity definitely indicates how much appeal "How to be friendly and let others influence me" might have.

Individual self-sufficiency to a very appreciable degree, the capacity to direct and govern one's own conduct, is admittedly *essential* to personal adjustment. A feeling of responsibility for one's own behavior and therefore freedom to choose one's course of response within wide limits are of paramount importance. Two parties to the married state should be two such responsible and self-directing entities. But self-direction in one spouse can exist only in constant conflict with a possessive (domineering) attitude in the other spouse. Deep respect or appreciation and tolerance on the part of each for the individuality of the other are absolutely essential to a truly successful marriage.

A woman who has been married to a prominent business man for a number of years recently made the following remarks to the writer: "When my husband finishes his reading in the evening—he never plays cards with me or talks to me or does anything but read, except when we go out—he tells me to brush my teeth. This means that he is ready to go to bed and expects me to accompany him without delay, which I have always done. On our way to the bedroom which is upstairs he nearly always asks me if I am ready to 'play house.' This means he wants to know if I have made preparations to have sexual intercourse." It is unnecessary to point out the implied utter disregard in this husband's remarks for his wife as an individual

who is separate and distinct from himself. His possessive attitude is apparently not only extreme, it is oppressively naïve.

A possessive attitude may lead to extreme jealousy and frequently does. One man would not take his wife to a movie lest it might be necessary for her to sit next to some other man. A second man refuses to take his wife to a dance because he cannot tolerate her dancing with other men. A third husband who philanders freely and makes no particular effort to conceal the fact, nevertheless assures his wife that if she ever deceives him, he will at least divorce her, more likely kill her.

A third and perhaps the most common of all mistakes made in preparation of son or daughter for marriage is the failure of many parents, particularly mothers, to wean their children emotionally from themselves. And intimately related to this failure is that of parents' failing to wean themselves from their children. Strong, unresolved dependent attachments to parents have been the prime causes of innumerable failures in marriage. The number of young wives who rush home to their mothers every time they have a tiff with their husbands is staggeringly large. The number of young husbands who carry their marital woes to their parents is much too large.

A girl of seventeen married an indolent, unreliable, and self-centered young man of nineteen against her parents' most vigorous protests. Following a short honeymoon, the daughter explained to her mother that inasmuch as her husband had no money and was *somehow* unemployed, they would have to move into the parental home till circumstances improved. Acting on the writer's advice and earnest insistence, the mother firmly refused them admittance to her home. The daughter was thrown on her own resources and soon found herself supporting both herself and husband. She rapidly became familiar with and convinced of the worthless character of the man she had married. He scoffed at any need of counseling on his own behalf and carelessly spent the money his wife earned. After less than a year the girl obtained a divorce. About a year later she made a second marriage, a very satisfactory one.

Had the mother just mentioned behaved in the usual manner and provided shelter and food and other help for her daughter and son-in-law, the marriage might well have dragged out for years if not for

the daughter's lifetime. As it was, the daughter was forced into a position where she could not fail for long to recognize various unhappy facts about her husband to which she had previously been entirely insensitive.

Excessive dependence on parents in young men and women is, of course, an expression of emotional immaturity. Emotional immaturity is one of the most common of all personal handicaps, at least in this country. *Children* do not get along well in the married state, irrespective of their ages in years. Too many parents do not help their children to grow up emotionally, to achieve a workable degree of self-sufficiency. This brings us to the problems presented by unweaned parents.

Doting, interfering, and know-it-all parents and parental in-laws have long held their own as a major menace to marital success and happiness. So many parents are incapable of letting go of sons and daughters when the latter reach maturity! A woman of *thirty*, *college graduate*, and *married nine years*, recently complained that her mother's attitude toward her was becoming unbearable. By way of illustrating what she meant she spoke of an incident which had just occurred. She had gotten herself ready to go out to do some shopping. She was fully dressed and in the act of leaving the house when her mother who was visiting her at the time asked: "Daughter, did you wash your face?" When at her daughter's home this same mother always refuses a cocktail before dinner but invariably requests a drink from the glasses of her daughter and son-in-law.

We gave up cannibalism, physically, ages ago, but it still flourishes, emotionally, among parents toward their grown-up sons and daughters. The following is a paragraph from a letter received by a twenty-four year old woman patient from her father. The patient has been suffering from a severe anxiety neurosis with various equivalents. At the time of the beginning of her treatment, she had reached a helpless and, in her feelings, an almost hopeless condition. The excerpt from the letter is indicative of the attitude of the parents since she left home to secure professional help. The parents, incidentally, are only in their middle fifties, in comfortable financial circumstances, and in good health. "We have looked for weeks for a letter from you which would say come and get me for I am ready to go home but alas you have not done so. When will you come for I am ready and willing to go after you for our little cottage needs a

flower like you to help us for it is so lonely. We go to all changes of the movies a thing I never dreamed your Mother would do but she is certainly changed in that direction. Come and go with us for we will take you to B—, O—, or some other good place for we need you here."

Disparities in age, intelligence, education, and culture are among the causes of unhappy marriages. A certain man had been happily married till he reached the age of fifty. He then began to grow restless and discontented. His wife was sixty-seven and was rapidly losing interest in many of the activities which they had engaged in together for many years. A young woman who made a very superior rating on intelligence tests was married to a man who made a dull or backward rating on the same tests. A young veteran in the very superior range of intelligence found himself unhappily married to an attractive girl who scored an I.Q. of 56 on the Binet. One encounters equally marked disparities in education and culture. When these disparities are large, little or nothing may be gained through counseling. If the marriage is of fairly short duration and particularly if there are no children, a quiet and speedy divorce may be the best recommendation the counselor can make.

The problems mentioned thus far are matters for counseling and in many cases for more or less educative and re-educative therapy. What the therapist or counselor is able to accomplish in any given instance depends, of course, not only on the nature of the difficulty but also on a variety of other factors. In some cases one spouse or the other will obstinately refuse to consult with anyone about marital difficulties. In-laws are not infrequently biased, hostile, and uncooperative. Parents or brothers and sisters or even close friends may lend their weight to the opposition against whatever the counselor is trying to do. The counselor will frequently find himself in the position of being able to discuss the marital problems freely with only one spouse, having to get along without the help which other interested parties could give.

Then, finally, there is that very sizable group of discordant marriages wherein one spouse or the other is distinctly maladjusted as an individual, that is, suffering from a psychoneurosis or other personality disorder. In not a few cases, to be sure, both parties are victims of personality maladjustment. In cases of this kind the writer has found that it is expedient, in fact, usually necessary, that the

marital discord as such be put aside and at least tolerated, if it cannot be ignored, while psychotherapy proper is undertaken with the maladjusted spouse. If both parties are desirous of making a success of their marriage, such an arrangement will usually be agreed to once the necessity for it is fully explained. To undertake intensive and prolonged psychotherapy, on the other hand, with one party to marital discord, and try to deal with the marital disharmony itself at the same time, is almost certain to end in frustration and failure for all concerned.

A few words remain to be said in respect to making certain whether there is a personality maladjustment in one spouse or the other. The statements of a complaining spouse should never be taken at face value, till fully substantiated. Even though functional nervousness is apparent, one may still not assume offhand the existence of a subjectively determined psychoneurosis or other personality disorder. Conditions of a distinctly reactive character may result from the stress of an incompatible relationship in marriage. Careful study and often quiet inquiries should always be made. A very religious and highly moral wife complained of various nervous reactions and attributed them all to the strain caused by a philandering and drinking husband. Inquiries from her husband's relations supported her charges and left no particular reason for supposing the existence of any pronounced personality maladjustment in herself as such. In the case of another wife, however, who made similar complaints and charges, study and inquiries revealed definite paranoid trends and paranoid jealousy in herself. The husband was apparently quite innocent of her charges against him. A third wife bemoaned the fact that her intense fear of riding in automobiles was threatening to disrupt her marriage. Her fear, she went on to explain, kept her and her husband from associating freely with their friends. Her husband was socially inclined and was becoming intolerant of her "silly" fear. Only careful study revealed that her husband was something of a flirt, though not unfaithful, whereas she was emotionally infantile and extremely possessive. Her fear of riding in automobiles was an unwitting and rationalized attempt to circumscribe her husband's associations. Then a husband complains that his wife is becoming cold and that he does not feel that he can continue with his marriage unless she can be made more appreciative of his needs and devotion. But he has committed numerous indiscretions and is also

becoming less potent sexually. He is very self-centered and his waning capacity is very painful to his self-esteem. His complaints about his wife are a childish effort to shift blame and to escape from a situation in which his lessened powers must become apparent.

COUNSELING A CASE OF MARITAL DISCORD

Clara N. was an attractive young woman of twenty-six, intelligent, of fair education, and pleasing manner. Although she had been married five years she had no children, for reasons to be mentioned shortly. She and her husband had come to the point of a permanent separation. In fact, she had her personal belongings packed, preparatory to returning to her parental home in a distant part of the country. A mutual friend and former patient of mine persuaded her to consult me about her marital difficulties before leaving.

It was obvious when Clara came in that she had done so wholly out of a desire to please her friend rather than with any hope of being helped. Nevertheless, she was entirely willing to discuss her marriage problems.

She and her husband, she declared, had been deeply in love with each other when they married. She believed that their marriage had been ideal till about four months prior to her visit to me. Her husband had become strongly enamored—infatuated, she said—with another woman. He had been completely frank with his wife about the matter and, indeed, in the beginning had solicited her help in his efforts to break free from his emotional entanglement. His efforts, even with the help of his wife, had proved unsuccessful and for some time he had been yielding without protest to his infatuation. He felt most miserable over the unhappiness he had caused his wife but as the weeks went by his interest in the other woman grew stronger. He and his wife finally agreed to a complete and permanent separation.

I could discern none of those traits or attitudes in Clara which sometimes cause husbands to leave home, taking with them the sympathies and best wishes of their friends. I gave her several tests, all of which indicated good intelligence and a normal degree of personal and emotional adjustment. Moreover, she apparently bore her

husband no ill will. She had little to say for her rival that was complimentary but that was to be expected. At the end of a rather long interview I was genuinely puzzled. I had discovered no reason why her husband should have lost interest in her and fallen in love with another woman.

I asked Clara to give me two weeks' time, coming to my office as frequently as I thought desirable. When she hesitated I assured her that I thought something could be accomplished and pointed out that after four months of trying to salvage her marriage she should not suddenly be in too much haste to effect a permanent separation. She consented to the further trial period but without any show of hope or enthusiasm.

I learned from Clara during her next visit that she thought very highly of her husband's moral principles. She said he was an honest, sincere, forthright sort of person. He was anything but a playboy. He never drank to excess, frowned on night clubs and wild parties, and had never before shown any interest in another woman. She felt he had been as surprised and, in a way, as keenly disturbed over his infatuation as she had been.

In view of the little I knew about the reasons for the estrangement, I considered it inadvisable to ask the husband to come to my office. In fact, I asked Clara not to mention the fact that she was consulting with me. I was afraid that such knowledge on his part might antagonize him or otherwise further complicate the already existing difficulties. Nevertheless I decided to have a look at him. As he worked in a business place where a number of other men were employed, this presented no obstacles. I surreptitiously studied his reactions to customers as I took my time over a small prospective purchase. I observed that he was neat in his dress, courteous and quiet-mannered toward his customers, and, I thought, of rather serious mien. He impressed me as being definitely introverted and somewhat submissive socially. Information supplied by Clara tended to support these offhand judgments.

I next questioned Clara very closely concerning her past relationship to her husband and his to her, their exact feelings toward each other, their reactions to each other, their sexual life together, etc., etc. Naturally I inquired into their reasons for not having had any children.

Clara and her husband began their marriage with definite but very

faulty ideas and ideals about such a union. They had felt and believed that they should be sufficient unto each other, not only as lovers but as companions in all things as well. They had never tried to make friends. During their five years of marriage they had invited others to their home only two or three times and had called on others no more frequently. They had been innocent victims of the adolescent, poetic philosophy which holds that the ideal married state involves a complete blending, amalgamation, of the partners ideationally, emotionally, spiritually; that possessing completely and being completely possessed is the *ne plus ultra* of marriage. They felt that even having a child might mar the perfect unison of their lives, so there had been no children.

The chief reason for their failure in their marriage suddenly became clear. *They had allowed no room in their married relationship for the continuance of each as a distinct and separate individuality and personality*. Instead of letting each other exist in his own right as a distinct entity, with only a partial overlapping of attitudes, feelings, interests, and aspirations, they had tried to achieve a single identity of the two of them.

We vary widely in our ability to tolerate emotional proximity to and identity with other persons. Moreover we differ widely in the intensity of our emotional responses to other persons. Emotionally intense, introverted persons function best at a considerable emotional distance from others. If such a person becomes too intimately involved emotionally with another, his emotionality thereby becoming concentrated toward and restricted to a single object, he will *unwittingly* endeavor to incease the emotional distance between himself and that person in one way or another. A common way of doing this is by becoming defensively interested in a second person. I became convinced that this is what had happened in the case of Clara's husband.

I explained these matters thoroughly to Clara. I pointed out that in her feelings her husband had become both husband and child, and that this fact, together with her rather extroverted make-up, and high affective tolerance had enabled her to lavish her attention and feelings on him without restraint. This had strongly encouraged a like response in him toward her, with the result that his life with her had become intolerably saturated with feeling and emotion. Just as a person will become nauseated (intolerant of it) if he con-

sumes too much sugar, and turn to foods less sweet, so will a person unwittingly and defensively turn away from an object or person who induces too much emotional intensity in him and toward some object or person who induces less. I used examples of schizophrenic and hysterical reactions to illustrate extremes of affective intolerance.

Clara had told me that she and her husband lunched together daily, although they were no longer living together. When I asked why they lunched together she explained, naïvely enough, that it was for the purpose of discussing their financial matters in line with their rapidly approaching permanent separation. Through a bit of questioning—and Clara was very frank and cooperative—I learned that she met her husband each day, tense with the hope that he had had a change of feeling overnight and was ready to return to her. I learned further that she invariably wept before the luncheon meeting was over and that he appeared very miserable and self-condemning.

I assured Clara that I had discovered no reason yet which led me to believe that her husband was in love with the other woman and that she was going to have to act very differently for awhile from the way she felt, if I was to succeed in my efforts. She readily agreed to do anything within her power and, I must say, she kept her word to the letter.

I explained that we were going to give her husband the emotional distance from her which he needed. I directed her to meet her husband with a smile thereafter, irrespective of how she felt; that she was not to weep under any circumstances when in his presence; that she was to appear to have fully accepted the idea of a permanent separation. In order to equip her with the devices necessary to the carrying out of these instructions, I suggested that without giving her husband time to begin the usual line of conversation, she begin it by mentioning some of her old girl friends whom she was looking forward to meeting on her return to her parental home. She was to mention in a casual and reminiscent way some boy friend who had been very eager to marry her and how unsophisticated and boyish she had thought him to be. She was to make it appear that she was already looking forward with some degree of pleasure to being back among her old surroundings. In short, she was to give her husband the impression that she was rapidly and successfully adjusting herself, not only to the idea of a permanent separation from him,

but to taking up her life again from where she left it at the time of her marriage. I cautioned her against overdoing her play acting and suggested that she allow herself a week to impress her husband with her "change of attitude." I warned her that if she permitted any familiarities—her husband had been kissing her good-by when they separated after lunch—she would certainly block everything we were trying to accomplish.

I continued to see Clara each day. She reported progress almost immediately. She reported that her husband appeared puzzled and disturbed by the change in her manner. As he became increasingly perplexed and disturbed, it became increasingly easy for her to carry out her new role. Although she did not say so, I am sure she was soon enjoying her new, albeit affected, relationship. She was no longer the forlorn, pleading, self-pitying wife. She discovered an unexpected strength in her display of independence. What had begun as a purely false show of self-sufficiency rapidly took on a genuineness and a highly important personal significance. She was finding in herself an unsuspected ability to function as a separate and normally self-sufficient individual.

By the end of this first week of our program, Clara's husband had made a complete break with his mistress and was begging his wife to return to him. I was pleased to observe that Clara was in no hurry to have her husband back. She was determined to make him suffer for his indiscretion and the humiliation he had caused her. Moreover she had done some hard thinking and was in the process of inwardly renouncing her old conception of mutual possessiveness as a basis for marriage. During the second week of the program, she announced that she had decided to have two or three children as soon as expedient and that from then on she was always going to have friends. Most important of all, perhaps, she seemed to have grasped the significance of the matters of affective tolerance and emotional distance and no longer desired to smother her husband with her feelings or to be smothered by his.

At the end of this second week—about three weeks in all—Clara and her husband resumed their lives together. If he found her somewhat coolish on his return, it is almost certain that he unwittingly appreciated the greater emotional freedom which this accorded him.

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GLOSSARY

ABREACTION. The re-expressing or reliving—usually in the therapeutic situation—of an earlier emotional content which had been held below the threshold of consciousness by inner resistance.

ACTIVE THERAPY. The deliberate interference by the therapist with a patient's thoughts, feelings, and actions outside of the therapeutic situation, by means of instructions, requests, or commands.

AFFECTIVE INARTICULABILITY. The relative inability of one to express feelings and emotions in a manner that is suited to his needs.

AFFECTIVE LOSS. Loss in intensity of feeling and emotional responses.

AFFECTIVE TENSIONS. States of feeling or emotional inequilibrium. An emotional state of an organism needing overt activity. Emotional strain.

AFFECTIVE TOLERANCE. A term initially introduced by the author and meaning the ability to resolve affective tension; that is, to endure and/or vent and appropriately express feelings and emotions in accordance with the subjective needs of the individual himself.

AFFECTIVE WITHDRAWAL. A functional decrease in affective responsiveness to the environment.

AFFECTIVITY. The sum-total of an individual's proneness to feeling and emotional experiences.

AGORAPHOBIA. A morbid fear of open places, or of being outside alone.

AKOASMS. Ringing, roaring, or buzzing sounds localized in the ears or head.

ALLOPSYCHIC. Pertaining to one's opinion of the relationship which exists between himself and another person or persons.

AMBIVALENT FEELINGS. Coexisting (consciously-subconsciously) or alternating feelings of opposite character in an individual toward a given fact or person.

AMNESIA. Abnormal forgetfulness.

ANAL-EROTIC FIXATION. An arrest of the migration of the libido at the anal region.

ANAL EROTISM. Pronounced sexual excitability, consciously or subconsciously, of the anal region. It is often accompanied by preoccupations with the eliminative functions and by certain character traits.

ANESTHESIA. Partial or total loss of sensitivity, particularly of the tactual sense.

ANOREXIA. Loss of appetite.

ANOREXIA NERVOSA. Loss of appetite due to emotional disturbance; or to displacement, resulting from resistance to subconscious desires.

ANTEROGRADE AMNESIA. Forgetfulness of recent events due to impaired attention and perception.

ANXIETY EQUIVALENT. Any physical disturbance or symptom which is the expression or manifestation of converted anxiety, and the occurrence of which frequently alternates with periods of neurotic anxiety.

ANXIETY HYSTERIA. A psychoneurosis which is characterized by unreasonable fears, anxiety, weird ideas, marked egocentricity, and various conversion symptoms.

ANXIETY NEUROSIS. *See* Neurotic anxiety neurosis.

ASCENDANT-SUBMISSIVE. Pertaining to a linear personality variant, concerning the ratio of assertive-aggressive activity to compliant-yielding activity manifested by an individual in his day-to-day life.

ASTASIA-ABASIA. A hysterical condition, without paralysis, in which volitional control of the legs is retained while sitting or lying down but lost when trying to stand or walk.

ATYPICAL RESPONSE. A response which is divergent from the norm.

AUTO-CORRECTIVISM. A term initially introduced by the author and expressing his conception of the development of many psychoneurotic symptoms as a purposive but unwitting and subcortical attempt to bring about a quantitative balance between conflicting motives.

AUTOMATISM. The involuntary performance of normally volitional (non-reflex) acts.

AUTOPSYCHIC. Pertaining to one's opinion of his own mind.

BEAUCHAMP. A case of multiple personality studied and described by Morton Prince.

BISEXUAL. Pertaining to sexual interest in members of both sexes.

CASTRATION COMPLEX. A subconscious impression or conviction in a woman that she is incomplete because of the lack of the male genitalia, particularly a penis, and its accompanying feelings of personal inferiority.

CASTRATION FEAR. A fear acquired by many boys during early childhood of the loss of the penis; and frequently accompanied by an impression or conviction that females have suffered such a fate. It often becomes repressed, instead of resolved, and continues subconsciously into adult life.

CATALEPSY. A sleeplike state characterized by plastic rigidity of the muscles.

CATATONIC. Pertaining to catatonia, a condition characterized in particular by catalepsy and negativism.

CATHARSIS. Re-experiencing or reliving past and repressed emotionally disturbing experiences in a psychotherapeutic situation. Essentially the same but a broader term than "abreaction."

CHRONIC. Applied to disorders which are of slow onset and persistent duration. Contrasted with acute.

CLIMACTERIC. The ending of reproductive capacity. In women, it is characterized, specifically, by a cessation of menstruation. In men, the changes, mental and physical, are usually less pronounced.

CLITORIS. A part of the female genitalia. It possesses erectility and high erotic sensibility. A homologue of the penis.

CLOSED ENERGIC SYSTEM. A term used by C. G. Jung, connoting his conception of the mind as an energic system of definitely limited capacity or potential.

COITUS. Sexual intercourse.

COMPENSATORY REACTIONS. Various kinds of reaction, the purpose of which is always to conceal, avoid, and make up to oneself for feelings of personal inadequacy or inferiority.

COMPLEX. Two or more associated or related and emotionally invested repressed (subconscious) ideas or impressions.

COMPULSION. An impulsion to perform an act which is irrelevant to the individual's intent, purpose and interest of the moment. Compulsive acts are more or less involuntary.

CONFLICT. Actively antagonistic or incompatible motives or desires within an individual, or the painful emotional state which results from such.

CONGENITAL. Actually or potentially present at birth but not necessarily hereditary.

CONVERSION. The transformation of repressed psychic content into a physical manifestation.

CONVERSION HYSTERIA. A psychoneurosis which is characterized by such conversion symptoms as paralyses, anesthesias, tics, contractures, automatic acts, etc.

CONVERSION SYMPTOM. A symptom which is physical in character but of psychological origin and supposedly brought about through the conversion of psychic factors into a physical disturbance or innervation.

CROSS-IDENTIFICATION. This term was introduced by the author. He uses it to designate feminine identifications in men and masculine identifications in women.

CUNNILINGUS. Using the tongue or mouth on the female genitalia.

CYCLOID. *See* Cyclothymic.

CYCLOTHYMIC. Pertaining to a psychic disposition, possibly innate, possibly acquired, to alternating moods of despondency and elation.

DEFENSE MECHANISM. An unwittingly adopted or effected device by means of which an individual seeks to avoid feelings of anxiety, guilt, frustration, failure, etc.

DELIRIUM TREMENS. An alcoholic psychosis.

DELUSION. A false belief which is symptomatic of a personality disorder or maladjustment and inconsistent with the individual's intelligence and education.

DEPERSONALIZATION. A decreased tendency to relate events and objects to oneself. Also, a loss of the sense of the reality of oneself or of one's body.

DIATHESIS. A constitutional or hereditary predisposition.

DIPSOMANIA. A morbid, uncontrollable and, usually, periodic craving for alcohol.

DIRECTIVE THERAPY. A therapeutic procedure in which the therapist endeavors to give some specific direction to the patient's thoughts and feelings within the therapeutic situation.

DISPLACEMENT. The phenomenon of an idea, function, or object becoming divested of its affective coefficient which, in turn, becomes attached to another idea, function, or object.

DISSOCIATIVE SYMPTOM. An act or activity which has become a symptom as a result of the individual's loss of his normally volitional control over it. Certain hysterical symptoms are the most common examples, e.g., automatisms and automatic acts.

DORMANT. Latent, unawakened, inactive.

DYNAMIC. Emphasizing the importance of motivation in behavior. Forceful, energic.

ECHOLALIA. The automatic, parrotlike repetition by an individual of words or sentences addressed to him by another person.

ECHOPRAXIA. The automatic or mechanical-like repetition or imitation by an individual of the acts of another person.

EDUCATIVE THERAPY. Informative procedures in psychotherapy.

EFFEMINATE. Pertaining to feminine features or traits in the male.

EGO. That organization of traits and capacities which comprises an individual's conscious personal identity.

EGOCENTRICITY. A peculiar attitude which indicates that the individual takes himself as a reference point for all surrounding events, particu-

larly the existence and behavior of other persons. His attitude implies that everything is or should be related to him.

EGO-DEFENSE. *See* Defense mechanism.

EGO-IDEAL. A standard of perfection, usually acquired through identification with someone admired during childhood.

EGO-IDENTIFICATION. A reaction pattern (implicit or overt), the exact character of which was the result of the individual's having more or less unwittingly adopted a similar pattern of another person as a model or guide for his own development in that respect. A psychological characteristic which is of an "identity" with the same in another person and which was acquired as a result of earlier association with that person. All types of identifications, as these terms are used in this book, are ego-identifications.

EGOISM. Self-interest, self-concern, selfishness. The sum-total of motivation and effort on behalf of one's own security, equality, and personal enhancement.

EGOTISM. Egoistically motivated self-display, psychical or physical.

EMOTIONAL DISTANCE. Possibly first used by Alfred Adler. Degree of emotional reserve around other persons; the intensity of emotional response which an individual condones in himself.

EMOTIONAL INFANTILISM. An extreme degree of emotional immaturity in an adult or older child.

EMOTIONAL MATURITY. Cannot be defined briefly. Any definition should include: The ability to assume and discharge responsibilities which are commensurate with intelligence, training, and experience; composure in the presence of adult members of either sex; a high degree of emotional independence of parents and older siblings; psychic flexibility; affective tolerance; and a true give-and-take attitude toward other persons.

EMOTIONAL TOLERANCE. *See* Affective tolerance.

ENDOGENOUS. Relating or due to internal causes. Produced from within.

EPILEPTIC EQUIVALENT. An acute emotional excitement with expressions of anger and violence, accompanying an epileptic seizure, or occurring in the place of such.

EROGENOUS ZONES. Sexually sensitive areas or parts of the body.

EROTISM, EROTICISM. Sexual desire and excitement.

ESOTERIC. Understood only by oneself or the specially initiated.

ETIOLOGY. The causes, genesis, or antecedents of phenomena, or the study of such, particularly ailments or disorders of organisms.

EXHIBITIONISM. Exaggerated self-display, psychical or physical. In its more narrow meaning, sexual display. A sexual perversion.

"EXTRACONSCIOUSLY." Excluded from conscious content by narrow personal ideals rather than by active repression as such.

EXTROVERSION. An orientation of attention and motivation toward objective facts.

FELLATIO. The use of the tongue or mouth on the male genitalia.

FIXATION. The arrest of the migration of libidinal excitability at a pregenital erotogenic zone. Also, sustained childhood erotic interest in a person or other object.

FIXED IDEA. A false idea which tends to persist and to influence the behavior of the person. It is symptomatic, and the most classical examples are found among the dissociated ideas of conversion hysteria.

FREE ASSOCIATION. Purposeless, uncontrolled, or undirected thinking. A thought or idea that comes to mind in the absence of conscious restraint or selective criticism. A psychoanalytic procedure in therapy.

FUGUE. A hysterical symptom. An episode of nonremembered activity of considerable duration, which usually takes the individual away from his former haunts.

FUNCTIONAL. Pertaining to functions as distinguished from organs or parts.

GENESIS. The origin or first steps in the formation, growth, or development of anything.

GLOBUS HYSTERICUS. A sensation of contraction or swelling in the throat.

HALLUCINATION. Misinterpretation of ideational content as a perceptual experience. A perceptual experience in the absence of objective data.

HEBEPHRENIC. Pertaining to a form of schizophrenia or a type of schizophrenic patient who manifests markedly regressive behavior, manneristic acts, silliness, etc.

HEREDITARY. Transmitted through the germ plasm of the parents.

HERMAPHRODISM, HERMAPHRODITISM. Physical: The presence of both the male and female reproductive organs in the same organism. True physical hermaphrodism does not exist in humans. Psychical: The existence to a marked degree of both masculine and feminine identifications or tendencies in the same person.

HETEROSEXUAL. Pertaining to sexual interest in the opposite sex; a normal sexual orientation.

HOMOLOGY. Similarity in position and basic structure of organs or parts, as the wings of birds and the front legs of quadrupeds.

HOMOSEXUAL. Pertaining to sexual interest in the same sex. A person who has sexual desires and feelings toward members of his own sex.

HYPERTENSION. Excessive tension. High blood pressure due, in some instances, to anxiety or fear.

HYPNOSIS. A markedly submissive and receptive state induced in a person by suggestions given to him by another individual.

HYPNOTIC THERAPY, HYPNOTHERAPY. The use of hypnotic suggestions or of hypnosis in psychotherapeutic procedures.

HYPOCHONDRIACAL. Pertaining to a personality disorder (hypochondriasis) characterized by morbid concern about the health and, often, by convictions of physical disease when none is present.

ID. In psychoanalytic theory, it is the primitive, unconscious, and undifferentiated part of the mind.

IDEAS OF INFLUENCE. Ideas entertained by some patients that they are being influenced against their will by hypnotic suggestion, electrical machines, X rays, etc.

IDEAS OF REFERENCE. Ideas entertained by certain patients that they are being spoken of disparagingly, plotted against, etc.

IDENTIFICATION. See Ego-identification.

ILLUSION. A grossly faulty perception and interpretation of an objective fact.

IMPERCEPTION. Vague or faulty perception due, often, to inattention.

IMPLICIT RESPONSE. A response which is not directly observable by another person, such as thinking, imagining, etc.

INACCESSIBLE. As used in psychotherapy, said of a patient who will not or cannot cooperate with the therapist in treatment.

INCIPIENT. Pertaining to the beginning of a process, as the beginning of a personality disorder.

INDIVIDUAL PSYCHOLOGY. The system of psychological theory and therapeutic procedures developed and propounded by Alfred Adler and his followers, and which placed special emphasis on feelings of inferiority, compensatory devices, lust for God-likeness, etc.

INFERIORITY COMPLEX. Ego-identifications of negative import. Morbid feelings of personal inferiority and inadequacy. The term is really a misnomer. The complex involved consists of partially or wholly repressed exaggerated cravings for personal distinction or power. The feelings of inferiority are usually symptomatic and are maintained and utilized to hold the repressed cravings for superiority in abeyance.

INNER PROTEST. Active subjective resistance, manifested symptomatically, against some personal orientation, interest, or tendency.

INSIGHT. Understanding. More narrowly used to mean self-understanding, particularly a recognition of one's own maladjustive trends and behavior and the probable causes thereof.

INSPECTIONISM. VOYEURISM. Looking at and examining the sexual parts of other individuals. When exaggerated or habitual, the practice comprises a sexual perversion.

INTEGRATION. A harmoniously organized and coordinated relationship of the various parts, processes, or functions comprising the whole.

INTROVERSION. An orientation of attention and motivation toward subjective facts.

INVERSION. *See* Sexual inversion.

INVOLUTIONAL. Pertaining to the presenile decline beginning with the climacteric. A retrogressive change in an organ.

INVOLUTIONAL MELANCHOLIA. A psychosis occurring during the involutional period and characterized by self-condemnation, despondency, agitation, and suicidal tendencies.

I.Q. INTELLIGENCE QUOTIENT. A designation of the relative intelligence of an individual as measured by certain intelligence tests and obtained by dividing the mental age by the chronological age.

LATENCY PERIOD. The period of time, in psychoanalytical theory, between the ages of 4 or 5 and 10 or 12, which separates infantile sexuality and pubertal sexuality.

LIBIDO. A psychoanalytical term meaning sexual energy.

LIFE-PLAN. A term used by Alfred Adler to mean one's integrated and over-all pattern of psychosocial activity.

MANIC-DEPRESSIVE PSYCHOSIS. A well-defined affective psychosis characterized by psychomotor acceleration and elation or psychomotor retardation and despondency or by an alternation of the two.

MANIFEST. Disclosed, or to disclose, to an observer by a patient. Hence, a manifest disorder as contrasted to a latent disorder.

MANNERISM. A recurring, stereotyped gesture or act which has no apparent meaning or purpose. Found in schizophrenic patients.

MASCULINE PROTEST. A term which was perhaps first used by Alfred Adler and connoting, in certain men with feminine identifications, an active resistance to, or reaction against, such identifications.

MASCULINE STRIVINGS. Masculine tendencies or inclinations in women.

MASOCHISM. Deriving sexual pleasure or gratification in connection with painful stimulation. In its extreme form it constitutes a sexual perversion.

MENTAL DISSOCIATION. A condition in which the different mental processes of an individual lose their relatedness or integrated relationships. Found in dreaming, hypnosis, hysteria, etc. It is less extreme or pronounced than mental disintegration, as found in schizophrenia.

MENTAL FREEDOM. The ability to think and feel freely, without inner blocking or resistance, about all aspects of one's experience, knowledge, and motivations.

MENTAL RANGE. The extent or variety of conscious thoughts and feelings

which an individual can easily tolerate in himself in relation to a given fact, situation, or experience.

MENTAL REGRESSION. The discarding of later and the resumption of earlier reaction patterns.

MENOPAUSE. *See* Climacteric.

MOTHER IMAGO. An idealization of the mother formed in childhood and continuing uncorrected into adult life.

MOTIVATION. The impelling forces within an organism, manifested by his activities. The sum-total of desires, impulses, motives, drives, etc.

MOTIVE. An impulsion to action of a relatively systematized and definable character; a purposive striving toward a goal; an inner drive.

NARCISSISM, NARCISM. Self-love, self-adoration.

NARCOSYNTHESIS. Psychotherapy carried out during or in connection with narcosis.

NEGATIVISM. Pathological obstinacy. A tendency to react in a manner which is contrary to that which is commanded or suggested.

NEURASTHENIA. A psychoneurosis which is characterized by sensations of fatigue, aches and pains, morbid attitudes, and self-preoccupation.

NEUROTIC ANXIETY NEUROSIS. A psychoneurosis which is characterized by anxiety, strong fears, uncertainties, doubts, feelings of personal inadequacy, and a lack of definite orientations.

NIHILISTIC DELUSION. A delusion of personal loss or of nothingness.

NONDIRECTIVE THERAPY. The deliberate avoidance of giving direction or orientation to the patient's thoughts, feelings, and actions in psychotherapeutic procedure.

NOSOLOGY. Classification of diseases or disorders.

NUCLEAR COMPLEX. The most significant, dynamic, or disturbing complex.

NYMPHOMANIA. Exaggerated desire for coitus in the human female.

OBSESSION-COMPULSION NEUROSIS. Any psychoneurosis which is predominantly characterized by obsessive thoughts or compulsive acts or both.

OBSESSIVE CHARACTER. A sum-total of characterological traits in a given individual and including niceties, exactitude, scrupulosity, ceremonial acts, etc.

OBSESSIVE THOUGHTS. Persistent, irrelevant thoughts over which the patient has little or no control.

OCCUPATIONAL THERAPY. A patient's performing various tasks or stipulated activities under direction and guidance.

OEDIPUS COMPLEX. Positive: An early established and later repressed sexual-affectionate attachment to parent of opposite sex, accompanied by ego-identifications and feelings of rivalry with and/or hostility toward

parent of like sex. Inverted: The converse of the positive. Complete: Comprising both a positive and an inverted, that is, having ambivalent feelings toward both parents.

ORGASM. Sexual climax. Consummation of the sexual act.

ORIENTATION. A conscious perspective on and a definite attitude toward an anticipated line of one's own effort and activity.

OVERIDENTIFICATION. Exceptionally strong and/or varied ego-identifications.

OVERPERSONALIZED. Pertaining to a tendency in certain persons to respond to most facts and situations in a strictly personal manner.

OVERREACTION. An exaggerated effort to perform in a given manner wherein the individual feels handicapped or incapacitated for such activity.

OVERT RESPONSE. An observable reaction in another person.

PALPITATION. A rapid or throbbing action of the heart, of which the individual is conscious.

PARANOIC TRENDS. Pertaining to tendencies to morbid suspicions, self-reference, projection, and systematized delusional formation, without appreciable loss of affective contact with reality.

PARANOID TRENDS. Pertaining to tendencies to unsystematized and bizarre delusional formation and ideas of reference and influence, accompanied by diminished affective contact with reality.

PARESIS. An organic psychosis, due wholly or in part to neurosyphilis.

PARESTHESIA. Wrongly localized or abnormal sensations.

PERFECTIONISTIC STRIVINGS. Egoistically motivated cravings for and strivings toward self-perfection, in one's own opinion, when subjectively orientated, or in the opinion of others, when objectively orientated.

PERSONAL IDENTITY. Subjectively, it perhaps consists, essentially, of a self-sentiment, that is, of an organization of thought, feeling, attitudinal, and emotional processes in relation to self. A knowledge or conviction of one's origin (parentage) appears to be its essence. The writer often uses the expression "sense of personal identity" or "feeling of personal identity" in an effort to emphasize its distinctly conscious and subjective nature.

PERSONALITY. The integrated functioning of an individual as a self-directing entity.

PERSONALITY INVENTORY. Any one of a large number of standardized psychological tests which requires the subject to evaluate his attitudes, interests, and other mental traits by selecting one of several answers following each item in the test.

PERSONALITY QUESTIONNAIRE. *See* Personality inventory.

PERSONALITY VARIANT. Any characteristic of personality which varies from

the norm. Introversion or extroversion is a variant from ambiversion, the norm.

PHOBIA. A morbid, symptomatic, and essentially uncontrollable fear.

PLATEAU. An appreciable period of time in psychotherapy during which the patient apparently does not change or make any progress.

PRECIPITATING CAUSE. Exciting cause. The specific agency or event which, acting together with existing causes or conditions, brings about a disorder.

PRIAPISM. A persistent or recurrent erection of the penis in the absence of conscious sexual desire. Its cause may be either functional or organic.

PRODROMAL. Pertaining to the early phase of a disorder, preceding the establishment of a relatively fixed and permanent symptomatology.

PROGNOSIS. An opinion given in advance concerning the course, duration, and termination of a disorder.

PROJECTION. The act of perceiving one's own intolerable and more or less repressed desires, tendencies, etc., as localized in others, because of inner resistance to perceiving them as localized in oneself.

PROJECTIVE TECHNIQUES. Various psychological tests, usually consisting of unstructured visual content. The Rorschach test is perhaps the best known example.

PROPENSITY. A motive; an impulsion to action of a definable type or mode.

PSYCHIC. Mental.

PSYCHICAL IMPOTENCE. The inability of a man to perform the sexual act to completion, in the absence of physical disease or incapacitation.

PSYCHIC DISSOCIATION. *See* Mental dissociation.

PSYCHIC DUALITY. Two relatively independent and prominent mental organizations in the same individual. Dual personality and, to a less pronounced extent, psychic hermaphrodism, wherein one set of ego-identifications is largely repressed, are examples.

PSYCHIC ENERGY. The energy which is discharged or manifested through the mental activities of an organism.

PSYCHIC FLEXIBILITY. Susceptibility to a change or modification, under appropriate influences, of sentiments, attitudes, convictions, etc.

PSYCHIC RIGIDITY. Insusceptibility to change or modification of sentiments, attitudes, habits, and other reaction patterns. The opposite of psychic flexibility.

PSYCHOANALYSIS. A fairly well-systematized, theoretical explanation and interpretation of the origin and development of personality abnormalities, disorders, and maladjustments, with particular emphasis on the role of early sexual development, motivations, fixations, and repressions. The word also denotes a well-defined psychotherapeutic procedure, in which much use is made of the patient's free associations, dreams, and recollections of early experiences and events.

PSYCHODRAMA. A therapeutic procedure in which the patient is encouraged to act out his inner conflicts; a play-acting technique.

PSYCHODYNAMICS. The energic aspects of mental activity and their interrelationships.

PSYCHOGENIC. Pertaining to psychological origin and development; functional.

PSYCHOMOTOR TENSION. Physical tension resulting from mental processes. Also, affective tension which is casually associated with an accompanying physical tension, as tautness of the neck muscles coincidental with anxiety.

PSYCHONEUROSIS. A neurosis; any one of various personality disorders; a functional nervous disorder.

PSYCHOPATHIC. Denoting pathological mental and social instability without intellectual derangement.

PSYCHOPATHIC PERSONALITY. A personality which is characterized by psychopathic tendencies and traits.

PSYCHOSEXUAL. Pertaining to the sexual life in a broad sense. More narrowly, the mental aspects of sex.

PSYCHOSIS. A mental disorder; an insanity.

PSYCHOSOMATIC. Pertaining to physical symptoms or disorders which are due partly to mental and partly to physical causes.

PSYCHOTHERAPY. The treatment of personality disorders and maladjustments by psychological methods.

RAPPORT. A tolerant, friendly, harmonious relationship between two persons, two groups, or a person and a group. Used particularly in speaking of therapist-patient relationships.

RATIONALIZATION. Unwitting self-deception. The act of unknowingly assigning a false reason for one's own motive, belief, feeling, or act because of personal intolerance for (resistance to) the true reason.

REACTIVE DEPRESSION. A depression or despondency which is essentially due to environmental factors, rather than to inner conflicts or frustrations.

RE-EDUCATIVE THERAPY. A procedure which consists primarily of correcting false impressions and erroneous convictions of the patient.

REGRESSION. *See* Mental Regression.

REPRESSION. The active exclusion from the system of conscious mental processes of certain thoughts, feelings, and desires because they are markedly incompatible with the individual's personal ideals. Also, any psychic process which exists and occurs only subconsciously (unconsciously).

RESISTANCE. Presumably, this may exist either in an active and symptomatic or in a passive form. Excessive and constant concern in a young

woman about her mother's safety, which concern conceals a subconscious wish for her mother's death and keeps this from erupting into consciousness, would be an example of the former. The mere reluctance of a patient to try to recall some early disturbing experience in detail, or to make an effort to gain deeper insight into his symptomatic motivations, partakes of the nature of passive resistance.

SADISM. Deriving sexual pleasure or gratification in connection with inflicting pain on another person. A sexual perversion.

SCHIZOID. Pertaining to a type of personality characterized by poor psychic integration, affective inarticulability, oddities of speech and behavior, seclusiveness, etc.

SCHIZOPHRENIA. The most common functional psychosis. Four different forms are distinguished and many different symptoms, important among which are emotional withdrawal, stereotypy, mannerisms, negativism, delusions, and markedly regressive manifestations.

SEDATION. Treatment by producing a state of lessened functional activity.

SELF-REFERENCE. A tendency in a patient to see every proximate event as referring or relating to himself.

SELF-SUFFICIENCY. The ability to resolve one's emotional tensions, assume and discharge responsibilities, give proper direction to one's own behavior, etc. Emotional maturity.

SEREOLOGICAL. Pertaining to the study, character, and examination of sera.

SEXUAL FRIGIDITY. The inability of a woman to consummate the sexual act with orgasm, even though external conditions are optimal.

SEXUAL INVERSION. A desire or preference for the role of the opposite sex in sexual intercourse.

SEXUAL PERVERSION. Any one of a number of abnormal sexual activities. A preference for one or more of such activities to normal sexual intercourse.

SHOCK THERAPY. Any one of several radical and traumatic procedures in the treatment of mental patients. Unconsciousness and convulsions are produced. Electricity, insulin, and Metrazol are the agencies which have been most used.

SIBLING. A brother or a sister.

SOMATOPSYCHIC. Pertaining to an individual's ideas or opinions concerning his own body.

SOMNAMBULISM. A trance state in which the person engages in various, even complicated, activities and for which there is subsequent amnesia.

STEREOTYPY. Automatization of an activity. Mechanical-like repetition of words, acts, or gestures.

SUBCONSCIOUS. The sum-total of the potentially conscious mental processes of an individual which are excluded from his normal consciousness by

resistance. Under certain conditions these processes may become conscious. Moreover, in some instances, they apparently possess a secondary consciousness of their own (coconscious processes). Pertaining to any unconscious but potentially conscious mental process.

SUBLIMATION. The redirecting of libidinal impulses or motives to ethical, cultural, and social objectives. A desexualizing of a part of the sexual motivation.

SUBLUXATION. A partial or incomplete articulation of the bones of a joint.

SUPER-EGO. The particularly moralistic and self-exacting part or aspect of the psychic system. It is supposedly derived from early identifications with the moral and disciplinary attitudes of the parents.

SUPERIORITY COMPLEX. Partially or wholly repressed desires for great personal distinction, power, or perfection.

SUPPORTIVE THERAPY. A procedure which readily permits of emotional dependence on the therapist and makes free use of reassurance, advice, and encouragement.

SUPPRESSION. Used by the writer to designate a less energetic and complete reaction than "repression" but of the same order. To suppress is to implicitly refuse, with considerable vehemence, to consciously entertain a given line of thought or desire and to do this more or less wittingly. It is more forceful and more characterized by bias, on the other hand, than inhibition.

SURROGATE. A representation of a person which, however, conceals the identity of that person from conscious recognition.

SYMPTOMATIC. Pertaining to a symptom or to thoughts, feelings, or acts which closely approach the character of actual symptoms.

SYMPTOMATOLOGY. The aggregate symptoms of a disorder; a syndrome; a symptom-complex. Also, the science or study of symptoms.

SYMPTOM-COMPLEX. A syndrome; the aggregate symptoms of a disorder.

SYMPTOMATIC TREATMENT. The treatment of a disorder by treating the symptoms.

SYNDROME. *See* Symptom-complex.

TEMPERAMENT. The general affective character and intensity of an individual's life.

TRANSFERENCE. The development and/or existence of an emotional attitude in a patient toward the therapist, either in the form of affection, admiration, sexual interest, etc. (positive), or of hostility, suspicion, resentment, etc. (negative).

TRAUMATIC. Pertaining to an acutely disturbing emotional shock or experience.

TIC. A recurring or persistent involuntary muscular contraction of nonreflex character.

UNWITTING. Embodying aim or goal without consciously recognized intent or purpose.

VAGINISMUS. Spasmodic, involuntary contractions of the sphincters of the vagina. Frequently of psychogenic origin.

VERBAL ARTICULABILITY. The ability to express one's mental processes precisely and concisely in words.

VERBALIZE. To express oneself, or any meaning, in words.

VISCERA. The internal organs of the body.

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