MENTAL DISORDER, LEARNING AND PSYCHOTHERAPY.

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PART ONE

I. Introduction.

In recent years there has been a renewed interest in the development of therapeutic concepts directly derived from learning theory. The aim of this thesis is to examine concepts of mental disorder and psychotherapy in relation to learning principles. This involves, after some preliminary definitions, a survey of theory and practice in regard to mental disorder and therapy from early times to the present day, in order to get some indication of the broad trends of development and some account of the major theories now competing for recognition. Some discussion of relevant learning theories and principles follows, but no attempt is made to give any comprehensive coverage of the entire field, which, in itself, would be an ambitious task for a thesis.

Having thus prepared the ground, consideration is then given to neurophysiological functioning and the drives of the individual, and the way in which learning operates on this structure to produce the developed personality. An examination is made of the learned structure as an hierarchical, integrated system, in the belief that it is the ramifications and interconnections of the whole system which are important, and not merely a sum of learned responses.

Relating to this belief some research, carried out with the assistance of my husband (C.J. Adcock) and the resources of the Laboratory for Personality Assessment and Group Behaviour at the University

of Illinois, into the nature of the ego reference-system is reported. The findings here clear up some points about the organization of a key area in personality development. They gain added significance from the prominence given recently to Mowrer's (1961) emphasis on "sin" and the super-ego as the key to mental disorder and therapy.

Seventy-eight cases were selected from the literature on a sampling basis to be studied as examples of current therapy in order to discover to what extent learning principles are actually involved in therapeutic practice, whether or not explicitly conceived, and to throw further light on the nature of mental disorder. Each case is reported and discussed.

Using my findings with regard to the learning process in personality development and the knowledge derived from the study of the cases mentioned above, a classification of mental disorder has been developed, and the cases are classified in accord with this.

In a similar way a schema has been developed for the classification of therapeutic methods according to the learning principles involved and reference is made to typical examples.

Finally I report ten case studies of my own in which learning therapy was used and note the outcome of these methods. The closing chapter takes up some controversial points with regard to choice of therapy and concludes with a short summary.

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II. Definitions.

The terms "mental disorder", "learning" and "psychotherapy" are frequently used differently by different people. Some authorities use the terms "mental disorder" and "mental disease" or "illness" interchangeably, although English & English (1958) approve the use of the former rather than the latter terms. They, however, proceed to differentiate between "mental disorder" - "any grave or disabling failure of adjustment....." and "mental illness", this term being defined as:

> 1. a disorder of behaviour.....
> 2. a disorder due to psychic causes, whether the symptoms are somatic, psychic, or behavioural; psychogenic illness. (pp.317-318)

But there is at present current in some circles an argument as to whether or not there is such an entity as "mental disease", (Szasz, 1960; Mowrer, 1960c; Ausubel, 1961). This question was also discussed by Eysenck (1958), albeit in a different context. The current argument is tied up, on the one hand, with the age-old notion of "sin" being the cause of "mental illness" and, on the other, with the equally old body-mind or psycho-somato-genic argument.

We have, therefore, three terms, "mental disorder", "mental illness", and "mental disease", being used more or less interchangeably. It may be found that I myself have likewise used these terms synonymously but, as I shall be concerned, inter alia, with disordered cognitive processes and reference-systems, "mental disorder" is the preferred general term.

Within this thesis, then, "mental disorder" is used as a general term to cover any form of behaviour whatsoever, whether immediately observable or not, which may be regarded as maladaptive, whether somatogenically or psychogenically derived. It is contended that, apart from organic lesions or organic malfunctioning, all such disorders are due to learning or the failure to learn appropriate behaviour patterns.

"Learning" may be defined as "a more or less permanent change in the state of the organism produced by interoceptive and/or exteroceptive input, and resulting in some modification of behavioural trends and patterns", or as "the process which leads thereto". The term covers both "conditioning" and "cognitive learning" and may be used interchangeably.

"Psychotherapy" is used as a general term for all therapeutic processes aimed at modifying any form of mental disorder. Eysenck (1960a) has used the term "behaviour therapy" to cover therapy which emphasises the study and modification of behaviour as opposed to "therapy for the psyche", i.e. psychoanalysis (pp.10-11). The former is explicitly based on learning theory principles, but therapy based thereon need not be restricted to the area which Eysenck assigns to behaviour therapy. I have, therefore, used the term "learning therapy" to cover all psychotherapy using techniques based on learning theory, whether behaviouristic or cognitive in orientation.

The major concern now, as it has always been, is essentially with the cause and development of mental disorder. Throughout history there has always been an inability to focus on the real

problems at issue because of theological and other preconceived beliefs on body-mind dualism and the nature of both physical ill-health and mental disorder, while vested interests of many kinds have sought to prevent the dissemination of factual knowledge and behavioural change. In order to understand more fully the underlying causes of current controversies, as well as to place modern therapies in their lines of historical progression, it will be necessary to have a look at the theories and therapies of the past.

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PART TWO

I. Historical Background to Modern Theory and Practise:

As this section is intended not so much as a history of the study and treatment of mental disorder as an outline of the trends of theory and action, in the main recourse has been made to major secondary sources only, viz. Zilboorg (1941), Lewis (1942), Guthrie (1958), Murphy (1949), Boring (1950), Ackernecht (1955), and Schneck (1960). As much which is recounted is a matter of general knowledge explicit reference to the source is given only in regard to specific quotations or arguments. Unless otherwise stated the discussion is in terms of temporal progression.

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The two great factors which have both caused and separated studies and treatments of mental disorder have always been (a) man's inability to transcend his biologically derived intelligence and the environmental conditioning he has experienced, thereby causing some men to cling to beliefs deriving from ancient experiences with authority and the projection of fears and hatred onto image distortions such as demons, and (b) man's drive to understand his world, including himself, and to master his environment.

Arising from this view we may delineate two major historical and practical emphases, viz. the magico-religious, and the scientific, though their boundaries are frequently permeable. Both schools utilise symbolic and physical or material treatments, "symbolic" here implying both imagery of various kinds, including the use of models,

and verbal symbols.

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1. The Magico-Religious School.

(i) Primitive Speculation and Therapy:

While very little is known about "primitive" medicine and still less about paleomedicine, it would seem that both mental and physical disorders were considered to stem from the same supernatural source, and, indeed, for these early cultures, magic, religion and medicine were practically one and the same thing (cf. Sigerist, 1951). Early man, therefore, as Ackerknecht (op. cit) noted, must have had a primitive unitary concept of man.

Therapy consisted in the main of suggestion, imparted by the magical actions of the shaman, magician or priest, or operating through verbal or semantic conditioning. It is sometimes contended that a further variable might sometimes be operating, i.e. identification with the healer. It is possible that this might heighten the power of the verbal stimulus, or that the patient might endeavour to imitate such a powerful authority.

In a world full of natural forces explicable, at that time, only in terms of "spiritism" by men who frequently went into trances in order to explain or "heal", exorcism was the major therapy to be offered. Ellenberger (1956) points out that not only could there be latent and overt possession (in the former the spirit speaks through the possessed, in the latter the spirit only speaks out on the demand of the exorcist); but that exorcism is a particularly well-structured

type of psychotherapy, involving faith on part of possessed and exorcist, encouragement of the patient and great preparation (including possibly both fasting and prayer) by the "therapist".

There has been considerable interest and argument in relation to the finding of trephined skulls from prehistoric times. It would seem this operation could have been carried out either with the purpose of liberating evil spirits responsible for headaches or epilepsy, or perhaps even possession, and/or in order to remove bone fragments and decrease intracranial pressure. This latter view arises from the fact that most of the bone surgery evidently occurred in areas where weapons likely to cause such brain injury were found.

It would seem reasonable to assume that both spirit-imposed and physical injury were treated in this way.

Massage was likewise utilised as a means of inducing the evil spirit to leave - at first in stroking the limbs in a centrifugal direction towards the extremities - later, as a knowledge of pathology grew, in a centripetal direction. (Bartels, 1893, quoted in Guthrie, op. cit., p.12).

It would also appear that it was believed that death was imposed from without, as a punishment for breaking the prevailing moral code - a reflection no doubt of what usually happened in actual fact. If disease in the form of "a visitation from God" or possession by a demon did not kill one, one's enemy almost certainly did. At the same time there was probably a fairly widely-held belief such as that reported in Borneo as late as 1926, where it was considered

that disease is caused by the separation of the soul from the body, and the professional soul-catcher or dayong, is called in to deal with this phenomenon, (Guthrie, op. cit., p.5). Perhaps a forerunner to the contemporary belief in "dissociation".

(ii) Early Civilisations:

The Ancient Egyptians were mainly concerned with the idea of devil possession and their exorcism by incantantations. The Assyro-Babylonians, on the other hand, saw disease as the result of sin or moral impurity and there was even a ritualistic questioning of the sick man regarding possible moral lapses, (Entralgo, 1955, 26-28). The Ancient Hebrews likewise saw disease and disaster as a punishment for sin, and healing the result of appropriate propitiation and the regaining of worthiness. The Indians, however, were in the main concerned with spells and incantations (as in the Rig-Veda, a manuscript known c. 1500 B.C.), although they excelled at surgery, (Guthrie, p.33).

(iii) Ancient Greece:

As in all other fields of knowledge, the origins of much of our theory and practice can be traced to Hellas, though some of the beliefs of the Ancient Greeks would indeed seem to have come via India.

While recognising that the mentally ill were somewhat different in behaviour from the average population, the Ancient Greeks seem to have displayed decidedly ambivalent attitudes towards

mental disorder. Some apparently went to the temples of Aesculapius, to the Asklepieia, to be healed through the rite of "incubation" or temple sleep, (Hamilton, 1906 - Quoted by Guthrie, op. cit. p.43). As the Asklepieia the patients first made a sacrificial offering, bathed in order to purify themselves, and then lay down to sleep in the abaton, which was open at each side. During the night the god would appear, probably in a dream, counsel the patient, and perform an operation if required, and the patient would depart the next morning, cured!

On the other hand, the Pythias of the Delphian oracle would appear from the records of their behaviour to have been severely mentally disturbed themselves. Yet others were driven away from the temples or stoned. (Zilboorg, op. cit. p.38). In general, however, but one cause for the illness was recognised - the person concerned must have offended the gods or the Oracle, must have sinned - a theory which, in slightly different terms, is to-day espoused by Hobart Mowrer.

(iv) The Roman Civilisation:

Although, as will be seen later, some members of the medical profession and others were concerned with more scientifically acceptable observations and explanations, many still held to the belief in demon possession or sinful behaviour being the cause of mental disorder.

Around the end of the 4th C.A.D. Caelius Aurelianus, whose "writings were considered more practical than those of any other medical authority of antiquity" (Everyman's Encyclopaedia, 1958, p.732), combined both reason and superstition. Perhaps due to reaction against

the licentiousness of much of Roman society or to the ascetic doctrines of the Pauline Christians, he himself rebelled against the sexual practices and sexually-derived pathology which he frequently observed. He wrote De Incubone in which

> he accepted and reformulated the increasingly popular ancient belief that there exists a special type of demon who appears under the guise of a man and whose business it is to tempt and seduce women sexually. (Zilboorg, op. cit., p.86, quoting earlier writers).

(v) The Middle Ages.

With the death of Galen (200 A.D.) we come not only to the end of an era of scientific development, but to the beginning of a practically total black-out. Rome itself did not fall to the Barbarians until the latter half of the 5th century, but much of reason had already fallen before asceticism, superstition and fear. For the next thirteen or fourteen hundred years - a truly incredible amount of time - the history of mental disorder and psychotherapy is largely a history of demonic possession and/or religious heresy and exorcism in some sado-masochistic form or other, or faith-healing, all fanned by extraordinary waves of mass and individual hysteria and sociopathy.

Nobody of sound mind and a real concern for humanity can look at this period of history without committal. Superstition must be controlled and replaced by knowledge, and over-emotionalism by reason. Superstition, unbridled emotionality and asceticism, dogma and fanaticism, not only stemmed from, but produced, disordered minds and societies. The conflict inherent in contradictory value systems, the demand for faith and a lack of factual information,

brought and still brings mental and social disorder on both the individual and grand scale.

The end of the 15th century was to see some of the most interesting and appalling psychopathy or sociopathy of all time. With the papal and academic (theological) endorsement of the Dominican priests, Sprenger & Kraemer's Malleus Maleficarum - the Witches' Hammer - there developed an hysterical, sado-masochistic orgy which was one of the longest in history. Mental disorder became not just "demonic possession" but could also result from either being a witch or being bewitched. Death was a relief from the merciless "therapeutic" torture which followed. In the 20th century the Jews played much the same role as the "witches" - Hitler and his minions were a shade less superstitious or a shade more materialistic in their theologizing, that's all.

We should, however, perhaps bear in mind the fact that the confessions wrung from any of the victims, and the devils exorcised (St. Fortunatus laboured so mightily he extracted 6,670 devils from one victim - Zilboorg, op. cit., p163), have strong links with the "sins" confessed in current Mowrerian therapeutic sessions, or the information given by a patient in any analytical or neo-analytical session - the difference really lies only in the therapy administered or experienced.

(vi) The Renaissance:

With the coming of the Renaissance the conflict between the two schools, the one concerned with superstition, concupiscence,

with possession, "sin" and final expiation, and promoting great carnage, the other, seeking scientific, factual information, concerned with humanity and led by men of great personal courage, became more obvious. Sometimes the conflict was found in one man - Plater (1536-1614), for example, attempted to classify mental disease into acquired, congenital and hereditary disorders, but, overcome perhaps by the bizarre nature of the delusions and hallucinations he observed, still believed in possession by the devil. Always the conflict appeared within society - England was no exception: James I ordered Scot's attack on witch-hunting, the Discoverie of Witchcraft burned; but along with the presence of Francis Bacon and his influence on the development of empirical scientific method, in 1547 "Bedlam", the monastery of St. Mary of Bethlehem of London, became a mental hospital. But the worst aspects of the magico-religious school's teachings and practice were not yet at end.

(vii) The 17th and 18th Centuries:

The witchcraft school continued its work and influence throughout the 17th and 18th centuries. Indeed it is still extant in some places to-day, (cf. Olsen, 1957).

The struggle between superstition and knowledge, also yet with us, still appeared in its more bizarre form. Thomas Willis (1621-1675) maintained his belief in devils and concomitant severe therapy; yet nonetheless was an outstanding neuroanatomist. The last major flare-up was possibly the infamous Salem witch-hunt and trials of 1692.

With the Reformation, however, there emerged fresh religious-inspired emphases on the scene. The Protestant movement towards a rational, scientific conception of the universe and life (joined in some cases by Catholic intellectuals) developed over several centuries and has affected much psychotherapeutic thought and practice. But Protestantism also produced the rigidity and bigotry of Calvinism and later, Puritanism, which has had a major influence on English and American behaviour patterns. Europe, on the other hand, in the main continued to be dominated by the Roman Catholic ethic, with its emphasis on graded "sins", confession, appropriate Church-imposed and approved penances or expiation, and re-acceptance, (or "redemption", to use the Protestant term), all playing a therapeutic role to some degree.

(viii) The 19th and 20th Centuries:

With the exception of the late 19th century elevation of Mary, Catholic dogma has remained more or less constant, and the practice of belief in the magical powers of various "saints" and their physical remains or images is still prevalent. Both Catholic and Protestant churches retain the idea of "sin" and/or immoral behaviour, although the punishment of hell-fire and damnation or eternal perdition is by no means preached so assiduously to-day. Nonetheless their various religious backgrounds have undoubtedly affected much of the theorising of the leaders of the various therapeutic schools.

Freud, an atheist himself, apparently owed much to the Jewish Kaballah as well as to classical works on mythology, such as those by Frazer, Reinich and Max-Mueller (cf. Bakan, 1957, Wells, 1960).

Henry Stack Sullivan, of Roman Catholic origin, could well have been influenced by early Catholic reaction against Freudianism and the Catholic concern with the family in his emphasis on interpersonal relationships. Jung was undoubtedly strongly influenced by his Protestant and theological background, as well as by Freud's emphasis on symbolism and dreams.

Of the Modern Schools, it is Hobart Mowrer and "Mowrerian therapy", which owes most to this strand of development. But with the exception of the faith-healing and laying-on-of-hands cults - both depending upon the power of suggestion and symbolic conditioning - all the current psychotherapeutic schools owe (or claim to owe) even more to the scientific school, whether their primary derivation is philosophically, observationally, or experimentally oriented. They are, therefore, dealt with under this second heading.

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2. The Scientific School:

As signified earlier, in the main this discussion is presented in terms of temporal progression, but, in this section, later developments are sometimes referred to in immediate relation to their point of origin, in order that the developmental pattern may be more clearly seen.

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(i) Primitive Medicine:

Note has already been made of primitive surgical practices.

(ii) Early Civilisations:

Among the ancient peoples, the Chinese would appear to have

been the most enlightened, perhaps because their religious or philosophical beliefs placed emphasis on good behaviour - Nirvana may only be finally reached through consistent "Right" behaviour - and not on the punishment of "sin". Certainly among the ordinary populace belief in demons remained dominant for many centuries, but as early as 2650 B.C. Hwang Ti is believed to have written Nei Ching, the Book of Medicine on which all Chinese medical literature is founded, and in which appeared the statement,

> All the blood in the body is under the control of the heart.....the blood current flows continuously in a circle and never stops. (Quoted by Guthrie, op. cit., p.35).

Two hundred varieties of pulse have been described, and it is believed that any internal disease may be diagnosed in this way.

Later they developed the theory of the two fundamental principles, Yang and Yin, which required to be in balance throughout the universe. The human body was believed to be composed of five elements - earth, fire, water, wood and metal - and health consisted in aharmonious balance between the various elements. From very ancient times the Chinese used massage and acupuncture, a clinic for the latter now being operated in Taiwan, and yet another in Paris, for the cure of neurosis.

(iii) Ancient Greece to Modern Times:

It is quite clear that from the time of Ancient Hellas onwards development has been occurring in four areas - (1) the medical (with both palliative and radical treatments) and physiological area, which merges with (2) the experimental; (3) the cognitive-

philosopho-speculative area, which also differentiates into two streams: the philosophically-derived ethical or value system developments, and the speculative-hypothetical deductions which gave rise to both cognitive learning theory and the mind-body argument, derived though theyboth were in part from the magico-religious school; and (4) the educational area - placing emphasis on either cognition or emotion and hedonism, and dividing into two emphases: (i) the punitive aimed at inhibiting or extinguishing unwanted behaviour patterns, and (ii) the preceptive and rewarding aimed at inculcating or developing and reinforcing desired or approved behaviour patterns.

All these trends of thought and activity have developed side by side throughout the centuries, sometimes integrating sometimes differentiating, with the dominant emphasis varying in time and place. It was not until the late 19th and 20th centuries that they finally merged to produce the "learning theory school" of to-day, split though this still is to a degree in terms of classical conditioning, operant conditioning and cognitive emphases.

The modern form of this argument probably has its foundations in the 18th century when Hartley (1705-1757) was concerned with "classical conditioning" - learning by contiguity or associative sequencing resulting in sequential neural patterns. Herbart (1776-1841), on the other hand, was concerned with dynamic relations. For Hartley, if A were followed by B in the past it will be followed by B again. For Herbart, if A were followed by B it will depend on the strength of other associations whether A is followed by B again or by C, Y or Z. There is a possibility of conflict, not only between A and B, but

between C-Z in relation to both A and B. But Herbart was not only concerned with the conflict of ideas competing for consciousness, he went further and postulated two thresholds to consciousness, the "static" and "mechanistic" thresholds, comparable to Freud's censors and separating the contents into levels analogous to Freud's pre-conscious and Unconscious (Wells, 1960, p.119).

But there is little of to-day's theorizing which has no basis in Greek or Graeco-Roman thought. The works of Plato and Aristotle are too well known to need comment here. What is not so generally realisèd, however, is that the important concept of man as a tabula rasa, with knowledge stemming from externally derived stimuli, was already accepted by the Cyrenaic School, the Cynics, the Epicureans and the Stoics, nearly 2000 years before Hobbes (1588-1679) and John Locke (1632-1704). This concept has been of considerable importance in the development of cognitive learning theory and played a leading role in the body-mind, religio-secular controversies.

Asclepiades (fl. 91 B.C.) held that disease depended upon the condition of the atoms of the body, health being the balance between their tension and relaxation. Themison (123-43 B.C.) elaborated this theory and provided the basis for Broussais' theory of irritation Brown's theory of sthenic and asthenic states, and Pavlovian excitation and inhibition. (cf. Guthrie, op. cit., p.67).

Cicero (106-43 B.C.) presaged current interest in attention. He noted that man is not aware of, or does not attend to, all the sensory impressions he receives, and concluded that it is the mind that

is of primary importance and not perceptions per se. He contended that mental disorder could be produced by fear, pain and anger, and in his writings distinguished insania - absence of calm and poise - from furor - complete breakdown of intellectual capacity, which makes the afflicted individual legally irresponsible. (Zilboorg, op. cit., p.66).

Galen (130-200) was an early Hedonic learning theorist, setting out clearly the principle which has finally led to the scientific interest in reward and punishment and emphasis,

> Truly, if there were no pleasure nor pain, nor even sensation in the elements devoid of passion, there would be no memory, no reminiscence, no perception; for sensation is the root, the very source, as it were for all these faculties. If there is no pleasure, nor pain, or even sensation, then there are no psychic functions, and therefore one would be forced to say that there is also no soul. (Quoted by Zilboorg, p.67)

Furthermore, he divided the rational or animal soul, whose seat was the brain, into two parts, the external functioning through the five senses, and the internal functioning through memory, judgment, imagination, apperception and movement. Disturbances in any of these functions, i.e. mental disorder, was due to either disease of the brain itself or to the effect of consensus.

But, as stated earlier, with Galen's death the Dark Ages were well begun. From time to time during these centuries some attempt was made at ameliorating the state and condition of the mentally disordered, but on the whole, from late Roman times until the 18th century and even beyond, psychotherapy was mainly punitive in nature. The flagellations, tortures and executions gave way to ducking-stools.

This primitive form of "shock treatment" gave way to the slightly more sophisticated version of Boerhave's (1668-1738) twirling stool, designed to produce unconsciousness in the patient (Stainbrook, 1946). Whether this idea stemmed in any way from Harvey's earlier (1628) discovery of the circulation of the blood remains a mystery. Certainly it did not stop blood-letting being used for mania as well as anybther disease, although it did lead in 1667 to blood-transfusion being used by one Dennis as a successful cure for melancholia. Blood-transfusions for the mentally disordered were also used by Sir George Ent in England and Klein and Etmüller in Germany. (Zilboorg, op. cit. pp. 275-276). A century later Benjamin Rush (1745-1813) was still using the ducking-stool, but added to this the tranquilizer (a chair for immobilization of the patient), and the gyrator.

So far as physical treatments are concerned, the 19th century finally saw the use of less punitive, though still quite "radical" therapies. Hydrotherapy, electrotherapy (utilising galvanic and faradic currents, a type of therapy which Freud is said to have used in his own early practice (Walker, 1957)) and chemotherapy were popular. Occupational therapy and "rest cures" (introduced in America by Mitchell, 1829-1914) utilising rest, good food and isolation, were also in vogue. Isolation from conflictual stimuli or undully stressful situations remains good therapy. Electrotherapy has its modern counterpart in negative or avoidance conditioning techniques. The 20th century has also seen the development of electro-convulsive therapy, and such techniques as leucotomy or lobotomy.

These so-called "modern innovations" are, however, slowly giving way to the increased use of modern drugs, i.e. a return to chemotherapy. Such physical treatments reflect the bias toward a physical explanation in terms of organic or biochemical malfunctioning as the cause of any or certain forms of mental disorder. At the same time they reflect the alternating emphases on surgery and medicine, neurophysiology and biochemistry, "tough-mindedness" and "tender-mindedness"; affect and cognition, and other aspects of psychosomatic functioning and its disorders.

The beginning of the 19th century saw a number of important developments in the area of verbally-mediated psychotherapies. Mesmerism led to the use of hypnosis, frequently used at the present time as a therapeutic adjunct (cf. Wolberg, 1945; Lindner, 1952). The work of Charcot and Liébault, using both hypnosis and suggestion, and Coue's enunciation of the laws of suggestion, are well known. But hypnotism was also used by Bechterev and has remained in constant use in Russia (cf. Platonov, 1959).

Also at the beginning of this century, Johann Christian Reil, the great neurologist, first utilised some semi-analytic techniques, e.g. he placed his patients in an absolutely dark and dead quiet cell and let them talk. He advocated what amounts almost to anticipation of Moreno's (1934, 1946) sociodrama, for he wanted a special psychotherapeutic theatre in which employees would play the roles of judges, prosecutors, angels coming from Heaven, dead coming out of their graves which in accordance with the needs of various patients should be played to produce the illusion of utmost verisimilitude. (Zilboorg, op. cit. p.287).

But Reil reflected also the growing interest in neurology, the cerebellum being his major interest and the "island of Reil" commemmorating his name. In the main it was the French school which was largely responsible for the development of modern neurology.

The various developments referred to above led directly to Freud, though many of his concepts cast back to other developing trends, including the increasing interest in neurophysiology, the interest in thresholds and states of consciousness already referred to in connection with Herbart, and the development of ego psychology. This last influence developed in early 19th century France and Germany. It was enunciated by such people as Broussais, who published a book in 1828, On Irritability and Insanity, in which not only did he speak of "le moi", but he described insanity as "a habit in which 'le moi', personal consciousness, can no longer distinguish it from a normal state," (quoted in Altschule, 1957, p.29), and Ernst von Feuchtersleben, the Dean of the Viennese Medical School, and Wilhelm Griesinger of Tubingen. Both von Feuchtersleben and Griesinger wrote (around 1862) of the Ego or "das Ich". von Feuchtersleben led the field in many directions - not only did he see the unity of mind and body, but he considered psychotherapy should be "a second education". (Altschule, op. cit., p.31).

The experimental school also had its effect upon the development of both analytic and learning psychotherapies. Freud's frequent references to Fechner clearly show the great influence of the latter. Wundt's Institute was not founded until 1879, but the work of Wundt himself

and his laboratory was also to have far-reaching effects on general and abnormal psychology theory and practice. Fechner was also a follower of Herbart, as was Maynert, Freud's teacher, while Herbart's textbook was in use at Freud's Gymnasium. Freud merely expanded and gave different terms to Herbartian notions, including one not yet mentioned here, viz. the concept that mental dynamics are the result of charged or highly energized unconscious ideas in perpetual rebellion against conscious ideas, ideas being eternal (Wells, 1960, p.119). This latter notion, of course, turns up to-day in terms of Hebb's (1949) reverberating circuits, or Penfield's (1958, 1959) experiments showing that memories are apparently always retained.

It is interesting to note the struggle within Freud of two major influences. Until he was 41 years of age, Freud's work clearly entitles him to be called a "great" neurologist, but after, first, his work with Liébault and Bernheim, and secondly, and perhaps more importantly, his new interest in Breuer's cathartic method, he became the therapist rather more than the scientist. In 1895 Freud and Breuer published Studies in Hysteria; the same year Freud wrote The Project in which he speculated on the physiology of the brain, actually allocating central roles to the processes of excitation and inhibition or "the principle of neuronic inertia". But, unfortunately, also in the same year, as he admits in Vol. V of his Collected Papers, Freud (1922) read the speculative social psychology of Gustave Le Bon as described in The Psychology of Crowds, which gave him the basis for his postulations regarding the innate nature of symbolisms. (For an expanded discussion of much of this material see Wells, op. cit., particularly pp.10-29).

The last major influence upon Freud, apart perhaps from Charles Darwin's theory of evolution, was undoubtedly the historical emphasis on sex and the sexology of Ellis and Krafft-Ebing and others who were responsible for the scientific approach to the centuries' old magico-religious and medical approach to sex, whether considered in terms of hysteria or not. This point is dealt with a little more fully below.

Wells, like many Behaviourists and members of similar schools, (cf. Salter, 1953; Eysenck, 1953b), concludes that

> Freud's unconscious, evil-wish, demon theory of neurosis has little in common with science, medicine, or psychiatry, that it is in fact anti-scientific and constitutes essentially a road-block in the path of further development. (Wells, op. cit., p.218).

This is an emotional reaction to the many examples of strained paleologic thinking found in the Freudian literature, and the lack of experimentation, but it fails to take account of such positive contributions as the description of the development of the conscience and non-rational factors in behaviour. The contention is dealt with both implicitly and explicitly within the body of this thesis.

We have already observed many of the influences which shaped Freud and his theories. Pavlov, on the other hand, as Wells himself notes (p.21) was an experimental physiologist, and by 1895 had already spent twenty years within that discipline, so that he was quite ready to "begin those experiments which were to lead to the discovery of the physiological basis of man's mental life."

But before considering the work of these men more fully and the psychotherapeutic schools of the 20th century, the classification of mental disorder, being part of the work of the "Scientific School", requires some consideration.

It would seem that there has always been a tendency to classify any form of illness in terms of the degree of seriousness or permanency of the complaint, as well as in terms of suspected aetiology. Even the magico-religious school differentiated forms of "sin", e.g. "venal" or "mortal". In Ancient Greece Hippocrates (460-377 B.C.), the "Father of Medicine", differentiated between the postulated sex-linked "hysteria" and "mental illness", which he defined as "mania, melancholia and phrenitis", the latter term referring to states of delirium. "Hysteria", "mania" and "melancholia", with some modifications in meaning, remained in common use until this century.

It might also be noted that Hippocrates is said to have been the first to pay attention to "spontaneous remission", or the principle of Vis Medicatrix Naturae. (Guthrie, op. cit., p.57).

It will be observed that classification may also be said to have centered around the apparent opposites of emotionality or excitability and depression or inhibition, as well as between what came to be called "neurosis" and "psychosis".

At the same time interest in aetiology, as well as in description and classifying per se, led to several different developments in classification:

(1) An emphasis on simplicity, stemming from or leading to, a unitary concept of mental disorder. (This can be seen in the work of Neumann, Janet, Menninger, Pavlov and Meyer, (cf. Schneck, op. cit., p.19).

(2) Differentiation and detailed classification. (Meyer's work also comes within this category, as does that of de Sauvages and Kraepelin.)

(3) An interest in the physical aspects of cause and effect, as espoused, for instance, by Erasmus Darwin, Maudsley and also Pavlov.

(4) Concern with psychological causes and effects. (Bleuler's detailed classification could be considered under this head; so, too, could Meyer's reaction types. Freudian regard for difficulties stemming from the various stages postulated for psychosexual development is also related to this.)

The most widely-used classification to-day is probably that of the American Psychiatric Association (1952), which owes much to the work of Bleuler and Meyer. This classification was originally formulated in 1917, revised in 1934, and finally laid down in its present form, largely as the result of pressures deriving from experience in World War II. (Coville, Costello & Rouke, 1960). It differentiates mental disorders into two main groups, (1) those caused by or associated with impairment of brain tissue function ("organogenic" or "somatogenic" disorders) and (2) those disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain. The latter in turn breaks down into the following categories of disorder: psychotic, psychophysiologic autonomic and visceral, psychoneurotic, personality and transient situational personality.

It is my contention, however, that the most meaningful classification can only be in terms of the learning or disruption of

learning involved in mental disorder, and I have accordingly endeavoured to formulate such a classification. This is set out in Part VI.

It is a moot point how much classification has affected the general practice of the modern psychotherapeutic schools or vice versa. Maskin (1960) has noted that

> Freud used hysteria as the model for his therapeutic method, depression as the basis for his later theoretical conjectures. Adler's clinical demonstrations are rivalrous, immature character types, Jung's examples were constructed to a weary, worldly, successful, middle-aged group. Rank focussed upon the conflicted, frustrated, rebellious artist aspirant. Fromm's model is the man in a white collar searching for his individuality. And Sullivan's example of choice is the young catatonic schizophrenic.

Commenting on this statement, Stein (1961) pertinently added,

> Rogers' original formulations were based on college students. (Stein, op. cit., p.7).

With Pavlov and the Russian schools, as also with the Behaviourists, I myself have endeavoured to formulate my theorising in terms of universality.

Undoubtedly the theoretical orientation of particular practitioners affects the classification tag, or diagnosis, they append to any given case. Unfortunately there is great variation in diagnosis, or prediction, even among so-called "experts" (cf. Cattell, 1957; Holtzmann & Sells, 1954), as well as in the psychotherapeutic terminology and some of the techniques they will employ. In any general consideration of psychotherapy, therefore, it is essential to have regard to the theories and practices of contemporary schools.

....

II. The 20th Century Schools.

(It should be noted that, as I am here particularly concerned with learning and learning situations involved in therapy, I do not intend discussing other than major schools or authorities. Likewise I do not propose to trace their historical development.)

..

The two great contemporaries who straddled the 19th and 20th centuries, Ivan Pavlov (1849-1936) and Sigmund Freud (1856-1939), brought to fruition many of the trends already considered. Pavlov, the neurophysiobgist, whose life-long interest in his discipline, particularly in the field of "higher nervous activity", led to the development of conditioning techniques and much of modern learning theory, as well as to semantically-oriented and behaviouristic types of psychotherapy, is the epitome of interest in physiology and neurology, experimentation, and physical or material explanations of the universe. Freud, a brilliant neurologist turned psychotherapist and psychological theorist, was the focus of the long historical development in speculative-hypothetical deduction (based on whatever knowledge appeared to be available), and in hedonism, affect, and the other concerns of what I earlier designated the "educational area" (see p. 17).

As, and when, first created, the Freudian system was scientifically sufficiently respectable, but its stress upon symbolic interpretation of all the patient's activities involved it not only in all the weaknesses of "mentalism", but made it a prey to all the confusions of schizophrenic-like thinking. Freud and his followers

developed stereotyped ideas which could not be adequately tested by their own methods because of the multiplicity of symbolic meanings, and which were not subjected to the ordinary checks of scientific method. Like more primitive approaches psychoanalysis, and its modifications, are full of suggestive ideas but need careful study by scientific methods.

The differing emphases of Freud and Pavlov and their followers have led to much conflict, as well as to sometimes strangely similar developments, for both are concerned, willy-nilly, with learning. In this respect the ideas of both these men are in strong contrast with the magico-religious thinkers, who tended to account for aberrant behaviour as the work of spirits or the punishing deity. The stress on the actual experiences of individuals as the origin of distorted personality enables the therapeutic problem to be tackled by scientific procedures.

Furthermore, the Freudian concept of repression has much in common with Pavlovian inhibition, while Freud's Unconscious finds its counterpart, and its physiological explanation, in Pavlov's "higher nervous system". Therapeutically, however, the distinguishing feature of Freud's practice was the use of the analytic procedure.

... ...

1. The Analytical Schools:

("Analytical" is used here to cover all schools using analysis, explicit or implicit, as the primary technique.)

On the whole, the concepts of unconscious motives and

repression, and the techniques of orthodox psychoanalysis, (i.e. verbalisation on the part of the patient, frequently as the result of free association; anamnesis of childhood experiences and fantasies; consequent and subsequent abreaction or catharsis (derived, initially, of course, from Breuer); analysis of verbalisations, dreams and both manifest and latent behaviour in general as well as in the transference situation), have remained in use by all the analytical schools, directive or non-directive in performance. There are, however, a number of major points of conflict regarding such matters as interpretation, the rationale offered for the therapy given, the Unconscious, and other inferred and stated explanations of the nature of human beings. Moreover, while the transference situation - the focal learning situation - is regarded by all as important, there are vital differences in the behaviour within, and speculation about, the "transference" itself. These differences are explored below under two main headings:

(a) Therapeutic aims:

The Freudian aim is not only to release the sexual drive, whether in pure or sublimated form, but to establish the control of the ego over the individual's instinctoidal drives, and incidentally modify the learned reference-frame introjected earlier from the parents or their surrogates to form his super-ego. In other words Freudian therapy is concerned with unlearning and relearning. (cf. Freud, 1949, pp.35-48). This emphasis on the ego is even stronger to-day with the avowed "Ego Psychologists", (e.g. Hartmann, 1958; Rapaport, 1958, 1959).

While concerned with the patient's goals and "life-style", Adler and his followers aim to re-educate the patient into adopting socially-directed aims and behaviour. Normality is equated with community, and therapeutic cure with a "turning of the patient back definitely and unconditionally upon society" (Adler, 1929).

Even more than Adlerian therapy, Jungian therapy is strictly individualistic, "a purely dialectical procedure, adopting the attitude that shuns all methods," aimed at individuation, i.e. helping the patient to achieve self-actualization. (Jung, 1935). The Jungian aim is to develop a fully-integrated, harmonious and balanced personality with a concomitant feeling of purposiveness.

Horney has defined her aim as:

> That a person gains the capacity to deal with himself and with his further development. (Wolff, 1956, p.88).

The Sullivanian, Clara Thompson, defines the goal of psychotherapy in somewhat Frommian terms -

> To make a person productive and able to love, not necessarily to become adjusted to his environment in the sense of conformity. (Wolff, op. cit., p.97).

The Existentialist therapists may be said to be concerned with enabling man to cope with his ontological anxiety, to experience his own "being", and to develop love and a sense of responsibility (cf. Van den Berg, 1955; Allers, 1961; May, 1958, 1961). Rollo May has defined the aim of therapy as being

> that the patient <u>experience his existence as real</u>. The purpose is that he become aware of his existence fully, which includes becoming aware of his potentialities and becoming able to act on the basis of them. (May, 1958, p.85).

Of those quoted, the Adlerians and Sullivanians may probably be regarded as the most moralistic of the schools, and the ones most super-ego or conscience-oriented. The remainder are, on the whole, ego-oriented, although they are also concerned with the other half of the super-ego function, viz. the ego-ideal.

A new European contribution on the scene, fundamentally concerned with super-ego functioning, and moralistic in tone, is that of the Greek Sakellariou (Professor Emeritus of Athens University). His Personality Scales and research (1953) and his aim of Character Training and method therefor (1960) are based on Pythagorean theory, particularly the three Pythagorean questions, "What did I do today? What wrong did I do? What did I not do, that I should have done?" and on the twelve virtues: philanthropy, temperance, cleanliness, good conduct, courage, contribution to the common good, respect for the law, diligence, truthfulness, co-operation, order and punctuality and justice. As will be seen later, he and Mowrer have much in common. It will be observed that a cognitive acknowledgment, or awareness, of "wrong-doing" is used both as a guide to right and wrong, and as a conditioning agent to inhibit "bad" and reinforce "good" behaviour patterns. Punishment in terms of social disapproval is also used as a reinforcer. Sakellariou has developed his "Character Training" essentially as a prophylactic technique, but it is also therapeutic in its effects.

Mowrerian therapy and Moreno's sociodrama are at least implicitly if not explicitly "analytical" in the sense in which the term has been used in this section. The former, particularly, is

associated, in my opinion, with the psychoanalytic and related schools in many ways, but, being a very recent, highly debatable, development, it is discussed separately. Sociodrama, with its very different techniques, is also dealt with separately.

The other major American school which I contend utilises implicit analysis, i.e. the Client-Centred Therapeutic School of Carl Rogers (cf. Rogers, 1954, 1959), is, like Existentialism, phenomenological in origin and orientation. Like Jungian and Existentialist therapeutic aims, that of Rogerian therapy is the development of a healthy self-concept. Like Adler, Rogers demands through therapy a cognitive recognition of those experiences or needs which the client is "disowning", i.e. refuses to recognise because they do not fit into his self-concept (i.e. ego-ideal), or of which the phenomenological self is unaware (except as some vague irritant or excitation) because they have not yet been symbolized. His theory, therefore, has something in common with the Freudian repression of affect, and with Maslow's hierarchy of needs (Maslow, 1948).

All these schools are quite obviously concerned with learning and the learning process, but the learning situation and its effects are sometimes quite different.

(b) The Therapeutic or "Transference" Situation:

Unlike the Freudians, the other schools mentioned are not particularly concerned with a total anamnesis of childhood memories. Both Jung and Adler and their followers interpret freely, whereas Freud interpreted only when forced to.

The Freudian therapist should ideally automatically (or consciously, if necessary) repress his own reactions and be completely neutral and impersonal - which, of course, would mean that the patient is supposedly faced with an ambiguous stimulus, leading to increased anxiety (cf. Frenkel-Brunswik, 1949), and/or that he is given a forced choice, and must interpret the possible reactions of the therapist for himself. Whether he does this in terms of past experience with apparently ambiguous other-behaviour, or in terms of past experience with the person/s of whom the therapist reminds him (no matter what the level of awareness may be), or in terms of his current needs or future goals, must be a matter of individual choice or preference. But an individual's choice may not be the same as his preference. It is quite obvious that the degree of his anxiety or fear will affect his capacity to choose, while the degree of his need will affect his tendency to choose his preference.

The Freudian, of course, probably does not think in such terms; but this, I suggest, is the crux of the transference situation. The behaviour of the therapist is going to affect the patient's perception of him and the role in which he will be cast; the patient's response to the stimulus presented will likewise affect the outcome. Their mutual interdependence cannot be gainsaid.

To the Freudian what it of major importance, and what leads to the goal of self-knowledge or insight, is the analysis of all the behavioural patterns which the patient demonstrates in this highly-structured yet possibly ambiguous situation. Freud himself saw transference more as an asset or technique in the aim of total anamnesis;

the Ego-psychologists and the Object-Relations School (cf. Klein, 1937; Fairbairn, 1952) see it as both the key-situation and the source of the material primarily requiring analysis.

The Jungian transference-situation, as with that of many of the neo-Freudians, is, however, quite different. In the first place it is more loosely-structured, depending not on a supposedly ambiguous, neutral analyst, but on the spontaneous interaction between patient and therapist. "Transference" and "counter-transference" is involved. While the analyst is considered to comprehend and be capable of explaining his own behavioural actions and reactions, as the result of his training analysis, unlike the Orthodox Freudian the Jungian is himself free to react to the patient's verbalised and acted-out behaviour. This is true, also, of many of the related schools.

Whether even the most orthodox Freudian is really able to maintain complete neutrality is highly questionable. I personally do not believe it possible, mainly because the minutest of practically imperceptible stimuli, such as kinaesthetic movements, are registered by the vigilant organism (cf. Heider, 1958, pp.20-58). Furthermore the value-system of the individual therapist is bound to affect his own interpretations and verbalisations and behaviour (Glover, 1955; Seward, 1961; Strupp, 1956, 1960; Wolff, 1954), thereby becoming cues for reaction to, or imitation by, the patient.

But, whereas in the Freudian transference situation, the cues are incidentally or accidentally derived, in the Jungian situation the patient is deliberately fed information as to the effect of his

behaviour upon one person, viz. the therapist, and thereby given cues as to understanding both his own behaviour and that of others in reaction to himself. As an incidental but direct result, the Jungian patient learns to modify his inter-personal behaviour; theoretically the Freudian patient learns only to comprehend the reason for, and incidentally the nature of, his own behaviour. The former situation is, in essence, less authoritarian than the latter, and conceivably less punishing, for it is only when the Freudian patient interprets "correctly" that the Freudian therapist may leave his seat of non-judgement, may re-humanise himself and unbend. The Freudian patient, therefore, is actually conditioned to verbalise, or actively mould himself, after the wishes of the therapist, his new model or surrogate-parent. Certainly the Jungian patient, if he admires his therapist, will tend to imitate him or introject his values - but this is a tendency, which may or may not require rectification; the Freudian patient is in effect required to develop a habit. (Although not couched in quite the same language as used here, for a full description of the therapeutic practices of the psychoanalytic and related schools, see Walker, 1958).

Within the therapeutic situation Adler found his patients essentially concerned with their inferior relationship to him - if they were friendlily disposed (i.e. developed "positive-transference") he considered them to be socially conscious, not "parent conscious" as it were, and he interpreted the transference behaviour accordingly. Like the Freudians, he demanded habitual responses and relation to a particular reference-frame from his patients.

Adler's view of the transference situation has much in common with the Existential notion that "in later years he perceives wife or therapist through the same restricted, distorted 'spectacles' as he perceived father or mother" (May, 1958, p.79). Within the Existentialist transference situation, however, the "presence" of the therapist is required, empathising with the patient, interacting with him, and living-out his problems with him as it were. This is also close to Rogers' position (Rogers, 1955).

Rogers' techniques may be described as (a) the provision of a warm permissive situation (the ideal infantile learning situation) in which the client explores his own needs and behaviour; (b) the understanding and clarification of what the client is endeavouring to communicate. The therapist, theoretically at least, does not direct, diagnose nor interpret; he acts primarily as a "sounding-board". In this latter respect he has a common orientation with Moreno (1934, 1946).

..

2. Moreno's Socio-drama School:

Moreno's psychotherapy is aimed at developing different behavioural habits or adaptation patterns as well as the solution of particular problems, or the enabling of the patient to achieve certain given goals. Moreno, however, defines the goal of his therapy somewhat more imaginatively -

> The organized manifestation of a new therapeutic religion on earth, involving all ages, classes and races of mankind. (Wolff, 1956, p.138).

His comments on transference are very pertinent:

> We agree that the patient projects certain images upon the therapist. But the therapist more or less projects certain images upon the patient..... (Wolff, op. cit., p.139).

Actually Moreno was one of the first to utilise the technique of group psychotherapy, first with children in Vienna and later with groups in the United States. He formulated his technique of psychodrama as far back as 1911.

Unlike other group therapists Moreno prefers a group to consist of a cross-section of the community. Patients and therapists are co-equal in the group. In the drama situation simple acting-out of problems may occur, members may co- or double-act, counter-act, or role-reverse. A. may also 'mirror-act' for B., i.e. A. may play the role of B while the latter watches. The patient gains insight into his own behavioural patterns; learns the roles of others; learns how to adjust in various situations and learns to adopt more adaptive behavioural patterns.*

The group situation, as in Analytic Group Therapy, is regarded as being a situation in which the patient can observe the differing reactions of others and in which there are more communication-producing stimuli. Obviously it is a learning-situation for each individual; equally obviously it is a socializing or conditioning agent. One major possible criticism, however, is that it may promote reliance on group-membership to the detriment of self-reliance and individuation.

3. Theory and practice of O. Hobart Mowrer.*

The latest major development in group therapy is "Mowrerian Therapy". (The term was possibly first used within the University of Illinois itself (Tentative Schedule of Meetings for Pyschology 445, 1962-63).) It is a development of considerable significance for a number of reasons not related to theory and practice alone.

In the first place Hobart Mowrer has one of the finest brains in American psychology - his work on learning generally is monumental. Nonetheless he is, temporarily it is to be hoped, for the present eschewing the language of learning theory and replacing it with the flamboyant, possibly more virile, language of Revivalism and of the "Bible Belt" from whence he originally comes. He is a symbol of the grafting of the magico-religious and scientific schools which appears to be burgeoning to-day. There is, for example, a tendency within the United States to incorporate religion and theology in the fields of medicine, psychiatry and psychology, witness the Chair of Medicine & Theology at the University of Chicago.

Mowrer, while publicly admitting (and interestingly enough, not always being believed by his followers) his disbelief in Christian dogma, is a regular Protestant churchgoer (a social phenomenon which is possibly more common in the United States than elsewhere), and constantly reiterates his desire for the clergy to become the nation's psychotherapists. Depending on the theology, or lack of it, there

*Personal communications and observations, University of Illinois seminars conducted by Professor Mowrer, September-November, 1962.

may be some justification for this. But Mowrer goes far beyond any reasonable point.

Actually Mowrer has been moving towards his present stand over many years (Mowrer, 1950, 1953, 1954, 1960 (a) and (b), 1961). An early statement of the theoretical basis for his conceptualising and practice was made to the Kentucky Symposium on Learning Theory, Personality Theory and Clinical Research of 1953 (Mowrer, 1954):

> The Freudian version of the etiology of neurosis holds that in the struggle between negative feedback (conscience) and positive feedback (appetite), the former sometimes seizes too firm a control over the latter and thus holds down, or inhibits, "instinctual" functioning to a pathogenic degree. Anxiety and depression are said to be the fruits of this stifling dominion of the superego over id functions....
>
> On other occasions (1950, 1953), I have argued for the contrary view, that neurosis arises when positive-feedback functions have out-contended the negative feedback, resulting in temporarily uncontrolled, "explosive" behavior for which the individual later feels remorse and shame (intensified negative feedback). The ego may then deal with this expression of an "aggrieved" conscience in several different ways, notably by making a confession and amendments, in which case inner stability and harmony tend to be restored; or the ego may set out to "disconnect" the conscience, like the governor on a steam engine, so as to let the "wild" behaviour occur unobstructedly (albeit usually surreptitiously). Conscience may be thus dissociated or repressed, and the individual may compliment himself on his new freedom, liberty, emancipation. But the forces of conscience are tenacious and usually come back to haunt their owner, but now not as intelligible guilt but as the unintelligible and torturing experiences of anxiety, panic, depression, and inferiority feeling. (pp.90-91).

Despite his presently-expressed violent antagonism to, and outright verbal rejection of, Freudian theory, Mowrer has taken over the Freudian concept of super-ego (as well, of course, as the theological concept of conscience), and Freud's notion that psychosis and neurosis were part of a single continuum. For Mowrer the only cause

of neurosis and psychosis is "sin" - an actual act for which one feels guilty and which, therefore, one hides, so becoming alienated from society in general and from the "significant other" in particular. The psychotic differs from the neurotic only in the degree of his sense of guilt - he may indeed be a much more worthy person than the neurotic for his value-system may be a morally better one which has driven him into greater mental turmoil.

Theoretically Mowrer employs two major techniques: open confession within the group, followed by confession to the "significant other" (sometimes with highly unfortunate results, as can well be imagined), and penance or "reparation". He is essentially concerned with building up the Super-ego in its role of conscience, and bitterly attacks Wolpe as a "Freudian" and the psychoanalytical school because he contends they are always concerned with the reduction of the Super-ego.

In practice* Mowrer and his theological cohorts exhort the group-members to "confession" (ostensibly they have been "open" themselves about their own "sins" in the early sessions of any one group), and constitute what is tantamount to a board of judgement. It is in effect a 20th century version of the Inquisition, only the "sinners" are frequently exhorted to burn their boats (the logical outcome to many "confessions") instead of their bodies.

As stated, at least inferentially, earlier, Mowrer does not accept the concept of "neurotic guilt" - one is supposedly actually guilty in regard to a specific "sin" or has committed no "sin", or is sociopathic and feels no guilt. Nonetheless it was quite clear

*Personal observation, Galesburg Mental Hospital, November, 1962.

that in actual practice Mowrer extends the term "sin" to cover total inaction as well as acts of omission and commission, and at times he comes very close to the Existential position, as well, indeed, as Jung, Adler and Sullivan. He judges, talks and acts in such a way that any logical, rational person must postulate for him that any behaviour, overt or not, which negates the possibility of self- actualization is a "sin" - although he demands that the "self" be a rigid, moral-bound system.

There are other important inconsistencies in Mowrer's theorizing. On the one hand he wants his patients to espouse "openness", to be in completely open communication with their "significant others" (though not apparently necessarily with the "insignificant others"); on the other hand he wants them to have a rigid, moralistic, Super-ego. Such a Super-ego could well demand silence in certain situations. Further, he admits by inference that the values of the "significant other" or of one's peers are of fundamental importance, yet he demands in effect that his patients introject his own particular moral code or that of his theological friends. This meant for at least one group of patients that certain forms of behaviour were labelled as "sins", regardless of the originating stimulus or cause. The rationality or otherwise of any belief is also apparently of little or no importance.

Interestingly, and amusingly enough - and completely in line with mediaeval and earlier magico-religious thinking - he seems to believe that women are the seducers, men the seduced.

There is little doubt that early conditioning and experi-

ences, Fundamentalist too, no doubt, still colour Mowrer's thinking; but he flagrantly disregards what Salter allegedly reminded him of on one momentous occasion, that "a habit is a habit is a habit".*

It is quite possible that by now Mowrer has modified his position, but two things stand out quite clearly: (1) he has followed what seems to me to be a natural and logical, if not inevitable, development of interest from the mechanics of learning to social learning(s) and value-systems, and to social communication (a somewhat parallel path to Freud's); (2) in therapy he is now mainly concerned with the development of a rigid ego-control, (which, however, he denotes as Super-ego and sees as conscience), and a puritanical moralistic value- or reference- system. He cannot tolerate flexibility because to him this means expediency, a term he would regard with considerable negative affect.

As I shall endeavour to demonstrate later in my discussion of the study of the Super-ego and ego-structure carried out at Illinois by my husband and myself, there are many factors operating in greater or lesser degree in any individual's conscience or moral-reference-system.

It seems highly probable that Mowrer's theorizing, as well as his personal problems, stem quite considerably from conflict between a possibly high sexual drive and/or the (mainly innate) temperamental impulsivity factor (see p. 128), and a conditioned puritanism. We could perhaps go even further, and suggest that only increased age and experience giving him greater control, and a possibly lessened

*Personal communication, New York, 30.11.62.

sexual drive, has led him to a point where he can inveigh so bitterly against the psychoanalysts and their earlier (successful?) attempts to free his own sexuality. Conceivably he is justified in his rationalisations - a freed sexual drive, allied with impulsivity and inadequate control, could well mean a complete or gross channelling of libido and psychic energy into sexual licence (which is what he inaccurately complains psychoanalysis creates), which could, in the presence of even a rudimentary puritanical reference-frame, create additional conflict and anxiety.

What, for the moment at least, Mowrer is disregarding is the conditioning or learning which occurs in the building-up of reference-systems. His emphasis is entirely on the lack of (necessarily learned) control of "sinful" behaviour and the new learning of control and "socially-acceptable" (or "Mowrer-acceptable") goals through what can only be regarded as "insight" developed in the therapeutic situation, reward and punishment derived from the group's acceptance or rejection of his behaviour, and semantic conditioning. He has not yet, to my knowledge, re-stated his aims and techniques in this terminology, but he may well find himself forced to do so.

... ...

4. The Learning-theory Schools.

As will have become obvious from the previous discussion, Mowrerian Therapy is, in part, a derivative from learning theory and behaviourism, and the related area of cybernetics. We could perhaps consider him to be a "neo-Behaviourist", though he owes much to the magico-religious school and the theological emphasis or moralism

which has been one of the major trends throughout history.

Not all sub-branches realise, or pay attention to, their learning-theory affiliations. "Suggestion" is nothing more nor less than verbal conditioning in interaction with the individual's temperamental inclination to inhibition or excitation, influenced in part by the prestige or authority of the suggester (i.e. with the conditioned response to authority), (cf. Salter, 1961). The semantic therapies of Alfred Korzybski (1941) and Wendell Johnson (1946) are concerned with semantic conditioning and the learning of reality-oriented conceptualisations. Ellis's "Rational Therapy", (1955), is similarly based on the induction of rational, reality-oriented, (though positively-biassed), self-conceptions brought about by verbal conditioning and insight. To Ellis the therapist is essentially a propagandist and directive teacher.

But let us look now at the late 19th century and 20th century discoveries and origins of the concept that mental disorder and psychotherapy is essentially related to the learning-process.

..

(i) Pavlov and the Russian Schools:

Psychotherapy in the Soviet Union stands mainly on the work of Pavlov and his laboratory, and to some degree that of Bekhterev.

Drawing freely from the works of Pavlov (1927, 1941, and an undated collection, Psychopathology and Psychiatry), as well as the excellent study of Wells (1956), it is possible to summarize the main contributions of Pavlov as follows:

(a) He discovered, and experimentally reproduced, conditioned reflex behaviour.

(b) He demonstrated how remarkably fine differentiations of stimuli and responses are learned through the conditioning process brought about by reward and punishment.

(c) He was probably the first to illustrate that neurotic behaviour can be produced experimentally in animals by being placed in a conflict or choice situation.

(Note: In a conflict situation the organism does not know how to behave, or which behavioural activity to use to bring about active reward or a cessation of punishment - "passive reward" we could term this. In a choice situation, the neurotic organism is driven by fear, or actual previous conditioning to expectation of punishment/reward, to "choose" behaviour or a goal/reward which it knows, or expects, will not be punishing though it does not bring the actual reward desired.)

(d) He showed quite clearly that environmental pressures had very much to do with the final development of types of nervous response and behaviour in puppies.

(e) He produced abnormal behaviour in animals by

(1) increasing the intensity of a noxious stimulus;

(2) punishing or non-rewarding the dog over a considerable period of time, i.e. he forced the animal into prolonged inhibition or response or into inhibition under conditions designed to increase stress and lower the inhibitory-set;

(3) producing conflict between reflexes in the presence of ambiguous or very similarly-structured stimuli.

From the results of this work he found a difference in individual stress- or inhibitory- limits, and a difference in reaction, some dogs becoming more excitable and others apathetic even to normal stimuli; and accordingly postulated there are two different types of animals (including humans) the "excitatory" and "inhibitory" (sthenic and asthenic) differentiated by the dominance of the excitatory or inhibitory neurones. In situations of undue stress, i.e. conflict, over-excitation, over-inhibition, there is a relative to absolute breakdown of the subordinate activity.

(f) He later expanded his typology as the result of distinguishing three properties of the nervous system:

(1) the <u>force</u> of the nervous processes of excitation and inhibition;

(2) the <u>equilibrium</u> of these processes

(3) their <u>mobility.</u>

Carrying on his experimentation in this connection he found four essential types of higher nervous activity in animals - weak inhibitory, strong excitable, lively balanced and quiet balanced or equilibrated. (This work has led to some of the emphasis on the extroversion-introversion continuum.)

(g) In humans he postulated three main types, i.e. the artistic (emotional), thinking, and middle (mixed), and found hysteria to be the result of general weakness in the artistic type; psychasthenia the product of weakness in the thinking type; constitutional neurasthenia a form of general weakness, occurring in the middle type.

(h) Also as the result of his work on experimental neuroses he found that overstrain of the property of mobility led to pathological inertness and pathological lability. (The latter term is to-day probably equated with "disruptively high arousal", (cf. Freeman, 1948; Duffy, 1957; Berlyne, 1960).

(i) He contended that schizophrenia in many stages is akin to, or the same as, certain hypnotic or inhibitory phases.

(j) Perhaps most important of all, he distinguished three higher nervous systems in man (two in other animals):

(1) the system of unconditioned reflexes or "instincts" located in the sub-cortical regions (decidedly analogous to Freud's "id");

(2) the first, or sensory, signalling system (concerned, I would suggest, mainly with perceptual learning), relating to emotional, imaginative reactivity to non-verbal stimuli (analogous to Freud's "primary process");

(3) the second signalling system related to speech, ideas and thinking. Both (2) and (3) are situated in the cerebral cortex.

(k) He considered "psychogenic" disorders to be related to malfunctioning of the first signalling system, and "somatogenic" disorders to the malfunctioning of the second system.

(l) In the clinic attached to his laboratory, he used bromides, narcosis-induced and natural sleep ("protective inhibition") together with suggestion or verbal conditioning, on his patients.

When one considers this monumental contribution to human knowledge and welfare there is nothing to wonder at in the veneration of Pavlov within, and increasingly without, his own country.

In much the same period as he was engaged on this work V.M. Bekhterev was busy studying and clarifying the role of reflexes in human learning and thinking. His first work, Objective Psychology, was published in 1907, and his theory was expanded in 1917 under the term of "reflexology", and again in 1924 to include social interaction under "collective reflexology". Bekhterev demonstrated experimentally that associated stimuli could become cues or surrogate-stimuli for the production of a particular stimulus-induced reaction. Habitual response depended upon the reflex response, particularly that of the striped musculature, while complex habits were built up as the result of the compounding of motor reflexes. Thought depended on sub-observable activity of the musculature involved in speech (though modern theorists of similar bent would possibly add, "and visual or auditory perception").

Bekhterev's theories were of considerable import to learning theory generally. Murphy (1949), has earlier pointed out that this was the beginning of the systematic reduction of higher processes to "symbolic responses based on conditioning" (p.259). They also relate to aberrant or maladaptive learning. But, nonetheless, modern Russian psychotherapy is firmly entrenched on the twin Pavlovian concepts of semantic (second signalling system) conditioning and individual conditionability.

A vast body of experimentally-obtained evidence of physiological functioning in relation to verbal conditioning and behaviour and behavioural change, has been built up in a number of different laboratories. For example, Platanov (1959, 1962), whose psychotherapeutic technique of verbal conditioning under hypnosis is Pavlovian in origin, quotes much experimental evidence in connection with associated physiological functioning.

Platanov notes, for example, that the laboratory of A.G. Ivanov-Smolensky has repeatedly demonstrated

> that it is possible to establish conditioned reflexes of the heart, blood pressure and the pupil of the eye by means of a command, not by a hypnotizing physician, but by the subject himself. (Platanov, 1962, p.24)

M.P. Nevsky, has studied bio-electrical activity in both normal and 20 patients suffering from neuroses (these included neurasthenics, psychasthenics and hysterics, but the numbers of each group were not reported). He found hypnotherapy of neuroses to be

> characterised by: (a) decrease of electrical activity of the brain during hypnotic sessions, with an occasional activization of the alpha rhythm or slow theta-waves; (b) increase of the alpha and beta rhythms, with the normalization of electrical activity of the brain on completion of each hypnotherapeutic session.

Further,

> the degree and type of changes in brain bio-electrical activity, as caused by hypnotherapy, have significant bearing upon the clinical interpretation of the state of the patient's sickness; small changes in electrical activity of the brain during hypnosis testify to the gravity of the neurotic condition..... (Nevsky, 1962, p.51)

Troshin (1962) reports three interesting experiments. The first, using electromyograms of the arm as a measure, demonstrated the quantity of muscular work done during hypnosis or suggestion. The second demonstrated that simple suggestion (in the form of 'an explanatory talk') - which must, I suggest, involve a certain degree of cognition and "insight" - produced a rise in the pain sensitivity threshold and an increase in the ability to endure the pain. The third, conducted by M.P. Malkova on 20 patients, found that, after 3 - 5 minutes of "positive" suggestion the number of leucocytes increased by 1200-1500; whereas suggestions of negative emotions were followed by a decrease of 1300-1600 leucocytes in the blood. Troshin notes that "in a few instances, positive emotions resulted in paradoxical reactions" (pp.55-56). It is to be hoped that the latter finding led to experimentation with larger groups and a correlation of results with other measures. Meantime it would be reasonable to hypothesise that either the leucocyte count was above normal and "positive emotions" restored balance; or in these people the "positive emotions" were outweighed by some associated negative fear.

Hypnosis and suggestion are also frequently used in the treatment of psychosomatic complaints (see, for example, the papers in Part V of Winn, 1962, pp.155-184).

Before leaving consideration of Russian methods and theories, however, we should perhaps extract a few of the more pertinent comments regarding Soviet psychotherapeutic aims and techniques contained in

the statement of V.N. Miassischev (1962, pp. 3-20). He states, inter alia,

> ...By human relations we understand the process of forming selective ties with various aspects of one's environment; and by one's personality we mean a pattern of such selective attitudes applying to all levels of human relations... These concepts have been shown to be of greater significance, from the Pavlovian standpoint, for gaining insight into mental as well as neural activities of man... The concept of human relations (applied in Soviet pedagogy specifically by A.S. Makarenko), which serves to synthesize man's manifold connections with objective reality, is derived from the concepts of reflex, reaction, and the underlying vital impulses, and also from the more complex processes of human neural activity. At the top of their development, human relations involve some exceedingly complex social products - such as beliefs - which are grounded in human speech and thought, and which represent the highest ideological level of conduct ..... Emotion (which may, phylogenetically, be a complex unconditioned reflex) is manifested by the formation of a dynamic system of close but temporary ties between cortical and subcortical processes ..... Intellectual interest, inspiration, or painful moral conflict do affect the entire human organism. These factors turn into a source of irresistable impulses, unforgettable experiences, and persistent impressions ..... (He says much the same for emotional reactions or states - Author) ..... Psychotherapy as a process of social interaction ..... must not be regarded, however, as merely verbal ..... the meaningful, expressive and activating elements of psychotherapy consist not only of speech, but also in facial expressions and gestures, in utilizing endless associative connections saturated with imagery and emotional components ..... (But) there are two basic forms of psychotherapeutic influence - suggestion and persuasion (direct or indirect) .....(However) the main and decisive element (in suggestibility and resistance thereto) is the patient's attitude towards his physician. Patients develop the feelings of respect, trust and affection toward the physician only gradually, insofar as he enables the patient, by a skilful approach to him, to comprehend in a sound perspective his life and particularly the complex, obscure and confusing circumstances of his past and present .....

I have quoted this decidedly lengthy statement because not only does it reflect the latest trend in Soviet psychological thinking, but it is essentially a <u>psychological</u> statement, and, although it only infers the learning involved, is close to my own position.

(ii) The "Behaviouristic" Schools:

The beginnings of American Behaviourism would seem to stem from the teachings of Jacques Loeb (1890) regarding tropism, the physicochemical instinct underlying all the behaviour of simple plant-life and much of the behaviour of all living organisms. Loeb himself went from Germany to the Rockefeller Institute in New York, so that his theorizing became readily available in America. (Gardner Murphy, op. cit., p.253).

In the final analysis it is probably the twin concepts of tropism and reflex arc activity which underlie all Behaviouristic theories, although Loeb himself postulated an "associative memory" in his Physiology of the Brain published in 1900 (Murphy, p.257), based on the much older notion of the association of ideas, or, as Murphy behaviouristically puts it, "the conception of attaching an old response to a new stimulus".

William James (1842-1910) also played an important role, stressing as he did the genetically-determined "retentiveness" of individual brains and the formation of specific brain pathways in his consideration of memory-function.

In line with the emphasis on experimentalism of the day, and influenced greatly by the work of Thorndike, J.B.Watson set out to study the learning process and behaviour-modification in terms of stimulus-response activity. It may be noted that, although in December, 1915, Watson had apparently become interested in the study of discrimination by the differential-response technique, it was not until the winter of 1916 that he actually read

Bekhterev in German and French translation, and finally came to the conclusion that all learning and the development of the "higher processes" was based on conditioning (Murphy, pp.260-1).

Yet the previous year (1915) Holt, in line with Pavlov's theory of the 2nd signal system, declared that

> Words, acting as substitutes for situations, evoke the same responses that the situations themselves would elicit. (Quoted by Murphy, p.262).

Unfortunately his remarks seemed to fall on deaf ears.

Watson began to study and formulate what was tantamount to a developmental psychology based on studies on conditioning in the neonate and young children. In 1920 he and Raynor published a paper on Conditioned Emotional Reactions, in which they reported the conditioning of fear to a furry animal in a 12 months' child, the fear having originated in response to the sound of a hammer being banged on a metal bar in the presence of an erstwhile unfeared furry animal.

However, another four years elapsed before the first case of psychotherapy by conditioning was reported in the American literature. Mary Cover Jones made history with her reversal of Watson's fear-production and de-conditioned or de-sensitized a child's fear of a rabbit by presenting the feared stimulus in conjunction with the eating of food. The rabbit was brought closer on a differentiated scale, until the child could bear to stroke it.

Wolpe (1958) explains this in terms of "reciprocal inhibition", the child's anxiety response being inhibited by the food-response, reinforcement of the pleasure-response being brought about

the reduction of the hunger-drive. I personally would argue for the inclusion of affective-gain and the temporary increase of the hunger-drive in response to the sight of food, as factors in the reinforcement and inhibition (i.e. learning) process. But the important fact was that conditioning and de-conditioning did occur as the result of the deliberate manipulation of the environmental conditions, and induction of behavioural change.

After Jones' work interest in Behaviouristic therapy apparently died down, and during the next fifteen years there was only sporadic, but nonetheless important, study in this area. Dunlap's (1932) book on the making and unmaking of habits; Max's (1935) aversive conditioning of a homosexual; and Mowrer & Mowrer's (1938) use of conditioning techniques with enuresis, will, however, all bear mention.

In 1938 Professor John Macmurray, in the Deems Lectures, (published as The Boundaries of Science, 1939), suggested that the therapeutic process of psychotherapy consisted of making a learned incorrect reaction (now automatic and uncontrollable, and interfering with normal behaviour) conscious (as it was when originally learned, as, e.g. the act of walking which later becomes automatic) in order to let it be relearned in the right form.

It required, however, the work of Hull (1943, 1951) and Skinner (1938, 1955) to provide sufficient experimental evidence of classical conditioning, reinforcement, and operant or instrumental conditioning, and perhaps sufficient weight of popular support, before psychotherapeutically-interested psychologists could begin

to cope with the extraordinary conditioned fear, sometimes approaching near-pathological proportions, of being tainted with "mentalism". Psychoanalysis is often blamed for the hold-up in psychological thought regarding both mental disorder and therapy, and certainly acceptance of any of the analytical schools' theorizing tended to place blinkers on the eyes of the practitioners; but this is neither reason nor excuse for the almost total disregard of Pavlovian theory and practice, nor, for that matter, of the work of such as Lashley (1929, 1941) who helped to place Behaviourism on a sounder neurophysiological footing, or of Tolman (1932, 1949, 1959) and his work on purposive behaviour and cue- and expectancy-conditioning.

Of all the Behaviour therapists, only Salter, who published his original book on Conditioned Reflex Therapy as long ago as 1950, bases his work on that of Pavlov. But even he disregards almost entirely the "second signal system", despite the fact that his own therapy utilised suggestion and verbal-conditioning as well as being concerned with behavioural change.

The Behaviouristic Schools may be broken up in terms of geography, emphasis or derivation. For example, there is the London School of Eysenck, centred at the Maudsley Hospital, and utilising whatever conditioning or de-sensitization techniques are required by the individual patient. The derivation here is primarily Hullian. The originally South African School of Wolpe (now in America) is primarily concerned with reciprocal inhibition and techniques by which this may be induced. Wolpe's basic theorizing has wider

derivations. It is based not only on the work of Hull and Skinner, but on the studies of the conditioning of neuroticism in animals carried out by himself as well as by people such as Liddell (1927, 1944), and on the work in neurophysiology of authorities such as Sherrington, who, according to Wolpe (1958, p.29) was the first to use the term reciprocal inhibition (Sherrington, 1947, pp.83-107). We may be grateful that psychiatrists such as Wolpe have been turning their attention to psychological theory.

On the whole the American schools are university and research-oriented. Mowrerian Therapy, although not strictly "Behaviour Therapy", is based on Illinois. Mednick (formerly of Berkeley and now at Michigan) is mainly concerned with his stimulus generalization theory of schizophrenia (1955, 1958). The major variation is that of Bandura (Stanford) and Walters (Toronto, Canada) with their emphasis on learning through imitation.

But, whatever their emphasis or their derivation, all the learning-theory schools base their work on the postulate that

> All neurotic symptoms are due to either the failure to learn an adaptive response, or the learning of an unadaptive response. (cf. Wolpe, 1958; Eysenck, 1960a; Jones, 1960).

It is also, I contend, also the underlying assumption of the practice and theorizing of the "Analytic" Schools, and is an essential part of their Scientific School heritage.

A diagram showing the major influences and schools is set out on p. 58.

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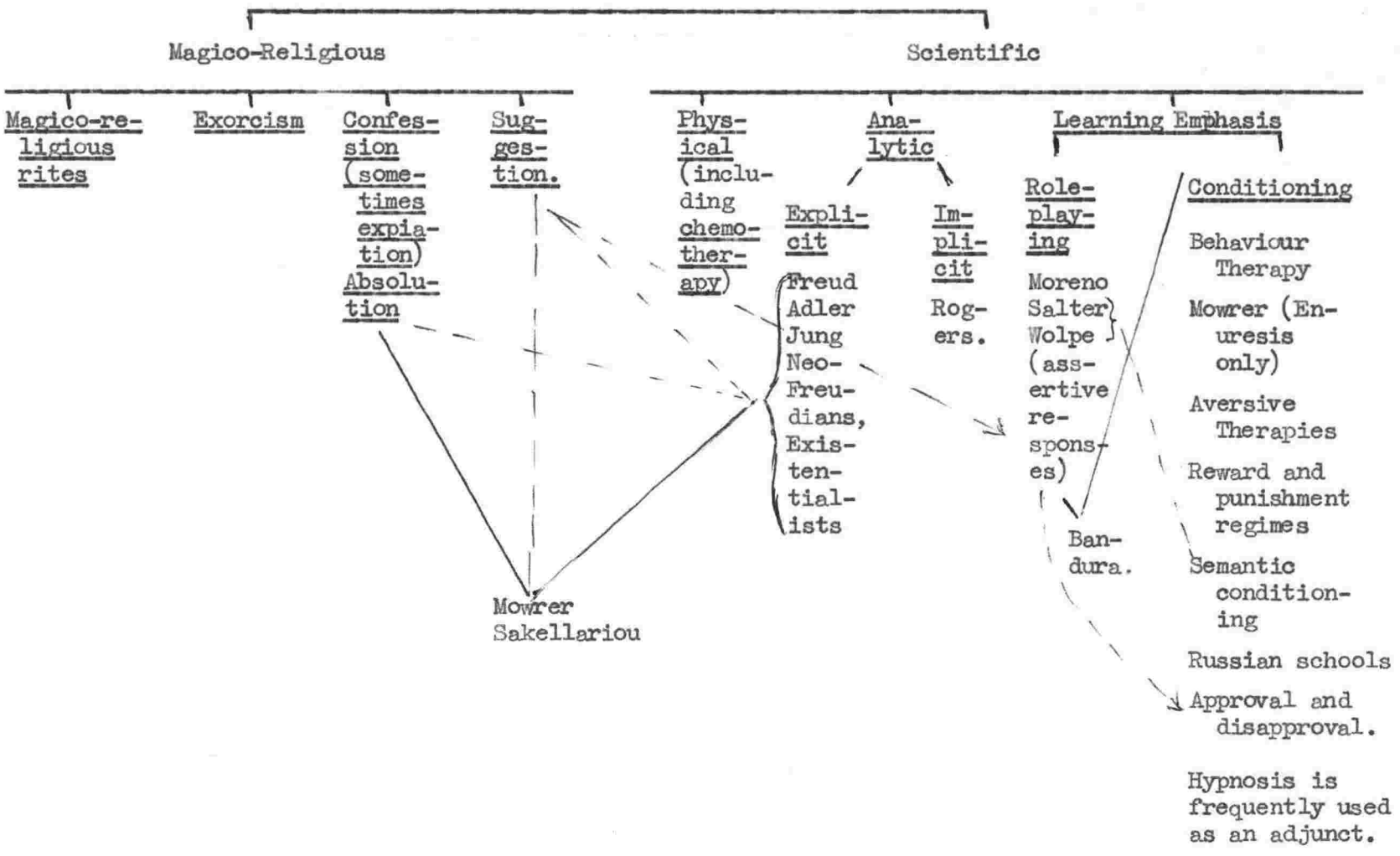
TECHNIQUES, MAJOR INFLUENCES AND SCHOOLS OF PSYCHOTHERAPY



PART THREE

Learning

I. Learning and Maturation.

Hilgard (1948) defined learning as

> The process by which an activity originates or is changed through training procedures (whether in the laboratory or in the natural environment) as distinguished from changes not attributable to training

(for)

> If a behaviour sequence matures through regular stages irrespective of intervening practice, the behaviour is said to develop through maturation and not through learning.

There is considerable evidence (Dennis, 1941; McGraw, 1935, 1946; Sherman et al, 1936) that growth changes and maturation of the neural and muscular systems - rather than environmental conditions, experiences, or practice - determine when the child will sit, stand and walk. The same is true of manipulative ability (Halverson, 1931) and apparently for early sound patterns (cf. McCarthy, 1954; Miller, 1951), (Mussen & Conger, 1958). It should be noted, however,

> Never does the infant pass completely and irretrievably from one stage into another. There is always a merging of patterns and parts of patterns both in the degree of perfection of the action and the frequency of occurrence. There are often regressions to the less mature response. (McGraw, 1935, p.69).

Nonfulfilment of <u>any</u> of the prerequisite multiple conditions create retardation, as, for example in walking (Wayne Dennis, 1943).

It is unfortunately quite impossible to differentiate

between "learning as a function of experience, and maturation as a function of genetic factors" at the practical or experimental level (cf. English & English, 1959, p.289). But, while the learning v. maturation argument only carries the nature v. nurture controversy a stage further, the level of maturation is undoubtedly an essential determinant of the degree and type of learning possible to a given organism at a given time.

As Halliday (1948) points out, the infant may be regarded as "decorticate" so far as voluntary muscle movement is concerned, the basal ganglia and the primitive motor tracts mediating the muscular activities. Until about the fifth month the great motor pyramidal tract remains unmyelinated, the development of which Halliday suggests may account for the child's becoming interested in exploration, manipulation and "primitive creation" around that time. While at birth myelination of the cortex is confined largely to (a) the kinaesthetic region around the fissure of Rolando - hence the infant's sensitivity to sudden movement or lack of support; (b) the region connected with the olfactory senses; (c) the visual areas at the tip of the occipital lobe (Halliday, p.95), foetuses of between $6\frac{1}{2}$ and $8\frac{1}{2}$ months are already conditionable, as Spelt (1948) has shown.

Spelt presented the stimulus of vibration to the mother's abdomen, followed 5 seconds later by the sound of a clapper near the mother's body. After presenting 100 such paired stimuli Spelt found the infant was responding to the tactile vibration alone. It would appear that four factors may be of major importance here:

the degree of maturation of the foetus; the intensity of the sound; the association of the two stimuli presented contiguously; and the time involved in (a) the gap between the presentation of the two stimuli and (b) the entire time-span of the series.

..

II. What is learned?

Among the various learning schools, there is still great argument as to what is learned. Seward (1958), after Woodworth contends that what is learned is in effect a sequence of responses. In the various forms of operant conditioning, however, it would seem that there may occur a hierarchy of response reactions, the place in the hierarchical system being determined by the given needs of the moment, habit, interest, pleasure/displeasure.

Hull (1952), beginning with stimulus and response, differentiated them into sHr and sEr, the former concerned with habit as the unit of bonding and the latter concerned with performance. This in turn involves:

(i) incidence of drive (d)

(ii) stimulus intensity (V)

(iii) incentive learning (K)

(iv) delay in reinforcement (j), which obviously is also an aspect of incentive learning.

So, in fact, Hull is concerned with two forms of learning:

(1) Response learning

and

(2) Incentive learning.

It has long been my personal contention (cf. Adcock, 1961) that there is, in fact, little conflict between Hullian and Tolmanian theory - they are simply concerned with different aspects or levels of learning.

Tolman (1959, p.133) contends that, in the main, we learn beliefs, e.g. that pecking at a disc results in food, i.e. hunger-drive satisfaction. Basically he is concerned with the environment and a re-arrangement of it. He does refer to skills, but expresses ignorance as to how they develop.

Estes (cf. 1959) is concerned with selection of response and would largely agree with Hull in his concept of the problem. Tolman's notions, however, would equally fit his data.

Mowrer (1960) has argued that what is learned is fear or hope; but I would reject this and would argue that fear is not an appropriate antithesis to hope and that hope can be meaningful only in relation to particular goals, thereby assuming other drives, including the fear drive.

Feather (1963) puts forward an alternative to Mowrer's theory which not only has much greater range and precision, but which avoids a basic weakness in Mowrer's theory. Mowrer appears to argue that hope and fear provide reinforcement for sign or solution in some sort of absolute way. I would argue that hope is always hope of <u>something</u> and that no particular solution can be just conditioned to hope in general but only to hope with regard to a particular goal. If one is satiated food cues may become threatening rather than hopeful.

On the other hand, fear, as I have argued, is a primary drive and permits of direct conditioning. A cue can thus acquire an absolute capacity to induce fear. I would query, however, whether what Mowrer is talking about in this theory is always fear. The prospect of failing to achieve drive satisfaction is not necessarily fear provoking: it may generate anger or just simple disappointment. Mowrer has made the fundamental mistake of confusing a primary exogenous drive with a secondary emotion.

In the theory proposed by Feather a careful distinction is made between motive (primary drive aspect), expectation (probability of success) and incentive value. It is the combination of these which produce the effects suggested by Mowrer. The latter's theory is summed up by Feather in the table below:

	Danger signal prior to shock onset	Safety signal prior to shock offset.
	FEAR	HOPE
Onset of signal.	Increase in learned fear Secondary punishment, Type 1. Anticipatory	Decrease in learned fear Secondary reinforcement, Type 2. Anticipatory
	RELIEF	DISAPPOINTMENT
Offset of signal	Decrease in learned fear Secondary reinforcement, Type 1. Not anticipatory.	Increase in learned fear Secondary punishment, Type 2. Not anticipatory.

It will be noted that all these effects relate to the fear drive, but Mowrer assumes that a similar schema applies to rewarding drives such as hunger, with appropriate re-arrangements of positive and negative terms. Feather sets out his own corresponding table as:-

	Expectation of punishment	Expectation of reward
Confirmed or over confirmed	Increase in fear motivation.	Increase in hope motivation
Not confirmed or partially confirmed	Motivational relief	Motivational disappointment.

It will be noted that here fear is invoked only with regard to punishment and not with regard to reward. This makes better sense.

If Feather's claim can be accepted at least two forms of learning must be accounted for: the learning of probability expectation and the learning of incentive values. The mechanisms involved in both types of learning may, of course, be basically the same. Unfortunately Feather does not discuss these implications from his theory.

Nonetheless it would seem that we may conclude that what is learned is primarily the expectation of degree of satisfaction (incentive learning) and the probability of satisfaction. Habits are indeed learned, but they are learned essentially as a means to be employed to obtain satisfying or chosen goals. Cognitive learning also serves this purpose, but, of necessity, cognition must also include relational learning and the learning of cue-specificity, which, in human beings at least, also requires the learning of verbal symbols and communication skills. Both motor and cognitive systems are involved.

..

III. Levels of learning.

If we begin at the purely organismic level, a total of 15 varieties of interoceptive conditioning is possible, and almost all have been demonstrated experimentally in Soviet laboratories. (Razran, 1961).

Razran himself at that time considered that there was a 3-level learning or conditioning process: (1) simple primary exteroceptive and sensory-interoceptive conditioning that is little modified by proprioceptive and motor-interoceptive CS feedback - the classical variety; (2) exteroceptive and sensory-interoceptive conditioning that is greatly modified by CS feedback and gives rise to operant and/or configural conditioning; (3) verbal conditioning which, beginning as simple classical-sensory and operant-motor conditioning, evolves into a special kind of configural conditioning in which sets or surrogate compound CRs emerge, and supraordinate semantic and subordinate phonetic (or phonetographic) units develop.

He further suggested that there are three signal systems: (1) primary environment generated exteroceptive and sensory-interoceptive signals; (2) secondary, response produced proprioceptive and motor-interoceptive signals; (3) a signals surrogate system of words and their equivalents.

By the end of 1962, however, he had thought beyond this and formulated the following hierarchy:

IV. Symbolisation and Predication
(Thinking)

III. Afferent domination and Afferent configuring
(Preperception and perception)

II. Reinforcement (Reward or Operant Conditioning)

I. Substitution (Classical conditioning)

b. Inhibition (Punishment)

a. Habituation and sensitization.

These Razran subsumed under the headings of "Evolutionary levels of higher nervous activity" or "Evolutionary levels of learning and perception and thinking", and he intended publishing a paper under such title.*

This is somewhat similar to the hypothesis of Goldman (1962), who, on an ontogenetic basis, conceived of

> at least three modes of learning - learning by classical conditioning, stochastic learning (instrumental conditioning), and recursive (sequential) learning (problem solving) .....the third learning mode is not only the most active in that there is a deliberate seeking for order and regularity, but there is a vigorous development and testing of solution hypotheses. This learning mode favours older and more intelligent Ss. (p.63).

(Goldman, who puts forward a very soundly based developmental theory of schizophrenia in this paper, was particularly concerned with the fact that the schizophrenic cannot adequately discriminate in terms of the relevance to a task of competing stimuli, and therefore learning or learned behaviour is completely disrupted.)

As far back as 1938 Razran expressed the view that relational learning is "a separate sui generis category of modifiability" and implied that relational learning is a higher and more complex form

*Personal communication, New York, 3.12.62.

of learning than mere conditioning. By 1955, however, he contended that conditioning with perceived relationships "is relational or perceptual learning", and that the higher perceptual integration is "an emergence through conditioning", (Razran, 1955, p.91).

I would suggest, as Razran now appears to have seen, that complex relational learning does not only involve perceptual learning, but also the adducing of meaning, which involves semantic conditioning.

Razran's (1955) contention is in line with Wohlwill's (1958) suggestion that perceptual learning should be regarded as

> the development of a generalization of a previously established differential response to a new stimulus (p.293),

and that there should be allowed a conceptual distinction between learning based on perceptual functions and that based on response association. Actually there is little or nothing to choose between these constructs and that of "sensory preconditioning", the literature pertinent to which was reviewed by Seidel (1959).

Seidel points out that the sensory associations are

> formed among the particular situation cues to which the animal attends (and that) the important stimuli for the organism in the preconditioning situation are constituted by the stimulus complex to which it attends. (p.72).

Razran explained his experimental results regarding configural conditioning using light flashes and tonal triads, as due to the fact that

> while the higher level of learning dominated the lower level when both were functioning, the conditions for the functioning of the higher level were more complex and more disruptable, so that the lower level did at times gain quantitative superiority. (Razran, op. cit., p.92).

This is reflected in the recent findings regarding the inverse U-curve in learning in high arousal (cf. Berlyne, 1960; Duffy, 1957), i.e. when the "functioning of the higher level.....is more disruptable."

In this connection it should be noted that Leuba (1940, 1941) and Scott (1930) found that

> susceptibility to conditioning is enhanced in states of lowered consciousness (quoted by Goldman, op. cit., p.62).

This is a fact which will shortly be discussed in respect of the vast number of Russian experimental studies leading to Platanov's (1959) utilisation of hypnosis and semantic conditioning in psychotherapy. Jones (1928, 1930a and b); Kasatkin & Levikova (1935); Mateer (1918); Razran (1933, 1935), are among those who have established that young children can not only be conditioned but are more easily conditioned than older children and adults; due doubtless to their greater "plasticity", as Pavlov (1927) has called it.

....

IV. Verbalisation and Conceptual Formation.

It is not intended here to traverse the literature, nor the process of development, of speech per se. It may be noted, however, that Mussen & Conger (op. cit., p.98) consider that the most systematic research on speech development in early infancy has been conducted by Irwin and his associates at the University of Iowa. Miller (1951) contends that not only is verbalisation dependent on maturation, but that there are successive stages of language development which are similar in all normal children, no matter what their nationality may

be.

There is no doubt that, as with all learning, while much early speech-learning is incidentally derived from the baby's reflexes, interest, and delight in making sounds, the major determinants are imitation, association of certain sounds with reward, ("mother's loving care combined with vocalization", as Mowrer (1950) phrases it), or punishment:

> In general, a child's first contact with the more formal aspects of language is in learning to use words spoken by other people as cues for his responses. A sharp 'No!' is followed by punishment, which can only be escaped by stopping or retreating. Eventually stopping becomes anticipatory and occurs to the word 'No!' spoken sharply, without the punishment. At the same time, 'No' is acquiring an anxiety-arousing value, so that any response which brings an escale from a torrent of 'Noes' is rewarded. Exactly which verbal cues a child will learn to respond to and how he will learn to respond to them depends, of course, upon his learning capacity at the particular age and upon what his parents try hardest to teach him. (Miller & Dollard, 1941).

Miller & Dollard are only partly correct in their assumptions. In the first place "No!" is not necessarily followed by any punishment other than the child not being permitted to carry out his original intention. In the second place, "No" does not necessarily produce anxiety; this will depend entirely on the strength of the wishes of the child and the threat of danger or punishment. "No" may merely become the instigator of inhibition of the response.

It is the utilisation of words as <u>cues</u>, or "verbal mediating responses" (Goss, 1961), which leads to conceptualisation at all levels.

A vast amount of experimental work in connection with

the second signal system has been carried out in the Soviet Union. As early as 1926 Platanov (1959), basing his work on Pavlovian theory as well as other early work on suggestion, had shown by recording the respiratory reaction, as shown by the pulse rate, that a verbal stimulus can provoke a reaction which replaces an unconditioned reaction. (Platanov, op. cit., pp.17-18).

Platanov also reports and reproduces A. Pshonik's plethysmographs showing conditioned vascular reaction to (a) the sound of a bell; (b) the words, "I am going to ring"; (c) the response to light; (d) the verbal signal, "I am going to turn on the light." (p.19).

He also refers to the work of L. Shvarts, who, in 1948-9, demonstrated that it is the semantics and not the sonorics of a word-stimulus which is the conditioned stimulus of the second signal system. He found that the

> primary conditioned reflex bond in response to the sonorics (consonance) of the word subsequently fades, while in response to the semantics (content) of the word it strengthens.

Having lowered the tone of the cerebral cortex by administration of chloral hydrate, Shvarts found

> the conditioned reflex weakened in response to the meaning of the word first, and in response to its sound image only later; contrariwise, the extinguished conditioned reflex in response to a similar word was again disinhibited under these conditions. (Platanov, op. cit., p.21)

Berlyne has recently reported a number of Russian experiments which he considers of great importance, (see Berlyne, 1963, pp.168-176).

For example, Luria (1956, 1957, 1958) has shown that words influence behaviour in different ways according to the age of the child. At about $1\frac{1}{2}$ to 2 years a verbal stimulus produces little

more than orienting responses; at the next stage language releases behaviour for which the child is ready or "set" (e.g. a child of this age, asked to "Give me the ball", will give the doll already in its hand); at the third stage, language is now a stimulus for a selective response; at the fourth stage (about $5\frac{1}{2}$-6 years) a child is able to either withhold a response, or perform a response where appropriate, according to "a set produced by previous instruction".

Ivanov-Smolenski and his laboratory staff, as well as Paramanova (1956), have all shown that children in the age group, $5\frac{1}{2}$-6, unlike those at earlier levels, are controlled by the second signal system and apparently think out their problems. As Berlyne himself puts it,

> the younger child.....is building up typical classically conditioned responses.....The other child.....is using what we call "mediating responses". He is reacting (to the stimulus) with internal verbal responses that amount to self-instruction, and he is reacting to the self-instructions (appropriately). Because this complicated learning involves the mediation of intellectual processes, it has the properties of flexibility and stability. (p.173)

Significant differences have also been found between the age groups as to their ability to "verbalize what he is doing or, in other language, whether he is aware of it", i.e. as to whether or not the "connection is reflected in the second signal system". (Berlyne, ibid. 173).

This work is very much in line with the model of verbal habit-families put forward by Staats (1961) and based on Hull's habit-family conception (1920). Staats has noted that

> language processes arise from response to the environment and in turn effect response to other aspects of the environment.....concepts develop and function in a process in-

> volving complex learning, communication, and mediated generalization.....Abstraction which is based on concept learning was seen to depend on verbal habit-families.

Staats integrates the theorising of Cofer and associates (e.g. Cofer & Foley, 1942), Mowrer (1954a), and Osgood (cf. 1953), and puts forward the principle:

> that when a word is contiguously presented with a stimulus object some of the unconditioned responses elicited by the object will be conditioned to the word. These responses when stably conditioned become the meaning of the word. (p.191)

"Meaning" is, therefore, a conditioned response. (A conclusion Ivanov-Smolenski and his co-workers had arrived at long before.)

Staats, Staats & Crawford (1958) demonstrated "first-order conditioning of meaning"; while higher-order conditioning - the pairing of a word which already elicited a meaning response with the verbal stimulus which was conditioned to elicit that meaning (or, as Staats put it, "both connotative and denotative meaning responses were conditioned in this manner", p.191), has been demonstrated by Staats (1959), Staats & Staats (1957, 1958, 1959a, 1959b); Staats, Staats & Biggs,(1958); Staats, Staats & Heard (1959, 1960).

Let us look at this from a homely and commonsense point of view. First, e.g. what does the word "geranium" mean? To the child who has been told that this-flower-in-his-hand is a "geranium" it means that, if he has attended sufficiently, henceforth he knows that stimuli perceived in this particular form are "geraniums", and, by association or generalisation, different-coloured flowers of the same or very similar shape, are <u>probably</u> (unless he has been so conditioned he submissively accepts everything told him as "gospel") geraniums too. (Note, the "probability" connotation will depend

upon the development of a critical or questioning "faculty" or set; and also upon the degree to which the original stimulus was clearly perceived or the word correctly heard.). But the word "geranium" is henceforth the symbol for the image.

White (1962) defined a "symbol" as

> a thing or event, an act or an object, upon which meaning has been bestowed by human beings.....(it) is, therefore, a composite of (1) a meaning, and (2) a physical structure.

He defines a "sign" as

> a thing or event that indicates something else

and suggests that the term "symboling" should be used to indicate "the giving of meaning to an object", which is a purely human ability. We should, therefore, "symbol" if we were to declare the geranium to be the national flower of New Zealand. We should be attaching to the geranium all the affective constellation surrounding our reactions to our national home. This is obviously setting up Ivanov-Smolenski's "conditioned-conditioned-reflex" or "higher-order conditioning. If we were to take a purely Hullian stand we should contend that all the intervening steps would require to be gone through, no matter how minute the form might be. But from a Pavlovian, or cognitive theorist's standpoint, we should argue that, once a word has become both sign and symbol, the intervening conditioned links may not be used or may be short-circuited.

This, however, has still not dealt with the question of "meaning". To return to the child with the geranium: As Osgood (1957a) has pointed out, different environmental stimuli can become associated with the same mediating response. In other words associations become signs or cues. The geranium has a colour and a scent.

Does the child like one or both, or neither? The geranium also has a shape - does the child like such a shape? This will affect his pleasurable-affect relative to the geranium. Has he already learned to like/dislike flowers, or the person teaching him the name? How much cathexis is involved in this particular situation at this particular time? All these factors will combine to give affective connotations to "geranium"; what facts he is told of the species of flowers, etc. - this will combine to give cognitive connotation; the combination of affect and cognition will give a more complex connotation to "geranium". The child's aesthetic response to the particular geranium will doubtless depend upon his cognition of various harmonious/inharmonious relationships. This may be an individual response; but, since human beings belong to one genus, there is undoubtedly a common factor involved in such a perception, as in the perception of human beings (cf. Cline & Richards, 1960).

It will be seen that the "meaning" of "geranium" to a particular individual will depend upon that individual's response-system and general learning-level. The "meaning" an individual attaches to a stimulus or its sign/symbol, may be affectively-oriented, cognitive, or both, depending upon the associations made with the original stimulus, or with its symbol, or associated symbols.

Mowrer (1960) has argued somewhat similarly, and contends furthermore that a stimulus such as a light will produce a sensation, which is "conditionable in the form of a light image".

Ausubel (1962), concerned primarily with meaningful learning

considers that the distinctive feature of such learning is the interaction of new learning tasks with the existing cognitive structure. (p.215).

Goss (1961) in his important paper on Verbal mediating responses and concept formation, is seeking for the principles involved in the strengthening, generalization, and weakening of the stimulus-response associations involved in concept formation. He does not, however, appear to have taken into account the process of differentiation, which is undoubtedly also essential before conceptualisation can be completed. This is, despite the fact that he quotes the work of Bruner, Goodnow and Austin (1956), whose subjects "distinguished wholist (whole, focusing) and part-scanning (part) strategies or sequences". (Goss, p.265).

It should also be noted - perhaps more particularly in connection with the discussion of attention in the next sub-section - that

> when subjects could select each successive initiating stimulus, the four sequences or strategies which were distinguished logically were simultaneous scanning, successive scanning, conservative focusing, and focus gamgling. (Goss, ibid.)

Goss found that important variables were

> strengths of relationships between initiating stimuli and mediating responses; some patterns of relationships among initiating stimuli (e.g. sets, hypotheses, attitudes); some mediating responses and stimuli, and terminating responses; and relative similarity of initiating stimuli. (ibid).

.. ..

There is by now a considerable body of literature relating to a breakdown in conceptualisation and simple verbal conditioning as well as disruption in speech patterns generally, in various forms

of mental disorder. It is not proposed to make a general survey of this literature, but in relation to the above discussion the following are of note:

Flavell (1956), reviewing the literature in connection with his own study, noted that Arieti (1948), Goldstein (1944), Vigotsky (1934), Werner (1948) and Yacorzynski (1941), had all pointed out that "schizophrenics differ from normals in their use and understanding of words," and that the schizophrenic appears to suffer from

> a relative impairment in the ability to focus upon, comprehend, and utilize the abstract and essential rather than concrete and superficial meanings of verbal symbols.

As Chodorkoff & Mussen (1952), Feifel (1949), and Moran (1953) had found, Flavell's own experiment confirmed (at the .01 level) the two hypotheses:

> (a) normals will exceed schizophrenics in the ability to select, as most similar in meaning to a given word, that word which is related to it in an essential abstract way; and
>
> (b) within a schizophrenic group, the above ability will be positively correlated with adequacy of everyday social interaction. (Flavell, op. cit., p.210).

There is undoubted mutual interdependence between social functioning and verbal behaviour. Language disorganisation may create social isolation (cf. Cameron, 1944); but a high level of abstraction and conceptualisation is a prerequisite for adequate functioning in complex interpersonal situations and relationships, as Sullivan would undoubtedly argue (cf. Sullivan, 1962). Further, conversation is an arouser, an emphasiser, a reinforcer, a stimulus

which always demands some response, and, initially, some level of attention.

In this connection we might note the findings of Murray & Cohen (1959) and Shipman (1957), that in sociometric studies paranoids tend to choose one another while schizoids do not. Murray & Cohen concluded that

> as the degree of mental illness increases, there is a decrease in social organisation and social relationships involving positive or negative feelings. (p.54)

They also found that this process appeared to be reversed by "milieu therapy".

Conceivably one of the factors involved here is that, apart from their delusional reference-frame, the paranoids retain their reality-testing as well as their powers of abstraction and conceptualisation. The paranoid indeed is frequently making use of high-level deductive thinking based on a wrong premiss, an activity not confined to paranoids unfortunately.

Some schizophrenics, on the other hand, are frequently responding to the sonorics or purely sensory associations of the words they hear, together perhaps with the semantics of some associated words. Flavell (1956) found that homonym choices

> appear to be the almost exclusive prerogative of certain Ss in the schizophrenic group (and) is in accord with both Baker's experimental results (unpublished thesis) and the clinical observation that some, but not all, schizophrenic patients exhibit 'clang association' in their everyday verbal behaviour.

It would seem reasonable to argue that reverberating stimuli, such as those involved at a simple level in "clang associations", and at a more complex level in the reference-systems of the paranoid, must act as constant reinforcers of attention and other behaviour related to the response patterns involved. They, therefore, block extinction and/or learning of more adaptive behaviour patterns, and indeed help the hapless individual to learn and re-learn maladaptive behaviour. I shall expand this in the following sub-section.

... .

V. What results in learning?

Of the major theorists Hull insisted that the necessary and sufficient condition for learning was reinforcement (cf. Hull, 1942, 1943); Thorndike (1913-14) postulated the "law of effect" and the "law of exercise"; Guthrie (1942, 1952) said contiguity, thereby placing himself in line with Pavlov (1927); while Tolman (1959) finally agreed that reinforcement enters into all learning.

In some former experimental work of my own (Adcock, op. cit.) it was clearly shown that a number of stimuli having attention-getting properties rather than reward or punishment qualities, were able to bring about conditioning and it was concluded that the direction of attention resulted in the contiguity of the stimuli in the perceptual field.

I would accordingly argue that:

(a) A common neurological focus will always result in associative bonds being formed;

(b) Attention is the chief agent in bringing this about;

(c) Reinforcement* operates largely through its effect on attention;

(d) Theoretical stress on reinforcement is due to it being a necessary component in incentive learning, which is essential to manifest behaviour or performance.

Before proceeding to the consideration of attention, however, it may be noted that Collier (1956) speculates that consciousness is "a regulatory field" which permits of ego-defensive behaviour. I should extend this notion to the hypothesis that consciousness is a regulatory field permitting the narrow or diffuse focussing of attention, and is an essential prerequisite for both active and defensive behaviour of the organism at all times.

.. ..

1. Attention, or the "Orienting Response":

While Pavlov's work on simple associative contiguous conditioning was able to show that the presentation of two associated stimuli were necessary and sufficient for classical conditioning to occur, the intervening variables of pre-existing level of arousal, emphasis, heightened level of arousal, and feedback as well as inhibition or extinction of the initial response were not thoroughly investigated. He did, however, note the presence of what he named the "orienting (investigatory) reflex", and, according to Razran (1961),

*Hullian type.

he later

> noted that conditioning proceeded best when the orienting reflex....is neither too large nor minimal or absent, and that in the course of CR training the OR tends to disappear.

Razran, himself, restates this by stating:

> The conditioned stimuli must arouse adequate but not overwhelming consciousness and that consciousness tends to disappear as habit develops.

We may re-state this by saying that conditioning or learning of the most complex kind is dependent upon the restriction of the focus of attention, as, e.g. Woodworth (1958) and his followers have also seen. Furthermore consciousness, or awareness, tends to disappear as both narrowed focus or adaptation occurs. It is a matter of everyday experience that one "loses oneself" in a book, or in thought, or activity - one is conscious neither of the surroundings nor or one's immediate activity, but only perhaps of one's emotional state or the images or symbols upon which one's attention is focussed.

Sokolov (1958c - see Razran, 1961) has shown that the OR is actually a constellation of activities - it is

> in all respects a centrally organized, holistic system of a variety of specifically distinguishable visceral, somatic, cognitive, neural and neuromotor reactions.

Vinogradova (1958, 1959a, 1959b), Vinogradova & Eysler (1959), Vinogradova & Sokolov (1955), have all demonstrated many times that, in response to stimuli of all modalities, the dilatation of the blood vessels of the forehead accompanied by the constriction of the digital blood vessels is an OR reaction and only an OR one. Razran (ibid. p.112) has extensively covered the Russian experiments in this connection.

Other main points to be noted here, however, are:

The Russians contend that all associative conditioning is mediated through OR conditioning (for examples, see Razran, p.117). Anokhin (1958) and Polezhayev (1958, 1960) state that the OR operates as an afferent and feedback central integrator of the stimuli before their actual conditioning to the peripheral food or shock reaction in all conventional (food or shock) classical conditioning.

Of importance to the main thread of this thesis, too, is Sokolov's (1958b) finding that animals higher in the phyletic scale extinguish their ORs more readily (the PGR component of the OR extinguishing more quickly than the respiratory component); and Lichko's (1952), Sokolov's (1959b), Usov, (1942) findings that there is less extinguishability in organic and functional psychopathology in human Ss. This ties, in, for example, with Mednick's (1955, 1958) work on stimulus generalisation and levels of arousal.

Berlyne (1963) also discusses the latest modifications to Pavlov's notions, and the "Orientation reaction", as it now appears to be called, (cf. Berlyne, 1960, Ch. 4).

Berlyne explains that the orientation reaction is of very considerable importance, not only because it sensitizes the organism as a whole so as to enable it to extract information from the environment the more easily, but because it prepares the organism for rapid and vigorous action. He adds:

> Lately, however, and especially in the Vygotsky-descended group, the orientation reaction seems to have acquired yet a third connotation embracing purely central attentive processes. For Zaporozhets (1956), the objective equivalent of a conscious attentive process, is the occurrence of an orientation reaction.
>
> He extends this reasoning to the analysis of voluntary behaviour

> to suggest that the essence of voluntary behaviour is in feedback.....He points out that there is a difference between primitive behaviour and complex voluntary behaviour with respect to how much feedback occurs and at what stages. If the organism is functioning at a primitive level, as is the case with most lower animals or with human beings at their more primitive moments

(and, I would suggest, in their partially disordered moments,)

> it has a stab at the problem and obtains feedback from the end product. It behaves like a rat indulging in trial-and-error learning. Having done something, it determines whether it has reached its goal or not. If so.....it continues to do more of the same. The response is learned and is performed with greater strength on the next occasion. But if the goal has not been reached, the behaviour is modified and another response is tried out.

But such behaviour may be dangerous. If the organism is to survive prior identification is a vital necessity.

> Therefore, according to Zaporozhets, it is important to reach the stage of voluntary behaviour, in which we receive feedback en route.....we (must) continually monitor our behaviour along the way and extrapolate from what has happened so far to anticipate the next move. (Berlyne, 1963, p.178).

I have quoted the foregoing so fully not only because of both its importance and its concise statement of much that I have been endeavouring to argue, but Berlyne, no mean authority himself, considers Zaporozhets' book

> one of the most important psychological books to have come out in any country within the last ten years. (Berlyne, ibid, p.176).

After reviewing and discussing various experiments carried out by Zaporozhets and various collaborators, Berlyne goes on to state:

> Zaporozhets has related this work to thinking. Voluntary behaviour is, or can be, planned behaviour. When a child has behaviour under voluntary control.....he can plan ahead
> .....
> Planning behaviour in advance means being able to reason about it, being able to think it out, and that means building up an image of the activity. The subject must build up an image of

> what he is going to do when he meets each of these cues .....In other words, we must have responses that move us from one part of the cognitive map to the other. We must have a motor pattern of some kind as well as a perceptual pattern. And according to Zaporozhets, the devices that conduct us from one element of an elaborate image or thought structure to another are orienting responses in an implicit form. (Berlyne, ibid, p.181).

In human beings, however, the cognitive map, postulated by Tolman so long ago (1948), surely consists also of symbolic verbally-mediated reference systems. And, as Tolman also realised, what is attended to, and what is learned, is frequently determined by the "set" operating at the time.

.. ..

2. Set:

We may postulate that, at the lower levels of learning, or organismic development, the organism responds first to irrelevant stimuli (cf. Krechevsky, 1938). This is true, also, of both young children and schizophrenics, who are "stimulus bound in that (a) stimulus **must** be attended to" (Goldman, 1962), (cf. Cameron, 1939; Kasanin, 1944).

But as experience broadens and the focussing of attention on particularly stimuli is learned, the organism develops "sets" predisposing it to search for, focus on, or respond to, particular stimuli in particular ways. In other words, incidental attention, or a more or less temporary orienting reaction, becomes selective attention.

It has been shown that such a narrowing of attention and a fall in incidental learning may result from high drive and over-

learning (cf. Bruner, Matter & Papanek, 1955; Johnson, 1953; Spence & Lippitt, 1940, 1946; Thistlethwaite, 1951; Tolman, 1948). Increased incentive likewise leads to selective attention (cf. Bahrick, Fitts & Rankin, 1952; Bahrick, 1954). Likewise "mechanization" appears to result in the narrowing of the range of cues (Walker, Knotter & DeValois, 1950): it may well be that such pathological phenomena as mechanization, stereotypy or fixations not only result in, but from, learned sets, creating circularity and reciprocal reinforcement.

The concept of "selective attention" or "set" may also be allied to Sullivan's (1948) notion of "selective inattention", which I contend would account for many of the perceptual defence study results. The idea of "selective inattention" is found again in Fenichel's (1945) notion of a "stimulus barrier" against traumatic stimuli, (cf. Welch & Kubis, 1947); and it must be noted that Samuels (1959) has reported that the studies of Ingvar & Hunter (1955) and Adey, Segundo & Livingston (1957) would appear to indicate that a blocking of reticular conduction could block ideation and reticular control of peripheral afferent input could disrupt the reception and transmission of external sensory stimuli.

But "set" depends, at least in part, on expectancy. Murphy (1956) realized that "expectancy leads to sensitization" (p.7) - as I have also endeavoured to show attention does. But Murphy's conclusion that

> during continuous or repeated stimulation, pleasant things tend to receive more and more emphasis in any unstable perceptual field

will hold true if, and only if, the S, from fear or conditioning

has not learned to attend to, concentrate upon, the more highly feared unstable area. Limen of satiation (cf. Glanzer, 1953; Allport, 1955) will depend upon the level of fear, or depression, and only with satiation and an emphasis on the pleasant withlearning not to fear the ambiguous, will inhibition of fear responses occur and the focussing on the pleasant be able to take place.

But while expectancy leads to sensitization, it is doubtless equally true that sensitization leads to expectancy, which is roughly the Hullian (1952) position, and was seen also by Tolman, (MacCorqudale & Meehl, 1954). As Seward (1956) comprehended,

> Hull's redefinition of habit strength changes the meaning of 'reinforcement', while his use of r_G in deriving the effect of delayed reward makes goal anticipation the major determinant of reaction potential (p.113).

As I suggested earlier, it seems that we have levels of learning in which Hilian-type learning predominates, and higher levels in which Tolmanian cognitive and expectancy (which relates to set) learning is dominant; but it also seems likely that there are levels in which there is a circular position with both sensitization and expectancy being mutually dependent. This equates with the position taken by Razran (1955, p.93).

In 1938 Mowrer published a number of findings which, despite some change in language, still stand to-day. Because of its present timeliness, as well as its importance, I present his statement fairly fully:

> 1. Apparent conditioned responses can be suddenly established and equally suddenly abolished in human beings merely by controlling the S's state of expectancy or preparatory set.
>
> 2. Many subsidiary facts (discovered from conditioning

> experiments) are due simply to changes in the nature and extent of the subject's preparedness or readiness to make the particular response under investigation.....
>
> 3. By acknowledging the mounting anticipatory tension (preparatory set) which precedes the presentation of a recurrent noxious stimulus as a form of motivation which is markedly reduced by the occurrence of the resulting response, it is possible to show that painful stimuli can be used to create and strengthen connections instead of weaken them.
>
> 4. Learned behaviour is (apparently) ordinarily changed only by the learning of new behaviour, which merely supersedes and suppresses (or represses) but does not destroy the earlier reaction tendencies.
>
> 5. The fact that anticipatory reactions, precipitated by an over-developed preparatory set, may be accompanied by an hallucinatory perception of the anticipated stimulus, points to a response theory of sensation and provides an approach to a stimulus-response analysis of suggestion. (p.88).

Strangely enough no-one seems to have been concerned with, or even noticed, the natural corollary to 3. above, viz. that "tension" increase resulting from the expectation of a pleasurable, rewarding stimulus also acts as a reinforcer. The constant emphasis on need-reduction has only recently been modified (cf. Miller, 1961).

Nonetheless all of the early work to which Mowrer here referred has considerable bearing on current research. Not only, as he himself was aware, did it relate to attention; but also to the relationship of the general level of arousal and learning , as well as the effects of anxiety and individual differences, and to stimulus generalisation, (cf. Schlosberg, 1928, 1932; Miller & Cole, 1936 - Mowrer, 1938, p.67).

Anticipating the recent work on arousal (cf. Berlyne, 1960) Mowrer, after criticising Pavlov (1927), commented:

> A much simpler explanation, and one which would seem to be more in line with established physiological principles, is that generalization is a function of the degree of readiness or preparedness of a given reaction system and that by virtue

> of the development of an unusually high condition of readiness, stimuli which would ordinarily be without visible effect are now capable of eliciting the response for which the pre-existing set was appropriate. (Mowrer, ibid. p.66).

Mednick's studies on stimulus generalization (1955, 1958, 1960) incorporate both Pavlov's theorizing of generalisation being due to an hypothetical excitatory brain state (though this is no longer "hypothetical" and must incorporate reticular and limbic system activity), and Mowrer's concept. The psychological correlate of a state of readiness, or arousal, however, must surely be the cognitive set of expectancy, the apprehended degree of probability of pleasure/displeasure, success/failure, being accompanied by the appropriate affective set relative to hope or despair.

If this set finds reward, i.e. reinforcement, in appropriate satisfaction learning will occur. On the other hand, when an organism has been conditioned to make a particular response the effect of such conditioning disappears after repeated stimulation without reinforcement.

.. ..

VI. Unlearning or extinction.

While the term "extinction" is generally applied to the disappearing conditioning just referred to, it is not at all clear just what is involved. The superficial conclusion that the response has now been erased from the neurological system is obviously wrong, as is apparent from both spontaneous recovery and the phenomenon of disinhibition. There is no loss of the original learning, but merely a failure for it to result in action. The arguments arise not from the Pavlovian and Hullian explanation of this as a process

on inhibition, but as the result of the hypotheses presented as to how this inhibitory effect is produced.

Hull (1952) based his explanation upon the generation of reactive inhibition, which supposedly gives rise to conditioned inhibition. Reactive inhibition may be regarded as a negative drive whose potential builds up during repeated responding and provides positive reinforcement for ceasing to respond. While itself a temporary effect, it produces permanent effects through conditioning the habit of not responding. A major criticism of this concept arises from experiments which show that extinction occurs even when the organism is unable to make the response (e.g. Hurwitz, 1955), and from experiments which show that the amount of work done in responding is not necessarily related to the rate of extinction (Hurwitz, 1954). Such evidence seems to indicate that a central rather than a peripheral process is involved, but it is still possible that peripheral feedback plays some, though not an essential, part.

I have already indicated my preference for the concepts of incentive and probability expectations as the basis of operant learning. Change of such expectations could be regarded, as Mowrer contended (see p.85), as the basis for extinction. Non-occurrence of reinforcement would progressively reduce the probability expectation until it would become virtually zero. At this stage the organism would cease to respond. Because a responding habit had been previously established non-responding would call for inhibition of response. Repeated experiences of such inhibition could eventually result in a habit of inhibiting under such conditions, and

this could result in the equivalence of Hull's conditioned inhibition.

The probability expectation referred to above would obviously not be based upon a simple average of experiences but would require some weighting with regard to time. Recent experience is obviously more important for the organism than earlier experience (e.g. the usual escape route may now be blocked), so there must be some means by which account can be taken of this. Differential weighting in respect to time would seem to be essential to any probability expectation and Broadbent recognises this (1961, p.181). Spontaneous recovery may be explained on such a basis.

In this connection it should perhaps be noted that the differential weighting needs to take into account a distinction between long-term and short-term effects. This is necessary to account satisfactorily for partial reinforcement effects. If, on the long-term basis, the organism finds that only one response in ten is reinforced, it will operate on this as a firm basis of expectation, and, if the incentive is sufficiently high, will make the requisite ten responses in order to achieve success. The effect of a single failure under these conditions will be only in the vicinity of one-tenth of what it would be if success had previously been at the hundred per cent level. The precise calculation of declining probability levels will need, therefore, to be rather sophisticated and probably along the lines of Estes' equations for rate of responding (Koch II, 1959).

At this stage in the development of learning theory the possibility of a definitive system, fully confirmed by experimental

evidence, is a utopian hope, and this thesis is not concerned to make contributions to learning theory as such. My aim is rather to select a set of simple principles which seem to cover most of the phenomena to be accounted for, particularly with regard to psychotherapy, and which, although not belonging to any one school, are themselves logically consistent and in accord with a considerable body of evidence. The final word here must come from learning theorists rather than from psychotherapists, but I strongly suspect that the system arrived at ultimately will involve the acceptance of multiple explanations for what seem to be similar effects. This seems particularly likely with regard to extinction. At the level of choice behaviour expectation changes appear to be the most likely explanation, but these generate more permanent effects in the form of conditioned inhibition which operates at a more basic and less conscious level. These inhibitory effects are mediated also, I wish to argue, by another process, that of satiation.

Satiation probably accounts for much of what Hull conceived of under reactive inhibition. As Mowrer points out (1960a, p.402) extinction occurs to responses of the autonomic system where no muscular activity is involved and nothing in the nature of "fatigue" can be postulated. Mowrer favours an explanation in terms of frustration so that anger as well as fear becomes a key concept in his system, but it is difficult to see how anger as such brings about extinction. Anger responses themselves may be extinguished; is this because frustrated anger results in anger? It is possible

but rather more likely that we are concerned with failure to confirm expectations. Aversive responses may also extinguish, and one could hardly become angry about not receiving an expected punishment, except, perhaps, where punishment has become conditioned as a cue to re-acceptance.

Pavlov (Psychopathology and Psychiatry, undated) uses the concept of "transmarginal" inhibition to explain the neurological reaction to undue stimulation. This is probably akin to the satiation effect invoked by Köhler (1940) in respect to perception, and is confirmed by the well-known effect of repeatedly eating the same kind of food, (cf. Young, 1948). Strawberry-pickers will eat large quantities of the fruit when first employed, but rapidly lose interest in the strawberries as food. The child who begs to be allowed to help in painting the fence will hate the task if compelled to continue the activity too long. In all these cases we are concerned not with lack of reinforcement in the ordinary sense of the term, but rather in a decline in the efficacy of what normally functions as reinforcement and even its conversion into a punishing experience. Satiation, too, then may be regarded as a temporary effect which leads to conditioned inhibition and so produces permanent effects. It does by both direct conditioning and by reduction or reversal of incentive expectancy.

.. ..

VII. SUMMARY:

A. General:

The major points with regard to learning and unlearning with which I have dealt are:

1. Learning depends in part on maturation. (pp.59-61).

2. The organism learns: Incentive expectancies
   Probabilities
   Relations. (pp.61-64).

3. There are several levels of learning, the main ones being:
   Classical conditioning
   Operant conditioning
   Language and conceptual systems
   Cognitive reference systems. (pp.65-68).

4. Verbalisation and conceptual and reference system formation is a conditioning and cognitive learning process, involving the "higher nervous system". (pp.68-78).

5. Learning results from contiguity alone, and operates through attention, or the "orienting reaction", and set. (pp.78-83).

6. Hullian-type reinforcement is necessarily involved in incentive learning, which requires reward or punishment, and operates as a factor producing contiguity in attention. (pp.78-79).

7. Set may lead to selective attention and selective inattention, and, in certain circumstances, to fixation and stereotypy. (pp.83-84).

8. Set depends on expectancy (p.84) and sensitization (pp.84-85), and level of arousal (pp.85-87), and may lead to satiation (p.85).

9. Unlearning or extinction (pp.87-91) depends on inhibition, change of probability or incentive expectancies, or satiation (pp.90-91).

.....

B. Principles of Learning and Unlearning:

Arising from the discussion in regard to the points set out in the above summary, I would propose the following principles of learning and unlearning, all relevant to psychotherapy:

1. A rewarded response will be repeated as soon as its essentials have been isolated by insight or by trial and error.
2. Non-reward will reduce the estimate of probability of reward, and when this falls below a threshold-value responding will cease. The weighting effect with regard to recency will result in a rise of the probability value with the elapse of time and response will again occur (spontaneous recovery).
3. The level of the threshold referred to in 2. will vary with degree of incentive.
4. Repetition of response with reward will build up a response habit.
5. Repetition of the response with non-reward will lead to its being inhibited and to the building up of a conditioned inhibition of the response.
6. The process of extinction may operate through:
   (a) reduction of incentive expectancies
   (b) reduction of probability expectancies
   (c) satiation.
7. A punished response will tend to be inhibited (all other things being equal) as soon as its essentials have been isolated by trial and error or insight.
8. At early age levels, or in pathological cases where all stimuli are being attended to or inadequately discriminated, an irrelevant response may be the one inhibited or reinforced .

9. In the case of aversive responses the withholding of reinforcement (punishment) will be immaterial until the organism ceases to make the aversive response, and with traumatic conditioning this may never happen. Extinction can then be obtained only by in some way instigating the organism to reality-test.

10. The frequent stimulation of a conditioned avoidance response when the organism is too afraid to resort to reality-testing will lead to sensitization, with probable strengthening and generalization of the emotional reaction (paradoxical effect).

11. If punishment is insufficient to inhibit a response (i.e. when the degree of incentive - need or "wish" - is still so great as to consciously or unconsciously predispose to action, either

    (i) alternative unpunished behaviour patterns will be found, or

    (ii) the same response will occur plus vigilance, and, if the punishment was sufficiently severe, appropriate anxiety, or

    (iii) ambiguous, alternating approach/avoidance behaviour may occur, or

    (iv) if the conflict is so great that no appropriate action is taken over a sufficiently long period of time,

        (a) reinforcement of maladaptive non-action and anxiety patterns and/or

        (b) extinction, will occur.

This leads me to three further postulates:

11. Innate temperamental factors and the functioning of the biochemical and neurophysiological systems will affect both learning and the behavioural patterns learned.

12. Innate and conditioned intelligence factors will likewise affect the results.

13. Too high or too low arousal, and too much or too little feedback in any neurophysiological system will impede or disrupt learning and may create some form of mental disorder.

... .

I shall now pass to some consideration of the functioning human being.

PART FOUR

THE PERSON.

I. Physiologically-based components:

From the point of view of psychotherapy, and indeed of psychology generally, it is most important to differentiate between genetically-determined and environmental factors affecting the human being. For example, inherited individual differences are concerned in emotional reactivity, general arousal, rate of response and intelligence (cf. Cattell, Blewett & Beloff, 1955; Eysenck & Prell, 1951; Eysenck, 1956).

The nervous system, which mediates these highly important behavioural components, apparently has parallel inherited structural differences, and may be broadly classified into four sub-systems:

1. The autonomic system which co-ordinates the internal, especially digestive, functioning with the activity requirements of the organism and adjusts it to changes in temperature. It controls and integrates the vegetative functions.
2. The central nervous system, which mediates between sensory organs and muscles, more or less directly, to produce appropriate orientation to the environment. It is concerned in the functioning of perception and intelligence.
3. The reticular system, which controls the attentional system and adjusts the activation level to environmental requirements. It operates through perceptual and autonomic feedbacks.

4. The limbic system, concerned in varying ways with what is subjectively experienced as affect. Here we seem to have the seat of at least some major drives.

.. ..

1. The autonomic system.

Of the entire nervous hierarchy the autonomic system is, phylogenetically speaking, probably the oldest part, having evolved in the first place to serve the gut. Apparently, although Galen first observed the sympathetic chain, it was Bichat who first used the term "autonomic nervous system", having mistakenly decided it was quite separate from the c.n.s. (Grayson, 1961, p.117).

The two subdivisions, the parasympathetic and sympathetic, are frequently considered to have completely opposite functions, but this is in fact not so, for, as Lindsley (1951) saw, the two systems interact, particularly in such complex functions as blood-pressure regulation, muscular action, temperature regulation.

One major difference, of course, is that acetylcholine is secreted at the endings of a parasympathetic nerve (as with somatic motor nerves) when stimulated, while nor-adrenalin is liberated when a nerve impulse reaches a sympathetic terminal. Acetylcholine causes the dilation of arterioles, while nor-adrenalin brings about their contraction. Another important difference is that the sympathetic nerves are concerned in the main with blood-vessels and preparation for action, while the parasympathetic nerves are mainly distributed to the abdominal viscera and concerned with the control

of alimentary activity and glandular secretion. This is, of course, important when one considers psychosomatic complaints, the effects of stress generally, or gut-experienced hysterical conversion symptoms: the tie-up between the systems explains, at least in part, the somatic complaints associated with an undue level of autonomic activity.

But the major aspect of the work of the autonomic system, in so far as the present discussion is concerned, is undoubtedly the fact that its activity creates visceral repercussions which in turn stimulate the interoceptors. These feed back to the hypothalamus information concerning the soma; so does the muscular tonus associated with emotion.

There is thus quite a rationale for the theories put forward by William James (1884, 1890) regarding fear and for the James-Lange (1885) theory of emotion generally. Of the modern psychologists Lindsley (op. cit.) was probably the first to emphasise the great importance of the feed-back mechanisms just considered. Samuels (1959) has reviewed the most recent pertinent psychological literature regarding the reticular system; but probably the work in cybernetics by Wiener (1948), Ashby Ross (1952) and Grey Walter (1953), really brought the importance of feed-back mechanisms in learning, communication, and behaviour generally, to the fore.

With regard to the specific effect of interoceptive feed-back, however, Woodworth & Schlosberg's (1954) comment, makes a number of highly pertinent points:

> Chemical changes in the blood stream furnish more energy to the neural centers as well as to the muscles, and at the same time these centers are subjected to an increasing barrage of return impulses from viscera and from skeletal musculature, which in turn increase the activity of the centers, leading to more muscular activity, and so on, in an ascending spiral of activity and reactivity. Fortunately, there are self-limiting mechanisms, notable parasympathetic, which check this build-up so that we do not always end in a state of violent emotion.
>
> Thus, at any one moment the organism is in balance at some specific level of activation. There are other possible terms for this level, such as level of energy mobilization, of excitement, of tension, of alertness, of effort, etc. Many of the terms are useful for limited regions of the range, but the best term is <u>level of activation,</u> which is to be understood as the factor which is common to many of the bodily changes involved in 'emotion'. (Woodworth and Schlosberg, ibid., p.136).

The autonomic system is directly involved in our two most intense emotions, viz. fear and anger, but the psychological experience of such an emotion involves something more. Grayson (1961) acted as subject in an interesting experiment requiring the slow injection of adrenalin into a vein. He reports that the subjective reactions vary, but, for himself,

> the heart beats faster, breathing is deeper, there is a sense of bodily alertness, an overall feeling which I can only describe as 'fear in a vacuum'. One feels as though one ought to be afraid, but nevertheless one is not afraid. Many of the physical concomitants of sheer terror are there, but all the time the mind is clear, one can analyse what is happening and, so to speak, dissect fear itself. It is impossible not to agree that the visceral manifestations of endocrine excess are an integral part of the total emotional state, but for the emotion of fear to be complete there must be a conscious recognition of the fact that the danger is real.....I have no personal doubt that emotion of this kind participates in full measure of all its ingredients, visceral, somatic and central. (pp.159-160).

Grayson is in no doubt that chemical stimulation of the

autonomic system is not sufficient to produce a real fear, but his postulation of a cognitive element with regard to the reality of the stimulus may also be queried. Fear is notoriously irrational and may be experienced in very real form when one consciously recognises that the danger is not real. Most phobias are an excellent example of this. Moreover some of the evidence adduced in refutation of the more literal acceptance of the James-Lange theory seems to indicate that fear may be experienced in the absence of feedback from the autonomic system, (cf. Arnold, 1960). We might speculate that what was missing in Grayson's case was more precisely a limbic system component. The function of the autonomic system is to mediate the appropriate pattern of vegetative adjustment and supply feedback to the limbic and central systems.

Before leaving this consideration of the autonomic system I should like to enlarge on an earlier reference (p. 97) to Lindsley's assertion that the sympathetic and parasympathetic systems do not act simply as opposed units. The work of Ax (1953) and others (cf. Funkenstein, King & Drolette, 1957), seems to indicate that there are distinct patterns of response, associated with epinephrine and nor-epinephrine respectively, which cut across the sympathetic-parasympathetic dichotomy, and which seem very likely to be the basis of the distinction between fear and anger responses which, despite some common elements, are largely antithetical in form. It is only within the last few years that introductory textbooks in psychology have caught up with this fact.

The point about the level of activation in my quotation

from Woodworth & Schlosberg relates to the reticular system and will be taken up in my discussion thereon.

.. ..

2. The central nervous system.

This is the key to cognitive activity. It mediates motor responses of a very simple kind by direct reflex action, but its chief function is to build up a vast fund of coded information in the light of which behaviour may be appropriately directed. It is very important to recognise that only the simpler forms of behaviour can be conditioned responses of the direct kind. In our complex environment to-day's response is seldom suitable tomorrow without modification. What is needed, therefore, is an ordered cognitive map of the complex inter-relationships of our universe in the light of which current sensory input can be interpreted and used to guide our ongoing activity. Each new sensory input serves to modify the total system rather than to provide another item of information to be recorded.

Perception is directed towards understanding rather than recording. It has sometimes been naively imagined that our senses are miraculously equipped to provide us with an appropriate record of the environment whenever we have reason to direct our attention towards it. Perception is not photographic in function and would be useless if it were, (cf. von Fieandt, 1958). In order to make complex responses it is essential to see the environment meaningfully, and this demands intelligence.

.. ..

"Intelligence" more often than not is thought of in terms of I.Q.s as originally measured by the Stanford-Binet (1916) or similar tests. Nonetheless this measure is practically unaffected by some of the most radical changes involving the brain. It is possible to remove the parietal or occipital lobes on one side, or both parietal lobes (Halstead, 1947, p.140; Hebb, 1942) or to cut off the supply of oxygen to the brain for long periods (Halstead, p. 114) and not affect the I.Q. A closer approximation to the truth was perhaps Spearman's "g".

In the early 1940's Halstead (1947) gave a battery of tests to a wide population, including brain-injured patients. The results he submitted to Thurstone and Holzinger for factor analysis, coming up with 4 factors A.C.D and P. These we may briefly refer to as (1) "Abstraction - the ability to abstract a principle from a mass of varied data, to determine regular similarities and dissimilarities between situations, and thus to discriminate a large number of different situations"; (2) Integration - the ability (as Russell & Russell, 1961 p.34, point out) "to compare new data with the old, and thereby qualify a generalization"; (3) Specific skills or "expression", e.g. the ability to compose music; and (4) what Russell & Russell (ibid. p.36) call the 'Exploratory Drive': the mechanism whereby variation is introduced into our behaviour."

The term as used here means more than the "curiosity drive" (Berlyne, 1960) for it implies both active overt exploration of the outer environment through trial, experiment, observation, imitation, and also with vicarious trial and error through the function of the imagination, i.e. "insight" (Craik 1943).

It should be realised that exploration also requires a capacity to tolerate uncertainty. As Frenkel-Brunswik (1949) has pointed out - the toleration of uncertainty is not an asset of anxious people. We have here, then, a most important focal point essential to any consideration of mental disorder - viz. that anxiety affects actual intellectual functioning as well as the learning process, and overt behaviour.

The Halstead factor described by Russell & Russell as "exploratory drive" is of particular importance in the light of a recent paper by Seward (1963) in which he discusses the problem of functional automomy and proposes three basic "exogenous motives" : curiosity, effectance and an affective dimension.

In his own words:-

> As we have seen, many of the activities of organisms appear to be aroused by and directed toward the environment with little help from the viscera. These activities may be grouped along several dimensions, that serve both to order the data and to identify possible mechanisms. They suggest, that is, a number of mediating processes - let us call them exogenous motives - each process or motive having a different function in dealing with the environment. The three dimensions I have in mind, with the motives and functions they subsume, are as follows:
>
> 1. A perceptual-motor dimension. Instead of lumping the exploratory behaviors I suggest that we distinguish between tendencies to explore and to manipulate the environment. An unfamiliar situation may move an organism to inspect it more closely, or novel

objects may induce it to lift or squeeze or pound or rearrange them. We may call the first motive curiosity and assign it the function of learning the environment (Woodworth, 1958). The second motive is what White (1959) called effectance, and its function is to control the environment.

2. An affective dimension. No matter how we try to evade the issue, it is hard to pretend that animals do not find some perceptual experiences preferable to others. What experimental work there is (e.g. Pfaffmann, 1961; Schnirla, 1959; Warren, 1963; Young, 1955) confirms our homemade convictions. There is little doubt that cats prefer soft cushions to hard floors, warm hearths to cold baths, and head rubbing to tail pulling. To make the assumption explicit let us borrow from common usage the terms attraction and aversion, and assign to them the function of improving the environment.

The conclusions to be drawn from this discussion and much related material which I cannot elaborate here, is that the organism is not merely equipped to receive stimuli from the environment and understand them (to receive, process and integrate impressions) but has also an actual drive to engage in such activity. It might be better to think of this as the cognitive drive. Novel stimuli must be integrated into the existing cognitive reference system and effort continues until this has been effected. This urge to understand is independently motivated and does not need to be deprived from the conditioning of other drives although it may be strengthened by such

reinforcement.

What we term intelligence is a measure of the efficiency with which the organism is able to carry out this task and will vary in relation to a number of factors but one will certainly be the coding capacity of the neural system. Organisms, like computers, will vary considerably in their capacity to handle data. Whether such differences will usually be crucial as between one human being and another we may still have to decide, but there can be no doubt when we compare a man with grasshopper. At this stage it may be useful to consider some of the evidence available with regard to the neural handling of data.

Lashley (1929) did much to throw light on the problem of memory storage. He propounded the "doctrine of equipotentiality", i.e. all parts of the cerebral cortex are concerned in the storage of memory, with the exception that the occipital cortex, the "visual cortex" is the region specifically concerned with the storage of visual impressions.

It was Cajal (1911) who first pointed out that cerebral efficiency could be regarded as function of the number of short axon cells in the cerebral cortex.

A great deal of attention has been focussed on the complexity of the neuronal connections within the cortex (cf. Penfield & Rasmussen, 1950). It is now clear that there exists many millions of inter-neuronal connections, a vast confusion of dendrites and nerve-fibres, forming chains of infinite complexity, a tangled maze along which action potential can theoretically wander indefinitely. (Grayson, op.cit. p.201.)

Ashby, (1950,1952) considers that these complex nerve nets, which occur both in spinal cord and cerebral cortex, have the property of "step-functioning", for such a circuit has been shown to be either fully excited or inactive, according to the degree of excitation or inhibition arriving at it.

Eccles, (1953, 1959) who, according to recent radio news report has recently isolated the cortical cells responsible for inhibition, thereby confirming Pavlov's (1927) view that inhibition (including "sleep") is a function of the cerebral cortex postulates that synapses have the property of "plasticity" and its reverse, "the tendency to atrophy with disuse". The combination of several afferent pathways, coming possibly via a "convergence centre" to a "receiving centre" (a reflex centre controlling any reflex) as well as through individual pathways, means greatly increased efficiency of synaptic transmission so that, after sufficient association, stimulation of either pathway alone might be sufficient to fire off impulses.

Eccles suggests that the supply reaching the convergence centre from any source, including a "conditioned" source, is less than that reaching it from the combined sources. Thus, although transmission will occur a few times, all the time resistance is building up again so that eventually it rises too high for one response alone to break through. This would appear to be the raison d'être for the necessity of reinforcement in learning or conditioning; and the underlying explanation of extinction over time. Nonetheless the trace has been laid, the pathway "forged", no matter how weakly, and

the "recovery" of "extinguished" material thereby possible.

One may assume, therefore, that, no matter how it may be coded, there is, in effect, a hierarchy of "memories" or "response pathways". The point so often neglected, however, in the plethora of facts available for physiologists' and psychologists' consideration, is that the verbalised "memory" will in all probability be a statistically averaged approximation of the happening, and will be encapsulated in a complex of associations. One notes this, particularly, in the aged and certain mentally disordered individuals who recapitulate an event woven into a whole scene, making up the "Gestalt" of the original perception.

Hebb's (1949) well-known concepts with regard to cell assemblies and phase sequences are well in line with the current theorizing about neural nets. The basic notions seem well fitted to explain both the actual formation of concepts and the equipotentiality effect observed by Lashley (1929). Many of the details of his theory will require modification, particularly his ideas of motivation, but there seems no doubt that neurological concepts are rapidly developing to a stage when they will begin to be productive of greater psychological understanding, and have already reached a stage when psychological theories no longer need to perch precariously above a neurological void. There seems no reason to fear that the central nervous system could not perform the complex functions we have to demand of it or to look for a supernatural "soul" to supply the missing magic.

.. ..

3. The Reticular System:

The reticular system is concerned with arousal but there is room for confusion in the use of this term. We need to distinguish between cognitive alertness and high emotional activity. High cognitive arousal need not involve emotional disturbance and very high emotional involvement may involve no greater cognitive arousal than medium stimulation. Stennett (1957) found that maximum alpha effects occurred with intermediate emotional arousal.

We may distinguish two distinct arousal systems: ascending reticular and thalamic reticular. The former responds to perceptual stimuli directly and serves the purpose of ensuring that certain stimuli or types of stimuli shall be appropriately attended to by an active cognitive system. In simple terms we may regard this as a stepping up of attention as opposed to inattention, boredom and ultimately sleep.

The thalamic reticular system operates in conjunction with the autonomic system and the limbic system and this makes it very easy to confuse cognitive activation with drive activation. This is doubtless the explanation for the U-curve relationship between arousal and efficiency found by Freeman (1948).

The respective functions of the ascending and thalamic reticular systems are still far from clear (Samuels, 1959) but there appears to be good evidence for considering the function of both to be best equated with attention or the "orienting reaction".

There appears to be a complex system of interconnections which result in drive activation resulting in specific as well as general reticular effects. As a consequence the organism seems to be able to monitor its own sensory input (Lindsley, 1961) and so operate a process of selective attention (and inattention) which makes it autonomous to a high degree.

4. The Limbic System:

Papez (1937) stressed the importance of a series of structures for emotional and motivated behaviour: thalamus, cingulate gyrus, hippocampus, amygdala and hypothalamus. The term "limbic circle" is commonly used to refer to these centres and more recent work has confirmed their importance (Diamond, Balvin & Diamond, 1963). This is the neural counterpart of Freud's "id" and the techniques of ablation and electrical stimulation have indicated areas concerned with fear, rage, curiosity, sexual behaviour, sleep.

The progress made in the identification of neural organization relating to motivation gives greater strength to the concept of drives. The biological concept of natural selection seems to be just as applicable to the inheritance of behaviour mechanisms as to the inheritance of muscular organs. A neural system which mediates rage may be just as important for an animal's survival as its equipment with claws or horns and may become selectively developed by just the same evolutionary process. There would appear to be a high probability that the existence of an important need should lead to the evolution of a behavioural system related to its satisfaction. A drive is a highly

flexible mechanism for securing need satisfaction. It has provision for activation when the need assumes certain proportion or when the environment offers good opportunity for anticipatory provision for the need and for deactivation of the drive when appropriate requirements have been met, e.g. the introduction of food into the stomach. While activated the drive is a source of striving in the light of past experience. Drives and their conditioning thus provide us with the key to the dynamics of behaviour. Their phylogenetic and ontogenetic development explains a considerable proportion of behavioural patterning. Skinner's (1963) introductory remarks in his recent paper on Operant Behaviour support such a position.

It may be convenient at this stage to tabulate the major aspects of our psychological inheritance. The following may be regarded as the chief genetically-derived components in the schema which explains our behavioural trends:-

(1) A cognitive drive to which is allied our outstanding cognitive ability, intelligence. I shall assume that human beings have a basic urge to understand their experiences in order to be able to control them and that both the urge and the capacity to satisfy it vary from person to person. Related to this latter are a number of specific abilities but these are not very relevant to problems of behavioural adjustment outside the vocational area and will be ignored here.

(2) A security drive commonly recognised as fear which in many respects acts as the complement of the cognitive drive. Novelty

will normally provoke curiosity, acts as a challenge to cognitive integration, but too great a discrepancy with the existing cognitive organization will provoke fear and an attempt to withdraw from the area of insecurity. The major stimulus to fear can perhaps be regarded as a threat to the ability to control the environment. Such control depends in the first place on an understanding of the functioning of the environment, how what relates to which, and a major breakdown in such expectancies will produce panic. Obviously a physical threat such as that of loss of a limb will have similar consequences. Pain plays an important part here. For many years it has been behavioural orthodoxy to regard fear as a secondary drive derived from pain stimulation. At this stage there can be little doubt that fear is not dependent upon learning from pain but is experienced in its own right. Nevertheless the avoidance of pain is one of the prime aims in the manipulation of the environment and inability to prevent pain is a major example of lack of capacity in this connection and so a potent fear stimulus. So fear may be aroused either by the threat of painless death or of an exceedingly painful experience which contributes positively to physical welfare, e.g. the extraction of a decayed tooth.

(3) What, in the tradition of White (1959) and Seward (1963), I shall call an <u>effectance drive</u>. This is the capacity to manipulate the environment in the interests of our needs. It may be suspected

that such manipulation may bring satisfaction in its own right and not merely because it is meeting a specific need at the time. Whether this is so or not there can be no doubt that the assurance that one can so manipulate the environment will certainly be comforting and may operate as a generalized motive. A momentary trial of the brakes when about to descend a steep hill may be very satisfying although not necessary for controlling speed. White's (1959) own summary of his opinions are relevant here:-

> The survey indicates a certain unanimity as to the kinds of behavior that cannot be successfully conceptualized in terms of primary drives. This behavior includes visual exploration, grasping, crawling and walking, attention and perception, language and thinking, exploring novel objects and places, manipulating the surroundings, and producing effective changes in the environment. The thesis is then proposed that all of these behaviors have a common biological significance: they all form part of the process whereby the animal or child learns to interact effectively with his environment. The word <u>competence</u> is chosen as suitable to indicate this common property. Further, it is maintained that competence cannot be fully acquired simply through behaviour instigated by drives. It receives substantial contributions from activities which, though playful and exploratory in character, at the same time show direction, selectivity, and persistence in interacting with the environment. Such activities in the ultimate service of competence must therefore be conceived to be motivated in their own right. It is proposed to designate this motivation by the term <u>effectance</u>, and to characterize the experience produced as a <u>feeling of efficacy</u>.

(4) <u>An anger drive</u>. This is essentially a mechanism to promote the combat efficiency of the individual. It mobilizes the resources of the body and focusses all effort on the subjugation or destruct-

-ion of an opposing organism. A frustrating object may be treated as an organism and during the period of high anger-activation be endowed with organic attributes of pain susceptibility and malicious intent. Obviously such aggressiveness could be of great importance in promoting the survival of man under primitive conditions and the drive seems widespread throughout the animal kingdom. I am not aware whether it is a common attribute of insects but bees and wasps are popularly credited with this sort of reaction.

All the above drives might be regarded as of the type of exogenous motives discussed by Seward (op.cit.). They are easily overlooked because they do not minister to any specific physiological need, but since they add enormously to the efficiency of the organism in coping with its environment there seems no reason why they should not be subject to the same process of natural selection which has led to the development of food-seeking or skin pigmentation. Because of their general nature these drives are extremely important for an understanding of the major dimensions of human behaviour. To them we must add two others which are rather more specific but not concerned with the specific physiological needs of the <u>individual</u>. These are the sex drive and the parental drive.

(5) <u>The sex drive</u> is an excellent example of the drive concept. The need here is a racial rather than an individual one. A particular

type of behaviour has become endowed with very high motivational quality because those individuals who have such a drive usually have offspring while those who are lacking in the drive will tend to disappear from the evolutionary sequence. I need not enlarge on the importance of this drive in relation to mental health and disorder. Freud has sufficiently sensitized us to this.

(6) The parental drive. This is the basis of affection, the prime ingredient of social cement and the tie which binds the parents to their children. At all levels in the animal kingdom we find manifestations of this drive. At the lowest levels it is little more than a mechanical instinct as in the case of the spider, but even fish may manifest the fiercely protective attitude distinctive of this drive. In human beings it leads to a valueing of the loved object in its own right. The welfare of the loved person may be valued more than that of the parent (particularly the mother) her/himself.

This drive is by no means a simple one. As Ausubel suggests (1958) it is probably linked to an endocrine reaction which increases the prolactin secretion just before childbirth but there appears to be typical perceptual patterns which act as innate releasers. Bowlby (1957) has an interesting discussion of this which gains added significance in the light of Harlow's work (1958) with surrogate mothers. It seems likely that specific perceptions ("sign releasers") and motor responses are innately linked with a complex parent-child relational system. These are reciprocally

adjusted so that caressing is both satisfying to the parent and to the child. Being fed at the mother's breast involves a pleasure not wholly restricted to the baby. Affection results in nurturant behaviour but this in turn produces reciprocal affection and it is such reciprocal affection which becomes the instrument of social cohesion of all kinds.

To these major drives we have to add another variable which exerts a widespread influence. This is what Burt (1958) called emotionality. Eysenck (1944, 1947, 1951, 1953, 1957) has referred to variously as neuroticism or emotional reactivity, and which Cattell and Scheier and Lorr, (1962)describe as anxiety. It might well be termed autonomic lability since it depends upon the ease with which the autonomic system provides emotional feedback in a given situation. Some people are exceedingly sensitive in this respect and so become very prone to neurotic disorders. Eysenck and Prell, (1951) have presented evidence for the genetic origin of this variable.

These then are the major genetically-derived components which I postulate to be involved in our psychological make-up and whose variations I feel must be considered in studying the origin of any mental disorder. We have now to consider how these components are moulded by the conditioning effects of the environment

... .

II. The Learned Components.

In Part III I have made incidental reference to the role of learning in the development of personality. In this section I shall be concerned with the systematic structure arising out of the effect of

learning mechanisms operating on the genetically-derived components just discussed.

It will be appropriate to begin with the cognitive reference system resulting from the cognitive drive. I have assumed that conditioning is primarily an associative process and that reinforcement in the Hullian sense of reward is helpful but not essential. Any appropriate generation of attention will be adequate to promote the bonding effect. I have also earlier emphasised the key role of attention in relation to the cognitive drive. It may be expected that much cognitive learning will be without drive reinforcement other than that provided by the cognitive drive itself.

Tolman (1951) has recognised the importance of curiosity (i.e. cognitive drive) in acting as a reinforcer in much learning and more particularly in the development of a comprehensive cognitive reference frame but he has not stressed the qualitative aspect of the functioning of the cognitive drive. Most writers have regarded curiosity simply as a motive for extending the breadth of experience and have overlooked the role of intelligence in integrating experience. The multiplication of facts is not so important as the integration of facts within a systematic schema.

This presents a facet of learning that few theorists have adequately recognised. Newton's legendary apple did not merely add one more association to his intellectual system; rather it produced a recrystallization of the total system and might be regarded not as adding to the total memory ballast to be carried but as notably reducing it.

In more minor fashion this process is continually going on with all of us. No elaboration of learning principles will adequately explain this; the problem becomes one of dealing with the process of understanding itself.

In popular speech the word learning occupies an uneasy position between the concept of recording in the memory and acquiring insight. Fortunately we have the term conditioning applicable to the former process and it would be desirable to avoid its contamination with the other meaning of learning. The associative aspect of cognitive learning is evident enough but the unique nature of the association must be kept clearly in mind. It is not an association between two simple psychological elements but between one or more of these and a system. When the process involves some restructuring of the reference system to accommodate the new observation we have gone beyond mere conditioning principles.

The cognitive drive is thus continually engaged in the extension of its own insight capacity. This is the central problem of the psychometrician in measuring "intelligence". Current intellectual functioning depends on the achieved reference system as well as upon native capacity and this latter can only be estimated. For many purposes, however, what matters is not what-might-have-been or even what-might-be but rather what-is and actual intelligence tests results may be the most useful measure.

From the point of view of mental health, however, the cognitive reference system is important not only as it relates to general intellectual capacity but with regard to specific content.

Many behavioural decisions are based upon particular conceptions of reality and if these are non-veridical or distorted in some direction an unrealistic pattern of behaviour may result.

1. Trait conditioning

Personality is frequently described in terms of traits. Such traits can frequently be regarded as conditioned drives. If a drive acquires a large range of conditioned stimuli it will come to play a much greater role in determining behaviour. Drives such as anger and fear, and even sex and affection, may frequently mediate goals other than their own specific one. If a child frequently gets his own way as the result of a display of anger he will become more prone to resort to such behaviour. Similarly a display of affection may become a method of achieving other ends. Both classical and operant forms of conditioning may thus aid in the development of major traits such as dominance, shyness, cyclothymia and amorousness.

In addition to these conditioning effects we have to consider the so-called pseudo-conditioning which probably results from stimulus generalization or sensitization. Whatever the explanation, the facts observed by Davis (1930), Martin (1962) and others seem to indicate an important mechanism which could be of considerable significance in increasing the part played by frequently stimulated drives.

2. Achievement motive

What we have referred to as the effectance drive becomes the core of a nuclear motive largely as the result of social reinforcement. The family situation provides both security and affection for the child. Parental approval thus becomes highly valued and this parental approval

thus becomes highly valued and this parental approval is commonly given because of some achievement of the child; learning to talk, to walk, to use the toilet, to dress, to read, etc, etc. This process of conditioning channels the effectance drive in the direction of socially approved achievement and at the same time results in the building up of an achievement reference frame: the ego-ideal or super-ego. The content of this reference frame is of crucial importance to mental health but even its general nature is by no means yet clear and so has been made the subject of an empirical investigation which I report in the next chapter.

3. Ego-control

An achievement reference frame can operate only if there is some control of our immediate impulses. Time and tension binding are developed early because such controlled behaviour is, on the whole more productive of drive satisfaction. It receives more or less consistent reinforcement and so we develop ego-control, corresponding rather to what used to be called "will power" just as super-ego corresponds to what traditionally is known as "conscience".

It must be emphasised that the effectiveness of ego-control depends very much upon the genetically-derived component, emotional reactivity, referred to earlier. High emotional reactivity results in overvaluation of the current drive impulses and so creates greater difficulty for any control function.

4. Introversion-extraversion

This has been very widely recognised as a major personality variable but recent factor-analytic studies seem to indicate two contenders for this title (Carragan, 1960). One of these is a broad trait of sociability with shyness and cyclothymia as central features, while the other has inhibition and control as its major features. The latter of these seems most in the Jungian tradition but the former conforms best to current American conceptions and it is this which appears to be measured by both the MPI of Eysenck (1944) and the 16 P.F. of Cattell and Stice. The Guilford-Zimmerman Temperament Survey favours the Jungian (1941) version. (Bendig, 1962).

Both these factors, however, have something in common (Eysenck, 1963) and this is probably the inhibitory effect of the fear drive. Both factors are probably conditioning effects operating on this factor. Since it is the chief source of avoidance behaviour it is not surprising that it gives rise to a wide second-order factor. Eysenck (1956) has found evidence for the predominantly genetic origin of this factor and has attributed it to a basic inhibitory component in psychological functioning, following Pavlov's classification of dogs into inhibitory and excitatory types.

In relation to this some work with the Stroop colour-word test is of interest. This test introduces a conflict between the name of a colour and the colour of the letters in which it is written. Holt (1960) found that subjects who make low scores on this test also have difficulty in controlling their impulses and Klein (1954) found that the inhibitory

control manifested by high scorers on this test was associated with the capacity to control the effect of a need on cognition. In line with this Gardner and Long (1962) found that performance on the embedded Figures test was related to that on the colour-word test giving further evidence of an inhibitory control factor.

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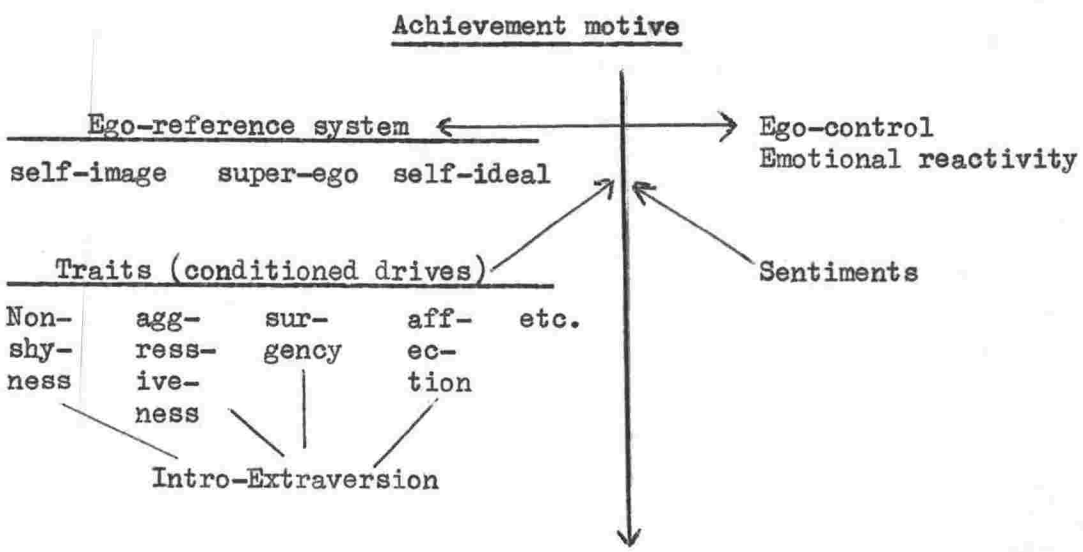
III Summary

The nature of the personality system here envisaged, may be made a little clearer by a schematic representation of the various elements. To represent all the inter-relations and interactions would be rather difficult and confusingly complex so they are shown here only in relation to their behavioural significance. The achievement motive is represented as the central element with the ego control factors and the ego-reference system as primarily involved in the selection of goals. Then comes the cognitive reference system which provides insight into the most appropriate ways to achieve the chosen goals. Finally we have general specific traits and sentiments which influence particular aspects of behaviour.



No account has been taken of motor conditioning here, but, as a source of skill which can be utilized by the organism in the pursuit of its ends, a motor reference system should probably appear parrallel to the cognitive reference system.

Three components have been included here in the ego-reference system but this is just a minimal number. Much has been written about this area and a discussion of the contributions made by Freud, McDougall and numerous later writers would occupy many pages. Since this reference system is the source of guilt and shame and the major psychological conflicts and so intimately linked with a large proportion of neurosis I have made it the topic of a specific research project which is reported in the next chapter. This has added significance because many recent advocates of psychotherapy based on learning principles appear to have neglected this area although it is obviously developed by a process of learning and is modifiable in like manner.

PART FIVE

A FACTORIAL STUDY OF THE EGO REFERENCE SYSTEM

This research was carried out with the co-operation of my husband, C.J. Adcock, and advice from R.B. Cattell, Research Professor in Psychology, University of Illinois, who kindly made available to me the facilities of his lab., and through whose good offices I was able to make use of the IBM 7094 computer at Illinois. I wish to acknowledge this help with grateful thanks.

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Freud's term "super-ego" has become almost as well-known as the word "conscience" with which he equated it, but its precise significance has always been a little unclear. Freud himself sometimes spoke of the "ego ideal" (1925) and this seemed more in line with McDougall's (1908) concept of the "sentiment of self-respect" which also stressed the positive aspects of ego-striving. The details of psychoanalytic doctrine are not of concern here but it is interesting to note that Freud himself had suspicions of the possibility that his super-ego had at least dual aspects.

The first explicit discussion of the ego reference system is probably to be found in William James (1890). His notion of a hierarchy of selves is, in some respects, more in accord with recent thinking than is Freud's own contribution but James was unable to give any hint of the unique development of the super-ego moral reference frame. What is involved is not simple aversive conditioning but the effect of a basic security threat i.e. loss of parental love. Both Freud and McDougall stressed the special role of the parents in the development of the super-ego system.

Factorial studies have confirmed clinical concepts in this area. Cattell (1946, 1957) found two factors which appear to correspond with

ego-control (Q3) and super-ego formation (G) respectively. These were sufficiently well confirmed to be included in the 16 P.F. test of Cattell and Stice (1957). Other studies have isolated a "self-sentiment", and "super-ego sentiment" and "a self-assertive erg". (Cattell, 1950, Cattell and Cross, 1952, Cattell and Miller, 1952, Cattell and Baggaley, 1958, Cattell and Horn 1962.) Cattell and Horn (1963) found confirmation of these three factors but the super-ego factor appeared in at least three forms: a factor highly loaded with the 16 PF G score, "commentive" super-ego characterized by a strong tendency to agree, and "attitudinal super-ego" with religion as a major component.

The Cattell and Horn (1963) paper emphasises the need to look a little more closely into the question of super-ego organization. It seems generally to have been assumed that Freud's super-ego corresponds to McDougall's sentiment of self-regard and that both of these refer to what has been known as conscience. Cattell and his co-workers raise the question as to whether we have just one function and whether the notion of introjection of the parental code does not mask more subtle factors. Unfortunately the Cattell and Horn study leaves some room for doubt as to the precise interpretation of the factors involved. With commendable zeal they included many objective type tests in their analysis but these do not lend themselves to fine distinctions in interpretation. It was decided, therefore to carry out a further analysis using individual questionnaire items which might give better clues as to the nature of the factors found.

Hypothesised Factors and Questionnaire

The Cattell and Horn research was studied carefully in conjunction with previous research and in the light of clinical concepts. With regard to the latter Flugel's Man, Morals and Society (1945) was especially helpful. The original naming of the Cattell and Horn factors was regarded as suggestive only and alternatives considered. In particular the Narcistic Self Sentiment was regarded as being more meaningful in its other-regarding aspect and to be better considered as centering around loyalty. The following factors were finally hypothesised for investigation and suitable questionnaire items written around them. The questionnaire is appended (see Appendix A) and the numbers of the relevant questions appear after the name of the hypothesised factor.

I. Super-ego (1,8,15,22,27,32)

The essential characteristic of this factor is the absolute nature of the moral principles concerned. There is no compromise, no justification in terms of other goals. It is surmised that this is possibly because of the religious element involved. Morality is God-given and man cannot distort it to his own ends. Even God Himself must conform to his own laws. So far as man is concerned the most seeming injustice may be just part of a grand process far beyond his comprehension and therefore not amenable to any reasoning process.

II. Ego-ideal (2,9,16,23,28,33)

This too involves high moral principles but the keynote is goodness rather than duty or absolute right. The agent is striving to be the sort

of person whom the significant social group will approve. This will usually be his own social group but not necessarily so; he may transcend this. His actions, however, are not to be judged superficially but with understanding: his intentions and ultimate goals are to be taken into account. It is not just a question of social conformity.

III. Self-sentiment (3,10,17,24,29,34,37)

This is a rather unfair use of McDougall's term since for him the previous factor would have just as much title to such a designation but Cattell and others have used the term in the sense we propse here so it will best serve our purpose. What we are concerned with is the material aspect of the agent's aspiration as opposed to his moral aspirations as subsumed under factor II, to what has often, rather derogatively, been termed "worldly success".

It is interesting to notice that society judges this type of success in relation to presumed capacity. We do not frown on an athlete because he has not reached Olympic standards; a man may receive high praise although he has not reached the peak of professional achievement. In comparison we expect everyone to meet moral requirements. Cowardice, dishonesty, adultery, deceit and the like are not regarded as in any way related to capacity. Everybody can be good.

IV. Loyalty (7,14,18,21,36)

There are some persons who are much more concerned with people than with principles. If they have to choose between conforming to a moral principle and being faithful to a friend they will favour the latter. One might presume that such persons have a high parental drive which has

been stimulated in the family situation, and that their behaviour has largely centred around affection. Parents will frequently strive to protect their children from punishment for criminal behaviour. How many mothers would surrender their murderer sons to the hangman's rope? A child with strong parental drives, brought up in a highly affectionate family atmosphere, may see moral requirements very much in terms of cherishing others, more particularly relatives and friends. His morality will be primarily a loyalty morality.

V. Integration (5,12,19)

The assumption here is that people will differ considerably in the degree to which moral reference frames are integrated. Lack of integration will result in conflict and difficulty in making moral decisions. It is very difficult to write satisfactory questionnaire items and a paired-comparison technique was developed as the chief means of measuring this factor. Unfortunately it was not possible to include this measure in the present analysis as it was not possible to administer this test to the original subjects.

VI. Ego-control (6,13,20,26,31)

This would correspond to the old notion of will-power. In voluntary behaviour we have choice made in the light of a reference system. The first step towards such behaviour is the development of time and tension binding. Freud regards this as the fashioning of the ego which he regards as some sort of mental entity. As such it later comes into conflict with the super-ego. We prefer to substitute the concept of a control attitude which makes possible both consideration of the time factor with regard to physical events and consideration of social implications.

The separation of the control function from the reference systems, to which it makes possible a suitable scanning as the basis of choice decision, seems to me an important distinction which brings such behaviour within the ambit of learning principles and avoids the undesirable reification of psychological functions. It also enables us to make much better sense of the role of emotionality in behaviour.

VII. Emotionality (4,11,25,30,35,38,39)

Eysenck (1953) has found differences in emotionality as the major basis of neurotic behaviour. Cattell has two factors in his 16 PF series which are concerned with an ego-control function but, while his Q3 is clearly a control factor, his C factor seems to waver between the effects of positive control and the interference produced by high emotional involvement. Much play has also been made with an "ego-strength" factor from the MMPI where there is a similar confusion of positive and negative aspects of control. It is important to recognise that high emotionality leads to instability of behaviour (impulsive as opposed to a decision in accord with the reference system) because the immediate drives are too powerfully activated by emotional feedback. Stable behaviour is controlled behaviour and the effectiveness of control depends upon the strength of the control function in relation to the emotion which it has to control.

Items were written for this factor with the above distinction in mind. It was hoped that the questionnaire would then give a measure of all the major aspects of choice behaviour: the inhibition of impulsive response, the emotional reactivity operating against this, and the chief affective reference systems appropriate to be invoked in the process of

deciding.

Administration and Analysis

The test was administered as part of their course to 269 students (164 M plus 105 F) in an introductory psychology class at the University of Illinois. Product-moment intercorrelations were calculated on the IBM 7094 computer and submitted to a principal factor analysis. After a first run with unity in the diagonals the number of factors was decided from a consideration of the latent roots. Ten factors were found to have latent roots not less than 1.1. Since this was more than originally postulated and since by Guttman's criterion factors with latent roots less than unity are not significant, it was decided to fix the number of required factors at ten and iterate to stabilize communalities. After twenty five iterations the root mean square of the residuals was .03114.

The ten factors were now submitted to varimax rotation because at this time a programme for oblique rotation was not available for this computer. This, unfortunately, precluded a second order analysis or even simple consideration of correlation between factors but did not interfere with the testing of the hypotheses in which we were interested.

The Factors and Their Interpretation

The full matrix of factor loadings will be found in the appendix. Here we discuss the factors in order of their contribution of the variance. No loadings below .20 are considered.

Factor 1. Ego Control. Variance 2.267

* .65 Q20. Often act without sufficient thought for consequences.

* .61 Q 6. Does things for which sorry afterwards.

*	.47	Q28.	Shame because fail to live up to ideals.
	.56	Q13.	Not careful control so shame.
	.42	Q12.	Attitude changes after decision.
	.29	Q 2.	One should not be over-concerned about respect of others.
	.28	Q 5.	Difficulty in deciding what to do.
	.25	Q11.	Panicky with little provocation.
	.25	Q35.	Wish emotions were not so intense.
	.22	Q25.	Embarrassed in social situations.
	.21	Q24.	Not seeking top marks.

The first three items belong to the hypothesised control factor and would seem to identify this factor. Q28 is very similar to Q13 although it was designed to measure ego-ideal which it completely fails to do. Q12 was included for the integration factor which has failed to appear, probably because of lack of adequate items. Q11 and Q35 are emotional measures and get much higher loadings (.384 and .46) on the emotionality factor than on the present factor. There is obviously some contamination here but the really important fact is that the two factors have been definitely separated. As will be seen below the emotionality factor emerges as a distinct well-defined factor.

Factor 2. Emotionality. Variance 1.851.

*	.58	Q30	Inclined to worry
*	.54	Q 4	Easily loses temper
*	.46	Q35	Wish that emotions were not so intense
*	.39	Q39	Swing from happy to sad
*	.37	Q11	Panicky with little provocation
*	.36	Q38	Intense thrill of delight

.35 Q26 Conscience nags

.28 Q32 Perhaps too straightlaced

.22 Q18 Sad story brings tears to eyes

.22 Q34 Ashamed of low grades

.21 Q22 Seduction a grave sin although done for country.

The picture here is very clear. The first six items are as predicted and all involve easily induced emotion although of diverse kinds. Only the last item does not have an obvious emotional aspect. Note that despite the worry item with the highest loading this factor cannot be interpreted as anxiety.

Factor 3. Self-sentiment or Material Aspiration. Variance 1.503

* .65 Q 3 Want to be leader in profession

* .56 Q10 Want to make creative contribution to world

* .41 Q24 Keen to get top marks

* .37 Q17 Aims at higher degree

* .33 Q33 Wants to satisfy sense of duty to community and country

.29 Q 2 Not willingly do anything to lose self respect

.23 Q23 At least one person whose moral behaviour he would like to equal.

The four highest loadings are as predicted and reliably identify the factor. The remaining variables have obvious links with personal reputation. Q23 and Q33 have significant loadings on the related ego-ideal factor while Q2 spreads its variance over Control, Super-ego and Compassion, all of which could be expected to get reinforcement from self aspiration, since they are concerned with commendable personal qualities.

This factor has an obvious similarity to the Self-sentiment factor of

Cattell and Horn (1963) which also stresses self-respect and professional proficiency.

Factor 4. Compassion. Variance 1.391

*	.54	Q14	Desires to fondle fluffy kitten
*	.49	Q26	Conscience nags
*	.48	Q18	Sad story brings tears to eyes
*	.35	Q 7	Refrain from action that may hurt feelings of others
*	.24	Q36	To betray friend more reprehensible than breaking abstract moral law
*	.23	Q21	Would not discourage keeping of pets
	.23	Q 2	Would not willingly lose self respect

All the predicted variables get significant loadings on this factor so there seems to be little doubt about it. The high loading on Q26 is interesting in its suggestion that the pangs of conscience may owe much to strong parental drive. Failure to establish an affectionate relationahip to the parents in the early family situation may therefore reduce susceptibility to guilt quite apart from its effect on the development of the super-ego. Alternatively we may consider that the actual development of the super-ego is a function of the strength of affection. The latter view has much to commend it. It implies that guilt is a product of love rather than of fear and this may explain why forgiveness and redemption have played such an important part with regard to guilt.

It is suggested that the Cattell and Horn Factor 11 (Narcistic Self-Development) has been given a misleading title and is equivalent to what

we have just described.

Factor 5. Religious super-ego. Variance 1.330.

*	.55	Q32	An action is right or wrong in the eyes of God
*	.52	Q 1	Frequent church attendance
	.29	Q 7	Refrains from action that may hurt feelings of others
	.29	Q 5	Difficult to decide what one should do
	.28	Q16	Hopes always to be able to control behaviour
	.24	Q 2	Not willingly lose respect of others
*	.24	Q15	Oedipus (not) excused
*	.21	Q22	Seduction a grave sin although done for country.

Four of the six predicted variables appear on this factor. One of the others has gone to the second super-ego factor while the other gets a significant loading only on the expediency factor. It is interesting that, while examples of ends possibly justifying the means (Q15 & Q22) get loadings on the present factor, a general statement that the end justifies the means is not picked up. Presumably, when stated in this bald form, most subjects fail to discern the implication that this involves a rejection of absolute moral law.

That the present factor relates to super-ego function and that it indicated a strong religious basis for the factor seems inescapable. Our expectation of the religious role is confirmed but there is a further factor (F 10) which has claims to represent the super-ego and which is devoid of religious relations. We can only conclude that while religion is very important with regard to the super-ego formation of many subjects it is not a necessary component.

This agrees well with the Cattell and Horn Factor 39 Attitudinal Super-ego.

Factor 6. Ego-ideal. Variance 1.113.

*	.48	Q16	Hopes always to be able to control behaviour
	.41	Q19	Not easy to have clear-cut priorities
*	.40	Q23	At least one person whose moral behaviour I would like to equal
*	.37	Q 9	Deny self because better in the long run
*	.25	Q33	I want to satisfy sense of duty to community and country

All except one of these variables are as predicted. One of the missing predicted variables is just below our level of acceptance (.199) while the other has gone completely over to the control factor. This is Q28 which involves shame because of failure to live up to ideals. In writing the item it was not realized that such shame was dependent on not living up to ideals so that the person with a strong ego-ideal would not have cause to feel shame. Had it been stated as: "if I failed to live up to my ideals I would feel great shame" we might have expected it to load the present factor. As actually stated the high likelihood of shame is cancelled out by the low likelihood of actual failure.

Again confirmation of the factor seems all one could reasonably ask for.

Factor 7. Expediency. Variance 1.018.

.54	Q37	Wants to be prosperous
.51	Q27	End justifies the means
.35	Q22	Seduction justified when for country

.25 Q 1 (Not) frequent church-going.

This factor was not predicted but it is delightfully self-explanatory. The urge for material success fits in beautifully with the ethics of expediency and the absence of church-going in this syndrome would gladden the heart of a theologian. It has a rather strong resemblance to the Cattell and Horn Factor 9 (Expansive Non-conformity).

Factor 8. Vacillation. Variance .998

	.49	Q29	Daydreams of success
	.44	Q39	Swings from happy to sad
*	.26	Q12	Changes mind after decision
	.25	Q 8	Would commit mild dishonesty for friend
	.23	Q33	(not) strong sense of duty to community and country
	.22	Q11	Easily becomes panicky
*	.21	Q19	Not easy to have clear-cut priorities
	.20	Q14	Desires to fondle fluffy kitten

Two of the three integration variables appear here while the third one gets a loading of .195 but this factor is rather wider than we had in mind. It seems to include several sources of indecision: emotionality, lack of strong super-ego, loyalty in conflict with moral principles and perhaps lack of drive.

Factor 9. Anti-social Bias. Variance .965.

.43	Q33	(Not) strong sense of duty to community
.41	Q25	Embarrassed in social situations
.40	Q21	Would discourage keeping of pets
.24	Q11	Easily becomes panicky
.22	Q38	Intense thrill of delight in aesthetic contemplation

.21 Q26 Conscience nags

No predictions were made. The pattern suggests an emotional recluse with a chip on his shoulder.

Factor 10. Non-religious super-ego. Variance .904.

.43 Q24 Not worried about getting top marks

-.40 Q34 Would be sorry to fail but not ashamed

-.39 Q 8 (Not) commit mild dishonesty for friend

-.32 Q15 Oedipus (not) excused.

This appears to be a somewhat attenuated super-ego factor. There is the insistance on absolute ethics to which reference was made earlier but there is no religious reference and a cold indifference to material success. One glimpses the person who would do his duty and be damned to what happens.

This may correspond to the second super-ego factor of Cattell and Horn (F6) which gets high loadings on the 16 PF Factor G but no religious implications.

Conclusions :

It is contended that this study provides justification for several important postulates:-

1. Behavioral control is a function of the strength of emotional reactivity and the degree of positive ego-control learned through the process of what Freud called "reality testing".

The distinction of these two components is important from the point of

view of the psychotherapist.

2. There is an "absolute" moral system which appears in two forms, one with strong religious reference and one without. This system appears to correspond to the function of Freud. Cross-cultural studies would be most interesting in providing further insight into the two forms.

3. The self-sentiment appears in both material and moral forms. The latter corresponds to the classical notion of ego-ideal. There is probably appreciable correlation between these two forms but the present analysis does not permit the assessment.

4. There are two important reference systems centred on parental drive and ambition respectively. The first of these is the basis of loyalty as opposed to duty and probably a potent source of moral conflict.

5. Finally we must note two important behavioural traits which must be taken into account when predicting behaviour but which are probably not so fundamentally part of the ego-system. These are a bias towards expediency and towards vacillation. The latter may be just a product of several causes rather than a true factor.

Revision of Questionnaire

In the light of this analysis the questionnaire was revised by dropping all questions which had loadings below or higher loadings on other factors and adding new items to bring up the final total to six per factor. Factors 8 and 9 were omitted as not sufficiently meaningful as ego-system components.

The new items were written in the light of the interpretation made of the factor but until a new analysis is done the test can be useful only as a research tool. In the revised questionnaire (see Appendix B)

factor references have been added and all original items starred. It should be noted that small changes have also been made in some of these original questions, e.g. descriptive details have been added to the Oedipus questions for the benefit of testees not familiar with the legend.

Finally some items have been replaced because they were too specific to a university student population: Q17, Q24, Q34.

PART SIX

MENTAL DISORDER AND PSYCHOTHERAPY - SURVEY OF PUBLISHED CASES.

In an earlier section of this thesis I have discussed some of the major hypotheses regarding the cause and treatment of mental disorder (Parts I and II, pp.3-57). Likewise I have discussed some of the mental disorder classifications, past and present (Part II, pp.25-27).

As is stated and re-stated in different ways throughout the thesis, it is my own contention that, apart from those disorders stemming from organic malfunctioning, mental disorders stem from:

(a) The conditioning or learning of behavioural patterns which are maladaptive, and either result in drive frustration, or in social disapproval and/or sociopathic behaviour.

(b) Inadequate stimuli or other frustration of the learning-process.

(c) Undue or prolonged stress imposed by the environment in general or a particular situation.

It is also my contention that:

(d) All psychotherapy, no matter what the theoretical orientation may be, utilises learning techniques.

In order to see precisely how learning principles are involved in the aetiology and treatment of disorders as reported in recent literature, and to get a wider background for the development of a system of classification, I have carried out a survey of published cases.

These cases are reported below, together with my discussion on the learning involved in both the development of the disorders referred to, the theories expounded by the authors, and their practices. As some of the cases are long and many points debatable, discussion follows either the relevant section, or the conclusion of each report.

A classification of mental disorders based on my study of the cases and theoretical considerations arising therefrom is presented in Part Seven. This is also related to the account of learning processes given in Part Three. Classification numbers relevant to this schema are given for each case.

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1. Procedure:

In order to obtain the cases I perused the catalogues of the N.Z. National Library and noted all the books which seemed likely to include case studies. These are not catalogued separately. I then sought the co-operation of the Library in making all these volumes available for study, and of the University Library Inter-loan Librarian, through whom the books were obtained. I received every facility in this matter and was able to examine 146 volumes and systematically extract cases from the 78 books in which cases were actually published.

The following procedure was adopted to ensure that a representative sampling of the literature was obtained: The books were handled in blocks of ten. Each book was divided into ten sections by the dividing of the total number of pages (less

index, etc.) by ten. From the first book the first sufficiently complete case in the first section was taken. From the second book the first case in the second section was chosen, and so on. The actual working procedure consisted of noting the number of pages in the book, dividing by ten, multiplying by the number of books already examined in the series of ten and commencing to read the next page. If no case were found in this tenth of the book reading was continued, and if the end were reached without a case occurring, reading was continued from the beginning of the book.

This procedure avoided the sample being biassed by any tendency for particular types of cases to occur in particular parts of the exposition. In some cases the whole volume was found to be concerned with a single case, when then naturally became the one selected. In some books no cases were found, or such as were available turned out to be too incomplete for consideration. In all 78 cases were collected in this way.

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Case 1: Cure of bomb-shocked, disoriented, airman by recovery of earliest traumata under hypnosis. Brown (1944,pp.17-19). Classification 3a(ii)).

Signaller in Flying Corps blown up by an aeroplane bomb whilst taking refuge in a disused trench in France. On recovering consciousness everything seemed twisted at right angles to its ordinary position. This particular feeling of disorientation persisted for many months and continued on his return to England.

After hypnosis and reliving of his experiences he was better (roughly about half amount previously) but feeling of disorientation recurred from time to time. A little later he informed his therapist that his mother had told him that when he was about six he told her the bridge was "the other way round" as he was crossing Tower Bridge. Under hypnosis he recalls sitting on a wooden horse (red with white stripes) edging away from his aunt, tipping the horse up, and falling on to the fender. He evidently "knocked himself out" and regained consciousness in bed while his aunt was bathing his face. He followed this up by recalling walking over the bridge and finding it "turned at right angles". After reliving these memories the patient was "much better" but still not cured. Under hypnosis he "regressed" to his 4th birthday and recalled a frightening dream he had had; the morning after the dream he had found the nearby pier the "wrong way round."

The following session the therapist directed him to recall his very first experience of disorientation; he relived an experience he had had when not quite three years' old. He had pulled a coffee-pot full of coffee over upon himself. The coffee poured down his right arm, and he felt it as a pain in his left side, over his heart. He knew no more until he woke up in bed as his father came into the room, and he felt that the bed was the wrong way round. The therapist gave "as a possible explanation of disassociation, that the scalding of his arm produced a fainting fit, in which he fell to the left and everything in his visual field twisted to the right - he fell through a right angle." To ensure that this really was the beginning of the dissociation, he was "regressed" even further, to his second birthday. He shouted, "He has bit me - Gordon has bit me" but was evidently "too young" to describe his experiences, though, after being told he would remember the experience when he awakened, once out of the hypnotic state he recalled the entire incident in great detail. (His small cousin and he had had a fight.) There was no associated feeling of disorientation. The following day he felt more disoriented than ever, but after

two days' stay in bed recovered completely. He did not contact the therapist again, though asked to do so if the feelings returned, so one assumes he was 100% cured.

Every particularly fearful experience obviously activated and strengthened (or reinforced) the neural trace (or memory) of the traumatic un-real sensation/perception experienced in association with the frightening and painful upsetting of coffee over himself. Reliving the later experiences was insufficient in itself because of the degree of reinforcement which had occurred on each subsequent occasion. It is arguable whether, or to what degree, extinction or satiation occurred as the result of the cognitive explanation, and acceptance (or insight which occurred, and how much was due to an emotionalised verbalisation. Whatever the constituents of "abreaction" may be, there is also reinforcement of fear-drive reduction and improved reality-testing.

Case 2: Inability to marry and guilt-ridden childhood experience; abreaction through psychoanalysis. (Berg,1944,pp.38-46). (Classification 3a(i) & (ii)).

(Note: In terms of the system of choice of cases being used, the preceding case should have been taken. It was, however, omitted as the information given was incomplete.)

The patient was a man who, in his early twenties had become engaged to a woman of 50 but broke it off as the result of parental interference (he saw a psychologist); then he became engaged to a girl of his own age, but this "frittered out". He had troubles with his third fiancee,, experiencing anxiety and panic when he arrived at their meeting-place, and depression afterwards. As a boy he had brought a girl from his gang into the garden (she was older than he) and they experimented behind some bushes. His

mother saw through the window and hammered on it with a horrified expression. His guilt feeling was the basis of later conflict.

Therapy consisted in bringing this into consciousness.

This case would appear to demonstrate the classical conditioning of fear to, and reactivation of guilt in connection with, females, (particularly of the patient's own age group) with dissociation from the cognitive reference frame.

As the result of therapy, abreaction occurred, thereby making normal extinction possible. There was probably also some satiation from continued analysis.

Case 3: Psychosomatic complaints and conflict; psychological treatment. (Page, 1947, pp.125-6). (Classification 8a, 5, 6a, 6b).

The patient is a senior student who develops cardiac and gastric syptoms in the absence of any obvious physical defects. It was discovered that he was strongly resistant to entering his father's business on graduation. Similar attacks of milder intensity were found to have occurred earlier in connection with social and sexual adjustment.

The emotional origin of his trouble was explained and a plan for solving his vocational conflict proposed. There was considerable improvement followed by a lapse after several days. Further physical checks brought nothing to light. He was advised by physicians to forget his symptoms and all would be well. He again sought psychological advice. Treatment aimed at convincing him that he must choose between chronic invalidism and normal health and that there was no reason why he should necessarily work for his father. He finally agreed that that it was a matter of his own decision and returned a few days later to report that he was completely well. Three months later he was still in excellent health.

Two major factors seem to have been involved in this case. The patient had to be convinced of the fact

that his trouble was of psychosomatic origin and he had to be prodded into the vital decision which would remove his conflict. The former involves suggestion and simple cognitive learning, the latter a form of psychological support during a crisis.

Case 4: Paranoid behaviour and illegitimacy; communication and psychiatric advice. (Strecker, 1956, pp.91-2). (Classification 7,5).

Woman 36. First 8 years of married life (during which two daughters born) miserably unhappy. She had been left on doorstep of Catholic foundling home when few weeks old. No-one knew her background. At 20 she had entered sisterhood as novitiate, left after several years - fell in love with young engineer and married. Almost immediately became somewhat paranoid - thought her husband "uppish"; considered sister-in-law "always hinting she was a bastard", when sister-in-law really liked her and loved the children; she was always rude to her mother-in-law; if the children asked any question, no matter how trivial about the family, or praised Granny or Aunt, she immediately sulked and fretted. She thought various people suspicious of her. Finally her husband managed to get her to tell him what was wrong; they had heart-to-heart talks and some psychiatric advice.

Shame and fear and probable grief had conditioned this woman's attitude to family and family-situations as a result of which she had developed a distorted cognitive reference frame.

Communication with "significant other" and verbal conditioning led to abreaction, reinforcement of loving behaviour, reinforcement of self-esteem, increased ego enhancement, all leading to inhibition, if not outright extinction of fear, suspicion, hostility and lessened self-esteem.

Case 5: Highly aggressive 7 year old girl; stuttering, apathetic, over-dependent 10 year old brother; environmental manipulation and individual psychotherapy for girl, group therapy for boy. (Polatin & Philtine, 1949, pp.97-100) (Classification - brother and sister, 5)

Mother brought brother and sister to clinic. "Dainty little girl" of 7 extremely well-behaved outside home; at home "fiendish nashiness" completely upset parents and ailing grandmother who lived with them. Daughter smashed windows, broke furniture, cut up mother's clothing, and tried to place blame on brother. She was forced to admit her guilt and given a good beating. Being brought to a psychiatrist would teach her a lesson. Boy, 10-years old, obviously mother's favourite, non-aggressive, always well-behaved, was brought to clinic as mother didn't want him made jealous by her taking sister some place on her own. Boy, however, fat, stuttered, and, it was finally admitted, had difficulties with his studies and unhappy at school. At interview, apathetic, held mother's hand. Girl, scrawny, tensed up and embittered at being dragged to psychiatrist.

Mother could not understand why a good boy should need a psychiatrist, but finally, resentfully, agreed to trial.

Little girl had always been a demanding baby. Both children were potty-trained from 3 months' old. Boy toilet-trained and wearing panties by end of first year; girl still wet herself until she was two. Mother was obsessionally clean and tidy; hated and feared her own mother (the grandmother) who was senile, and "could not stand" daughter who had apparently inherited grandmother's "bad" traits. "Her own guilt was roused because she must have handed on those traits" She smothered her son with love and kept him dependent.

Mother had to be made to realise that her mother's symptoms due to old-age; her daughter's behavious due to environmental attitudes, particularly those of the mother.

Children were treated by two different psychiatrists - would not talk. Girl treated individually with doll-play. Beat up "family" dolls, more particularly the doll-brother, finally shyly caressed mother-doll. "Destructive behaviour essentially a bid for attention, even if it won her only beatings."

Brother treated in a group. At first "so fearful all the other young patients wanted to beat him up" and he

required protection. Then, he began to throw things about untidily; when no notice taken he gave vent to "regular orgy of disorder" which he would have been too scared to do at home. Following this he offered to beat up toughest children; and whenever he vented aggression stuttering diminished.

Mother was seen regularly by psychiatric social worker. She was persuaded much of her own tension and that of her children stemmed from presence of grandmother, who was placed in old age home. She gained some insight into her behaviour; gave daughter more attention and also gave boy more freedom at home, though "she still worried about the untidy effect upon her house of setting up a corner where he could saw and hammer and paint and build as he pleased."

All family relationships, physical condition and psychological attitudes of children improved.

These children would appear to have had dissimilar temperaments from birth; so we may say they were largely inherited. Girl's irritability and aggressiveness reinforced by mother's own irritable attitude and fight for love or its surrogate, attention. Boy's passivity reinforced by mother's attitudes. Mother herself in conflict over ambivalent attitudes to own mother and her own obsessional-compulsive behaviour regarding dirt and order, obviously earlier conditioned by her own (now "dirty")mother. We could say that in this situation the daughter was being conditioned to hate and aggress as the result of frustrated love-need; the boy was being conditioned to withdrawal and lack of initiative because he both feared to aggress and had no need to explore his environment or seek relationships. Mother smothered him.

Therapy consisted of environmental change, suggestion, and the inculcation of insight and different

behaviour patterns in the case of the mother; the acting-out of their feelings in a permissive, surrogate-parent situation for both girl and boy; while the boy also learned group-participation behaviour.

Case 6: Severe neurosis and catharsis; patient (nurse) later empathises with her patients and relives own birth traumata. Psychoanalytic interpretation. (Winnicott, 1958, pp.1780180). (Classification 3a (ii) and 5).

The patient, Miss H. was a 50-year old nurse. When she was about 25 she had been treated by Winnicott for a very severe neurosis, "including constipation of (an extreme) degree". Her treatment had been mainly cathartic. She "would lie and sleep and then suddenly wake in a nightmare." The therapist helped her to wake "by repeating over and over again the words that she had shouted out in the acute anxiety attack. By this means when she wakened I was able to keep her in touch with the anxiety situation and to get her to remember all sorts of traumatic incidents from her very eventful early childhood."

"Birth memories appeared with fantastic embellishments clearly derived from all stages of development and from the sophistication of the adolescent, if not of the adult. Nevertheless the effect seemed.... to be real in its terrific intensity. <u>While disbelieving the details described as memories (he) found (himself) prepared to believe in the accompanying affect</u>."

Miss H. had changed her occupation after therapy from shorthand-typist to nurse specializing in the care of psychotic children. She "has an unusual intuitive understanding of the needs of children who are in a state of aggression." Not long before the report was written, Miss H. had been "looking after a little girl of seven, a psychotic case (autistic) undergoing analysis." She was suddenly taken ill and quite unable to discharge her duties. On Winnicott's visiting her he "found that she was just beginning to recover from an illness of a kind that was not new to her, but which had previously never been so acute. She had suddenly had to go to bed with what she called a 'blackout'. She had lain absolutely rigid and curled right up tight on her side, unable to do anything at all, and as near unconscious as may be. A doctor was called in

who said he could find nothing wrong with her body. While she was in this condition she was unable to do anything about food at all. Gradually she became conscious, and allowed herself to be moved to a friendly place, and in the course of a week or ten days she was able to get about again."

Before returning to work she visited Dr W., asking "What about this blackout? What had it to do with?" He had no idea and said so. "Then she went on talking, and (he) gradually realized that . . . . she was giving (him) from her unconscious the material which would enable me to explain her blackout." He found, inter alia, that "in order to understand the child's condition, she had been imitating her more and more, putting a hand here, and walking in this way, and that, and doing everything she saw the child do 'in order to get the feeling of the child's state of mind and body'." The child, was in an acute anxiety state and "had developed a very great fear of travelling in the Underground. Miss H. had been trying to take her in the Underground to distract her attention and to show her by experience that the Underground was not as bad as expected."

Dr W. states, "A great deal of material of this kind suddenly showed me that I must say to Miss H. that she herself was reliving the birth experience along with the little girl. Here was no hysterical reconstruction. She had been actually having to re-experience the physical thing, which in her case had included a feeling of asphyxiation. Interpretation along these lines produced a most dramatic effect. Miss H. felt better, felt she understood what was going on, and went back confidently to her job. The doctor of the case said to me, 'somehow or other Miss H. looks much better since her illness.' After this she continued to do good work with this little girl, and with a more objective understanding of the anxiety that is actually important in the little girl's case."

This is a most unusual case, from many angles. Here we see imitation and 'learning by imitation' carried to such a point that it probably reactivated all associated learned/conditioned material and the memory-traces of her own birth. (Imitation of this type is the basis of so-called "Method" acting so popular today.) The ensuing

arousal patterns forced the nurse to completely re-enact the birth scene. From Dr. Winnicott's early remarks it would also appear that Miss H. was particularly sensitized to birth and associated stimuli.

The nurse was also actually seeking to de-sensitize or de-condition the child to/from her fear of the Underground and re-condition her to associate a more pleasurable affect to the activity of travelling thereon.

. . . . .

Case 7: Pseudocyesis; "superficial psychotherapy". (Mackay & Lewis, 1951, pp.459-461). (Classification 8b, 7 - derived from folklore 15).

After discussing Pseudocyesis in general, and concluding "Pseudocyesis cannot be regarded as a purely psychologic disorder. Most of the symptoms are the result of real endocrine changes. It is what stimulates these hormone-producing organs that poses the final problem. Many more investigations will be needed before the etiology of this curious condition can be settled, "MacKay & Lewis quote a study by Fried et al (1951).

27 women (23 negro, 4 white) aged 18-36 who believed themselves to be pregnant, and presented common symptoms and signs of pregnancy,were studied. "19 were hypomenorrheic, 7 amenorrheic". 24 showed "normal pregnancy type" rate of abdominal enlargement. Breast changes, secretion of a milky substance, etc. were common. 27 reported fetal movements; 19 had a softened cervix, 11 had an enlarged uterus approximating 6-week gestation.

"Psychic disturbance was the etiologic factor. All consciously intensely desired children; 24 had tried to conceive for 2-17 years." "The 'pregnancies' were motivated subconsciously to secure the husband's affection and bolster a faltering marriage, prove ability to conceive, achieve parity with other women, obtain a companion or effect self-punishment. The basic psychologic mechanism was a conversion type of anxiety arising from (1) conflict between innate sexual drives plus the stress of present life

situations in favour of pregnancy and (2) folklore, early teachings and experiences that had negatively conditioned patients in regard to reproduction."

"Hormonal assays, vaginal smears and endometrial biopsies, established that the women had persistent luteinization of the ovaries, apparently due to ovarian stimulation by the pituitary lactogenic (luteotrophic) hormone. 'The psychic factors acted on the endocrine system by utilization of pathways from the cortex through the hypothalamus to the anterior pituitary lobe, causing release of the luteo-trophin and suppression of the follicle-stimulating hormone.'

"Treatment consisted of superficial psychotherapy in most cases. The patient was informed of the true diagnosis, given a psychiatric interview, then psychotherapy and finally endocrine therapy. Of 27 who were told the real diagnosis, 13 accepted it with loss of symptoms but had recurrence in a few months. Psychotherapy was curative in six and effective in five when combined with testosterone propionate or curettage. Curettage with psychotherapy cured three patients. Bluntly telling the patient that she is not pregnant is to be condemned. Psychotherapy gives the patient insight. Testosterone and curettage produce mormal menses as a final convincing measure."

These cases are typical of "hysterical conversion." There is doubtless some element of suggestion in the initiation of the response and one would expect operant conditioning principles to operate in fixing the response. The cure has typically consisted in providing the basis for accepting a new suggestion as to the inapplicability of the response. In some cases the doctor's diagnosis has been sufficient but others needed treatment which would restore the menses. It is interesting to note that the patient's understanding of the situation can play an important part in her reactions even at the physiological level.

Case 8: Mother dominates via her ulcer; child attempts same through real or imagined psychosomatic complaints.
(Small, 1944, p.18).
(Classification 8(b)).

Mother with ulcer, which she apparently used to dominate her husband and obtain what luxuries she wanted. If she was refused, her symptoms worsened until she got her way. "Her small son", says Small, "apparently sensed the value of illness as a means of attaining one's desires." He pleaded a stomach-ache when confronted with any difficulty at school and was sent home. After a while it was noticed that the child thereupon lost his symptoms and completely recovered. On a physician's advice the school-teachers disregarded the stomach-ache when it reappeared. The child promptly developed severe headaches whenever faced with difficulty. Small concludes, "The utilization of such a retreat into illness may ultimately become a fixed pattern of response and lead to a chronic psychoneurotic condition."

There is not the slightest necessity to postulate that the child "sensed" the value of illness. Either he was sufficiently intelligent enough to consciously realise it and was actually guilty of malingering, possibly in the case of both headache and stomach-ache; or he imitated his mother's behaviour, found it rewarding (he was sent home and was free to play; his anxiety was reduced as he was no longer presented with noxious stimuli); and either tried another means of escape by simulating a headache and/or actually developed a headache as the result of (a) being forced to remain in an anxiety-provoking situation, or (b) approach-avoidance conflict plus increased anxiety because he could not escape.

Certainly he could be conditioned either to malingering or psychosomatic response. Obviously therapy should involve an attempt to uncover and rectify the causes of his anxiety, and he should be conditioned to more adaptive habits of response; equally obviously his mother required insight into her own behaviour and its effects on her child; with a subsequent alteration in the child's environment.

Case 9: Psychosomatic "heart attacks" and insight. (Strecker, 1952, p.165). (Classification 8(b), 3(b), 11).

Middle-aged woman wrongly suspected her husband of having an affair with a hypothetical "other woman". Her heart was slightly impaired as result of acute rheumatic fever in childhood. Otherwise she was physically healthy. One night her husband returned from a business conference to find his wife having "a heart attack." A physician was summoned, prescribed some medicine and said everything would be all right. However the heart attacks continued, particularly on the nights the husband was out. A heart specialist examined her and sent her to a psychiatrist as he found her heart in a satisfactory condition. After a dozen interviews, during which it was made clear that the attacks were not deliberately planned, the patient apparently admitted her fear and unjustified suspicion and her wish to keep her husband where she could see him. "With the understanding of the situation, there came quite an emotional outburst with tears and a feeling of shame." Some minor attacks occurred in the ensuing weeks and then died out altogether. After several years there had been no recurrence, and the patient "is definitely better adjusted and happier."

Conceivably this patient had found her childhood illness rewarding in some form or other - possibly increased attention and "spoiling". The "minor heart condition" was

undoubtedly conditioned to fear; it provided also a somatic locus in which any anxiety-created "stress" could manifest itself, and a rational "locus" for any morbid state which could demand sympathy and attention from her husband. Probably all these factors were involved at least to some degree.

Therapy consisted of the induction of insight into the wished-for effect of her behaviour and reality-testing as far as her suspicions of her husband were concerned. Presumably there was "relief" (i.e. increase in positive affect) at her actual understanding of the situation, anxiety-reduction with regard to the nature of the attacks and with regard to her suspicions being unjustified. Possibly her age was the basis for much of her suspicion; on the other hand apparently the husband did not stay home even if she was having heart-attacks. Both these facts may account for the apparent slowness of extinction, as well as her somewhat lowered self-esteem ("shame"). However, reality-adjustment was complete, and presumably her relations with her husband improved also.

Case 10: "Depressive reaction with hysterical features, moderately severe"; psychosexual guilt; individual and group therapy.
(Powdermaker & Frank, 1953, pp.580-591).
(Classification 6(a), 6(c)).

(Only full clear report of any individual case in book).

The patient was a 24-year old single man, who complained of "seclusive-ness, depression, apathy, tearfulness, difficulty in concentration and memory, fatigue, weakness and visual disturbances." He was afraid he would lose his job because of the mistakes he was making. Guilt feelings were present in connection with masturbation (he had masturbated with other boys in childhood, compulsively later) and sex play with a girl (after kissing her and touching her breast everything went blank, his hands seemed to be cut off, he felt weak and was temporarily amnesic). This "stroke" was however also association with brother's leaving for Europe. Guilt was supposedly affected after hearing a sermon on the subject of sex, six months' prior to his visit to clinic. Diagnosis was "depressive reaction with hysterical features, moderately severe".

His father, unstable and abusive, had been hospitalized for many years. 3 siblings, 2 sisters, 1 brother. Mother possessive toward patient, picking his girls, whereas she approved of his brother and his 'more carefree attitude'; this the patient resented. In childhood patient frequently changed domiciles, finally living with a maternal aunt 'whom he never mentioned'. Early childhood quite happy; he played mainly with group of other boys. Later family moved from South America to United States, after which he became more or less an isolate (through language difficulty, boys' teasing thereon, and money problems, though he did join in sports.) He was in the Army for 34 months, 18 overseas, but rarely went off the post.

Characteristic patterns of social relations and responses to stimuli as determined from clinical, social work and psychological interviews and group therapy records were regarded as being: (1) Compliant, but with undertone of hostility, to authority figures, e.g. mother, teachers, officers; (2) Tendency to deal with disturbing situations by avoidance; (3) Unwillingness to assume responsibility, lack of ambition and self-assertion; (4) Fantasy (as measured on Rorschach and illustrated by his own comments), immature and childish.

Therapy consisted of two individual sessions (initial and terminal interviews) and participation in a group therapy course. He attended 13 out of 15 group meetings over two months, and then left ostensibly because office hours prevented his attendance at group sessions.

In meetings 1-4 he is said to have "moved from the periphery (taking no part in first discussion) to centre of the group", while in meetings 5-15 he "oscillated between withdrawal and increased participation". Although he made comments, questioned others and answered questions, it was not until the tenth session that he actually talked freely of his own problems. However, by then he had evidently given up masturbation (though he did not "confess" to the practice); and in the 15th meeting spoke of his fiancee, so that he must have become engaged during the period of therapy. He did speak of his own depression, lack of self-confidence, hostility toward officers and belief in body-building.

In the terminal interview he stated that he had stopped masturbation "because the doctor had told him that his depression was due to guilt"; but 14 months later had apparently forgotten this, stating that marriage had solved his sexual problem though he himself was worse as the result of the increased responsibilities it brought.

Changes as the result of therapy are seen as:

"Symptoms. Gone except for slight concentration difficulty.

"Relationships. Less repressed. Fewer feelings of hostility and increased ability to express them. Markedly increased self-confidence, with greatly diminished sense of isolation and increased ability to take the initiative and to assert himself.

"Characteristic responses to stimuli. Less immaturity. Showed willingness to assume greater responsibility and increased accuracy of thinking."

This case is particularly interesting as therapy was largely indirect and somewhat superficial. The authors consider the benefit to have derived primarily from his free interaction with the group, which "seems to have given him the experience of acceptance by a gang which he had missed in adolescence", and the acceptance and mild direction of the doctor. They quite correctly point out that the fact that he had been accepted by an earlier peer-group may have been of help in this group.

We see here some direct verbal conditioning, a considerable amount of suggestion and learning by inference or verbalised (i.e. symbolized) example (the patient appears to have been rather an intelligent type); and a certain amount of learning by imitation (the patient first disagreed with the doctor only indirectly by linking with another patient; finally managed to disagree outright). The patient learned to be more "excitatory" or expressive (apparently initially an introvert) - inhibiting only his masturbatory practices, and this not completely. (14 months later he admitted to doing it on one or two occasions, but without the previous excessive guilt and depression). Reinforcement of his "positive" responses stemmed from a number of factors, including the fact that his own verbalisations acted as stimuli for others to verbalise also; he was fed more information as a result, which in turn increased positive affect; he was increasingly accepted as one of the group, and he was also accepted by the doctor as authority; also his feelings of guilt and depression were reduced, his social and mental activity generalised and increased, and he developed more "adaptive" behaviour generally.

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Case 11: War neurosis; "brief psychotherapy". (Grinker & Spiegel, 1945, pp.5-7 and 77-78). (Classification 3a(ii), 5).

(First case in the book. Of particular interest because of comments on possible diagnoses and therapy).

32-year old infantryman. Nothing known of past history except that his company had been under heavy mortar fire and dive bombing. On arrival at hospital "he was unable to speak . . . presented typical picture of severe terror . . had coarse, persistent tremors of hands and lips and started violently when any part of his body was touched. . (occasionally) inaudible whispers . . made no effort to get out of bed or help himself in any way but lay in a flexed posture with his body curled up like an intra-uterine fetus." Field diagnosis and the tentative diagnosis of admitting officer was schizophrenia. "It was decided to give the patient a few days' rest, sedation, and adequate nourishment before specific therapy initiated."

At the end of two weeks patient out of bed, but "walked with a peculiar simian gait. . ." He always displayed extreme anxiety and was easily startled into fear. He stammered considerably and asked continually, without satisfaction, who and where he was, and what had happened to him. "From time to time a fatuous smile would cross his face, he would laugh and, leaping from his cot, he would jump up and down on the springs and shout 'Dive bombers! Dive bombers!' as if it were a huge joke." Apparently an accomplished accordian player, he repeatedly played the song 'Maybe', singing the words . . without a trace of his usual stammer . . his whole face lit up in a kind of ecstasy, tears (running) out of his eyes, and (without) apprehension, only to (have it) return as soon as he put away his instrument. There was considerable stereotypy and various bizarre mannerisms reappeared in a regular routine."

It is not clear what the actual treatment consisted of in this particular case (however, see extract below), but the patient is said to have made a good recovery. "He was able to reconstruct his battle experience, and to orient himself in relation to his past life. Before his breakdown he had been worried concerning his wife's pregnancy, and it appeared that the song 'Maybe', was her favourite melody. The behaviour disappeared, and, although much anxiety and depression in relation to his battle experience remained, there was no longer any question of a diagnosis of schizophrenia. It was obvious that the patient was in a severe anxiety state with much regression and disintegration

of the ego. As is typical in the severe anxiety states, recovery of the ego's functions proceeded rapidly after treatment. For a few weeks the gait continued to be somewhat shuffling and stooped, without the normal swinging of the arms. The facial expression was masked, the skin of the face oily, and the eyelids blinked rarely. A moderate tremor of the extremities persisted, which was associated with rigidity of the cogwheel type. Without a knowledge of the past history of this patient, one would have been tempted to diagnose an organic lesion of the extrapyramidal system. After four weeks of psychotherapy this patient recovered from his depression, and the facial expression became spontaneous and lively and the gait normal. Anxiety disappeared except during air raids. The patient was able to assume duties in the ward and about the hospital, and was eventually discharged."

. . . .

On p.77 the authors comment that they "have mainly employed two therapeutic methods: the use of intravenous barbiturates to induce a semi-narcosed state, during which the patient is able to live through his traumatic battle experience" (i.e. narcosynthesis with pentothal) and "brief psychotherapy."

On p.78 they state, inter alia, "Under treatment (i.e. narcosynthesis) the patient actually synthesizes the emotions and memories connected with his experience, putting together what has lain fragmented between consciousness and unconsciousness into a complete whole, which corresponds in almost every detail with the original experience.... The ego, freed from the impact of the immense forces of the repressed emotions, in turn gathers new strength....."

"Brief psychotherapy" is summarized under the following headings:

(1) The establishment in the patient of a positive transference with the medical officer:

(2) The interruption at the earliest possible moment of the apparent advantage to the patient of his illness.

(3) Desensitization to the anxiety-producing situation. (This is brought about by constant verbalised recounting to the M.O. of the traumatic experience and a related discussion. During these periods it is "explained to the patient that the problem is not one of forgetting and running away from a difficult situation, but one of gaining some sense of mastery and confidence over the difficulties.... ")

(4) The handling of the superego reaction. (In all patients there is a varying degree of sense of failure. In war-neuroses the ego-ideal insists the patient is a coward, the weak link in the battle unit with which he is so identified and upon which he was so dependent. The task of the therapist "is to substitute a new identification" (helped in part by the transference-identification with the M.O. who also appeases the super-ego by utilising his own authority. He also reassures the patient and assures him that in fact he "stuck" to his guns as long as he possibly could; every man has his limits.)

(5) The therapy of passive-dependent trends. (The therapist at first gives much-needed support, then demands increasing independence and activity from the patient).

(6) Release of conversion symptoms. ("A great many of the so-called conversion symptoms are not truly conversion phenomena, though they resemble conversion symptoms in some respects, especially in regard to their anxiety-sparing function. They represent, rather, restrictions or failures of ego function before the onslaught of intense anxiety connected with the traumatic events....").

(7) Release of unconscious hostility (sometimes of inefficient officers; usually to all authority figures who have abandoned them to injury and death.)

Discussion: This is a case of classical conditioning with dissociated affect. Therapy has involved:-

(1) Prevention of reinforcement of "conversion symptoms" (operant conditioning).

(2) Change of cognitive reference frame to reduce guilt.

(3) Abreaction to break down dissociation and permit normal extinction.

Case 12: Anxious rejected child; group psychoanalysis (inferred).
(Slavson, 1950, pp.124-5).
(Classification 4, 5).

(Therapy is not reported. The case report shows conditioning stimuli involved in development of the disorders).

"Mike, an only child, very bright, who came for treatment at $5\frac{1}{2}$ because of extreme stubborness, whining, frequent illnesses, fears of being left alone, nightmares, complaints of being unhappy, continuous masturbation, and severe constipation. Masturbation became excessive when Mike was treated for multiple congenital stricture of the urethra at the age of 3. Dilation of the urethra was performed regularly every six months. Mike had never played with children and slept in the parental bed at the time of referral.

Mike was unwanted. The father felt financially unready for the child and the mother was extremely fearful of birth pains; delivery was by a Caesarian section. Toilet training was begun at six months' old and completed when Mike was 18 months old.

The mother was[a] very disturbed, unstable and immature woman, cried a great deal, had a tendency toward hypochondriasis, was chronically sorry for herself, worrisome, entertained thoughts of and threatened to commit suicide, and had fears of going insane, occasioned partly by the fact that two of her sisters receive shock therapy for psychotic conditions. She was diagnosed as psychoneurotic, anxiety hysteria.

The father was a rigid, neurotic, compulsive man, unsympathetic toward his wife and her difficulties. He had gone to quack psychotherapist and accepted will power as a cure for all illnesses. He therefore, had no patience with people with emotional problems. Actually he had many fears and felt insecure and weak. He opposed treatment for both the mother and Mike.

Diagnosis of child: primary behaviour disorder with neurotic traits (though a full-blown psychoneurosis can be suspected)".

Case 13: "Delinquent" adolescent girl with illegitimate baby and highly aggressive family; psychotherapy. (Peck & Bellsmith, 1954, pp.42-46). (Classification 4).

Mary J, 15½ "showed marked distrust, hostility, and resentment when she was interviewed at the clinic. She had been brought into court by the Society for the Prevention of Cruelty to Children because she had given birth to an out-of-wedlock baby." The parents had arranged for the child to be adopted, while Mary continued to live at home. The Judge had referred her for examination by a psychiatrist who described her as "anxious and guilt ridden", made a diagnosis of "psychoneurosis, hysterical type" and recommended psychiatric treatment.

"Mary had been subjected to almost incredible rejection by her family. Her mother, the dominant figure in the family, had allied herself with an older son, John, 29, who still lived at home. The father allied himself with Mary as much as he dared. Peter, 17, also lived at home. Three of Mary's siblings, two brothers and a sister, were married and away from home. Mary, as the youngest, had been tyrannized by her mother and the older siblings, particularly John."

On Mary's referral to clinic.... "the mother and John made it clear.... that they expected the court to exercise a restrictive role." The mother actually unsuccessfully tried to terminate Mary's relationship with the clinic. No member of the family "was willing to continue contact." Mrs J. "impressed the worker as an extremely rigid and compulsive person, with so much hostility toward Mary that she had blocked every normal step Mary had taken as an adolescent in the growing-up process. When ordinary suppressive measures failed, Mrs J. had used her ill health to increase her daughter's guilt and to curb further movement toward independence. She stated several times that she did not like girls, had never wanted any of her own, and had been sure ever since Mary's birth that she would 'disgrace' the family."

Mary was first placed in an intake group as this was thought "a less threatening experience than a direct relationship with an adult." However, she was then transferred to individual treatment. When first seen she was 'apprehensive and under a great deal of tension, (and) had a tic in her right eye which she attempted to conceal.'

Mary had not known the father of the child very long and had had sexual relations with him only twice. When she had told him of her pregnancy he had "refused to see her or take responsibility." She told the worker that "if she could not have the baby she would have lost two people."

Mary wanted the baby herself, but "her planning was unrealistic". She spoke of living with one of her married siblings, though every family member had rejected this suggestion in court.

She "continued to visit her baby regularly during the first three months of treatment." The first foster parents were proved unsatisfactory in court but Mary was "denied custody," though the baby was placed in another foster home.

"The family continued to exert pressure to prevent Mary from obtaining custody of the child. Her mother became seriously ill during this period and, she, as well as Mary's sibs, accused Mary of being responsible..... (her) guilt was intensified.... and (she found it) difficult to maintain the rather tenuous stability she had achieved....." The family kept her completely isolated... they "even had the telephone removed and literally kept her a prisoner."

Despite all this Mary insisted she wanted to remain at home until she was 18, when she thought she could be "free." The family situation worsened however, until "after a particularly severe family quarrel (she) had an attack of amnesia and was taken to a psychiatric hospital. The attending psychiatrist diagnosed it as an hysterical attack in response to her unbearable situation." Mary then decided to stay in hospital until her case worker could place her in a hostel.

She remained "in treatment for 18 months. In that time she made sufficient progress and achieved enough strength to go ahead with a plan for foster home placement of the baby. She made it clear to her family that she wanted her baby in a supervised home where she could visit it and be known as the child's mother. She made regular financial contributions for board, with a view to assuming eventually full responsibility for the child.

"The treatment at the beginning was centred on making plans for the baby. This practical approach enabled Mary to think of the worker as a helpful and supportive person. The experience provided her with the opportunity to feel, for the first time, that not all adults were allied against her....."

This case is particularly interesting because the "dynamics", i.e. the conditioning experiences, are particularly obvious. The most notable factor seems to be the somewhat surprising (in the midst of hostile or noxious circumstances) positive conditioning of a rudimentary sense of responsibility, due possibly to imitation, or introjection of mother's "rigid" value-system; though undoubtedly reinforced by her own strong love-needs. Mary, however, has the capacity to love and to relate to others, so that sib-acceptance must be postulated, while the maternal rejection would appear to have been incomplete, at least in infancy, and to have been based on, we may postulate, the mother's incomplete identification with her own mother (i.e. lack of female-role-acceptance) or fear associated with earlier guilt/punishment in connection with her own behaviour. Possibly mother had "had to marry" herself - it is noticeable that she was possessive toward her own eldest child; a behavioural pattern Mary could well have learned by imitation. Mary was somewhat dependent herself (otherwise she would have wanted to break the family relationship earlier) - a "masochistic" trait or behaviour pattern conditioned by the familial dominance.

Therapy depended on imitation of the therapist's attitudes and behaviour; reinforcement through therapist's verbal conditioning and increased self-esteem, "reciprocal inhibition" of anxiety by reality-bound and goal-oriented activity, and the development of self and other-love; insight through therapy.

Case 14: Fear of "sin of impurity" and inability to marry.
(Terruwe, 1955, pp.100-101).
(Classification 6(c), 3(a)(i)).

"Already in childhood a girl of a very sensual disposition had become very much afraid of the sin of impurity and this fear had grown to an intense fear of everything that was sexual. For instance, she did not want to marry and still had not done so at the age of 35, even though she had plenty of opportunities. She even avoided every contact with unmarried men because such contact presented the possibility of eventual marriage. She had, on the other hand, an enormous need for erotic gratification. This was quite evident from her appearamce which, in spite of herself, attracted many men. She purposely rebuffed the bachelors but she did not have any fear of men with whom marriage was out of the question, such as married men or priests. Accordingly, she was less reserved in her contact with them. At times she was even very affectionate, which occasionally would lead to difficulties. But she immediately resisted every man who would try to take liberties with her and if anything happened she lived in terrible fear. Inwardly, the repressed craving continued to exert its influence by repeated masturbation which out of fear she tried her best to suppress, though in vain."

"The pleasurable emotion, the sexual need was consciously repressed in such a radical manner that its deliberate expression, even in marriage was blocked by fear. But in the phenotype (the individual's external behaviour and appearance) the repressed emotion of the sexual drive emerged not only unconsciously but also unrestrainedly. She was totally unconscious of this, because she did not have the slightest insight although the facts spoke for themselves, and she rejected every attempt to make her realize what was going on."

If I were a Freudian I should be tempted to explain this, at least partly, in terms of an Oedipal conflict. It would seem probable that in early childhood this girl had either been violently punished herself, or seen/imagined someone else so punished, or more likely committed an act about which she felt guilty and for

which she expected the dire punishment extolled by the priest (and doubtless family) for such offences. Constant verbal repetition of the necessity for virtue and the possibility of punishment by priest and/or family would continue to reinforce her guilt and fear of being found out/and/or punishment.

There are many unanswered questions relating to this case. (a) From the context of the case the patient would appear to have been a Catholic. If she had "confessed" to whatever was bothering her and been granted "absolution" one would expect extinction to occur - as it did not either her confessor must, wrongly, have continued to reinforce her fear (possibly in connection with any confessed sin of masturbation) to such a degree that she could not accept "absolution" or herself; or she was so "disordered" she was obtaining some affective gain or pleasure from the constant round of confession-expiation-absolution-masturbation-confession-expiation-absolution and this had, in effect, become the surrogate for actual sexual intercourse, and accordingly symbolised "pleasure".

(b) What were her early relations with males - what was the familial matrix from whence she came? Whatever the answers may be this girl had experienced considerable religious conditioning to fear.

Case 15: Airman suffering from anxiety and related symptoms is treated with narcosynthesis, reliving traumatic event under narcosis. (Grinker & Spiegel, 1945, pp.396-7) (Classification 3a(ii)).

This patient was suffering from subjective anxiety, insomnia and loss of appetite. Under narcosynthesis he relived the experience of being hit while "strafing Jerries"; seeing that his ripcord was shot in two and being unable to bail out, and how he made a crash landing. It is interesting to note that: "At this point (after just lifting his 'plane up to about 6000 feet and finding he couldn't bail out) the patient complained bitterly of pain in his abdomen, stated that he felt like vomiting and began sweating profusely; his face was a green-grey colour; his pulse was nearly 150 per minute, and its volume was very poor. The therapist turned the electric fan on him and told him that the canopy of the plane was now open and that he should breathe deeply."

Although the therapist had in effect disocciated, or disoriented the patient, so that now he was in an imagined situation only (though obviously the experience had its basis in memory: "I can feel the wind in my face," said the patient), the patient did not altogether leave the traumatic situation - he recovered from the "typical peripheral circulatory collapse" in a few minutes and then went on to describe in the past tense the following events. He, therefore, began in the past tense, "lived through" the traumatic "shock" episode, and ended in the past tense.

At this point it was suggested to the patient that he "was making a splendid recovery and that in a short time he would recover completely" - two days later he was strikingly improved and soon made a complete recovery. The authors state: "This history indicates that synthesis by the ego of a dissociated fear of death, sufficiently complete to effect a cure, need not be accompanied by conscious insight. It is not necessary for the patient to be able to express verbally what he has learned. Learning occurs just as surely at an unconscious level."

Actually, in the authors' own terms (see pp.127 - 128) it is quite unnecessary to postulate anything except perseveration of reverberating circuits stemming from the

traumatic situation (and all the interoceptive and exteroceptive derived bombardment of stimuli) being finally inhibited by the output (through acting out and verbalisation) of the "information" accreted so violently, permitting the information that he was actually alive and safe to dominate the cortical centres.

Therapy here involved abreaction and extinction of fear, and suggestion, while the patient was unaware of this secondary experience.

Case 16: "Deteriorated schizophrenic" of puritanical upbringing; auditory hallucinations; supportive and "rational" therapy and suggestion. (Kraines, 1948, pp.442-445). (Classification 5 and 6(c)).

The patient was a man of 29 years discharged from a psychiatric hospital (summer 1935) as a deteriorated schizophrenic. He was mute, violent, negativistic, sometimes cataleptic, incontinent of urine and faeces, which he sometimes smeared on the wall, listened to, and answered hallucinatory voices. When first seen by the author (August 1935) he barely spoke, but did tell of the voices which constantly reviled him, accusing him of various antisocial and immoral acts, and for which he felt that a certain doctor was responsible.

The patient had five brothers, several of whom, like himself had gone into the ministry. His father was "kind and loving to his children", but was a "devout and strict" Fundamentalist, demanding that his sons be likewise. A. "grew up to think and feel that almost every action of the human being was sinful and motivated by the devil". After working his way through a seminary, he volunteered as a missionary and was "put in charge of a foreign mission". Although his work went well he was very much disturbed by the native women's "relative undress" and he "felt with horror that his mind was contemplating unholy ideas". He walked considerable distances, worked very hard and slept little, but he could not evade either his "tantalizing

awareness of the women nor the excoriating accusations of his conscience." Finally, he "seized the coloured maid in a frenzy and raped her.... stripped naked and ran out into the clearing, screaming with excitement". He then manifested other acute symptoms of catatonic excitement. Shortly after he "developed mutism." "All the voices he heard in his schizophrenic state, were those of persons whose opinion he cared for or feared; and they all accused him of immorality and degeneracy."

.....

Dr Kraines thought it necessary to add a note (p.443) to the effect that "at the time in question 'little was known concerning the shock therapies'." Instead he began therapy by "making every effort to establish rapport with the patient." Social conversation on topics and incidents unrelated to the patient was carried on, and at the end of two weeks he was permitted to go home. His family, however, were instructed that he "was to be left entirely to his own devices, except for an occasional and not too persevering effort to have him enter into groups and activities about the house. No allusions were to be made to the past; and in every way the patient was to be treated as an ordinary member of the household and not as one to be looked after. Members of the family were seen as often as the patient, for the success of his treatment was dependent upon the family's intelligent co-operation."

Therapy at first was purely supportive and encouraging. "The past", the patient was told, "was to be regarded as a bad dream which he needed to forget.... every attempt was made to give (him) a sense of security and to remove feelings of guilt and remorse." Later explanations, first general then specific, were "given to him.... about the universality of the sex drive, and its normalcy. Emphasis was placed on the normal basic nature of the impulse, and dispassionate explanations were given as to why society has developed a code of morals in regard to sex. He was made to feel that his impulse was normal and that his standards were high. It was a moment of weakness which had caused his digression from his standards, but he was reminded of his preachings about the humanness of errors." Three months after he was first seen (i.e. November 1935) the "voices" changed to "a scroll" at the back of his brain which kept repeating the previous accusations. This "scroll" "was like a phonograph record" which varied from a "soft sibilant whisper" to an "acute and extremely irritating sound."

This sound continued to diminish in intensity, particularly when the patient was busy, until it became a "constant ticking inside like a clock" inside his head. When he explained this in February 1936, however, he added significantly, "Besides I can't forget my past."

During this entire period therapy remained largely supportive, but where possible, "some pseudo-scientific reason was given to form a rational excuse" for any of the delusional ideas, the importance of which was always minimized.

Dr Kraines modestly comments, "The process of recovery was slow, and just as important as the psychotherapy (the patient was seen once a week) was the factor of time."

But by June, 1936, the patient admitted, "I don't hear the scroll, but my conscience always keeps bothering me about my past, and it becomes so intense at times, that the scroll sometimes takes over and keeps on saying what my conscience said."

Says Dr Kraines, "The patient was definitely on the road toward getting well. The general formulations of mental hygiene were constantly applied. General discussions of the driving forces in life, of different methods of meeting life situations, of the need for self-tolerance while exercising self-correction, were carefully but continually made. The attitude adopted was of giving the patient understanding, rather than that of urging correction; for understanding in itself is corrective".

The patient "was urged, and his family encouraged to have him form social contacts, and his brothers asked him to help in all sorts of chores, in an effort to keep him occupied. For a while he filched money from purses about the house but it was deemed wisest not to shame the patient by bringing his actions to his attention. Instead his spending allowance was increased, and in a short time the stealing ceased.

In August 1936, the patient came into the office with a red, non-itching maculo-papular rash over his entire body." A Wasserman test proved positive and the patient "admitted having had sexual contact with some prostitutes."

The "scroll" promptly returned, only this time it repeated, "It's all your own fault - it's your punishment for the terrible sins you committed in the past."

Dr Kraines reports, "Every effort was made to prevent the patient from becoming too remorseful, and although his sex contact was not condoned, he was taught to regard it as 'a human error.' By November, 1936, the scroll had again disappeared, and 'I'm doing my best not to let the past bother my conscience.' He continued to become more interested in work and persons, and by the spring of 1937 procured a temporary position. By the summer he was working steadily and at the time of writing (1942) was normal andhad had no relapses."

Discussion:

This case is a classic example of the conditioning of fear and guilt to normal biological drives and heterosexual relations and the attempted repression of the sex drive. The patient's normal sex-drive level would undoubtedly have been increased by the very alerting, the conditioning of attention,to any suggestive stimuli. Not only was the patient subjected to considerable simple verbal conditioning in childhood and early adulthood relating to sex, sin and accepted/ ideal behaviour, his entire value and belief system was involved.

If one wished to fit the therapy used into any of the current "schools", undoubtedly it should be called "rational therapy". Rational explanations were offered consistently of his behaviour and his delusions. At the same time it was consistently being "suggested" to him, i.e. he was being verbally conditioned to accept the idea, that he was improving and his "sin" was "a human error". No attempt was made to interfere with the patient's belief

in God and his inferred belief in "sin" (the word is not used in the report), nor to quite a degree with his ego-ideal; though this was apparently modified to permit of his self-acceptance. His Fundamentalism, however, was undoubtedly considerably modified by increased knowledge of the "driving forces in life" and his insight into, or comprehension of, his own behavioural patterns must have been considerably enhanced. No mention is made of any normal heterosexual relationship developing, apart from the unlucky episode with the prostitutes, and one would like to know what happened.

Although the report is only of the patient's progress we should not lose sight of the fact that his primary group were also involved in the therapeutic process. It must be assumed that their belief systems were modified to much the same degree as the patient's and he was, therefore, not involved in any conflict in this area. His acceptance of the therapist's rational explanations and information must have been reinforced by similar acceptance by his family. Manipulation of the environment and its enrichment as well as primary-group-acceptance were therefore undoubtedly potent factors in the "cure" of this patient as well as the primary technique of semantic conditioning carried out in a warm, relatively permissive atmosphere.

Case 17: Psychoanalytic study of development of athletic and academic achievements.
(Porteous, 1941, pp.498-9)
(Classification 6(a), 9).

This is an example of psychoanalysis which does little more than indicate the formative factors which have operated in the life of a man who has grown up as the only boy in a family of four with a mother twenty-five years younger than the father. Mother and girls consitute a feminine group while he choses to identify with the father who has many stories of his adventurous youth. Although small for his age the boy is agile and builds up athletic proficiency to establish his masculinity and carries over his confidence into the academic field. He achieves success in sport and science spurred by Adlerian-like motivation.

No therapy is involved in the case and there would seem to have been no need for psychoanalytic techniques to achieve this insight. The case is a good illustration of the way in which learning factors operate in the development of personality.

Case 18: Hysterical conversion through fear of Electrocution.
(Moncrieff, 1945, pp.76.77).
(Classification 8(b) and 3a(i)).

A printer's apprentice is treated for spastic paralysis of the right arm. Any attempt at movement produces intense spasm of the antagonist muscles. His job had included pulling down a large switch to start some motors. He complained of feeling shock on one or two occasions but his employer disagreed that the switch was defective and asserted it would not hurt him anway. He confessed to terror of being electrocuted. He had been able to carry on his work despite paralysis but could not manage switches. The condition was cured in a few minutes by assuring him that his muscles were sound but "he had forgotten how to use them".

This is obviously a conversion symptom rather than a case of conditioning. One suspects that the cure involved in some way an assurance that he would not have to handle the feared switch but this is not mentioned in the brief account given. Given this preliminary the treatment becomes a matter of convincing the patient of a fact and instigating him to take action on the basis of this. Direct reinforcement then accounts for the remainder of the learning process.

Case 19: Gambling mania, psychosexual conditioning, psychoanalysis.
(Stekel, 1938, pp.249-255).
(Classification 3b).

The patient had a mania for gambling for which he asks hypnotic treatment but later agrees to accept psychoanalysis. In first interview he relates his marital disappointment, wife was resistent and finally he established a system of paying her only to find later that she was having affairs with other men and had not been a virgin at marriage. Later he volunteers that this is the third time he has been deceived. He had masturbated since childhood. His mother had deceived his father with a number of lovers of which the boy knew. After masturbating at the age of 19 in his mother's bed where she has just had a lover he swears to masturbate no more and keeps his vow. After losing faith in his wife he began to visit his sister again. This, according to Stekel, is the major factor. His gambling is just an augury: "If I win this game it means I gain my sister." When he later became wealthy, partly through playing the stock market with advice from a banker friend, he bought a large villa and supported his sister and brother-in-law despite his wife's opposition.

Details of analysis are not supplied. It presumably followed the usual analytic lines and resulted in decrease in his gambling with increase in his sexual potency. He ceased to go to horse races and reduced cards to a few hours a day. Stekel's thesis is that gamblers are disappointed people confronted by something which they are eager to forget or do not want to see. If this can be accepted the problem of therapy becomes one of changing the reference frame for past events, a reorganization of the cognitive system relating to ego-involved activity, a process akin to rationalization but having therapeutic respectability.

Case 20: Hypnoanalysis of an anxiety hysteric.
(Freytag, 1959)
(Classification 6(c)).

This book covers one case only. Hypnosis is used as both a method of analysis and therapy, but is supplemented with non-hypnotic discussions. During the course of 78 sessions it emerges that the patient (a medical doctor) suffers from oedipal complications (from his ninth to eleventh years he slept with his widowed mother), resulting in sexual behaviour becoming a major source of anxiety. The analysis reveals in some detail the conditioning processes which had resulted in the development of the patient's attitudes.

An important aspect of the treatment is the use of hypnotic fantasy to enable the patient to counteract infantile learning. A castration fear, for example, is dealt with by having the patient fantasy his ability to defend himself against the threats of the man who had threatened to cut off his penis. He imagines himself kicking his tormentor in the shins and stomach so that the latter desists. Thus he rids himself of the childish fear.

The whole process is a combination of developing insight which fundamentally alters the cognitive reference frame, and re-conditioning by reciprocal inhibition through hypnotically guided fantasy. This latter technique is a powerful addition to the re-learning tools available to the therapist.

The outcome is highly satisfactory in this particular case, but it should be noted that the technique depends very much on the insight and skill of the therapist.

Case 21: Inability to eat in public and guilt. (Alexander & Ross, 1950, p93). (Classification 6(c)).

The following history is that of a patient treated in the Chicago Institute for Psychoanalysis by Saul.

"An attractive twenty-six-year old girl complained that for the past six years she had not been able to eat in public because of embarrassment, anxiety, nausea and faintness. This seriously handicapped her social life and her relations with men. She was the oldest of seven children. While the children were still small, the father gave up all efforts to support the family, which sank into poverty. The patient remained overtly cheerful and generous and was soon earning money, but unconsciously she bitterly resented the mother's repeated pregnancies by the lazy, dependent father. Each new child deprived her further of her mother's attentions and increased her burden by bringing another mouth to feed. She expressed her feelings by references to eating and food. For her the most touching expression of love was a gift of food, and when in her dreams she attacked people it was by biting. Her repressed bitterness against her mother resulted in a pervasive sense of guilt. This guilt was attached for specific reasons to eating and sexuality, both of which were consequently inhibited. The eating phobia began when she was taken to dinner by a boy of whom she thought her mother disapproved. She could eat freely only when her mother served her at home, for then she was doing only what her mother urged; then she had her mother's approval and love, and her resentment and guilt were reduced."

This is clearly a disorder of Super-ego Functioning, brought about as the result of (a) ambivalent attitudes to the mother; the focussing and conditioning of the patient's attention on the problem of feeding the family and on food itself as an object of pleasure, and of anxiety. The situation where the phobia began produced anxiety and guilt as well as pleasure as the result of being out with a boy of whom her hated/loved mother disapproved; and this was reinforced by her equally ambivalent attitudes

to food, conceivably reinforced even further by guilt arising from the fact that she was probably eating better food than her mother and sibs. The consequent state of arousal and stress was sufficient to produce conditioning of such intensity that she could no longer eat food in public.

Therapy may be assumed to consist of verbal conditioning, support and abreaction, leading to change in the cognitive reference frame.

Case 22: Social maladjustment; Non-directive psychotherapy.
(Muench, 1947, pp.24-56)
(Classification 5, 4, 6(b)).

"The 'client' was a young, unmarried, personnel officer who suffered from social maladjustment and feared that if he did not get help soon he would lose his job. He felt inferior, found difficulty in relating to persons of either sex and tended to take refuge in dreams and daydreams."

Therapy involved two major aspects. The client was led to verbalize his major difficulties and to make decisions with regard to directing his future behaviour. The development of insight does not differ very much from the psychoanalytic approach except for the more subtle control and the absence of jargon. There is evidence of the use of objective self-analysis to desensitize emotional situations. "I have looked at my dreams logically and they in turn have disappeared. Now I am trying to look at the

fears objectively and I realize they are unfounded in fact." Again "Recently when I work up a resentment I try to see what is at the root of it. I absolved a resentment easily yesterday."

Parallel with this is an attempt at training conditioning. "I've been trying to plan out my future programme..... then I said to myself I should follow through even with this person because if I get into the habit of following through then following through with fellows and girls my own age will be so much easier."

.....

This is not a case with a dramatic ending but there is a steady improvement in several directions. The major difficulties gradually fade away and the client acquires a new optimism. The skill of the psychologist guides the client into a state of insight or self-knowledge which enables him to develop his own behaviour in a way which will enable him not only to cope with current problems but to attempt new behaviour patterns which become operantly conditioned.

The case itself is one of abnormal conditioning of the affection drive in relation to peers. There is insufficient evidence to explain the causes but he has also been conditioned abnormally to withdrawal (trait abnormality).

Case 23: Highly aggressive, adopted 5-year old boy, psychotherapy.
(Lowenfeld, 1948, pp.95-106).
(Classification 7, 6(a)).

A boy of five years was under treatment for 15 months. His behaviour was violent: he would sweep crockery from the table, break windows if unable to get into the house, hammer holes in the wall, smash furniture etc. The parents were tolerant.

The boy was adopted. During the course of treatment his (adoptive) mother told him his own story in the third person. Tom burst out, "It was me, it was me." The crucial aspects of treatment centres around his own origin and the origin of babies in general. He was given full details of coitus and birth, even of menstruation following an incident in which he scattered sanitary towels around the neighbourhood.

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Treatment evidently resulted in his developing a satisfactory feeling of acceptance in the adopting family. This seems to have been helped by the parents setting limits to their tolerance, which had a calming influence on him and seems to have increased his feeling of security.

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This is a good example of the importance of the cognitive reference frame in determining behavioural tendencies and emphasises that significant learning in the therapy situation may be largely cognitive and not simple conditioning. An equally important causative factor, however, was the child's lack of ego control produced by the parents failing to "set limits" to their permissiveness, thereby producing a learning deficit with regard to socially acceptable behaviour and considerable anxiety as regards his parents and his relation to them, as well as to himself.

Case 24: Abnormal interest in urination; modification of urinary mechanism.
(Menninger, in Hall, 1959, pp.266-268).
(Classification 3a(i) and 8(a)).

From the age of five the patient had an extreme phobia lest anyone should see him urinate. As a young man he had spent much time in toilets motivated by a voyeuristic interest in urination. During the course of treatment he developed haematuria (blood in the urine) with extreme pain. This was interpreted as "the symbolic enactment of his conflicting wishes to masturbate and the fear that if he did so he would be castrated and made into a menustruating woman." Such a role he was prepared to accept, having frankly avowed his wish to be a woman.

Menninger speculates that lifelong (25 years) sexual gratification by urination made it not inconceivable that the urinary mechanism had been modified in some minor way to afford maximum organic adaptation to the perversion.

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The case seems to be well authenticated and seems to confirm that organic processes can be modified by psychological factors. The "symbolic" concept may be ignored in terms of learning theory. What we do know is that certain major forms of motivation appear to have been present and these have resulted in certain physiological outcomes. The notion of urinary modification is, of course, pure speculation, but it could be the outcome of constant physiological stimulation parallel to the more striking haematuria effect. Whatever the case, there has been classical conditioning of drives resulting in the phobia, while there would also appear to have been the development of a physical symptom by operant, or instrumental, conditioning.

Case 25: Claustrophobia and early conditioning.
(Fisher & Hawley, 1952, pp.106-8).
(Classification 3a(i) and 3a(ii).

A young wife suffered from claustrophobia and found it impossible to ride in a lift. She recalled that when she was very small her father had demanded that she confess to writing on the walls of the house with coloured crayon. She had not done it and refused to say she had. In a fit of temper her father had locked her in the wardrobe, shouting outside the door: "By God I'll leave you in there until you rot, if you can't learn to tell the truth. I'd rather not have a daughter than to have one who is a liar." After screaming her innocence for some time she decided to "confess" in order to get out, but father did not let her out - said he would think it over and she spent another hour wondering how long it would take a person inside a wardrobe to rot.

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This situation, of course, involved not merely fear but hatred of her father, guilt about the hatred, loss of faith in justice and other complications. There is an interesting parallel with the classical case of Dr River's patient. The key point seems to be dissociated affect arising from a highly emotional experience and consequent conditioning of the fear drive. Unfortunately no account is provided of therapy and its outcome in this case, but one may assume that abreaction with consequent extinction of the fear, plus a changed cognitive reference frame would occur.

Case 26: Depression and insatiable eating; early conditioning; psychoanalytic interpretation. (Linder, in Freeman, 1959, pp.167-198). (Classification 3a(i) and 3b.)

The patient was subject to episodes of depression when she would eat insatiably, not because of hunger but to fill a void. The orgy would often end in unconsciousness and she would need two days to recover.

As a child she had a crippled mother and a father who drank and sought other women but who seems to have made a favourite of her. One night when her father returned home late after drinking her mother goaded him until he finally left the house never to return.

As developed by Lindner the case involves two crucial points. The first (a) is that the patient had associated the mother's crippled condition with the sounds of sexual intercourse and so had developed a fear of intercourse. This discovery effected appropriate improvement in her sex life. The second point (b) is that her eating was due to a longing for a baby by her father. She had to "Mike (father's name) a baby." Presumably this interpretation led to cure of her compulsive eating.

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There is some difficulty in reconciling the patient's fear of intercourse with her intense desire of a baby by her father. A fuller account of the case history might clear up this point. Alternatively it is quite feasible that one or even both of the interpretations is in error but sufficiently "rational" for the patient to be led to remodel her attitudes.

Case 27: Reactivation of previously experienced pain in conflict situation; interpretation. (Brun, 1951, pp.325-332). (Classification 3a(ii) and 8(b).

The patient, a 29-year old bank clerk, had suffered sudden attacks of pain in both knees since marriage three years ago. No organic cause could be found. Some months before marriage he had had pains in the pelvis. He had been engaged for $2\frac{1}{2}$ years and marriage had been delayed because of a severe masturbation complex. He had been introduced to masturbation at junior high school. A lecture by a naturopath had informed him that masturbation was the principal cause of spinal consumption and later he had confirmation of this in a popular medical pamphlet. He had practised coitus interruptus in marriage for fear he should have weak children and be unable himself to support and educate them. Knee pains, he discovered from the medical book, were the dreaded shooting pains of spinal tuberculosis.

During military training he had fallen on his knees and his joints had been painfully inflamed for several weeks. During this period he had been consoled by a girl friend whom his parents had previously insisted he give up. The knee pains usually afflicted him after intercourse (unsatisfactory) or a quarrel with his wife.

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In the light of the above the pain could be regarded as the outcome of a wish for his former love and so a regression to the last period when he was able to enjoy her company. This wish aroused guilt which probably led to his accepting the pain as punishment.

The mechanism involved is that manifested in hypnotically induced pain and organic disturbance. The earlier situation had led to conditioning effects and a cognitive reference system which make the subsequent psychological processes quite comprehensible. This is in accord with the author's interpretation of his case.

Case 28: Boy's refusal to eat: parents' refusal to be dominated.
(Strecker, 1946, pp.195-6).
(Classification 3b and 6(a).

A sturdy boy of seven years occasionally came to the table and refused to eat. The situation would end with father threatening and mother in tears. Finally they consulted a psychiatrist who advised them on the next occasion to "do or say nothing." They were rather disappointed by this advice but decided to try it out. About a week later the boy declined food and announced that he did not intend to eat anything. His parents went on with their meal. After failing to get their attention by squirming and other means he said "Maybe you didn't hear me, Dad. I said I wasn't going to eat." Father replied that they had heard but it wouldn't hurt a healthy boy like him to miss a meal. After a long silence the boy burst into tears, pounded on the table, again asserted that he was not going to eat and demanded if his mother was not going to cry and his father to swear. He was told to keep quiet and let them finish their meal in peace.

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There was no repetition of this behaviour. It had ceased to "pay off." The failure of reinforcement had led to extinction. Such rapid extinction of a response is not usual but it should be noticed that once again the cognitive system is involved. Not merely had the boy failed to get the usual reaction from his parents but he had realized that this was likely to be the case with all future instances. Cognitive anticipation of outcome would thus operate whenever he contemplated such behaviour and short-circuit the actual performance. True extinction may thus have been delayed for a considerable time. Environmental manipulation was also a major factor in the therepeutic process.

No further details of this case are given so it cannot be evaluated in any wider sense. Further study would probably have cast some light on the origins of the behaviour in the first place.

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Case 29: Fear of women's sexual demands; psychoanalysis. (Mitchell, 1960, pp.147-160). (Classification 5).

(Allowance must be made for the fact that this book is written for the public. According to the author the essential facts are true.)

The patient in this case used a subterfuge to gain some knowledge of the technique of inducing hypnotic trance. When this was seen through he was led to explain that he wished to hypnotize his wife and it emerged that his sexual relations were inhibited by fear of being hurt. If he could hypnotize his wife he felt that he would not need to be afraid.

This case was handled by psychoanalysis although the crucial material firstly appeared in a semi-hypnotic trance, wherein it transpired that, as a little boy of six, the patient had been induced to play a game with the maid whenever his parents were away. This proved to be the origin of his fear of the sexual demands of women and his need to have an unconscious sex partner who could not hurt him.

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A spontaneous cure resulted from the revealing of the information given above. It is not clear whether abreaction actually occured; or whether the cognitive understanding (i.e. relearning) led to the development of new attitude towards the sexual situation which more

than counterbalanced the old fear cues which were soon fully extinguished. This is another example of the ability of re-learning or new learning followed by cognitive reorganization, to modify effective attitudes.

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Case 30: Overworked housewife develops high anxiety after accident; environmental manipulation. (Alexandra Adler, 1948, pp.104-5). (Classification 3a(i) and 8(b)).

A housewife of 46 years was knocked down by a tram car. She lost consciousness for only a few seconds, just long enough to have no memory of the accident. Physically she had only skin abrasions but after a few days she began long terrifying nightmares when she felt mortally wounded and bleeding from many wounds. On her return from hospital she was too frightened to go out in the street alone, was very nervous and cried a great deal so that she was unable to attend to her housework.

Adler found that she had long felt her household duties a crushing burden in which she was not sufficiently assisted by her husband and daughter who did not appreciate the amount of work she was doing. Her neurosis thus appeared to be an escape from an intolerable situation. Treatment was the establishment of a compromise which involved being relieved of part of her household duties. Symptoms then subsided.

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So far as therapy is concerned this appears to be a case of environmental manipulation rather than any aspect of learning, although the desensitising and re-conditioning of affect is involved. It is only if one regards the family as the unit that the learning aspects become evident. Quite obviously the family had to develop

insight, and pattern its behaviour as well as divide its labour, along new lines in the light of such insight.

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Case 31: Extreme masochism in rejected adolescent; psychoanalysis.
(Brenman, in Knight, 1954, pp.29-51)
(Classification 3a(i), 5, 6(c), 7).

(This is a very difficult case to summarize. The analyist presents much detail but this is a selection from a vastly greater amount. Brenman's aim was to illustrate an hypothesis with regard to masochism).

The patient was a girl of 15 who had been withdrawn from boarding school after her own frantic complaints of "mistreatment." A number of major points are made by the therapist:-

(1) The girl, both at school and with other patients, acted the buffoon, saying "I guess I keep them in stitches."

(2) She had been, from a very early age, desperately ingratiating with her mother, who found this "palled."

(3) She had used the same approach with her sister who had accepted her as a "lady-in-waiting", receiving part of her pocket-money and innumerable personal services.

(4) She became strongly attached to her Catholic nurse-maid and became converted to Catholicism at seven years of age and remained secretly a Catholic until she was twelve.

(5) She frequently phantasied dying of some fatal disease and her family then discovering that they loved her, and she actually dreamed repetitively a scene where she died from a fatal disease, "not her fault", with the mother and sister discovering they loved her and telling her so before she died, and father discovering the same thing only after her death. From nine onwards she consciously determined to achieve these results by 18 years of age. Later she made attempts at suicide

and the crisis in treatment was her efforts to precipitate illness by not eating and systematically depriving herself of sleep.

(6) From 12 onwards she consciously wanted to kill her mother. In therapy she explained this, adding these impulses "had nothing to do with anger whatsoever."

(7) She had formed an attachment to a young artist who, with his mother, had attacked the girl's parents as "never having really loved her". But the boy failed in his scholarship examination through psychogenic paralysis and recrimination was now directed to the girl who confessed to the analyst that she had yielded to the boy's sexual advances on one occasion. (His mother complained that she had "drained" his energy.)

(8) The patient now embarked on a systematic process of self-punishment.

Brenman attempts to explain this masochistic behaviour in terms of an excessive demand for love which, on not being gratified gives rise to rage. This is denied and reaction formations develop which, by projection, lead to a regarding of people as essentially good.

Nonetheless she, herself, actually reports many of the experiences which resulted in the initial conditioning and development of the various behavioural patterns observed.

For example, referring to the phantasy described in (5) above, she comments, "Here too we see - in addition to her immense yearning to wrest love from her family - a bitter caricature of her demanding hypochondriacal mother who would constantly go to bed with various infections, commanding thus everyone's undivided attention." (p.36). On p.31 Brenman notes that the patient had been given an unusual masculine-type name, being "so named by her wealthy, snobbish mother who had expected her to be a boy", while on p.32 she reports, "Her mother stated quite frankly that she had begun to dislike Allerton consciously when she was no more than four or five.... She was chronically afraid of her impresario father who constantly boasted of his effective intimidations of successful concert artists." Both parents recalled a warning from the pediatrician that "Allerton's immense need for attention will get her into trouble.". Brenman further records, "Her parents who set great store by decorous manners did not permit her to enter the living room while there were guests present until she had mastered the art of curtsying properly. The patient, much later in therapy, recalled

her debut as a young curtsy-er when she bowed so low that she fell flat on her face arousing much consternation in her parents and merriment in the assembled guests." (p.33)

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There was obviously a number of factors operating to produce the patient's maladaptive behaviour.

(a) If the mother "expected" a son it is quite probable that she rejected the patient, at least to some degree, from birth onwards. In any case the child had a high affection and security needs.

(b) She experienced rejection and reacted with repressed anger.

(c) She sought social approval by sacrifice and clowning (deriving initially from the curtsy incident, when pleasure and a feeling of acceptance were conditioned to buffoonery).

(d) Rejection by the boy-friend (via his mother) resulted in depression and guilt as there was some truth in the accusations.

(e) Self-punishment to gain sympathy could well have developed and been reinforced from two sources: viz. imitation of mother's hypochondriacal behaviour, and the curtsy incident where her initially lowered self-esteem conceivably rose as the result of the (apparently kindly) merriment of the guests, while her hostility to her parents received some gratification through their "consternation."

(f) The self-punishment behaviour could also have been propitiatory in nature. Where social approval is so greatly needed we can well expect rigid super-ego formation, with consequent strong guilt feelings and need for propitiation.

Therapy brought the much-needed warmth and support of the therapeutic situation and of the therapist herself, with a different model for the patient to learn to imitate. At the same time verbal conditioning and the gradual learning of the causes of her behaviour was bringing about changes in her cognitive reference frame and super-ego. Abreaction broke down the dissociated affect and permitted of extinction.

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Case 32: Aggression and self-realization in a young woman with difficult family background. (Burton, in Burton & Harris, 1955, pp.117-155). (Classification 4, 5, 6(b), 11).

Rita L. entered the hospital voluntarily at the age of 29 after a history of treatment by many psychiatrists. Her father had been an unsatisfactory breadwinner and the paternal uncle who had paid his fare from Poland to the United States refused any further help. Father seems to have returned to Poland later and the uncle then assumed control but not support of the family. Cosmetics and dancing he considered immoral and there was soon considerable friction between him and the children. The elder sister left home and then Rita went to a neighbouring city. On the uncle's death it was found he had left Mrs L. and Rita's two younger siblings as his heirs - Rita was disinherited.

Father had been an ineffective person and himself appears to have had severe mental difficulties with fear of being poisoned and an attempt at suicide. He also escaped from the State Hospital - which caused Rita much alarm. The mother had been trained as a teacher but does not seem to have been able to make adequate use of her abilities. All the children (two girls and a boy) seem to have suffered from unsatisfied affection needs despite the mother's conscious attempts and to have acted with aggression. The main features of Rita's case were a very high degree of aggression and depression. "I just hate myself. Life is so futile." She was infuriated by what she regarded as the therapist's passivity. She looked for some magical rescue. She brought up a fantasy of a knight in armour who would provide her with a castle, coach and beautiful clothes. The reality equivalents of this were, "a young blond, handsome and worshipful man providing a custom house, a Cadillac and clothes from the most lavish shops." She resented men, liked to tease them sexually and watch their discomforture.

There had been a period during the war when Rita had been frequently dated by army officers and enjoyed a round of hectic entertainment with brief alliances culminating in sexual intercourse which she never quite enjoyed but which she felt were required of her. Only one serious attachment developed but she could never bring herself to accept his proposal and there were violent quarrels about her other dates. It was soon after she terminated her relations with this man (he had been a psychology student before the war) that her illness seems to have begun and it seems likely that this initiated a serious psychological conflict. Later during her illness she attempted to return to this man but he had married

in the meantime and was not interested.

A further complication was her Jewish background, which, for various reasons, she had repudiated.

Without acceptable national or family affiliation it was understandable that she should become selfish and aggressive and despise humanitarianism. She could not accept the affection which she so much craved and when substitute satisfactions failed (her officer companions) she fell into an angry depression. Therapy here might be regarded as a battle to establish a satisfactory human relationship for her. The continued support of the therapist despite all attacks and the insight which she was given as to why she was negatively aggressive finally got her to a stage where she could say that her hostility towards the therapist was unjustified although she could not help feeling that way. She became able to see her mother as a person with problems like her own. Finally she was able to resume life outside the institution and to enter into more normal relationships with other persons.

Case 33: Rigid Super-ego and difficulty with social relationships, analysis.
(Katz & Thorpe, 1955, pp.74.76).
(Classification 4, 6(c), 7, 9).

This is a very brief account of a young teacher who sought psychological help on the advice of the principal of her school. She had great difficulty with her social relationships, culminating in her accusing another teacher of sexual irregularity. Treatment consisted largely of developing insight into the source of her highly puritanical attitudes which were found to originate in the chronic fault-finding of her mother, a highly strung, self-centred woman. Her one sexual lapse had occasioned an excessive degree of guilt so that she became highly critical of the moral behaviour of all her acquaintances.

With the development of insight the patient's reference frame became modified so that she was able to make a satisfactory adjustment socially.

The re-learning involved here can reasonably be regarded as basically cognitive. Cognitive learning involves the understanding of relationships and the integration of knowledge into logical systems. Changes in the moral reference system may follow as a by-product of this.

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Case 34: Obsessional thinking related to anxiety and behaviour.
(Anderson, 1957, pp.90-91).
(Classification 4, 5).

"Robert was always having what he called 'funny notions' which worried him and made him wonder if he wasn't 'cracked'. In the midst of carefree play with his children he would suddenly wonder why he should be enjoying himself that way. While he was having quite satisfying sex relations with his wife he would start wondering why he was not having homosexual relations or whether he might not be a criminal at heart.

"To understand this phenomenon, one would have to go back to his past. He was raised in an orphanage from the time he was a baby, and there were two distinctly different sets of significant people for him: (1) the teachers, housemothers and fathers - the adults; and (2) the other boys. It was easy to get lost, as far as the adults were concerned, unless one were 'different' or outstanding in some way. At the same time it was extremely dangerous to follow the demands of these same adults and be outstandingly 'good', because he had to live with the boys twenty-four hours of the day, and they would have made life thoroughly wretched for him had he been a 'teacher's pet'. Besides, teachers came and went but the boys stayed on for years. Therefore some compromise was essential if he would survive without too much pain. He schooled himself to be 'different' in the sense of being a 'bad boy', so that he would get plenty of attention short of severe punishment from the adults and run no risk of retaliation from his peers.

"Later, when he caught himself behaving like other people or enjoying what adult people seemed to regard as right and proper, there would come over him a sudden flash of anxiety, and his mind would race toward 'security', i.e. that which he had learned to consider different and bad or non-acceptable. We may say that it was not a tendency to be a 'bad character' against which he was struggling but his fear of being a 'good' one.

"The only thing that was in his conscious awareness was the 'funny notion' of which he complained. Everything else was unconscious because none of it had been labelled or otherwise put into verbal symbols while he was having the experiences which led to his basic assumptions."

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As Anderson clearly shows, this boy was conditioned to (a) anxiety if behaving in a fashion not approved by his peer group, (b) anxiety and some degree of guilt if behaving in a normally enjoyable manner, and (c) seek disapproving attention from significant adults. Although it is not stated, one may legitimately assume that therapy consisted of a change in the cognitive reference-system gained through some form of analysis, the inhibition or extinction of his anxiety and related symptoms, and the re-learning of guilt-free and enjoyable behaviour.

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Case 35: Rejected, aggressive boy suffers paranoid reaction; Sullivanian analysis. (Sullivan, 1956, pp.152-165). (Classification 3(b), 4, 10(b)).

This case,"the only paranoid preadolescent boy with whom I had worked at all intensively" (p.152) is quoted by Sullivan to illustrate what he regards as a very important point. Here was a boy who had an appalling life and who, except for one person and for a short time, had found everyone unfriendly and frustrating. At school he was a "holy terror", feared by teachers and boys. When eventually he did seek friendship with other boys he found himself rebuffed, even when he tried "serious application and much disciplinary planning". The result was a paranoid reaction. The boy explained that he had been stolen from hospital by the woman who now claimed to be his mother. He was really a very important person and she had been interested in blackmail. This, he claimed, was evidenced by the fact that the family lived much better than any obvious source of income would justify. He not only had practically no relationship with people, he also had no pets. "Part of the thwarting business was that the mother

would not put up with his having any animals in the house."

Sullivan is at great pains to deny any element of homosexuality in the case. Relation to the mother could be instanced as a likely basis for homosexuality, but "in my simple-minded world, it is a little bit difficult to talk about homosexual conflict where there is no homosexual attachment. What he had was an inescapable barrier to intimacy with man, woman or beast."

Further on he makes this point: "And since he has recently come from the preadolescent era, when his prestige in the eyes of his own sex was what was important and gratifying; it is easy to spread this feeling that, 'no woman would put up with me' into a valuation which he assumes intelligent men would hold of him. This idea that 'Men know that women would not put up with me, that I'm no good with women' is then likely to be followed by, 'They think I'm a fairy - that I'm sexually interested in them'."

Sullivan considers that to interpret the behaviour of a paranoid patient as a desire for homosexual relationship when there is no active evidence ofthis is "an atrocious miscarriage of the therapeutic process and merely exacerbates the paranoid's condition by still further accentuating his inferiority."

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Unfortunately the outcome of this analysis is not stated, but, bearing in mind that this is Harry Stack Sullivan writing, one is entitled to assume (a) the success and (b) the warmth and support of the therapeutic relationship and the modelling of the boy's behaviour; and (c) the Interpersonal orientation of the analysis and re-learning involved.

The conditioning to a drive for attention, and the aggression stemming from his frustrated need for personal relationships, love and communication are self-evident.

Case 36: "Split-libido" due to broken love-affairs; insight.
(Barker in Squires, undated).
(Classification 4, 7).

The patient was an unmarried Jewish man of thirty-three who complained that his "back teeth closed before his front teeth". This had undermined his health, prevented him from working and made him sexually impotent. He talked of his former sexual exploits. He had been in the habit of having sexual relations once in three or four months but would then have seven or eight orgasms in one night. Several months previously he had found himself impotent.

Associations with his dreams revealed that at the age of eighteen, while at camp during the war, he had met a girl with whom he had fallen deeply in love but had broken off the relationship because she was a Roman Catholic and she was so fine and sensitive that their marriage would do her great spiritual injury. Six years later he discovered that she had married and died in childbirth. After parting from the girl he had never allowed himself to get to know fair-haired girls. He did not feel "spiritual" towards brunettes.

Two days after parting from the girl,he had met a man who made an insulting sexual remark about her. He wanted to fight the man, who he recalled in a dream, looked very like his dentist, but a dark girl who had been present separated them and as she walked away with the patient said, "Why fight? No girl is a maid." This made him very angry but he could not assault her because she was a woman. When this memory emerged the patient decided that now he knew why he had trouble with his dentist and why he wanted to tease brunettes, as had been his custom. There was a spectacular change in his attitude towards work and eventual marriage. Unfortunately his therapist was away for some time after this and was never able to make conact with him again to follow up his work. In his report he confesses that the real problem, the split between sexuality and "spirituality" had not been touched and that when had been achieved "would have to be won many times over in the daily combat of life."

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We can see here the process of conditioning, and an example of a symbol being drawn from associations - i.e. the symbol for the split in his referemce, affective

and action systems relating to women, is an inability to close his back teeth before his front teeth. One could speculate (as psychoanalysts' compulsions will drive them to do) on the experiences which led to the "choice" or use of this particular symbol - it still rests firmly on earlier conditioning or learning.

Therapy appears to have consisted of analysis leading to insight and (we hope) to re-learning of appropriate and adaptive behaviour.

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Case 37: Jungian analysis of a depressed and anxious widow of 40.
(Adler, G., 1948, pp.129-138).
(Classification 6(a) and 11).

This case is reported by Adler primarily as background for a discussion on dreams and the concept that consciousness effects healing.

The woman - a German, aged 40 - underwent a "long analysis" due to "depressions, and a general state of anxiety." She was "handsome", looked younger than her age, was the mother of two "obviously gifted and attrative children". Her husband had died a few years previously. "To find out the causes of her anxiety and depression", Dr Adler had "asked her to tell me the story of her life, with special reference to her marriage. Everything appeared to have been in order and, according to her account, she had lived on the happiest and most harmonious terms with her husband, who had been a very distinguished doctor and scientist. She herself, before and immediately after the outbreak of the first world war, had been a medical student, and it was at the university that she had got to know her future husband.... who actually was a most devoted and kindly human being, and she had in addition every reason to be proud of her two children..... her financial circumstances were assured, so that the only external cause to account for her depression was,

apparently, the loss of her husband about five years previously..... However, she always strenuously denied this very obvious suggestion. She admitted willingly that she had suffered deeply and was still suffering from his loss, but she was absolutely convinced that this was not the cause of her neurosis, more especially as she now remembered that even during her marriage she had suffered from similar, apparently causeless and quite inexplicable, attacks.

"..... analysis gradually revealed the fact that my patient's husband was almost completely absorbed in his work and that he made great claims on his wife's help and support, both inwardly and outwardly, so that she had very little time left 'for herself'. In spite of this she repeated again and again that she had accepted this state of things without the slightest feeling of being coerced..... Although from all she told me I had some notion of the line our enquiry would ultimately take, namely that of the suppression of her own individuality and personal development, she was not ready to accept my suggestion, so that my knowledge would have been of no help to her. It was at this juncture that this dream made its dramatic appearance:

"I was in a large, beautiful ante-room, built in the classical style. Although there was a good deal of open space between the pillars, there was no view as the view was entirely blocked by hanging rugs. The space between the two middle pillars was filled in by a beautiful soft blue-grey kangaroo skin. I knew that it was from between these two pillars that the courses of the Nile should gush out, and I was longing to see them burst forth. I attempted to drag away the skin but it was so firmly attached that this was impossible. It was only in my mind's eye that I could see the waters flow". (p.131.)

After questioning and some thought, "at last it suddenly occurred to her that she had seen this very kangaroo skin twenty years before in the house of her mother-in-law..... she told.... with considerable emotion, the following story: Shortly before the outbreak of war in 1914 (she and a young English doctor) fell deeply in love with each other. They were just about to become engaged when war broke out, and the abrupt departure of her English friend put an end to all.....plans. (During the same period) she had formed a friendship with her future husband, who held an appointment at the same hospital. He fell in love with her and made her an offer

of marriage. Although she liked him well enough, she had at first refused his offer, as she intended to marry the Englishman, but in the difficult situation in which she found herself, she agreed, not without considerable inner conflict, to become engaged to the German. Her inner resistance finally became so strong that she decided, in spite of all her liking and sympathy for her fiance, to break her engagement. With this purpose in view, she took the train to another town where her fiance happened to be staying with his mother. As she entered the house of her future mother-in-law, the first thing she saw was an enormous kangaroo skin, which had a peculiar connection with her fiance. In his scientific capacity, he had been commissioned by the directors of a large Zoological Garden to carry out post-mortems on their deceased animals. In this way the kangaroo skin had come into his possession, and he gave it to his mother..... (On) this visit (she) was so overwhelmed by the affectionate greetings of her mother-in-law and by pity for her fiance, that she felt unable to..... break off her engagement, and only succeeded in binding herself to him even more closely, with the result that she very soon married him. In the course of her harmonious and, on the whole, very happy married life, she had managed to repress all this, and consequently she also managed to forget completely the existence of the kangaroo skin. Nevertheless, her unconscious mind retained the image and, because of its striking and impressive appearance, and above all because it was the first thing that struck her in the home of the mother-in-law, where such momentous events took place, the kangaroo skin became, so to speak, the symbol for her equivocal decision about her marriage.

"..... Just as the kangaroo skin had damned back the accumulated waters of the Nile, and prevented their flow along their natural channels, so my patient's marriage had put a stop to the development of her own personal life and individual abilities. She had obviously made a heroic attempt to suppress her dimly-felt knowledge of having made a mistake, by subordinating herself entirely to the interests and personality of her kindly and gifted husband, at the cost however of completely losing her own line of life. The seriousness of the resultant split and the degree of her resistance to any conscious admission of the real state of things can be gauged by the fact that not only she should be able to forget so completely such a remarkable object as the kangaroo skin, but that it should require such concentrated effort on her part to reconstruct its history.

"..... The aim of analysis is, so to speak, to free a passage for the damned-up waters by helping to remove the kangaroo skin which was blocking their outlet. However vehemently my patient had previously refused to accept my suggestion that her marriage might to some extent account for her difficulties, she could not deny the facts of her dream.

"..... No doubt this mistaken decision had hampered my patient's inner development very considerably, but it must not be forgotten that, in spite of this, her marriage had been very happy and had consequently provided her with sufficient positive values to compensate for its more doubtful aspects.....

"..... If the recognition of past mistakes is to be of value, in other words productive, it must contain a hint as to how the error can be rectified and so conduce to a better life in the future..... This constructive aspect is immediately seen if the mistake, as revealed in the dream, is understood to refer not only to one isolated instance in the past but is considered typical and sysptomatic of the patient's whole attitude to life. The dream disclosed a difficult situation in which my patient had acted against her 'better judgment' and allowed herself to be fatally influenced and led by the wishes and needs of others instead of pursuing the path which she herself instinctively knew to be the right one. She had submitted passively to the influence of others instead of actively shaping her own life. In other words, she had adopted a typically one-sided feminine attitude.

"It is significant that this same problem was adumbrated in the preceding dream of the horse and rider. ('A quiet lake in a forest. A black horse is grazing in a meadow alongside. After a time, it becomes restless, pricks up its ears and seems to be waiting for its master. It approaches the lake in order to drink. The image reflected in the water, however, is not that of a horse but a horseman, that is to say of a man in the position and action of riding, but without a horse. This figure is that of a handsome man in a purple cloak. The horse enters the water in order to reach the rider, whose image, however, recedes before it. The animal waits irresolutely and then trots away'). This dream revealed the necessity of correcting and supplementing the purely feminine and instinctive side of her nature by conscious control through the intellectual or masculine principle, thus lifting her whole life on to a higher level..... It stands to reason that if an intelligent and gifted woman of forty is entirely sunk in memories of the past and the care of her children, she is seriously neglecting

the duty of developing her own spiritual personality. Her development has been arrested by becoming fixed in a typically feminine and passive attitude to life, and she must learn to compensate for this by adopting a more active 'masculine' attitude. The kangaroo dream recalls to mind her previous mistake as a warning in her present difficulties, where similar influences are still at work threatening to block the outflow of living water..... The first step towards the adoption of a more active and vigorous way of life will naturally be to acknowledge her previously repressed conviction as to what she should have done..... "

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Apart from general discussion of the dream content and Jungian theory this is all the information regarding this case. We may assume, probably, that the therapeutic outcome was successful - we might, for example, hope that the lady would complete her own medical studies if not already finalised or return to her own profession in some form.

In any case, we have, by inference at least, a picture of an intelligent woman who was built up through learning, reinforcement and possibly genetically determined temperament, an habitual pattern of giving way to the wishes and needs of others she likes (reinforced powerfully by a form of partial reinforcement for, in part, this is what she also wants); who, in a more-or-less traumatic <u>forced choice</u> situation is so aroused that the memory-trace of the most novel stimulus in the environment is 'cathected' or reinforced so strongly that it erupts into near-consciousness as a fully-formed dream image. Conflicting loyalty to husband and the most-beloved object undoubtedly produced enough guilt

and conflicting responses to create some amnesia, and this would be reinforced by the real pleasures experienced in and through her marriage v. her desire to follow her own interests and wishes. The therapeutic situation as experienced here is a beautifully constructed learning situation.

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Case 38: Nondirective therapy of insecure, purposeless, married man.
(Snyder, in Watson, 1949, pp.528-578).

This is a typical example of Rogerian-type therapy. The record is verbatim and only the highlights can be reported here.

(a) The client recognises that he has a habit of hiding things, of running away from the results of his own actions under pretence of protecting others, e.g. he does not discuss his troubles with his wife because she will worry.

(b) He decides he must have a real purpose in life and not be pushed around, and embarks on a new behaviour policy.

(c) Presumably he will now develop a new "style of life."

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Essential Aspects;

(a) Cognitive insight into behaviour.

(b) Recognition of weaknesses.

(c) New policy motivated by ego involvement.

(d) Consequent learning with reinforcement.

Note that elation at his own discovery of mechanisms involved motivates positive action. Explanation by the therapist would presumably have been depressing and possibly inimical to positive action.

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Case 39: "Spontaneous remission" through authoritative suggestion, and placebo-type suggestion. (Kenyon, undated).

"Dr A.T.Schofield mentions. . . . the case of a child afflicted with paralysis who was brought up from the country to Paris to the Hotel Dieu. The child, who had heard a great deal of the wonderful metropolis, its magnificent hospitals, its omnipotent doctors, and their wonderful cures, was awe-struck, and so vividly impressed with the idea that such surroundings must have a curative influence, that the day after her arrival she sat up in bed. much better. The good doctor just passed round, but had no time to treat her till the third day, by which time, when he came round, she was out of bed walking about the room, quite restored by the glimpses she had got of the majestic presence."

The indifference of the method employed to bring about the necessary conviction is well illustrated in the following case cited by the same author (p.101). "Sir Humphrey Davy, wishing to experiment with some new preparation on a paralysed patient, put first a thermometer under his tongue. The man, believing this was the new remedy, soon felt so much better that Sir Humphrey told him to come the next day, and in a few days, with the thermometer applied for some minutes each day he was well."

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Case 40: Psychoanalysis of case of obsessional questionning and sexually-related anxiety. (Nunberg, 1955, p.343). (Classification 2, 5, and 7).

The patient suffered from attacks of obsessional questioning which began when he was sixteen years old. On his way home from school he asked himself for the first time when precisely did the Renaissance start and when did it end. He could find no satisfactory answer and became panicky. After much analysis associations brought to the surface a recollection of asking what his sister was carrying to the dustbin. She had been embarrassed and did not answer, so he unwrapped the parcel which contained used sanitary napkins. This had upset him greatly.

The previous year he had seen through a neighbouring apartment window a couple having intercourse and had been concerned as to how the man penetrated the woman with his enormous penis. He had envisaged injury to the woman. He had also wondered, but dared not think about it, whether his father did that to his mother. Further analysis revealed that, as a small boy (1-3 years old) he had heard the noise of his parents' intercourse while he pretended to be asleep.

"His questions about the Renaissance period were probably, therefore, a displacement of his question about the menstruation period and his problems with regard to sex." He had always shied away from all sexual problems and was still so bashful that he would not undress even in the presence of his own wife.

. . . . . .

Here again is a typical example of the need for straightening out a distorted reference frame. It is a quest for insight conducted by analyst and patient, but the aim is to remove conditioned misconceptions on which important attitude biasses have developed. A different cognitive appreciation of events has then led to the conditioning of new affective attitudes.

. . . . . .

Case 41: The psychoanalysis of a homosexual.
(Eidelberg, 1948, pp.5-15)
(Classification 4, 5.)

(This case is presented so fully here as it permits of an excellent opportunity to observe and criticise pure psychoanalysis in action, to consider the learning actually involved and permit of a probably more accurate assessment of the events described.)

When seen the patient was a 21 year old man who consulted Dr Eidelberg regarding his homosexuality. He was extremely depressed, felt unable to attend his college lectures and was overcome with anxiety even on entering the college building. In appearance he was quite masculine. He considered his anxiety as due to his homosexual ideas which had become particularly intense during recent months, and of which he claimed he had attempted to rid himself. His attempts in this and his endeavours to become heterosexual failed.

Although he had never actually had homosexual intercourse, only the thought of a young man's body produced sexual excitation. He masturbated frequently "mostly before a mirror, without any fantasies." "He thought that since he was no longer able to refrain from this frequent masturbation, he would inevitably 'decay'."

(It is interesting to note that this author makes no suggestion of narcissism in his interpretation - nor does he consider anxiety or depression in relation to the fear of "decay").

The patient informed the analyst that he "hated and feared his father". "Out of weakness and fear, the patient reluctantly fulfilled his father's wish and attended the lectures. But he was unable to learn anything, and the very sight of a book aroused great anxiety.... (He) felt the same anxiety before all officials". According to the author's report "material supplied by his dreams showed a clear connection between the father and authorities."

This is a very common "generalisation" as the result of (a) conditioning to authority and (b) the

classification of conceptualisation of authority-figures.

"Upon the discovery the patient's anxiety grew less intense but did not subside completely, and in the course of the treatment reached its original intensity several times."

His relations with his mother were warm, friendly and free from anxiety, even during any quarrel. Indeed he obtained "a certain gratification" from such quarrels. He "could not understand the success of his aggression." Meat was an object of considerable distaste, especially stringy meat. He was "inordinately fond of drinking coffee and milk" . . . habitually ate yoghurt "with his evening meals" . . . "would have liked to suck candy" but always chewed it immediately.

Even more intense than his hatred for his father was his conscious hate for his governess, Erna, who had lived with the family from 1911 to 1918. She was "strict, repressive, unjust, particularly toward the patient" (who could never placate her) . . . . . (Reading between the lines she seems to have favoured a younger brother).

At that time he "suffered from enuresis nocturna". Neither strychnine injections nor 'electrical treatment' (this is not explained) proved efficacious. The enuresis finally disappeared when he was 13.

Dr Eidelberg reports, "On the basis of associations and dreams it was possible to interpret the enuresis as follows: (1) There was sexual gratification behind the conscious aversion and unpleasure; (2) Since the act took place during his sleep, the patient felt only partly responsible. This symptom was therefore a masturbation equivalent: the patient identified himself with his father and had intercourse with his mother."

(Other than the reference-frame he adopts, the author apparently has no justification for this interpretation. Possibly it is correct - it is much more likely to be the result of a combination of anxiety, hate and aggression against the household staff who had to wash the sheets).

Dr Eidelberg immediately continues, "since his hatred of the governess was unchanged by this verbalization, I pointed out to him that perhaps his feeling was not directed against Erna alone, but also against other persons who were in some respect like her." ("Generalisation"!) "Thereupon the patient recalled several clashes with house servants. On one occasion the altercation even came to blows, and the patient was hailed to court for having tried to strangle the girl. He recalled that his hatred often broke out with great intensity on insignificant occasions, and that he could control himself only with great difficulty."

Dr Eidelberg pointed out to the patient that, far from being indifferent to women he violently hated a number of them.

During this period (of treatment) the patient "developed a close friendship with a boy whom he met at a swimming-pool, exchanging kisses and caresses and mutual masturbation." "He was happy, but the orgasm was unsatisfactory."

"Dreams and associations opened access to the Oedipus complex." The patient recalled: "he feared to sleep in the same room with his mother, lest he rape her while asleep. Up to puberty he had found several women attractive and had erection at sight of them.... Once he had observed a naked woman from the window of his home, but became extremely frightened upon noticing his father was close by.... although he knew that his father would be pleased at his having relations with women, the idea filled him with violent fear of the father." "Some minor wounds on his fingers and his interest in all scissors (he sometimes unconsciously stole them from friends) led to associations the interpretations of which made the patient conscious of his castration complex." His "first puberal masturbation" was somewhat accidental - he "was standing before his mirror, dressed in only a swimming suit, and was trying to make his genitals disappear from view, as a result of repeated pressure he ejaculated; he was frightened, thinking that the sperm came from the spinal cord. His fear was so great that he refrained from masturbation for two years following."

For the most part interpretation was left to the patient. "Gradually, the following facts were made clear. (1) He loved his mother and wished to possess her, but renounced this wish for fear of being

castrated by his father. (2) Other women were associated with his mother; they were mother images and therefore forbidden. (3) With regard to the actual mother, the prohibition was made stronger by fear of the father. (4) Homosexuality protected him from anxiety in the presence of other women, and since these women did not appear to him attractive, anxiety about repressing his urge was superfluous."

Dr Eidelberg writes, "I pointed out to the patient that there was no longer any reason for this protection against anxiety - that such a protection would be justified only if every woman were really his mother, because only then would there be danger of punishment by the father in all instances. I explained to him that in his childhood his solution of the problem was justified, for then his mother was really his love object."

The patient said he "often behaved like a baby and felt himself to be one, and demanded that his mother take special care of him." This behaviour was even more exaggerated in his homosexual relationship where he could not deny himself the satisfaction of receiving and accepting gifts.

Dr Eidelberg "pointed out that the gratification of the castration wish through identification with his castrated mother, who had no penis, would free him from his castration anxiety; then he would renounce his genitals and thereby his love for his mother, and would no longer be a burdensome rival of his father; thus he might achieve reconciliation with the stern parent."

Enough has now been reproduced of the report of the ongoing analysis to demonstrate the way in which psychoanalysis works and the general orientation of both the analyst and analysand in such a situation. The analysis produced the following additional important historical (and learning) material:

"He had been told that in the third month of his life he was put in charge of a wet nurse, because his mother did not have enough milk, and in her doctor's opinion his health had been affected by this. His two

brothers also had wet nurses." He "recalls clearly that he had envied his brothers, and once he had looked at the nurse so greedily that the nurse had splattered him with her milk." Later he had occasion to travel some distance to get milk for his brother. Twice he accidentally dropped the bottle and "reacted with violent guilt feelings."

Deriving from this memory "the patient became aware that there was a connection between his greediness for food - even more for drink - and his early oral frustration. He admitted that his behaviour was often reminiscent of that of an insatiable suckling. Thus his hatred for women was connected with this first disappointment. "

The actual material is not reproduced in the report, but Dr Eidelberg claims that "on the basis of his associations it was impossible to prove that his aversion to meat, and the fact that he would not order it in a restaurant because it was 'too expensive', arose from "the loss of his mother's breast after the appearance of his first teeth. It was as though he wished to say: So long as I renounce meat, and therefore biting, I am allowed to remain unmolested at my mother's breast."

(I assume he means the surrogate-mother's, or wet-nurse's breast). The alternative Freudian explanation that the patient was "mean" because of fixation at the anal level is not adduced despite the anal associations also recovered. Nor, of course, was there any consideration of early experiences with meat as soup nor with weaning on to "solids." An alternative could have been, "I would not eat the 'meat' or solids I was given, therefore I was permitted to remain on milk, or at the breast."

There are certain discrepancies in the analyst's record, as I have shown, It is almost certain that his "set"

will also have influenced his particular interpretation - or his acceptance/approval of the analysand's attempt at interpretation. It is possible the interpretation given is accurate - it is, I suggest, more probable that the explanation given, as are many analytical explanations, is an approximate or one (among several) probable explanation which it is possible for the analysand to accept and to conceptualise or interpret his behaviour patterns accordingly.

To return, however, to the case at issue:

> The patient recalled three other important compleses: (a) at least when he was four, and again when he was seven, he had positive feelings toward his father (the recovery of these memories led him to admit to a "timid feeling" of love for him hidden by his hatred); and he thought his father was "old, unattractive and had pronounced Jewish traits"; (b) deriving from consideration of his emotional rejection of "Jewishness", he remembered unpleasant experiences in connection with circumcision (in his second year he had been circumcised for a second time; at his father's behest at nine he observed the circumcision of his youngest brother, of whom he was extremely fond (N.B. he had "loved and protected" the middle brother until the youngest was born, when he changed his attachment). (c) He had at one time believed in anal birth, due apparently to lack of knowledge of the existence of the vagina. "For a long period he had difficulty in his bowel movements, had often been constipated, and suffered from flatulence. To safeguard himself he had wedged paper plugs in his anus."

The analyst's comments are enlightening: "The foregoing material was used to supplement the interpretation .... of his homosexuality (1) When the rectum becomes an erogenous zone, the conclusions of castration anxiety are drawn: the patient has renounced his penis, but is ready to receive his father's penis in his anus."

(Possibly there are particular cases where this explanation is reasonably accurate. But, in general, the explanation is much more likely to be along the following lines: the anus is an erogenous zone from the manipulation of which the individual is conditioned to affect-gain; expulsion may normally prove more pleasurable; but accidental/deliberate tightening of the muscles concerned may prove equally or more pleasurable; an experimental finger, straw, etc. inserted upwards likewise. If one has become conditioned to the association of pleasure with the anus the logical sexual partner is a male; though any article regarded as suitable may be used - there is not the remotest reason why it should be necessary to postulate a specific desire for penis-homosexual relations apart from prolonged association (and perceptual conditioning) on the part of the hypothesiser).

It is interesting to follow the report:

"The patient realized this (see (1) above, but insisted that he had not renounced his penis, because in his homosexual relationship it was penis masturbation, not coitus per anum, that played the main part....."

After discussion on his "castration complex" and a verbalisation of his hatred for women (he "wished to cut their stomachs open . . .tear off their breasts") analyst and patient "discovered the additional reasons for his homosexuality: (2) anxiety that he might commit aggression during intercourse with women, hence (3) fear of reprisals. (4) Further, homosexuality implied the gratification of the aggressive feeling, 'I don't need women'."

Later in the analysis, following consideration of the "oral" behaviour referred to above, it allegedly became possible to "give a more complete explanation of the patient's enuresis nocturna. As a result of his oral frustration, his hatred for his mother, and his identification with her, his penis became a substitute for the breast; what had previously been passively received was now actively given. The mutual masturbation in his homosexual relationship, the sucking of nipples and penis, signified playing of the game of mother and child. The patient represented the phallic mother, was active in relation to the friend who sucked his penis; sometimes his friend played the role of the phallic mother."

(I fail to see the logic of the "explanation" of the enuresis nocturna. If the writer had been endeavouring to explain nocturnal emissions within the reference-frame used there might be some justification. As it is the only justification would be the postulation that the mother's milk was sour, watery; stemming from his frustration and concomitant aggression the patient was returning the water via his penis. I think when we consider such hypothesis we should bear in mind that the child is most unlikely to think in such terms - this is the later association or hypothesis of the adult. In an earlier case(No. it was shown that when the patient was "regressed" under hypnosis to a certain age-level he could only reproduce his reactions, and was unable to explain because of lack of language; when he was "returned" to his actual age he was able to describe what had happened.

Certainly, however, in terms of learning theory it is possible to accept the explanation that in his homosexual relations the patient was either repeating his

own earlier learned behaviour of nipple-sucking and drinking from a nipple or bottle-teat (much more like a penis incidentially, although I have never seen such a suggestion from our analytical friends); or imitating the observed(and intensely desired-to-be-imitated) behaviour of his brothers. I should like to suggest that whatever is observed or experienced with great interest or affect (which includes "wishing-for" behaviour) is later acted-out or "ejected" in some form; it is the only possible way in which final inhibition can occur. The greater the amount of affect or identification involved; the greater the reinforcement and the more times the behaviour will be repeated and the more difficult it is of inhibition or extinction; obviously!)

Dr Eidelberg comments: (p.11): "His masturbation was interpreted as a repetition of his first pleasure experience at his mother's breast; he renounced his mother and a part of his own body took her place. The mouth or hand embodied the libido with passive instinctual goals, the penis that with active goals. The unpleasure produced by the weaning trauma, the repeated circumcision, and the castration was supposed to be lowered by the repetition compulsion. Thus the masturbation signified castration, which was no longer passively received, but actively performed by the patient on his own body.... "

(If the patient were, in fact, re-playing the circumcision scene, which would require translation by a particularly vivid imagination into these terms, we could, of course, suggest that the "sin" which he was committing of his homosexuality was reinforcing his guilt and anxiety

so that he was continually in fear of castration and would continue to repeat and play out the scene.)

It is interesting to note that the patient "was distinguished by great self-confidence, which he associated with his homosexuality," which he said was "interesting". "For a time he was inclined to believe that homosexuality was an attribute of genius and feared that his talents would be impaired by the analysis." "This exaggerated self-confidence contrasted with his feelings of inferiority . . . in his daydreams he saw himself as a celebrated artist, a beautiful dancer who was loved and admired by everyone. In a comparison with this idealized image, his actual appearance seemed ugly to him." Yet later it is reported, "Because masturbation with the fantasy of a beautiful boy's body, or the contemplation of his own image in the mirror, sufficed for his gratification, he was freed from striving for external success in the search for objects.... "

(Obviously it is possible to suggest further hypotheses in Freudian or in Adlerian terms, as well as in Behaviouristic terms. Again there are inherent contradictions in the report itself, e.g. did he "contemplate his own image" or an idealized version of it or yet some other unverbalised association?)

During the analysis the patient advised that during his 13th and 14th years he had actually fantasised great wealth and power. He "saw himself as an efficient banker operating successful enterprises." He had "renounced this power fantasy because of its relation to money." During the course of analysis, "after his passive anal attitudes had been discussed, he began to earn money (something of which he had been incapable before) and had daydreams in which the wish for power and money came to the fore."

(We must accept, I think, that not only has extinction occurred as the result of abreaction in interaction with an increase in self-esteem and a difference in significant-other-relations; but that the analysis has brought this healthy result. It is a result not likely to have occurred by "spontaneous remission").

It should be noted, however, that, if my reading of the report is correct (and I am not discussing it in terms of the sequence of the report) the homosexual relation had been renounced somewhat earlier in the analysis. Any sense of guilt in this connection therefore would have been ameliorated, and the next prepotent anxiety-factor (i.e. a desire or need for wealth or income) could come to the fore.)

The patient did not have an easy time, though. The first time he actually visited a prostitute he was impotent. "He reacted with an outbreak of fury (though not vented at the prostitute) and a wish to give up his treatment." After calming down and discussing the situation fully however, he "displayed shame and vexation over his incapacity." In the following weeks he surprised himself by having "a vigorous erection while exchanging carresses with a woman friend. As he began to have real sexual successes, he discovered that quantitatively they fell below the fantasied ones, but that qualitatively they contained a new element that made them more pleasurable."

(It would seem very likely that that "new element" was associated with positive affect for the female/s(?) concerned.)

Dr Eidelberg goes on to comment: ". . . He was able to have homosexual relationships only on condition

that the father-son relation was eliminated. The object that he sought was supposed to represent the phallic mother, or himself as a child. His friend answered this requirement; but women who recalled the father or the castrated mother were unsuitable. The contact of his active striving was the activity of the suckling mother; in his passive role he was the nursing child."

(I have discussed this in somewhat different terminology above.)

"During the analysis of the oral phase I discovered a number of reactions that arose as a consequence of the weaning of the patient. In an essay written in collaboration with Bergler (Der Mammakonplex des Mannes, Intern, Zeitschift f.Psychoanalyse, vol.19, no. 4, 1933) the sum of these reactions is designated as the mammary complex."

Eidelberg and his co-author have developed a pretty theory of the type which makes most Behaviourists' hair stand on end. Nonetheless if we strip the theory of its wordiness and terminology and ourselves of our own emotional reactions, what can we find? A rationale based on learning and on learning alone:

The child suffering from frustration arising from the change from the familiar breast to some new feeding system looks for some other stimulus similar in some familiar way to the breast and from which it can gain the same affective satisfaction. The only object within the environment which can fulfil these criteria apparently

is the penis. The penis, however, cannot normally be reached by the mouth (which ought perhaps to cause the child to try drinking urine); the child therefore imitates the beloved and desired breast-mother (if the child were two or three at the time of weaning one might accept this far-fetched hypothesis more readily) but continues to wish for the breast/penis himself, obtaining it only in the homosexual relationship.

One must admit that, this particular theory can stand up, but only if an apparently "normal" 6 - 9 months' old baby is capable of confusing breast and penis and equating the affective satisfaction gained from intake and output from the two, or feeding and masturbation. There would surely require to be an extraordinary level of arousal, or high drive directed at the "milk-situation" - though, again it must be admitted this would be possible in the particular case under discussion; it will be recalled that the child was apparently not receiving adequate milk from the real-mother, following which, however, it gained satisfaction (apparently) from the wet-nurse, and it is possible that weaning from the wet-nurse occurred when the first teeth appeared (or had his teeth appeared at three months when he was weaned from his real mother?). Either the level of arousal was so high that the baby could not differentiate between similar stimuli or similar affective states, or conditioning to similars ("generalisation") is/was inordinately high at this age/in this particular case.

Such passages as ".....Part of this aggression, together with a corresponding component of the libido, was used for identification with the mother, which was ambivalent from the outset. Another part was transferred to the penis, a third remained with the mother, and a fourth cathected the anal zone by way of the oral incorporation of the breast . . . the breast at this stage was cathected with a mixture of two instincts, eros and thanatos. . . . . Instead of passively receiving his mother's milk, the child, psychically possessing himself of the penis, now actively gives urine. (Originally milk is identified with urine). For that reason, later incontinence often sympolizes the eternal flow of maternal milk transferred to the child's own body; it is a magic invocation, so to speak the child's gesture intended to demonstrate his wish. . . ."

have that queer mixture of sense and nonsense so peculiar to much psychoanalytic writing. One need not look at the psychopathology of the authors, only to credit them with an imaginative attempt to explain something they do not understand in the only language they believe they do comprehend.

Assuming (with considerable reason) that the infant did react with both pleasure and displeasure to the breast which was warm and soft and did give some, but insufficient, food, it seems somewhat strange that there was apparently no carry-over of the hate for the mother herself in adulthood, and scant attention to the "hate" which mother must have received in childhood (two incidents not quoted in my report should be expected to have this result, see p.8 of original report). The degree of hate experienced for the governess apparently overshadowed all else, but temporally could only have reinforced the pre-existing hatred for mother. Obviously it was permitted to hate one's governess, but not one's mother.

What this case does do, however, is clarify the mechanics of many of the perversions, i.e. the conditioning of affective satisfaction gained from some sensual pleasure to a particular erogenous zone reinforced by, and in interaction with, fear/anxiety conditioned to some other sensual pleasure or erogeneous zone. e.g. the passive homosexual may receive pleasure from manipulation of the anus and suffer from castration-anxiety so great he may fear to use his own penis for other than domestic urinary purposes.

Treatment has consisted of (a) the gaining of "insight" - i.e. enabling, by self-and other-interpretation of behaviour in the light of remembered experience (gained via free association) the patient to formulate an adequate "rational" explanation of his behaviour acceptable to himself and his analyst; (b) "abreaction" i.e. complete or near-complete recall of emotionally-laden experiences and the verbalisation of con/sub-sequent felt states/ attitudes thereto in a "warm, safe and secure environment/ relationship"; which, in fact, permits of a certain measure of "reciprocal inhibition"; (c) the development of "normal" behavioural patterns strongly approved and therefore strongly reinforced by therapist, parents and his own super-ego as well as society in general.

Case 42: Conditioning and Anxiety and "Spontantous Remission."
(Jenkins, 1954, pp.37-41).
(Classification 5 and 6b).

This is not a case in the ordinary sense at all. The report relates to a 38 year old woman who heard a talk on mental health and was stimulated to write to the speaker. She suffered from excessive anxiety. Her mother had evidently also been very anxious and prefaced every remark with, "I'm afraid." ("I'm afraid for you to go for fear you will have an accident"). Her brothers scorned such timidity but she was a sensitive soul who developed numerous worries about her health and other things. Her marriage to her high-school teacher was partly an escape from intolerable maternal solicitude and partly a seeking of security but her role of wife among much older people was not easy and the new leisure gave her ample time to savour her worries and develop hypochondria. Pregnancy and caring for her children provided relief but at 38 she was suffering from grave digestive troubles with vasomotor complications and numerous allergies. Her husband was now principal of a high school and she felt obligated to help him in numerous social activities but found herself suffering from incapacitating inferiority complex in relating to people.

The author was unable to meet this unfortunate woman but did write to her in some detail and two years later sent a follow-up letter of inquiry which revealed that she was now in much better health. They had moved to a new town where she no longer had to feel the inferior schoolgirl among her elders and the superior teachers wife among her own age-group, and in addition she had started writing. This latter she found "acted as a sort of purge for me" and success with her writing built up her confidence.

Four years later she wrote that she appeared much more adult, "not completely emancipated from this rotten, inherited nervous system of mine, and my sensitive petals still shiver in the wind at times, but I am learning to brace myself and that is important. I do have my periods of dejection and despair, but then all my friends seem to be in the same boat with me, and I shrug them off as menopausal bogies." Jenkins comments that "no small fraction of our literature consists of books about psychopaths, written by neurotics"!

One might well regard this as a case of spontaneous remission and as such it is interesting to note how specific factors contributed to the cure. It is possible that many so-called spontaneous cures are due to influences introduced by other than a therapist.

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Case 43: Schizophrenia mitigated by "Direct Analysis" (role-playing by therapist). (Rosen, 1953, pp.38-40). (Classification 6c, 10a).

The patient, diagnosed a schizophrenic, catatonic type, was a 22 year old man who four months before had been discharged from the army for a neuropsychiatric illness. He complained that his mind was separating from his body. Two weeks later he became so excited that he had to be placed in restraint. He talked continually, mostly about sex matters and appeared to hallucinate. At one stage he said: "This is a wonderful airplane. It's over the Atlantic ocean. I can see her down there. My mother. She's floating. Here I go. A dive bomb. I have her centred. Here I go. Here I go." After this he screamed in terror and implored his father not to cut off his genitals. The therapist acted the role of father and assured him that there would be no punishment although he had seen what happened. The patient became much calmer after this. He was removed from restraint and fed by the therapist. During the next four days he was free from excitement and partially in contact with his environment. During the periods the therapist dropped the role of father. One day he announced he was going to kill the therapist. When asked why he would kill someonewho loved him he began to cry - said he threatened so, only to make sure the physician loved him. Five weeks later he was paroled and told to report once a week. He complained several times a day that his father was constantly threatening him and was found board elsewhere. He was working continuously after this. Subsequent adjustment adequate.

It is somewhat difficult to evaluate this case. The patient's later complaint suggests that there was continued friction with the father and his fantasy suggests an oedipal conflict but one suspects it was not quite so simple as this. The chief point of interest, however, is the significance of the role-playing involved here. Did this, during the patient's break from reality function, modify deep-level attitudes? If so conditioning of the affective drive must have occurred as well as inhibition of anxiety and generalisation therefrom.

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Case 44: Manic reaction; analysis and somatotherapy. (Masserman, 1961, pp.66-7) (Classification 6b and 7).

A wealthy business executive of 48 years developed manic behaviour requiring hospitalization. One day when being gently chided for some irresponsible act he suddenly covered his face with his hands, began sobbing and said, "For Pete's sake, doc, let me be. Can't you see that I've just got to act happy". The manic mood returned in a few moments but under sodium amytal his defensive euphoria again disappeared and he burst into tears. He then confided that during the preceding year he had suspected his young wife of being unfaithful and had accused her of this. Her reply had been an offer of divorce. This was a tremendous blow to his pride and in a frantic attempt to avoid scandal and to keep her as long as possible he had sent her on an extended tour of Europe. Behind this was another threat. He felt that his business position was threatened by younger, more energetic and better trained men and he had reacted by being ultra-progressive. His marriage had been partly motivated by this fight against obsolescence. Now, instead of supporting him it had

backfired and emphasised the very weaknesses which he feared. He prized his wife as a symbol of his renewed youth.

Sedation, physiotherapy and "working through" of his emotional difficulties prepared him for the necessary adjustments in his business, marital and social affairs and his tension abated.

This is another example of therapy which involves changing the cognitive reference system. Arising out of this there is a modification of ego-structure. Ego-aspiration becomes more realistic and the patient is able to face up to the future without panic.

. . . . .

Case 45: Psychoanalysis of a Compulsive Alcoholic and Homosexual.
(de Forest, 1954, pp.95.102).
(Classification 3b, 5).

The patient was a young man suffering from homosexual and alcoholic compulsions and from a deep sense of the worthlessness of life. His youth had held no experience of loving security. Born into a luxurious and spendthrift family, he had known only the care of nurses and tutors.

"He had been enchanted but neglected by his mother. He could remember the despair of watching her leave the house in company with men other than his father; and with this desertion, a sudden hatred and wish that she were dead. In his early adolescence came the shame of his parents' divorce, the baffling visits to his highly emotional and hypercritical mother, and the custodianship of his father, full of anger and blame toward the wife. For his father he seems at that time to have felt some tender affection and loyalty. This was soon abused by a brutal sexual attack, which occurred suddenly, and was repeated over a period of four years.

The result was an almost insane confusion of mind and feelings. His heart was torn between his former affection for his father, his physical and emotional dependence on him, and a new-found terror of him and shame for himself.

"He could turn to no one for help in this crisis. As a result he continued the motions of the necessary acts of living and buried the frightening distraction beneath his consciousness. Photographs of him at this age look like those of a feeble-minded child, nor could he afford to develop his thinking powers of his understanding.

"Although circumstances later separated him from his father, his course of self-destruction continued, manifesting itself in unsuccessful attempts to be self-supporting, in unhappy love affairs with older men, and in a generally dissolute life . . . . His whole energy was devoted to protecting the secret of the disgraceful treatment by his father. He could therefore be very frank about his contemporary homosexuality and alcoholism.

Fortunately, but somewhat surprisingly, he sought help, and went to Mrs de Forest for psychoanalysis. The entire period was a "battle of need, frustration, distrust, fear of cruel treatment and anger", which constantly repeated itself. First he learned that the bouts of drinking or making of homosexual attachments were "suicidal, despairing and indirect attempts to put the only life he knew behind him; and that they represented the wish of his adolescent years to leave his father, to die if need be. They also, by self-punishment, cancelled his shame and guilt, and effectively put the blame upon his parents, with the wish to punish them severely."

A considerable time later he "recognised (a) wish to determine his own fate" and came to believe that this was possible. This was followed by his changing mode of life. "He found work that held good future possibilities, lived alone for the first time, began to lose his fear of women, and made new friends of both sexes."

This was however, followed by a fear that the analyst, like his father, would bring about the downfall of his new life. Having finally assured himself that

these fears were groundless, he moved on to recognise that, "had it not been for his mother's negligence and desertion, the shameful abuse at the hands of his father would never have occurred." He then sought to force the analyst to "take care of him by every wile at his command," and became very angry when he failed.

At this stage Mrs de Forest went away on a short holiday. He acted out his feelings of aggression and "seized the opportunity to revenge himself on (her) by "contriving to submit to an almost exact repetition of his father's abuse." This was followed by intense shame, and an outbreak of hives. He became somewhat confused. "But accompanying it was an ultimate determination to take care of himself and an awareness that to do so he must 'be himself' - that he could not afford to be otherwise, and that he no longer needed my maternal care, but instead preferred my affectionate trust and belief in him..... "

He began to evaluate her "character on a realistic basis"; followed this up with a "great sadness and lonliness." He finally acknowledged that "he, as well as his parents, had been responsible for his wasted talents and years. This was followed by shame, and renewed aggression against the analyst.

"The last months of this patient's treatment were given over to his defiant refusal to sense his 'loathesomeness' and his shame in his everyday life; to the final admission that his refusal kept him bound to his shameful past; to the gradual humbling and opening of himself to the entrance into consciousness of these deeply repressed sensations of mean enslavement; and to the awareness that he could now start from rock bottom to build an integrated and self-satisfying life" which he evidently did.

. . .

Here we see a conditioning to homosexual behaviour based first on his mother's rejection of himself and his shame and hate at her own promiscuous behaviour, and reinforced to a nice degree by his father's homosexual attack upon him and their prolonged relations;

reinforced doubtless by a subsequent feeling of guilt and loss of self-esteem which demanded that he continue to seek other-relations in this form. His alcoholism, primarily an escape from awareness of his feelings, if not his thoughts, would be reinforced as the result of the satisfaction gained by such an escape, no matter how brief it might be.

The course of the analysis is shown quite clearly, and we see a pattern of realisably free communication with a significant-other, a gradual learning of the problems he had been, and was, confronting in reality as well as a learning of his own patterns of behaviour and an acknowledgment of what was "truth"; the conditioning of new behaviour patterns, first in regard to his interpersonal relations, and then in regard to his environment and own activities. There is a constant circular pattern of tension-reduction followed by an increase in positive affect, followed by tension-increase as self-knowledge leads to further shame/guilt and aggression, until finally self-knowledge (or "insight") leads not only to tension-reduction but to positive action and drive-increment. The final outcome in operant conditioning of the more satisfactory behaviour patterns leading, probably to a modified self-ideal.

Case 46: Hebephrenic-Catonic and Puritanical Parental Judgments.
(Sechehaye, 1956, pp.111-112).
(Classification 3(b),,5, 6c and 10).

"A young girl . . . had just gone through a hebephrenic-catatonic episode during which she seemed obedient to a single imaginative fantasy. Practical jokes, tricks, droll notions, puns and somersaults comprised her activities, making her life a perpetual game and an endless agitation. She belonged to a family of narrow and formal religious convictions requiring her to repress all thoughts of independence. Her conduct, her behaviour, her very thoughts were controlled, commented on, judged in slightest detail. The break-through of the psychosis was for her the inevitable climax of a long stifling period, and its essential function was to free her ego from the family grip, to let it live without constraint and, above all, to protect it against external interference. Nor would she obey the doctors and nurses, paying attention only to a succession of fantasies. Because of her agitation and marked impulsivity, she had been placed in a ward with patients of an inferior type whose promiscuity she found extremely painful. I saw her occasionally in a beautiful room in the first-class pavilion. At such times she behaved very well. On first entering this room she had exclaimed, 'Oh, I should love to be alone in a beautiful room like this." And I answered, "Why couldn't you have it?" She responded vehemently, "Because one must pay and pay dearly for freedom. I pay for it in the agitated ward, playing the marionette. If I should go into a private room, I should have to leave the marionette's life and my freedom with it; they are only waiting to get me again. I must choose and I have chosen." And getting up abruptly from her chair, with a strident shriek of laughter and a clown-like caper, she seized a flower vase and hurled it against the door. Two nurses led her away to the manic ward: she had chosen and paid!

" . . . One day when the physician had prescribed narcosis . . . the patient cried out, 'Oh yes, I should like that; I am so tired playing the marionette." 'Then why do you?, the physician asked. 'They make me. If I am quiet, they will take me and I shall be guilty again.'"

Mme Sechehaye comments, "For this girl the principle frustration was presumably a nearly total privation of freedom. Her hebephrenic behaviour compensated for the desire in a playful psychomotor form and in activity as intense as it was futile. In fact, she had returned to the lower level of personality development at which the small child is obedient only to transient impulses and not yet to social discipline, whence derive the intermittent deterioration and disorder of the patient. It might be said that she was acknowledging only the pleasure principle, satisfying her instinctive drives freely and without inhibition, (but by the statement last quoted above) she means her family would take her back if she were quiet, and she would again experience that terrible sense of generalized guilt imposed by her family's moral narrowness. To escape the authoritarian domination of her family, she felt forced to play the marionette, to be agitated and unstable; to enjoy a little freedom, she had to continue to live on the purely autistic plane . . . . Of course, beneath this insistence on liberty were hidden other affects: sorrow over being unloved by her mother, an inhibited, authoritarian and castrating woman, and formidable aggression directed against the whole family."

. . . .

I have quoted Mme Sechehaye's comments practically in full to show how nearly we speak the same language.

We have here a picture of familial-conditioned guilt and super-ego (conscience) structure so strong that the patient cannot escape from her family into another normal social environment; and a healthy drive for full living so strong it drives her to escape in some form or other. Doubtless her aggressive feelings toward her family receive some reward or satisfaction from the shame

such a family would doubtless feel from having a psychotic member. Her so called "hebephrenic behaviour" is surely a combined acting-out of her desire for pleasureable activity within the framework of those particular activities to which she had already conditioned pleasurable affect in the earlier stages of her life, and, to paraphrase a common maxim, "Madness is not worth while unless it's well carried out."

There is no report of the actual therapy or results, though the former was possibly carried out utilising Mme. Sechehaye's technique of "symbolic realization" (i.e. the production and manipulation of the actual symbols expressed by the patient - e.g. "on one occasion another patient was fed a piece of apply, apples being her symbol for the mother's breast," pp.18-19), and undoubtedly any healthy result would demand the patient being desensitized to her guilt and taught to express her own individuality and live away from her family.

. . . . .

Case 47: Obsessive-compulsive neurosis and homosexuality; psychoanalysis. (Grotjahn, 1960, pp.195-208) (Classification 3(b), 4 and 5).

A thirty-year old married schoolteacher sought treatment because of obsessive-compulsive thoughts and fears. She was afraid she might drown herself, stab her mother, strike someone, run out nude or "go crazy". She complained of frigidity. Her mother had indulged her. Father was a puritan and she had accepted his moral concepts. He died during her second year in college. Mother had turned to her for consolation but eighteen months later remarried to a man even more passive than the girl's father. She left home and entered into a homosexual relationship, supporting her girl friend. Soon she returned home again.

She had two older sibs (boy and girl) and a younger male sib. The birth of her younger brother activated strong feelings of rivalry and envy. She pretended she had a penis while masturbating. She also developed reaction-formation and played mother to her brother for many years to conceal her deeper resentment towards him.

All the evidence seems to indicate a strong attachment to and dependence on the mother with resentment against the younger brother and her father, (upon whom her mother had "waited hand and foot", giving him the best of everything.) The homosexual attachment probably arose from this. Her marriage was an attempt to escape from her homosexual wishes, frustration on her mother's remarriage and her unpleasant family life. After the marriage she persuaded her husband to give up his job and eventually to assume responsibility for cooking and housekeeping.

She had sought therapy three weeks before marriage but no progress was made during a year's treatment. (She came once a week for individual sessions and once a week for group sessions for four years in all.) The husband was then brought into the group sessions. The wife confessed to guilt about not having an orgasm. The husband assumed blame because of lack of staying power, but later revealed that he had been fully potent with his first wife, whereupon his wife disclosed that she had no interest in sex with her husband. She also felt guilty

because her husband compared her with his first wife who was an affectionate, companionable person. The husband then expressed his unhappiness in the marriage; his wife was unaffectionate, uncommunicative, a disorderly housekeeper, lazy and irresponsible. This profoundly affected the wife who went away to cry.

. . . . .

We may note the learning involved in the spoiling by the mother and the early envy of the males of the family; the conditioning by her puritanical and passive father, leading to guilt about sex and also frigidity (and perhaps being a factor in the development of the homosexuality - which was also probably related to conditioned dependence, but an equally conditioned need to be dominant.

Psychotherapy here demonstrates that certainly only a measure of insight is not enough for a cure. Presumably disapproval expressed in front of the group constituted the punishment or degree of emphasis required to make the wife comprehend the results of her behaviour. Group discussion and reinforcement of socially approved behaviour patterns, and the information gained from any exploration of her disinterest in sexual relations resulting in changed, cognitive reference-frames and behaviour, should have been the outcome of the therapeutic process, but no further specific mention of therapy is made in the report.

Case 48: Schizophrenia and Character Analysis.
(Reich, 1950, pp.398-508)
(Classification 6, 10(a)).

This is an extensive account of the treatment of a schizophrenic. It is difficult to draw conclusions from this account since the patient developed more acute psychotic symptoms during treatment and then, unfortunately (allegedly through misunderstanding) was suddenly whisked into a mental institution at a stage when some improvement was taking place. Although eventually the patient recovered she had spent far more time in the mental hospital than under treatment by Dr Reich and we have no first-hand account of what happened to her there.

Reich's orgone theory on which he based this treatment has no known scientific basis in fact. It postulates that there is a form of energy "discovered" in 1939 which becomes blocked in various ways and so produces various psychotic and neurotic symptoms. The schizophrenic is afraid to accept the "orgonotic streaming" and solves the problem by a schizophrenic split which primarily affects the perception process. The patient here spoke of personified "forces" beyond her control who at times dictated behaviour to her, such as the cutting of a cross on her breast or an attempt to drown her brother (this obviously destined to failure).

This is not the place to attempt a solution of the vexed problem as to the nature of schizophrenia or the reality of orgone energy but we can note some of the ways in which learning is evident in this specific case. In the first place it is quite obvious that numerous environmental

influences have contributed to the development of a maladjusted ego-structure. It is regrettable the case study does not make any attempt to clarify these. The one thing which cannot be overlooked is the development at some stage of a highly negative attitude to sexual expression. To her almost anything is preferable to defiling herself and she frankly resists the seeming progress of her cure because it threatens her with facing this sexual conflict. During her major catatonic episode she assumes the pose of Isis who, according to Everyman's Encyclopedia (vol.7, p.186) "became the type of a dutiful wife and mother" and who may therefore have represented for the patient an acceptable feminine role without the taint of carnal sin. At another stage she developed dysfunction of the right hand in a way which seemed to indicate deep masturbation guilt.

Without having to subscribe to the validity of the orgone theory, it can be seen that it could offer to the patient an acceptable (pseudo) "scientific" explanation of her behaviour and lead ultimately to a more rational attitude. The fact that the therapist's "explanations" produce curative results is not necessarily a proof of their validity. In this case there is no certainty that they played any permanent part in the curative process. Orgone therapy was terminated after three months and was followed by a year in a mental

hospital. Final recovery may have been due largely to treatment (if any) there or have been just an example of spontaneous remission.

A very important aspect of the case is the fact that the therapist had established excellent rapport with the patient during the three months of treatment. He had shown great faith in her and kept her out of hospital despite episodes which would have led most doctors to immediate committal and this could have provided her with very important social support. During her sojourn in hospital she wrote frequently to him and we may presume he replied. No details of his participation are given but the patient refers in one letter to his promise to her brother that he (the therapist) would write. Even if no therapy were given in the mental institution itself the support of a doctor in whom the patient had great faith might have done much to sustain her.

Finally we may speculate that the fact of confinement may have acted as an antidote to her exaggerated moral aspirations and have motivated an attempt to establish a more tolerable super-ego system. There is not enough evidence to judge. Our final conclusion can only be that it would be possible to account for the behaviour actually described without going beyond learning principles. This is not to imply that all schizophrenia is to be explained in terms of learning theory.

Case 49: Tic and learning inhibition in small boy, play therapy.
(Alexander & French, 1948, pp.463-9).
(Classification 2, 4, 5, 7).

A $7\frac{1}{2}$ year boy suffered from a learning inhibition. He could write letters and numbers but not use them in meaningful combinations. He had also had an eye tic for three years. He was conforming at home and over-solicitously affectionate with his four year sister (who was father's preferred child). He had a fear of dogs and the dark and suffered from frequent nightmares. Mother was tense, active and perfectionistic. Father was a successful professional man but often irritable at home especially when he suffered from pain of leg amputated in his youth.

At $1\frac{1}{2}$ mother was hospitalized with pneumonia and the boy was cared for by a strange nurse of whom he was afraid. During this time a large dog jumped into his play pen and pawed and licked him while he screamed with terror. This initiated night terrors and fear of dogs. He was also aggressive and hostile to mother's direction when she came home. Mother controlled by spanking and by praising him when he was gentle and quiet.

At four there was a second trauma. He saw his father's amputated leg for the first time when, after a terrifying dream, he dashed into his parents' room. Father was embarrassed and exploded in a temper. The next day the tic was noticed whenever father was present. At $4\frac{1}{2}$ he was scolded by the mother of a neighbour child who had caught him looking at her little girl's genitals.

Play therapy revealed his concern about father's mutilation and the reaction of this on castration fears. He admitted to trying to look at girls in the bathroom to see their penises and was given pictorial instruction about male and female genitalia. He admitted his fears of paternal jealousy and worries about castration and later his fears of mother. His tic (protection against seeing father's disability and incurring his anger) now disappeared. Solicitude for sister gave way to teasing and later to neglect. His fear of dogs decreased and finally he welcomed the therapist's dog as a pet and intimated that someday he would have one too.

The production and conditioning of fear is obvious enough in the development of the boy's symptoms. Therapy consisted in providing knowledge which would undermine the basic castration fear and verbal revival of the situations which had become cathected by this fear. This amounted to causing extinction by lack of reinforcement. Throughout there was support by the therapist which provided counter-conditioning.

. . . . .

Case 50: Depressive reaction in divorcee and psychotherapy.
(Karush in Stein, 1961, pp.319-337).
(Classification 6b, 5).

This is a case of "depressive reaction." Mrs M. an attractive 38 year old married woman, with no children, was actually sent to Dr Karush by her husband, on the advice of his own analyst. The husband, an attorney, intended to seek a divorce and wanted Dr Karush to "help her over the shock." The wife, an interior decorator, initially tried to joke about the irony of the situation, but "the facade quickly broke down, at least in part, and (Karush) could see a bitterly wounded and outraged woman whose brittle defence by denial of the truth about her marriage had suddenly been shattered." She was fearful and despairing of the future, "but an even more important factor in her depression was the intense rage at her husband and the scheme at having her failure in marriage exposed to the world."

During the first three interviews she spent the time mainly railing against her husband ("she had supported him, without her he was nothing, etc.") occasionally weeping, then trying to be cynical.

"Mrs M. had always been strong, self-reliant, and independent. She was competent in her work, was well liked, and apparently made friends easily. Her childhood had been one of deprivation and tragedy which enforced an early self-sufficiency. Her father had deserted his wife and only child when she was one year old. Mrs M's mother . . . promptly became a promiscuous alcoholic and when Mrs M. was nine years hold, killed herself at the doorstep of a rejecting lover. (The) patient felt no grief but only a guilty satisfaction at being rid of the mother of whom she was both afraid and ashamed. From then on an intense determination to make something of herself, and to be as different from her mother as she could, took over. She had succeeded - until her marriage crashed around her ears."

But "the marriage had indeed been one in which she had 'worn the pants', while the husband, a weak and passive man who was sexually impotent, leaned upon her until he had found another woman. Then all his resentment at her domination emerged with his decision to leave her."

During her third interview the therapist "commented on the discrepancy between her continual smiling as she talked and the pain I knew she must be suffering." She broke down into weeping and from then perceived the therapist as a "friendly ally." Things did not look so bad to her for the next fortnight, but then her husband, "whose vengeful hostility for his years of 'castration' had not abated, entered their apartment in her absence and removed all the treasured furnishings she had collected", whereupon she attempted suicide, but fortunately failed and rushed to the hospital. Dr Karush visited her daily at the hospital, "encouraged her to describe her feelings, and carefully avoided showing any of the chagrin (he) felt at (his) failure to anticipate her suicidal gesture." A short time later she told him that never in her life had she felt so close to anyone as she did to him during that period. "She determined then that she would never again fail (him) . . . .'it was an ungrateful thing to do'."

During the next six months she continued to see the therapist and meanwhile "obtained a divorce and a favourable settlement from her husband. Then, with (the therapist's) encouragement, she began dating other men. . . had a few satisfying sexual affairs and regained a sense of strength and attractiveness as a woman. She could now admit her part in the failure of the marriage and recognised her need to dominate and control a weaker man. The suicide

represented, she thought, an identification with her mother and would, if successful, have killed two birds with one stone. She would have committed the ultimate aggression (? query mine) against the man who had rejected her, and she would have expiated her guilt for her own destructiveness. The real fault, she felt, lay in her fear of any dependency and of being disappointed as she had been as a child, when no one seemed to care what became of her. As she admitted all this, she shyly told (Dr K.) that her relationship to him had taught her that she could dppend upon another person without disappointment or betrayal. She wanted now to go off on her own and (he) agreed that she should."

Dr Karush adds, ". . . the emotional consequence of the relationship to me was the critical factor in the improved function. In both cases, there was a salutary cathartic release of angry affect and a change in self-esteem. . . Mrs M. needed only to be helped to regain her previous level of functional efficiency . . . . . chance will probably play a large part in deciding how (she) will fare in the future." (p.337)

. . . . .

It will be seen from the above that Mrs M. had been conditioned in early childhood to despise, fear and hate men (and their effects upon women) and then women who rejected their children and themselves. The latter, however, could have been, and probably was, a secondary conditioning, following a primary conditioning to loving her mother, a conditioning which would have helped her in her relationships with other people. She was undoubtedly an intelligent woman, and the relationship with her therapist desensitized her attitude of (or conditioning to) rejection to the male, and conditioned her to a positive regard for men. As she was "self-reliant, independent, competent and well liked" there must have been much

conditioning to and reinforcement through positive affect and relationships with others in her life - associated now with the image of "men you marry/would like to marry".

As for the suicide - I should have thought murder was the "ultimate aggression" against others. Her attempted suicide could easily have been the result (partial or total) of fear and despair and flight. First her self-image was destroyed or badly damaged; then her ego-extension and refuge, her home and its "treasured furnishings" is destroyed, apart from its shell. I do not doubt that some degree of imitation, and conditioning of motoric response to the memory-image of her mother was also involved; pure "identification" however, should surely have required suicide on the husband's doorstep.

Therapy included a necessary relearning in regard to her own behaviour and her ego-ideal as well as a change in her cognitive reference frame.

. . . . .

Case 51: Lack of Male Role-pattern; Freudian interpretation.
(Steinfeld, 1951, pp.26-31)
(Classification 4, 5).

E.T. was the only child of parents who separated when he was six months old. Until he was two he saw his father occasionally but "since then he never questioned about his father, but seemed to accept his grandfather (maternal)." From early childhood on he lived with his mother, several aunts and a grandmother - the only male around was the aged grandfather - each of whom sought to bring him up in her way. "Surrounded by such conflicting feminine influences, E.T. developed a chronic constipation in his early childhood, which became a topic for discussion among all the women in the house. This constipation later developed into a condition called Hirschsprung's disease, which is characterized by an extensive enlargement of the colon and rectum. For the past few months the patient defecated only about once every week, when he symbolically gave birth from his rectum-uterus to a "stool-child" which had to be cut up by him or the mother so that the toilet could be flushed. This fact was not mentioned by the mother in her lengthy consultations with the therapist; thus showing that she associated inhibitory feelings of guilt with the situation."

(No evidence is adduced to support the author's Freudian interpretations).

The boy had an I.Q. of 147, and was said to be six years ahead of his age group. He was "very happy and thrilled when he started to go to school at the age of about five. Soon he was put ahead a grade and still he did better than most of his new class fellows, among whom was an older friend of his, Larry." Larry and some of the other children "ganged up . . every now and then and teased or beat him up," often repeating, "You're not smart, are you Eddie?"

"Within a year of beginning school, E.T. began to show marked signs of nervousness." A neighbour reported that she frequently saw him going home from school "sobbing

painfully". About the same time he developed chorea. . . The choreiform movements and grimacings varied considerably, partly depending on the patient's state of mind at the time. An e.e.g. taken when he was about eight was within normal limits. When during this beginning of his nervous condition, at . . . about seven, he was brought to the hospital for a tonsillectomy, E.T. is reported to have said, 'Well, I guess I'll just have to die then'."

(It is not clear from the report whether the following incident occurred before or after the tonsillectomy - one would suspect beforehand.)

"When the patient was about seven years old, he disappeared one day, and after a long search his family found him alone at the top of a hill. 'He told us that a boy had made him 'put it in his mouth', the mother said. She admonished him severely, and told him never to do that again or he would get sick. On another occasion he admitted having masturbated for which he was ashamed; mother, however, 'just told him it was a very nasty thing to do'."

He graduated from school at sixteen but shortly thereafter facial contortions became more apparent, and were followed a few months later by spells of being suddenly frozen tense and motionless like a statue. Another e.e.g. taken about this time was "normal". He did quite well at a local guidance clinic, but, "when he began attending college on the insistence of a psychiatrist, his jerkings and facial contortions became worse and he finally flunked out of college". Electroshock treatments were commenced; the patient was terrified each time. However"the jerkings were apparently eliminated by treatment for some time, only to reappear after four or five days. He frequently walked in zig-zag fashion and about this time began to hallucinate, sometimes hearing voices."

He received 29 electroshock treatments during a 3-4 months period, was then referred to Dr Steinfeld's sanatorium, diagnosed as a "pre-schizophrenic". He was then 18 years old, "suffering from symptoms that showed tendencies toward a schizophrenic breakdown." He "sat around at home unable to concentrate on anything"; jerking, twitching and grimacing were markedly present, increasing with any strain.

Psychotherapy was based on the conclusion that the early absence of the father and peculiar family atmosphere was the "primary dynamic factor in the development of the boy's illness. He defensively bowed to the overwhelming feminine atmosphere by a rebellious and ambivalent acceptance of castration and exhibited female characteristics (see the reference to the "stool-child") . . .His choreiform movements frequently resembled the coquettish movements of a flirtations woman."

From the first session the therapist assumed the role of a strong, loving but non-permissive father. "I verbalized my position in about the following words, 'I shall not permit you to go to with your mother any more. I am the father; your desire for her is not acceptable.' The patient reacted with violent contortions of the face" and threatening behaviour. When he saw the therapist was calm and not intimidated he said "he wanted to leave." Next Steinfeld told him, "I will not accept you, unless you come back on your bended knees." "The patient left; but he came back two days later, altogether submissive and ready to co-operate."

After brief psychotherapy the patient "began to go to work on a farm" . . . "When during the next weeks I suggested to him that he should return to school, he came out with a violent grimacing response again." However, on Steinfeld's reassurance that he would still support him, even if he failed, E.T. went to school and has been attending there for the past six months. Recently also he took up a part-time job on his own initiative, and for the first time in his life has developed friendly relations with a girl."

. . . . . .

Here we have a sensitive, highly intelligent boy without an adequate male figure with whom to identify, dominated almost exclusively by women; rejected at school by his peers, and undoubtedly suffering from a physical inferionity and lack of appropriate social relations. It would seem that despite early homosexual experience he

was unable to develop either homosexual or heterosexual relationships and schizophrenic-type reactions became manifest. This is an example of the kind of development Sullivan describes as typical of the paranoid schizophrenic reaction.

He has now learned to identify as a man with the therapist, who provided a dominant male father-figure. In the course of therapy he learned also to express and control his aggression. (He disturbed his neighbours by playing his radio, built by himself, full blast late into the night, until the therapist finally threatened to smash it himself, when requests had gone unheeded.) This is re-training under the guidance of a father-surrogate.

. . . . .

Case 52: Kleptomania.
(Lorand, 1950, pp.33-44)
(Classification 3b).

"The following case deals with a person whose criminal actions, to use Alexander's phrase, were neurotically conditioned. (No reference given for Alexander)."

The patient was a 21 year old girl, whose kleptomania "reached back to puberty, with a few intervals of inactivity that always ended in a new yielding to the compensatory impulse of stealing. She was above average intelligence, had graduated from a conservatory of music and was a piano teacher." She stole from her pupils' homes "small objects that had been left lying around, and sometimes even valuable objects, such as jewellery. She hid these stolen objects in her home, but never sold them. At other times she would steal money from her father's or step-mother's purse, and send it to a poor aunt to whom she was very much devoted."

She was an only child. While she was still a baby her father went to the United States. The mother had claimed he had emigrated "to earn a better livelihood" but "her life was nevertheless one of constant sadness and crying, which the child noticed." Any questions the child asked remained unanswered. Presumably as a result, she had fantasied that she "was not the real child of her parents."

Her mother had died when she was twelve, after which she was cared for by an elderly spinster paternal aunt. During her lifetime the mother "had swung from intense concern for the child, during which time she used to spoil her, to those periods when her depression had driven her to neglect the child altogether." "The aunt adopted stronger educational methods" (whatever that means). At school she was regarded as "precocious" but stubborn. "Her talents centred in music, and her aunt chose the piano as the child's profession." The aunt was poor and her father contributed less and less. Consequently the girl "managed to earn something by helping other children with their music lessons, and in this way gained entrance to the homes of wealthy families."

"At this period she used to think a great deal about the futility of life, and . . . also began to suffer from the compulsion of kleptomania.

During her earlier school years she had sometimes taken the books of other children and returned them, or else taken the sweets the other children had brought with them, for which she was occasionally severely punished by the mother. Now, after fourteen, the compulsion became more acute and at times involved even the taking of money when she had the opportunity. This money she later gave to her aunt. She also stole jewellery and small articles, all of which she kept hidden at home. When she was 17 she became so concerned herself about these activities she "actually curtailed her work and gave up helping the children of wealthy parents . . to avoid the danger of temptation." She still took items of lesser value from less wealthy homes."

Although she did not remember him, when she was 19 her father, having remarried in the States, took her to his home, mainly through the urging of his new wife. Almost from the beginning there were "incessant arguments." She was "discovered taking money from her father's brief case" following which he found her in possession of jewels which he realised she must have stolen. "When an argument arose she never missed the opportunity of telling her father that he had never taken care of her and her mother, and was not now taking care of his only sister who had brought her up. She also said, and was convinced, that the stepmother's urge to bring her to the United States was to get her to work and to give the money to her. She excused the taking of the money from him by saying that it was intended for her aunt, which was true. The father admitted his fault . . . Each time there was such a scene, ending in the father's admission of guilt, the girl promised to act differently, but after a short while the father would find other things in the girl's possession which he knew must have come to her illegally. The girl always confessed, with childish penitence, and promised to change."

Upon the urging of the stepmother, the father took the girl to Dr Lorand, who noted during the first interview that she was most "defiant", either constantly contradicting her father or maintaining a "defiant silence."

She "could not enter regular analysis" and Dr Lorand therefore considered it "hard to try to eliminate the girl from the emotional fixations extending from early childhood, to make way for the conscious aims, and to sublimate into healthy channels her unconscious asocial,

criminal strivings." However he did see her irregularly for some six months after which he lost sight of her for some time, and "could by no means consider her cured." However later he met her father who informed him that "the girl had been living away from home for more than a year, but she was working in a necktie factory, had friends of both sexes, 'went out' and occasionally visited him. She was apparently 'quite happy and contented'."

.. .. ..

Dr Lorand comments inter alia, that "the most powerful factor in the development of her criminal tendencies was the feeling that she had been cheated . . from childhood; . . . the mother, who played the role of both parents in the child's life, was always evasive and never told her the truth about what was to the child the most important of all matters - the father."

In learning theory parlance we can say that the girl had been conditioned (reinforced by the partial or intermittent reinforcing behaviour of the mother) to expect ambivalent attitudes from significant-others and to rejection, and also through conditioning to behave in the same way. She was also conditioned through imitation of the mother to evasive and lying behaviour and also, but later, in contradiction thereto, through the teachings and imitation of her aunt, to more moral behaviour. She herself had sorely needed a constant feeling of love and security, and had endeavoured to repay her aunt's gift of care and affection.

"<u>The action of stealing is a displacement and represents another action around the oedipus situation - taking love</u>" and gave symbolic sexual satisfaction to the girl, contends Lorand.

We would expect that in a love-frustration situation such as the girl experienced in early childhood, the individual concerned would be conditioned to experience considerable aggressive-affect against society.

To suggest that to steal such articles is due to a seeking for love, is to suggest that the appropriate articles must at some stage have been associated with the experience of love and security. Symbolism is based entirely upon association. Lorand is more correct in his suggestion that behind the patient's sexual attitude there was "the strong craving for love, and the lack of gratification drove her to compensation, which she derived from her stealing." She aggresses against society (the-others) surrogates for those who rejected her and compensates for her lack by "jackdaw habits" of pilfering and keeping those items which take her fancy, i.e. have positive affective-associations for her.

The girl appears to have been quite intelligent and we may assume that the therapist has modified her reference-frames, both with regard to herself and others. At the same time there would seem almost to be some element of "spontaneous remission" brought about no doubt by the fact that she had left the stressful home environment, where her anxieties, hatreds and any feelings of guilt were constantly being reactivated and reinforced. Acceptance by the therapist (a surrogate-father-figure

probably) and later by her co-workers (to whom, considering her former profession of music-teacher, she may have felt rather superior, and with whom she may, therefore, not have been ego-defensive), may have conditioned more acceptable behavioural responses.

. . . . . .

Case 53: Psychoanalysis of six year old Compulsion Neurotic.
(Anna Freud, 1946, pp.46-49, with earlier references to case on pp. 6, 7, 21, 22,23, 24, 25,26.)
(Classification 6c, 7, 4).

The patient was a six year old compulsion neurotic, of considerable intelligence and "keen logical powers". On the first occasion Anna Freud saw her (in the company of a slighter older friend, who was also being analysed) she was left to become acquainted with the environment. The second time A.E. pressed her for the reason of her being sent there; the child replied, "I have a devil in me. Can it be taken out?" Miss Freud replied that it could, but that it would take a very long time and that the work would not always be agreeable. The child thought deeply, then replied, "If you tell me that it is the only way to do it, and to do it quickly, then I shall do it that way." The child was somewhat "retarded", for "on account of her numerous inhibitions she had as yet no knowledge of arithmetic". However, she resolved the problem of understanding how long it would take, by pointing out the carpet-pattern and asking "Will it take as many days as there are red bits? Or even as many as the green bits?" When shown an appropriate number of medallions she understood; and helped to persuade her parents to send her to Miss Freud for an expected long period of work.

When the child had become sufficiently confident to permit her "devil" to speak, "she began to communicate. . a large number of anal fastasies, hesitatingly at first

but soon with ever increasing boldness and detail as she saw that no expressions of displeasure . . were forthcoming." "Gradually the analytical hour became emtirely given up to anal confidences, and was the repository of all the daydreams of this kind which otherwise oppressed her." She told Miss Freud, "My time with you, Anna Freud, is my rest-hour. I don't have to restrain my devil. But no, I have another rest, when I am asleep." Her "nature" began to alter and she became "lively and alert."

A little later she began to become more unguarded in her comments at home, indulging in "half-audible comparisons or a 'smutty' joke to the other children." Advice was sought from Miss Freud as to how this should be dealt with. "At that time," says Miss Freud, "I was inexperienced, and I took the situation lightly, advising that one should . . . . simply let (these manifestations) pass unnoticed." Whereupon the child became worse, so disgusting the adults with her anal verbalisations, particularly at table, they "lost all appetite", and the other children finally "left the room in silent disapproval." "Since she was not penalised by being removed from the company of the others, the consequence was that they avoided her." She "abandoned all restraints . . . In a few days she had become transformed into a cheerful, over-bold and naughty child, by no means dissatisfied with herself."

When the guardian again complained Miss Freud "had to realise that (she) had made a blunder, in crediting the child's Super-ego with an independent inhibitory strength which it did not possess. As soon as the important people in the outer world had relaxed their requirements the child's Ego-ideal, which was previously so strict and had been strong enough to bring forth a whole series of obsessional symptoms, suddenly became compliant." The analysis ran into difficulties for the child "had her 'rest-hour' all day long", saved little to tell Miss Freud, and lost insight generally.

Miss Freud soothed the guardian, telling her to do nothing but have some patience until she, Miss F. could resolve the situation. She then confronted the child with the facts of the situation and the choice of two alternatives - to give up her sessions with Miss F. and retain the pleasure of telling everybody what she thought, or to tell these things only to Miss F. for "the more I would know about her and the more I would be able to rid her of."

As on the first occasion, the child again thought deeply and finally replied that "If you say that that is how it is I will not talk like that any more." Her obsessional conscientiousness returned: she made no more public announcements on the subject, "but she again became, from a naughty and perverted child, an inhibited and apathetic one."

In the course of the treatment, (which also included a certain amount of dream analysis) the same pattern recurred several times, but always with diminishing intensity, "and with greater precautions and gentleness than home education had used, until finally (Miss F.) got the child to hold a middle course between the two extremes."

The climax of the analysis was the eliciting of the child's admission of her hatred for her mother, "against the knowledge of which she had previously defended herself by the creation of her 'devil' as the impersonal deputy for all her hate-impulses." Her previous co-operation began to diminish, and "she" relapsed at home into all manner of insolent naughtiness, from which (Miss F.) daily proved to her that one could only hate anyone to whom one behaved so badly." However she demanded to know the reasons for her "hostile feeling towards her apparently well-loved mother." Miss F. could not help her because so far she herself did not know the underlying reason. Finally the child herself commented: "You know, I believe it is the fault of a dream I once had" (some weeks before) "that we never understood . . . . . 'All my dolls were there and my rabbit as well. Then I went away and the rabbit began to cry most dreadfully; and I was so sorry for it." I believe I am always copying the rabbit now, and that is why I keep crying like it did." This was interpreted as meaning that the mother "had always gone away just when the child most needed her". Several days later on being pressed she said suddenly, "It is so lovely at G. . ., I should like so much to go there again." Closer questioning finally elicited the information that she had been very unhappy indeed during a holiday there. Her brother had developed whooping cough and been sent back to their parents in town, while the nurse actually preferred the younger children to her. "Thus at that time the actual preference of the nurse for the younger children was added to the supposed preference of the parents for the brother. She felt herself neglected on all sides and reacted in her own way."

. . . . . .

As has been clearly stated by Miss Freud herself, therapy here included permissive behaviour in the therapeutic situation plus discipline with regard to socially-acceptable behaviour. The essential self-discipline was retained - and the social conventions regarding permissable speech and actions reinforced - but the over-rigid conscience was liberalized or dis-inhibited. At the same time the original reasons for the child's feeling of rejection by the mother and nurse (both of whom would largely constitute the Super-ego system), and her consequent rejection of herself, and hidden hostility towards them, were finally uncovered; thereby desensitizing the particular memories and permitting of extinction, and also giving the child insight into possible reasons for similar future behaviour.

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Case 54: Fear of rape - analysis directed to birth trauma. (Fodor, 1949, pp.120-136). (Classification 3a(ii), 5, 8a).

This case is presented as evidence for Fodor's major hypotheses that all neuroses or phobias, in this case fear of rape, have their basis in the birth trauma or pre-natal conditioning. The original report is not developmentally-oriented as reproduced here; the material was recovered by dreams, associations, and verbal report of information gleaned from the mother.

Fodor's final summing up may be quoted first:

"The data are sufficient to warrant the conclusion that the fainting dream re-enacts birth and that the patient's rape fears were cover symptoms for the greater fear of birth, by a displacement of the all-over pressure on her body into a pressure within her own genitalia. The memory of the ordeal of birth laid the bedrock for her neurosis and also seriously interfered with her sexual gratification, as intercourse always tended to mobilize the forgotten injury. To escape it, she preferred a man with a small penis, as that permitted her unconscious mind to be less alarmed. In her sexual behaviour, she was still the little girl who, with a frighteningly small anus-vagina, fantasied herself in her mother's place with her father and also re-experienced anal-vaginal birth in each intercourse.

"It took forty analytic sessions to uncover this identification between rape fears and birth. Many problems remained for future sessions to deal with, but the findings as presented have made a great difference in the patient's emotional life and in her health. She lost her urination compulsion, her constipation and her nightmares. The rectal and vaginal pains rarely returned and she was able to reach a sexual peak which she had not known before." (p.136-136).

The patient was an extremely beautiful girl, "twice unhappily married and about to make a hit-or-miss attempt at happiness for the third time." From the report it would appear that the symptoms referred to above caused her to go for analysis, plus her fears of marriage.

According to her mother, her father had not wanted children and "went into a fit" when she became pregnant. The parents argued violently before her birth. The patient had "weighed eight-and-a-half pounds at birth, and was delivered after 15 hours' labour, with forceps that left two bad bruises on each side of her forehead. Before birth, her mother was taking sulphur baths. During labour, towards the end, the mother was put to sleep by gas . . . The gas given to the mother apparently put the child also to sleep (for) the mother did not hear (her cry) at first."

She was a "cry-baby, always very nervous." After eleven months, she was weaned because her mother became pregant again. The weaning was done in a brutal manner. To make nursing disgusting to the child, the mother covered her nipples with alum. The disgust reaction duly took place, but it was directed both at the breasts and at the mother. All her life, the patient was filled with revulsions at the sight of her mother's breasts. The bottle used to give her constant colic. She is irritated if she sees her fiance suck at his pipe and she cannot bear the sight of a suckling child; but she bites her thumb and smokes thirty ciragettes a day. She starts as soon as she wakes up, smokes in the lavatory and smokes in bed. Yet she does not like the taste, puffs once or twice and then throws the cigarette away.

"Her own breasts . . . are almost completely flat."

She "suffered from chronic constipation and from haemorrhoids. As a small child she passed a tapeworm. Menstruation and intercourse gave her pains in the rectum."

It is not clear from the report at what ages the following events occurred but childhood was full of traumatic incidents:

"When she was very small, she witnessed intercourse between her parents. Having seen her father behind her mother, she assumed that he was urinating into her mother's rectum. A large part of this patient's incestuous

fantasies with her father was built on this memory, and this became an important component of her urination compulsion.

Fodor contends, "The excitation was probably also responsible for her involvement in sexual situations with her young brother, who appears to have been responsible for her rape fears, both genital and anal, to a considerable degree." He then goes on to quote a dream, from the associations to which she finally recalled memories of "digital exploration by Jack (her brother) in the barn-like garage (which) . . .reminded her of a man who had tried to rape her in his car in the garage-way while she was still a virgin."

Earlier "Jack's anatomy used to excite her imagination and she remembered playing doctor and nurse with him, during the course of which mutual exploration of the genitals and of the anus took place. Once they were caught by the mother, and she was considered the initiator of the game as she was the older one. The feeling of humiliation and guilt stayed with her and, at the time when she came to analysis, she was shy about looking her brother in the face, wondering if he remembered."

The nurse had also caught her masturbating, and she was "threatened with the cutting off of something." "This recalled a mysterious remark which the doctor made when he circumcised Jack . . . to the effect that she, too, would need circumcision. The meaning of this remark was never cleared up." But she was extremely frightened as a result, so much so that "when the memory returned she hardly could resist the desire to take a mirror and look for some abnormality or traces of operation."

Her relations with her father were also unfortunate. "As a very young girl, she was shocked by catching him with a woman in his lap. She felt that she had lost her father to a stranger. The feeling was aggravated by her mother, who used to take her along to trail the father and this woman to a movie.. . . . When finally he deserted his wife and child, the mother developed an attitude of excessive morality, trying to live down her own guilt and dreading that her daughter would go her way." "At the age of four or five, she enacted a perfect fantasy of matricide by shutting up a cat with a bulldog in a large garbage can. The bulldog killed the cat, and she could never forgive herself for the cruel deed."

"At one time she believed that when a child is ready to be born, the mother's body is cut open by a knife." This was associated with early childhood fears of "Jack the Ripper." Mother had constantly warned her against disease from toilet seats and strangers. "The result was that she became very timid in the company of men whom she had not met before. This timidity was very much in evidence at the time that her analysis began." About the time analysis began her mother had an hysterectomy due to a tumor, and this activated much of this earlier fear and excitement.

The whole history of this patient is studded with traumata associated with sex - when small she had seen her father urinating and been frightened by the size of his penis; another man had exhibited himself to her; when she married the first time she had "refused consummation of marriage" - after a month "her husband raped her, and she suffered excrutiating pains." "The only way she could find sexual gratification was by masturbation." She "had herself surgically stretched; but it made little difference." This husband also habitually practised cunnilingus and forced her to practice fellatio on him. He also tried anal intercourse unsuccessfully. Both practices filled her with disgust. She never could kiss a man with a moustache." (Her associations to this led to the recovery of the memory of seeing her father, see above.)

She "had an abortion after her first marriage and later underwent ovariotomy."

Fodor comments about the patient's painful urination and chronic bladder information from which she had suffered for the past three years, that "The pattern may have been her mother's, who had a bladder inflammation after hysterectomy. For neurotic purposes the bladder is a good substitute for the womb because it is near the genital area and it is expendable. Sexual guilt is frequently converted into bladder affliction . . That in this patient's unconscious a link,indeed, existed between childbirth and the bladder was presently shown (in a dream) . . . People can cry with their bladders; and she seemed to do so. If she quarrelled with her fiance, she had to rush to the bathroom again and again until the quarrel was smoothed over."

This is by no means a full account of this case; but the following should probably also be mentioned: The aunt who looked after her disciplined her by locking her in the cellar or cupboard, threatening her with the "bogeyman" or washer-woman, who would wash her away. She had two operations for anal fissure; she had also "caught" crabs from her first husband; she had been in bed with her fiance when a knock at the door brought an onrush of fear that it was her mother (catching her again!); during her second marriage her husband had tried to strangle her. (She had also seen her father seize her mother by the throat) and she had lost a promising voice as a result.

Certainly in this case one sees an unholy continuation of conditioning and reinforcement in one well-nɸigh continuous pattern throughout the whole of this patient's life. One can well imagine that any one symbol will stand for practically everything else. Again and again this patient's fears are reinforced by real experience.

What "healing" has occurred is apparently the result of abreaction, and "insight" or explanations of the behaviousal patterns and the effects of the events.

Fodor would undoubtedly agree that this patient's troubles were due to conditioning.

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Case 55: Fruit phobia; hypnoanalysis.
(Wolberg, 1945)
(Classification 3a(i) and (ii)).

The patient, a woman, "had a neurosis in which one element was an aversion to fruit, particularly peaches. Through the medium of automatic writing she was able to recall an experience she had when she was three years of age. It occurred while she was on an automobile trip with her father, during which they stopped off at a road stand to pick up a basket of peaches. Placing the peaches in the back seat, her father warned her not to touch any until they got home. Defying his warning, the patient, who had seated herself near the peaches, stealthily nibbled one, even though she realized that she was doing something wrong. At this moment her father swung to the side of the road to avoid an approaching car, and capsized his car. The patient was badly frightened, though neither she nor her father was injured physically. Shortly thereafter she developed a dislike for peaches, and the aversion was extended to other fruits also."

Utilising Wolberg's technique of Automatic Writing, "she wrote of this experience in detail, and its reality was corroborated by her father, she was unable to recall it as a real experience, nor did recall of it through writing materially affect her fruit phobia. She was regressed to the age of three and it was suggested that she would see the incident as it had actually happened. She gazed at the mirror with intense fascination and, in great excitement, described the entire experience as if she were actually reliving it. At the point when she related how the automobile overturned, she brought her hand to her face to cover her eyes; yet she could not resist looking into the mirror as she described how her father helped her out of the automobile and how badly frightened she was. The recovery of this event through actual perception resulted in disappearance of her phobia."

. . . .

Conditioning to fear of peaches, and thence, by generalisation, to fear of other fruits, was brought about as the result of a prohibited action, i.e. eating peaches, with associated guilt being experienced in contiguity with a highly traumatic incident. As the child was only three

when this occurred, and accordingly highly "plastic" and suggestible, we might expect that the entire incident would make a very deep impression on her.

It was not until a comparatively deep re-experiencing of the incident, and consequent abreaction, occurred that the phobia disappeared. Such "re-experiencing" must bring "insight" to the ego, or put another way, must release previously inaccessible information to the ego which thereupon brings about reality-bound action.

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Case 56: Epilepsy in four year old; play therapy. (Erikson, 1940, pp.646-662) (Classification 8a(i), 5 and 7).

Fred was a boy of four years and addicted to teasing and occasional tempers. He hit a boy on the head with a shovel and teased his grandmother by threatening to jump from the window thereby precipitating a heart attack. She spent several months in bed and then died. Five days later he had an epileptic attack followed by two others during the next ten weeks. He was hospitalized for a few days. There were two minor attacks and nothing more until the anniversary of his grandmother's death when he again had to be hospitalized. Since his epilepsy was precipitated by psychic stimuli he was treated by play therapy.

His first reactions to the psychiatrist (female) indicated aggression. He discussed burning, moved a screen so that it fell on her, crawled under the screen calling that he was "climbing on top" of her, stood on the screen through which he fell $1\frac{1}{2}$ feet and then crawled in and out of the hole ("window"). It was suspected that he was reacting the guilt about his grandmother and in the tenth session the psychiatrist decided to raise this question. When Fred suggested that she write his name on the blackboard she asked for the names of all the other

members of his family to write these down too. When he got to the name of his grandmother (pronounced with special tenderness) she remarked, "Your grandmother died, didn't she?" His reply was violent: "No, she didn't die - she went away - didn't she go away? Why did she die? She was sick in my house. Did she die in my house? Is she in my house now? Well, where is she? Do you mean that I will never see her again? Let me see her." The psychiatrist explained that this was impossible and suggested that he must be thinking he had done some harm to his grandmother which he decisively denied. That evening he cried and asked why his grandmother had died. During the night he soiled the bed. In the morning he vomited and then slept far into the day. He had seen the grandmother's coffin and the family mourning, but had seemingly accepted the parent's explanation that grandmother had gone on a long journey.

Before treatment was completed, the psychiatrist left the city and Fred reacted to this break with new epileptic episodes. At this stage Erikson took over. He was not satisfied that the grandmother incident was a sufficient explanation of the guilt reaction and questioned the mother further about preceding events. With some effort he discovered that a week before the grandmother incident, Fred had "accidentally" thrown a toy at his mother and loosened one of her front teeth, as a result of which she had administered corporal punishment for the first time in his life.

The next highlight occurred when Fred became exasperated by being beaten at dominoes by the psychiatrist and hit him in the face with a rubber doll. He then stiffened, turn pale and vomited. Immediately on recovery he urged, "Let's go on playing" and set up his dominoes in front of him in the form of a triangle with all the faces turned inwards. In this form he could not inspect them properly but they made a neat model of a coffin. It was then suggested to him that whenever he hit anyone he was afraid he was going to die. His response was a breathless, "Must I?". This situation was used to "interpret" his behaviour to grandmother and mother (this latter incident he did not remember) and his fear reactions. Threatened loss of the mother was obviously more disturbing than loss of the grandmother and the mother's violent reaction had aroused his fear of aggression in those he most trusted.

Mother was appropriately instructed and under guidance was able to develop a much more understanding relationship with her son, so that he became able to tell her of his aggressive feelings without fear of reprisal and with having to act them out.

Bringing these emotional situations under control prevented major epileptic episodes but it would appear that he would retain the potential for such whenever unduly disturbed emotionally.

The play situation here seems to have served primarily as a means of communication, chiefly from psychiatrist to patient. Diagnosis depended more on historical material although the play situation provided a means of checking hypotheses. Cure seems to have depended on clearing up some of the boy's misunderstanding about the nature of his environment. As the result of this he was able to change his own attitudes.

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Case 57: Chronic alcoholism; hypnosis.
(Gordova & Kovalev, in Winn, 1961, pp.136-140)
(Classification 3b).

The authors had 150 chronic alcoholic patients under observation. Of these 28 were treated by hypnosis; hypnosis and apomorphine combined were used in 62 cases; 60 patients were given apomophine only. "In the first of these groups the use of apomorphine was definitely counter-indicated, because they suffered from hypertonia (12), ulcers or gastritis (8), and heart ailments(8). About half the patients (72) were between 31 and 40 years of age."

Three of the patients "began the abuse of alcohol" by age 20; 114 began while in the 21-30 age group; 24 in the 31-40 age group; and three at 41 years or over.

"The hypnotic sessions were conducted in groups of 4 or 5 persons, twice a week for thirty minutes; altogether there were from 5 to 12 sessions. There were individual talks before each treatment, during which the effect of alcohol upon the human organism was explained and detailed instructions given with regard to conduct during the coming session. The sessions themselves were conducted in a special room ('hypnotarium'), slightly darkened. The methodology of hypnosis consisted in verbal suggestion of sleep, accompanied with stimulation by rhythmic sounds (clock ticking).

"When the patients were all under hypnosis, it was suggested that the sight, smell and taste of alcohol will cause nausea and vomiting. After two or three sessions each patient received specific suggestions to have hallucinatory experiences connected with episodes of drinking resulting in feelings of disgust toward anything containing alcohol. For instance, a patient would be told that he was in a bar with a glass of vodka in front of him; and that the taste and smell of it made him vomit. During this suggestion the patient's face would plainly express disgust, and initial vomiting movements would be observed. This effect was particularly well achieved in the somnambulistic stage of hypnosis. When the intended result was not observed, the suggestion was supported by a wad of vodka-soaked cotton placed in front of the patient's nose. During the next session, vomiting was observed at mere mention of passing near a bar.

"The treatment with apomorphine (62 patients) began with a minimal dosage which was gradually increased until the vomiting reaction was produced. Later on the doses had to be somewhat increased, for there is a certain tendency to become habituated to the drug.

"Suggestion enabled us to effect the vomiting reflex also with smaller doses of apomorphine. The patient was told under hypnosis that each new injection of apomorphine would cause stronger vomiting, though the dosage remained the same. Particularly good results of this kind were obtained from the patients readily reaching the somnambulistic stage.

"The effect of this treatment was subsequently verified through catamnesis among 110 patients. It showed that hypnotherapy (with or without apomorphine) was more successful than the treatment relying on apomorphine alone.

This is clearly indicated in the following table:

		Subsequent Abstention			
Method of Treatment	No.	3 mo or less	3-12 mo	Year or more	Recent cases
Hypnotherapy	23	6	3	11	3
" and apomorphine	47	13	7	20	7
Conditioning with apomorphine	40	20	13	7	-
Total	110	39	23	38	10

"The effectiveness of treatment depends on the number of hypnotic sessions. According to our data, we are in a position to recommend no fewer than nine to twelve sessions for a course of treatment of chronic alcoholism.

"It may be interesting to note that, when the patients are classified by age, it is observed that the younger people show on the average a more lasting effect of treatment; but then it will be well to remember that the same group was also exposed to fewer years of alcoholism."

. . . . .

We see here "aversion therapy" being practised, with the conditioning of a painful or unpleasant physical condition (vomiting) as response-reflex on the presentation

of the stimulus of alcohol. The techniques used all involved the association of an unpleasant physical state and its concomitant affect with the stimulus which was previously found rewarding and/or pleasurable (i.e. alcohol). Simple classical conditioning is found to be the least effective of the three techniques used. Suggestion alone (under hypnosis) - i.e. verbal instructions issued by the therapist ("significant-other" - "super-ego" - "authority") causing possible an association of disapproving authority and previously liked/now feared stimulus to act as arousal-agent or reinforcer of the noxious response, produced better results; but the best results were obtained from a complex conditioning pattern: verbal instructions (auditory stimulus) given by authority (another complex stimulus) to produce unpleasant affect (disgust) in association with hallucinatory images (visual stimulus) of loved-and-feared alcohol and, therefore, with ambivalent affect, in association with noxious stimulus, combined to produce a noxious physiological state and its concomitant unpleasurable affect (reinforced, in the waking state, by increased self-seteem when the alcoholic drinks less or not at all). Put differently, the response (or reflex) of vomiting becomes conditioned to a complex or constellation of stimuli, any of which can act as a cue to produce initially the memory of the feared state and, when conditioning has been sufficient (in time or intensity), to inhibit the unwanted behaviour.

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Case 58: Gunner's war neurosis.
(Fairbairn, 1952, pp.261-265).
(Classification 5, 4).

The patient was a gunner, aged 24, who suffered from "war neurosis."

A.M.'s mother died when he was three years old, following which he was brought up by his maternal grandparents. He rarely saw his father, "towards whom he displayed an unnatural (? - why 'unnatural'), and almost complete, absence of feeling." His grandmother "doted" on him and he seems to have been extraordinarily dependent on her. When he was 15 years of age he saw a woman collapse in the street. A "state of acute anxiety" ensued, and that night he had a fainting attack. During the next few months similar attacks recurred frequently; he was kept away from school and "was not allowed to go out of sight of his home unescorted." When he was fit enough to return to school, he was afraid to go alone and was therefore always escorted. "Even after leaving school at . . 16, he remained afraid to go out alone in case an attack should occur when he was any distance from his home." When he did go alone he always went on his bicycle so that he could return home quickly if he felt the need.

After his first fainting attack he "slept between" his grandparents until the death of his grandfather. . . a few months later; and after his grandfather's death he occupied the same room as his grandmother until, when he was 18 years of age, she also died."

When he realised his grandmother was failing he "spent more and more of his time in her company" and became very much concerned, if not obsessed, with the prospect of being left entirely alone in the world. "He had made no male friends; and he never had taken up with any girl." However, one day he bumped into a girl with his bicycle, following which he arranged "frequent surreptitious meetings" with her, of which he told his grandmother nothing. When his grandmother finally died "His sense of desolation was certainly mitigated by his friendship with the girl; and indeed it was only this attachment that reconciled him to the prospect of continued life." He was financially too insecure to marry the girl immediately, and went to live with an aunt, but "went about in a trance waiting for (her)". He "achieved some remarkable success in football pools" and this, together with some money inherited from his grandfather, was sufficient to purchase a "small 'gent's outfitters"

business." He thereupon married; but fretted because his shop was too small and his home too distant for his wife to be with him all the time. He tried employing a boy as assistant, but this was unsuccessful, following which he installed telephones in his house and shop so he could communicate with his wife when he wanted to. When it became vacant he immediately took possession of the flat above his shop, so that his wife could always be with him. He was, however, called up for military service, which he managed to have deferred for three months on business grounds. When he was finally forced to go into camp he insisted his wife accompany him to the town where the barracks were situated. When she was forced to return home six weeks later he got special leave to accompany her, remained in the house the entire time, and only returned to the Army with great difficulty. Following this he telephoned her as often as he could; but his obsessional thinking about her prevented his being able to write to her."

"Inability to concentrate also resulted in his being the only man who failed to pass the prescribed test at the end of a course of instruction in gunnery; and owing to this failure, combined with a fear of guns which he displayed, he was allocated to routine telephone duties." He "was very self conscious", "felt 'different' from other men", "tended to feel that his company was not wanted; and ... made no friends... with the exception of one man fifteen years older than himself." He "had felt 'depressed' from the day he entered the Army; and, in the absence of his wife, he felt completely 'alone'. It seemed to him that everything was against him; and he felt that his only hold on life resided in the hope of seeing his wife again - a fact in explanation of which he volunteered the remarks, 'She is like a mother to me', and 'She is all I have'." He had difficulty in sleeping, being obsessed day and night with thoughts of her and the distance which separated them.

Three months after entering military service he reported sick "on account of two fainting attacks, which occurred on successive days, and the first of which came on while he was sitting in the confined space of the telephone exchange," and ten days later was admitted to hospital."

. . . . .

We are not told the outcome or type, or length of treatment given; though we may assume, in view of the writer's orientation, that it was psychoanalytic and

directed towards establishing "mature" instead of "infantile" "dependence upon the object", which would, of course, necessitate a change in the reference-frame and behaviour patterns.

On the evidence presented here - we may assume that the major traumatic event which precipitated a catastrophic attack of separation anxiety was the death of the patient's mother. This doubtless left a residual of continued panic attached to (a) the threat of separation from a loved-object and (b) an inert, or similar, human body. With regard to (a), the positive affect cathected to the grandmother; the great love-object during childhood and adolescence, who apparently identified with him and whom he imitated and with whom he was identified, undoubtedly laid the basis for the strong separation-anxiety leading finally to his marriage and identification with his wife. Fairbairn, himself, (p.276) states . . .

> ". . .separation anxiety is a characteristic product of the tendency of individuals who have remained in a state of infantile dependence to make identification the basis of their emotional relationships with those upon whom they depend. The figure with whom the dependent individual is originally identified is, of course, his mother; and, whilst it is not long before he begins to identify himself with other figures, particularly his father, the original identification persists underneath all others subsequently made.... "

We may hypothesise that the inert body of the woman who collapsed in the street reminded him strongly of the death of his mother, resulting in his identifying with the prostrate

woman, and his own fainting-fits were either the result of the physiological disturbances associated with panic resulting from separation-anxiety and/or his own fear of death, or an hysterical motor-activity directed at imitation of the "beloved object." It is to be noted, however, that his most recent fainting-fits were not associated with others' inertness or death, but were experienced while he was "in a confined space," (insufficient air?) with relatively little outside stimuli, and while dwelling on his separation from his wife and, seeing it was wartime, conceivably with the possibility of her or his own death.

We have here a lack of learning, or a negative conditioning. The patient would appear never to have learned to separate himself from his mother and develop his own identity. He had been conditioned to concentrate almost entirely upon the nearest woman-object; and, because of the positive reciprocal affect associated with this "selective attention", his "identification" was quite abnormal.

. . . . .

Case 59: Behavioural maladjustment in child; Play therapy.
(Noyes & Kolb, 1958, pp.588-9).
(Classification 4, 5)

A seven year old boy was referred because of his inability to make satisfactory school adjustment His behaviour was aggressive and bizarre. At home he was restless, blinked frequently and masturbated constantly. His mother said that the change in his behaviour had begun at $2\frac{1}{2}$.

Discussion with the father suggested that he was competing with his son in many ways. Mother also was self-centred and immature. The child had been planned and early development had been normal, but bowel training had been punitive and the mother had been constantly frustrated and angry in caring for him. There had been continual struggle between mother and son,and father's competitive feelings had added to this. The boy's only concept of existence was that of struggling to attain the position of "boss."

Residential play therapy was directed to change this attitude. The protective milieu and supportive behaviour provided gradually reduced his aggressiveness. In the meantime his parents had also been given some treatment and were ready to treat the boy with greater understanding on his return eighteen months later. No mention is made of "interpretation" in the play therapy briefly referred to here. It may be concluded that the chief therapeutic factor was the change in milieu which reversed the effects of the earlier environment. This is relearning through milieu control.

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Case 60: Fraudulent and deceptive behaviour, spontaneous remission.
(Abraham, 1955, pp.291-305)
(Classification 3b, 4).

This is interesting as a case which was investigated by Abrahams in some detail but not treated and again investigated after what could be described as spontaneous remission.

The subject of this study had a fantastic history during the 1914-18 war of fraud and deception. As a deserter from the army he promoted himself by various stages from private to lieutenant, mixed in the best circles, obtained money on false pretences, showed an unbelievable capacity to charm people of all kinds, including prison guards but invariably betrayed any confidence placed in him. He was finally convicted and served his sentence. On his release at the end of the war he broke out in a new spot and then, before being apprehended, reformed. When finally brought before the court he claimed to have been a respectable citizen for four years.

The first investigation had revealed that he was the youngest of a large family of children. He had repeatedly heard his mother say how unwanted he was and felt unloved by parents and siblings. He learned to spurn his parents as they had seemed to spurn him. His efforts at social popularity are seen by Abrahams as compensation with parent substitutes for the attention he did not get from his real parents. His high abilities enabled him to achieve great success in these endeavours but the need for revenge led inevitably to his betrayal of them. Finally, however, he met up with a widow with whom he went into partnership and whom he married. She appears to have been able to give him the maternal support which he had lacked and established a reciprocal relationship which none of his more casual acquaintances had been able to do. Moreover, the business firm into whuch he thus came provided him with an outlet for his obvious artistic abilities and everything conspired to break the vicious circle in which he had previously found himself.

. . . .

The picture painted here is probably by no means a complete one but the main outlines seem feasible. Parental attitudes such as described could well produce such effects on a sensitive but capable person such as he appears to have been. The very different relationships in which he found himself in the world of the widow, plus his romantic attachment, might well have provided the new learning situation required to develop a more constructive attitude towards life: an accidental example of milieu therapy.

. . . . .

Case 61: Paranoia, reserpine and psychptherapy. (Tyhurst, in Leighton & Wilson, 1957,pp.31-76).

A 44 year old unmarried Catholic lawyer was hospitalized because of an illness involving profound distrust of people around him. He had studied Communism (which he had feared since the war) in connection with a legal case he was engaged on and became suspicious of acquaintances he thought were Communists, whom he felt "he could recognise as he recognised homosexuals - by looking at them." Three days before admission he complained to the F.B.I. and two days prior he thought that there were men on the top of a nearby building shining lights into his room to watch him masturbate.

He had had difficulty with his education and left two universities before finally qualifying with good grades at a third. He drank and gambled, openly dropped his religion and became interested in Fascism.

He became a captain during the war and had a good record.

He had nocturnal emissions from his 14th year (age 13) and masturbated at 17. At university he had intercourse with prostitutes. He had no homosexual practices nor fantasies but was preoccupied with recognising homosexuals, especially when drunk. He had been called "pretty" most of his life and was very sensitive about this.

In hospital he was withdrawn, suspicious of food, regarded the place as a government "brainwashing" establishment. He regarded his masturbation and discovery of it by the F.B.I. as the source of his troubles. He was treated with Reserpine but he complained that this caused agonizing feelings of depression and fear so it was discontinued. Anxiety and hallucinations decreased.

Tyhurst finds several features which characterize the paranoid reaction: feelings of insecurity, deep-seated childhood guilt feelings, a continual failure to achieve over-valued goals, a need for defence against repudiated impulses (homosexual). His sex adjustment was doubtless influenced by a weak, passive father (whose dependence on his mother the patient regarded as "unmanly") with whom he could not identify and a harsh mother, but this seems to have produced fear of family ties, rather than direction towards the same sex. His guilt seems to be centred round masturbation and fear of Communism seems to have identified with fear of his own masturbating activities being revealed.

It is not very obvious what therapy did to help the patient during the critical stages of his breakdown.

Reserpine affected him adversely and there is no indication of insight until the major disturbance had passed. One suspects "spontantous remission" (assisted by the knowledge that he was being taken care of and accepted by the therapist), as the major factor, with therapy, simply leading to better adjustment for the future.

From the learning point of view, the case suggests that certain forms of temperament react to abnormal family situations in a way that makes the person neurosis - or even psychosis-prone, by hindering normal sexual and social adjustment and providing a source of guilt which can be evoked with great ease and is exacerbated by any depressive circumstances. He had also been conditioned to attend to (focus on) homosexuality in men and fear his own tendencies due to his own "prettiness" and father's "unmanliness."

. . . . .

Case 62: Psychoanalysis of Parents and Child.
(Mittelman, in Bychowski & Despert, 1960.)
(Classification: Child (62) - 8a(i), 4, 5;
Mother (62b) - 6b,6c, 5;
Father (62c) - 5).

At the time this case was reported the wife was 36, the husband 40 and the child 8, the couple having been married 9 years before the child was born. Husband and wife "are compatible in their interests and activities."

Ten years previously the wife became very "hysterical" after seeing a child run over by a trolly. "Two nights later she had a nightmare in which she saw her husband with his genitals cut off. She became anxious and depressed and the family physician suggested that she have a child. During her pregnancy her depression and anxiety disappeared."

When the child was a month old he "developed eczema which lasted for a year." During this period the child's hands "were at times tied to the side of the bed to prevent itching." "The mother was quite upset by this, as well as by the child's later gastro-intestinal symptoms of vomiting and diarrhea, caused by allergy. The child turned out to be a feeding problem and when he was a year and a half old, the mother developed obsessional thoughts of cutting her child's throat. About a year later(i.e. about five and a half years ago), she started analytic treatment. In addition to her obsessional thoughts, arousing profound guilt, she had another complaint, this one deeply injurious to her self-esteem, namely, frigidity. Soon after the beginning of her analysis she staked the success of the treatment on the cure of her frigidity."

Six months later she informed the analyst that she (correctly) "thought her suffered from premature ejaculation." As he did indeed reach orgasm within half a minute from the commencement of intercourse, after discussion between husband and wife and analyst, the husband also commenced analysis. A month later, on the wife's insistence (contrary to the analyst's opinion) that she might not be frigid if her husband were "adequately potent", she ceased treatment "until her husband's potency improved."

We might note here that the wife "had been a perfectionist since the age of five" (reason for this date not given). Resulting from this perfectionistic

drive she (a) always had to put the blame on her husband for any marital problems, (b) demanded the child be perfect according to her standards and (c) became hostile when he was not in the same way as she was hostile to her husband, and indeed had a castration-wish where he was concerned. The child consequently "became perfectionistic as well as hostile." He had nightmares from the age of three. "The mother and father were fairly permissive in the home. However, in school his hostility was thwarted and loomed hopelessly dangerous; from this resulted increasing anxiety and the nightmares . . ."

Within ten months from his commencing analysis the husband's "sexual performance improved so much that the wife had to agree that she ought to be able to reach organism. This she was not able to do, and she resumed treatment in a most disappointed mood."

During the course of the two analyses the analyst had only used "indirectly" any information he had obtained from the other partner. However, $2\frac{1}{2}$ years later, the wife, while reporting that "in the course of the summer the potency of her husband declined again (therefore) the situation was pretty hopeless," failed to report (a) that intercourse had occurred only three times in two months (the husband's frequency was usually three to four times a week); (b) that the boy (then six years' old) was sleeping in the same room and she was afraid he would observe his parents; (c) that she would not agree to having intercourse in the daytime." This information was all given by the husband during his analytical hour on the same day. "Indirect questions in the next analytic hour did not lead her to add the omitted information to her hopeless story of the summer." Dr Mittelmann then "decided to confront her directly with the information, and she confirmed it. (He) pointed out to her that the reason she had omitted this information was because she had to put the blame on her husband, even at the cost of a hopeless outlook; to her it meant catastrophic failure and humiliation to admit that she had any fundamental problems."

From then onward he used directly information obtained from the other partner. Both frequently failed to give vital information, and both would appear to have benefited from this material being made available.

For example, the husband complained of being "depressed" from time to time; but without being able to explain why. From the wife's information it became clear this was associated with an act of intercourse which he failed to report, and which depressed him because "his wife had no orgasm." "This had two opposite meanings to him simultaneously: one that he was sexually inadequate; two, and this was accompanied by quickly repressed bitterness, that no matter how he performed there was no way of getting his wife's approval. The latter meaning confirmed his unconscious conviction of an unfriendly, depriving fate, built up since the age of five when his father died and his mother sent him to an orphan asylum. The fact was . . that his wife had reached a 'fifty per cent or seventy per cent orgasm' but would not talk about it to her husband.

"In the past, if his depression lasted a while, his potency declined. This then confirmed the wife in her false conviction that her difficulty was to be blamed on him. The recovery of his potency in a week or two would not eradicate this effect, and soon the wife's behaviour would lead to another temporary decline in his potency. This vicious circle was first broken when the causes of the husband's depression were immediately recognised and analyzed with him and thus a decline in his potency prevented; second, when the wife was confronted with the nature and analysis of her behaviour and its effects on her husband. Within four months the wife had adequate orgasms during intercourse."

Six months after this the child's nightmares (referred to above) became worse. In them he was usually being chased by a monster. During the following six months whenever he was "awakened by a nightmare, he (went) to his parents' bed, where he (quietened) down, and then (went) back to his own bed." During the course of his analysis he had a nightmare that he had lost a bicycle and a library book; which was analyzed to show that: "the child is afraid of failure and disapproval in school; he is afraid of abandonment by his mother; afraid of abaddonment by his father; the bicycle being a male symbol, very likely he is afraid of not being a boy, and of being completely hopeless and immobilized." To the latter comment the analyst associates the fact of the child's being tied down while he had eczema.

Dr Mittelman explains further: "The child's symptoms made the mother feel all the more that she had failed in her maternal role, reinforcing her feeling of failure as a wife. This in turn led to sexual disinterest and refusal, which re-enforced the husband's

potency disturbance. This aroused the wife's hostility and castration-wish because of the resultant frustration, which then was again displaced on to the child. In the simultaneous treatment of the parents (particularly of the mother) and the child, this vicious circle was broken . . . . "

"Excellent therapeutic results were obtained with both parents and with the child. The mother lost her obsessional symptoms, has adequate vaginal orgastic responses, has developed her art work successfully, treats her child well and has become self-assertive with her mother and her friends. The husband developed adequate potency, lost his spells of depression, and is self-assertive with family, friends and colleagues. The child lost his anxiety and is well adjusted in work and play situations. The results could not have been attained with the parents, without their being treated simultaneously by the same analyst, since both of them, largely unconsciously, excluded crucial information from the treatment. This excluded information could gradually be collected from the mate and utilized in the treatment. The simultaneous treatment of the child by the same therapist was not indispensable, but was of advantage in the treatment of the child as well as of the parents."

. . . . . .

This case shocks me. The length of time taken and the cost involved must have been very considerable; and I am positive that the same results could have been achieved with much less effort, time and expense through the use, for example, of "reciprocal inhibition therapy", with its emphasis on such techniques as assertive responses and the reduction of anxieties. It is clear from the report that the husband had been conditioned early in his life to rejection and to accepting it in somewhat passive form; equally the wife had been conditioned (at least from the age of five - see the report) to perfectionistic striving, obsessional thinking and concomitant guilt feelings; the

child was conditioned to a feeling of helplessness, an element of rejection and anxiety.

The practice of doing therapy simultaneously with various family members in an individual setting is a variation of the practice of family therapy in a group setting. It seems to me to be a pre-requisite of either type of simultaneous familial treatment that there should be an understanding that all information relating to mutual and common problems should at least be available to all of the family.

Therapy here would seem in the main to have been directed at the recovery of information and the exchange of relevant information regarding mutual problems, with a consequent modification of behaviour and reference-frames. Conditioning of positive affect and reinforcement of desired behaviour patterns was also involved. Reduction of anxiety on the part of any one member naturally generalised too.

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Case 63: Schizophrenic reaction.
(Sullivan, 1962.)
(Classification 5, 6c, 10)

Man of 24 years. Older brother had died when patient was seven years, younger brother earlier. He did well at school and graduated from university. He entered naval reserve and given aviation training during the course of which he complained that he had to swim across an icy cold lake in February. This made him nervous and caused him to have trouble with his legs. On discharge he had dreamy spells and was very irritable. He had a prolonged engagement with a girl of his own age, whom he called Buddy. While they were at college he would write every few days and then miss for a month. The girl remarked of him that he was "morally the cleanest boy I know."

In 1922, after a postgraduate course followed by a job, he began to suffer from insomnia. At times he would cry; said his nerves were bad and his legs would start twitching. He had an operation to repair deformity of his nose and was markedly disturbed for some ten days after local anesthetic. His salary was reduced because of lack of initiative and efficiency and this stimulated him to greater effort. Then two accidents to workmates whom he had to help, and sleep was much upset again. He made arrangements for marriage but developed acute catatonic excitement on the eve of the wedding. He showed marked improvement after a dream in which he was the recipient of pederasty and fellatio. During convalescence was distressed about having venereal disease although he was aware that he had not had it. It was discovered that the distress he referred to might be due to fallen arches and measures for their relief improved his confidence. "As his perplexity diminished he made a rather paranoid readjustment, clinging to some somatic ideas, in which he was discharged."

. . . .

Details here are meagre but there is the common reference to sex problems and moral scruples. We have traumatic fear and several fear-provoking incidents following. His anxiety culminates in the near-approach of his marriage. The nature of the therapy is not clear

except for the help given with the leg symptoms, but it is largely analytic. It can be presumed, therefore, that the cure consisted of some development of insight while given appropriate support. This could be expected to reduce the moral problem somewhat.

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Case 64: Childhood neurosis.
(English & Pearson, 1937, pp.94-96).
(Classification 3a(i), 3a(ii), 5).

A boy of twelve years had suffered for six years from vomiting and nausea when he saw blood or faeces or when he heard either colloquial or technical names for various parts of the body. The birth of a baby sister had caused him to turn to his grandfather for consolation. This resulted in witnessing a homosexual episode between his grandfather and another man and his being forced into some sexual act by the latter. His mother caught him masturbating and threatened him with castration. She was a very untidy person and menstruation always soiled her clothes. The boy experienced his first attack of nausea on seeing his baby sister's dirty diaper changed. Her genitals indicated castration to him. This he associated with his mother's menstruation and blood, faeces, masturbation and guilt became tied up in one glorious complex with disgust as a major element.

As with many cases treated by psychoanalysis, this disturbance was the outcome of traumatic conditioning. Details of treatment are not given but the context suggests that it consisted of discussion and abreaction, essentially a process of desensitizing.

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Case 65: Psychosomatic complaints, psychotherapy. (Wegrocki, in Burton, 1947, pp.274-280). (Classification 5, 8a(i)).

This case is reported with full medical and psychological data - but briefly:

The patient was "a 20-year old Army Air Forces sergeant, serving as clerk in a headquarters section in the China-Burma-India theater" who was "referred for psychiatric evaluation" because his commanding officer thought he was suffering from "nervousness." "Presenting complaints were those of consistent and repeated abdominal cramps, frequently accompanied by dull, frontal headaches . . . present mostly during the day and while R. was on duty."

The abdominal complaints "began at the age of 16. Because of the recurrence and severity of the attacks, a diagnosis of 'chronic appendicitis with acute exacerbations' was made and, at the age of 18, an appendectomy was performed." Soon after convalescence the symptoms returned. There was "moderate improvement" after he went to college but the symptoms returned when he was drafted into the army, quietened down again as he became used to the conditions, but "recurred in greater intensity after his shipment overseas . . . when he arrived at his first airport . . and again just before arrival at his permanent port in Eastern India." He was medically examined, the results being mainly negative, though there was "a moderate pyloro[illegible]spasm and a mild spasticity of the colon." He was ordered tincture of belladonna, but because of side-effects used it as little as possible. "Spontaneous improvement soon followed this initial period. However, because of his superior performance at work he was transferred to the position of clerk in a headquarters section. Very soon after, his previous acute symptoms returned."

His family history showed that his mother, "an over-protective individual but with no outstanding neurotic traits" had died when he (the only child) was eight years old. The father was a successful businessman whose original attitude of a somewhat benevolent severity changed to one of more definite affection "after the death of his wife" and toward whom the boy's early attitude was "a mixture of fear and resentment combined, however, with no little admination for his air of authority."

The patient himself was as a child, "nervous", "tending to lean on others", and "frequently subject to headaches and 'belly-aches'," He also had "five somnambulistic experiences, the last at the age of ten, and he was enuretic until the age of eleven." "A moderate tendency to stutter when excited was noted during the interview, but had never been a source of distress to him in earlier life."

The father had objected to the mother "coddling and babying" R., but after her death had tried "to create an atmosphere of spontaneity." There were "alternations of instances of friendly solicitude with episodes of paternal dominance" which produced conflict in the boy; but by the time of puberty relations were particularly good, and the boy "adapted his behaviour to his father's standards". However, when he was in his sixteenth year the boy's father had "became enamoured of a woman many years his junior and within a month married her. Resentment of the stepmother was intense on the part of the patient, specially when her suggestion that he be sent to a military school was interpreted by him as a desire on her part to eliminate him from competition for the affection of his father."

The father had reverted to his original attitude of "arbitrary authority" and R. "experienced a strong feeling of rejection. His childhood attitude of resentment reasserted itself; this time, however, there was no understanding mother to whom he could look for sanctuary. <u>It was within a month after his father's remarriage that the first attacks of abdominal cramps began</u>... ."

"In examining specifically the circumstances precipitating the attacks of abdominal cramps, it soon became evident during the interview that they were always associated with anxiety-producing situations. Thus it was his fear of the unknown dangers facing him in overseas posts which provoked (one particular attack) . . . Initial attacks of abdominal cramps subsided as sonn as he made a moderately good adjustment to army requirements. His subsequent abdominal difficulties, however, were found to have a different foundation underlying the anxiety pattern. It was discovered on enquiry that in all those situations where R was exposed to the authority of an arbitrarily dominating individual whom he resented but at the same time feared, the attacks of abdominal cramps would come up. Bullying sergeants who provoked hostility within him, but toward whom he felt superior socially or educationally, would not precipitate any abdominal difficulties . . . "

"But when the individual who was 'bossing' him in such high-handed fashion was a person to whom he would look up (and unconsciously identify with), he tended to resent criticism of him by others. In this situation abdominal cramps would often arise" . . . . "At the time of the interview, R. was working directly under a somewhat bullying and arrogant master sergeant who, however, was very competent in his speciality. . . "

Therapy consisted of explaining to the patient "the genetic pattern of his abdominal difficulties while living at home and that his relation to his father was the prototype of his subsequent reactions"; also, "that in his pattern of reaction to the master sergeant he was actually fitting into the mold cast for him by his relation to his father; that just as he resented his father's arbitrariness - but respected him and feared to show his hostility - so also he hated his immediate superior, swallowed his resentment because of the respect he felt for him, and expressed his internal tension via the abdominal symptoms." He was also told that he had a "nervous sensitivity" which was "pictured as a value and not as a defect."

Following upon receipt of this advice, the next time the master sergeant started bullying him, the patient "let go with both barrels at him right in front of all the other men." According to the patient, "the Major busted me down to private for that, but when he saw me this morning he told me confidentially that I would be soon getting my promotions back." Whether or not the fact that his punishment was apparently only temporary hdd anything to do with the result is unclear; but from then onwards there was no single recurrence of abdominal pains or headaches.

. . . . .

We see here a conditioning of anxiety and ambivalent attitudes toward a specific type of authority figure which could be identified with the initially severe and rejecting father, who was also admired. A probable genetically determined predisposition to anxiety or "nervous sensitivity" was doubtless reinforced in some ways by mother's over-protectiveness as well as by

father's behaviour. "Insight" - or a rational explanation of his symptoms plus an increase in self-esteem produced by the therapist's evaluation of his "nervous sensitivity" led to a (therapist - and therefore, authority-permitted) expression of his hostility, which found reward in being partially accepted by the major. The patient subsequently identified to some degree with the father "as evidenced by his subsequent casualness toward authority . . . and his general air of self-sufficient confidence . . . "while he also took to smoking cigars as his father did."

. . . . .

Case 66: Anxiety and panic reaction in child.
(Kanner, 1935, pp.290-291)
(Classification 5 and 7)

"Elizabeth W. eight years and three months old, in good physical health, normal intelligent (I.Q. 101) had always been a fearful child. She was afraid to go upstairs in the dark and tried to persuade her mother to go with her. This her mother refused to do, so her little sister was drawn into the service. When she first began to talk, she lisped quite badly, the adults in the family used to tease her by mimicking her; she had never talked as willingly and freely as the other children and was considered rather timid. Her father was a stable electrician. Her mother complained of nervousness and headaches; she cried a great deal 'when the children upset her'. She got excited if the radio played too much, especially on Sundays, when her husband liked to listen in. She was afraid of hospitals and could not even go there to see a sick friend. Elizabeth was the second of three children. Dorothy, aged thirteen, was a 'nervous' child and cried easily, particularly 'when spoken to crossly'; she frequently walked in her sleep. Caroline, five years old, offered no problem. The maternal grandparents had been separated for many years. Five years ago, the father lost all her savings, since

then, there had always been financial stress in the home.

"Elizabeth developed normally. She had chicken-pox and pneumonia at three years and measles at five years. When not quite two years old, she was ill with pyelitis and did not walk for eighteen weeks, having to stay in bed. Her progress in school was satisfactory until June, 1931.

"At that time Elizabeth was playing with some other children in their backyard. One of them must have done something to the house, for the woman who occupied it came running out and, far from questioning her own offspring, immediately began to scold Elizabeth and threatened to have her arrested and sent to jail. The child, who did not even know that anything had happened to rouse the woman's anger, was overcome with fright. That woman's daughter, just a little older than Elizabeth, assisted her mother in scolding and added that she would put the child's parents in jail. It was around this girl that Elizabeth centred her fears. She would not go near the house where the F. girl lived. She would not go to school because the F. girl was a 'monitor' on the playground where they had their lunch, and she was afraid that the girl might report something about her that was untrue and she would be blamed for it. After a short time, she became so frightened that she would not leave the house at all. At home, she kept crying violently for hours. She slept poorly; she woke up fifteen to twenty times during the night, especially between three and six o'clock, and called for her mother to sleep with her. Her appetite was very poor. 'She is always irritable now and does not seem to be herself. She talks louder and hollers louder than she did before that thing happened.' She could not be examined; she kept sobbing all the time. The mother was in another room while the child was interviewed and was almost as agitated as the patient herself and walked back and forth, quite upset.

"The condition lasted from June until October (when she was first examined.) The situation was talked over with the school and the child taken back to the classroom. At first the teacher stayed in the room with her for lunch, then she was replaced by a classmate, and finally she was lured back to the playground, where she again learned to play normally with other children. With the school routine established, her other difficulties disappeared gradually. The absurdity of the threat that she or her parents would be jailed had been explained to her as soon as she was willing and able to listen.

Dorothy was treated at the same time and was no longer troubled with somnambulism. With the improvement in the children's conditions, their mother's headaches and excitability diminished markedly."

. . . .

Kanner actually quoted this case to illustrate his comments:

"An understandable and, for the moment, normal fright reaction may sometimes be continued in a rather sweeping fashion for several days or even weeks. The child, under the influence of the original strong emotion, is agitated, sleeps restlessly, is startled by the least occurrence, has no appetite, may even temporarily, lose his excretory control, and is utterly unable to take care of himself. We may designate the condition as a panic reaction. Ziehen (n.b. no actual reference given) has coined for it the name of ecnoia, or protracted lability of affect. Orientation and memory are fully preserved (in contrast to twilight states and delirious conditions)." (p.290)

This "ecnoia" probably is dependent on a genetically-determined predisposition to lability of the autonomic nervous system; but, at the same time, "contagion of affect" and imitation of the mother's behaviour will undoubtedly have assisted in the conditioning and reinforcement of the child's responses to feared stimuli.

Psychotherapy has consisted primarily of "supportive therapy", i.e. de-sensitizing of the generalisdd fear response to other people and the re-learning of play and friendly social habits. This is actually "reciprocal inhibition therapy". But, added to

this, was "higher learning" in the shape of the explanation of "the absurdity of the threat that she or her parents would be jailed"; one may cite this as an example of simple semantic conditioning or suggestion an already-believed authority-figure, or as "cognitive learning", i.e. the incorporation of additional relations in an existing (earlier conditioned) reference-frame. Perhaps both were involved.

. . . . .

Case 67: Schizophrenia and hunger trauma.
(Steinfeld, 1958, pp. 97-100)
(Classification 3a(ii), 5,10)

(Although reproduced here practically in its entirety, I have twisted the sequence to make it easier to follow.)

"The history of Jack, a university student, twenty-two years old upon admission, is enlightening. We can explain the entire psychotic process up to the present hallucinatory period from the originally suffered hunger trauma and the 'vegetative' fixation on the mother as the result of the trauma."

(p.99) "We feel that the patient's present illness can be understood only if we consider it as a reactivation of a dormant process, the roots of which originated in the first few weeks of life. The earliest history given by the mother is as follows: 'He was born blue, was breast-fed exclusively for almost six months, but he did not get enough food. He was not crying, but rather 'quiet' (semi-stuporous). He gained weight well for a while, but lost it again, all this during the first year. In addition, he developed pneumonia which added to the loss of weight.' Frequent intestinal troubles have been observed up to now, with occasional spells of vomiting when he gets excited. Such spells recurred during his recent psychosis. At the beginning of his psychosis two years ago, he craved sweets which he then took in large quantities, in contrast to usual eating habits."

"Jack was first admitted to our institution in 1954, for five weeks." He was then suffering from auditory hallucinations and paranoid delusions relating to mind-reading.

"The precipitating causes of the present illness are not too clear. His parents reported that he had always been extremely dependent, with a great attachment to the mother; towards the father, he tried to be friendly, but that friendliness was not genuine; often his hatred for the father became evident. The family equilibrium became increasingly upset when his younger brother had to leave for overseas duty. The departure of the brother, who shared with him the oedipal attachments to the mother, so-to-speak, burdened him too heavily. The 'ally-rival' was no longer present. These wishes, intolerable to him, then assumed the form of hallucinations. (It was later confirmed that his hallucinations on first admission concerned mainly wishes for the mother.) Suicidal tendencies and, at times, homicidal fantasies were outstanding. On several occasions we were afraid he would actually attack people. Accomplished homicides - of the parents and the therapist - would have constituted a 'solution', since with their elimination his fantasies would no longer have had substantiation.

"The patient during his psychotherapeutic sessions elaborated greatly on homosexual wishes, on painful ideas of reference, feelings of estrangement, etc., but obtained little relief from all these 'revelations'. Interestingly enough, there was hardly ever any mention of his mother attachment. The only intimations leading in this direction were hallucinations (and a quoted dream) pointing to the mother . . . Not much was associated with this dream, but we felt that he actually knew more than he could verbalize. There was a temporary improvement, which made discharge from the institution followed by ambulatory treatment possible. However, after another half-year a second admission became necessary, for the symptoms previously described with increased suicidal and homicidal tendencies, became evident.

"Now we felt that direct interpretation could elicit more and would be the only way to break into the psychotic process. In this respect, we became even more encouraged since the patient openly stated that in recent months he had made stronger attempts than ever before to 'cut the apron strings to the mother'. His mother had

been advised by friends to follow suit and to stay more and more out of her son's life. In addition to his brother's absence, the mother's aloofness was probably the precipitating reason for his illness.

"In order to combat Jack's states of severe panic connected with homicidal and suicidal wishes, ECTs were given followed by mid brain stimulation. (Each ECT, twenty-one in all, was followed by thirty seconds of stimulation which produced fine subcortical tremor, in recent months acetone inhalations (seven in all) were added to the ECTs.)

"Psychotherapy, which ran parallel to organic treatment, was changed in goal and concept. It was interpreted that all his hallucinations and wishful fantasies were expressing desires to be united with the mother. Unless he would accept these wishes, psychotherapy would be of little avail. His constant deprecating talk about his father was only a form of covering up. The response forthcoming after such explanations made an avalanche of new material possible. He became increasingly convinced that psychotherapy was not a mere construction, but had a realistic background. The following incident was impressive: one day when Jack was supposed to go to the treatment room, he became panicky, misreading a handwritten note on the door. He read, 'Through this door, Mother' (in reality the note read, 'Use this door, Mona' (name of the head nurse). This elicited a terrifying panic in him. Material then brought forth pointed to a most severe anxiety resulting from his wishes for the mother he was now able to understand more distinctly. While these wishes on the surface appeared to be incestuous desires, they seemingly revolved around a deeper fixation to the mother. What occurred was an instinctual understanding due to 'vegetative remembrances'. His condition improved as his fears decreased, and he was again able to return to his professional work.

"Simultaneously we convinced his mother to give up her attempts to 'wean him and let him grow up', which she had been preventing for approximately two years (as long as the duration of his illness). She was advised to give him all the support of which she was capable and to cater to him as she had done prior to the onset of the illness. Anxiety did not increase; on the contrary, because of his new understanding he began to enjoy the mother's care and revived interest in him."

"The progress of this patient, still under treatment, now shows increased attachment to the therapist and a decrease in his desire for the mother's over-protection. Occasional ECTs followed by acetone inhalation are given whenever states of panic (repetitions of the earliest, non-verbalizable trauma) occur. The patient is able to live outside of the institution near his parents, and does well in his professional work. On various occasions, the inclusion of the mother into the interpretive process was helpful. For this purpose another therapist was called in, and the patient's therapist was excluded from such conferences so as not to break into the transference relationship, as yet not solid.

"We very clearly see that there exists a continuance of the first trauma, the hunger trauma of the first few months of life, up to the present, in nature almost identical but different in manifestation. The modes of expression depend on the various ego-states in which the psychotic symptoms became evident."

. . . . .

As De Steinfeld has seen, but describes in somewhat different language, we have here an example of predominantly interoceptive conditioning. The conditioning which was incorporated in, and followed, his physiological states was associated with, and acted in circular reinforcement with, the conditioning relating to his mother's (environmentally-reinforced if not created) excessive care. Because of his physical state he required extreme care and attention; at the same time he was undoubtedly frustrated considerably by the insufficiency of his food. It is noticeable that in infancy he reacted to this lack or frustration with a state of semi-stupor (possibly akin to marasmus).

No indication of the mother's reactions at this period is given - it is possible she became over-solicitous due to reaction-formation later. In adulthood he reacted to the lack or frustration associated with the apparent withdrawal of mother's love, care and attention with the opposite of stupor - arousal, and aggression. We may postulate, therefore, that his life-force, "life instinct" if one prefers the term, is now strong. At the same time he would appear to have been conditioned to fear of socially-disapproved thoughts or actions (possibly he believes in principle in the law of talion), as witnessed by his "suicidal wishes" and paranoid-type hallucinations. He seems to have been attempting himself to "grow up" or "stand on his own feet" or reject mother (possibly this is related to his presence at the university and learnings associated with this experience). He could not, however, stand the associated stress when mother appeared to reject or punish him in turn. What he required, indeed, was the continuing love and permissiveness of his mother to enable him to separate himself from her and his previously held attitudes in his own way at his own time. Indeed, this is very much a repetition of 2-3 year old behaviour, played out on a much "deeper" level because of the greater maturity and wider experience and conditionings of the patient concerned.

Therapy has been of two types - physiological, in the shape of ECT and acetone inhalation, both of which

would appear to have been only of use, if at all, as adjuncts to the psychotherapy given, which here consisted mainly of rational explanations or semantic conditioning (or interpretations - changed from "oedipal" to "actual experiential" orientation); suitable manipulation of the environment (i.e. changing mother's behaviour) which would incidentally lead to an enhancement of her own feelings of self-esteem, "she had been acting correctly before, after all", and would undoubtedly reflect back to the patient); and permissive support.

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Case 68: "Psychotic" reaction - family therapy.
(Auerback, 1959, pp.158-177).
(Classification - Daughter: 5,10; Mother: 9).

The parents were in their fifties. The elder of two daughters had been psychotic for six years. Father had always worried about financial security and devoted himself to his business interests; mother was an aggressive resourceful woman who made the family decisions. Mother had wanted children while father wished to build up financial security first. She was over-protective even after the birth of the second daughter who "somehow was able to get along by herself." The patient was very much attached to the mother but had not learned to relate to other children. At adolescence she began to break away from dependence on her mother and to become outgoing and overactive. She looked forward to college and living away from home to bring about emancipation, but developed psychosis when she got to college. Mother insisted on hospitalization against the daughter's protests and father's passive opposition. When funds ran out she was transferred to a state institution where she spent six months and then returned home. During periods at home she retired into isolation and delusion. Family life was stormy; father had lost

his business, as the result of business reversal within the year of the daughter becoming psychotic. The younger daughter finished college and began work as a teacher in another state.

Family therapy was begun six years after the onset of the psychosis. For twenty hours discussions were largely attempts by mother to prove that she had been a good mother and that daughter was terrible and ungrateful and attempts by daughter to rebut with proof that mother was terrible and she a good daughter. Father stayed on the periphery of this battle. Anxiety about the possible failure of the father's new business led to the patient making paranoid attempts at help which finally led to hospitalization again at the instigation of the mother. There were violent scenes when mother visited the hospital so she desisted and left this to father. The acute upset subsided as the result of tranquilisers and soon the daughter was able to return to the family therapy sessions and finally to the home. She took a job again and mother went on vacation for three weeks while she kept house for father. On her return little progress was made until finally she attacked the father for being "an unemployed executive" while she supported the starving family. Shortly after this he was hospitalized with an intestinal upset. (Psychotic probably).

Mother now began to realize how closely she had identified with her daughter and made some attempts to make her more independent. The latter also realised her extreme identification with and dependence on her mother. She had "depended on her mother to tell her how she felt and looked" and similar suggestible behaviour occurred when she was at school. The latter now began to develop socially and dated several nights a week. She moved to a better job and met her old friends again. Father began to assume a more adequate position.

. . . .

This case is distinctive in its social approach to the problem and it seems to have been particularly appropriate in this case. Possibly many cases would turn out to be similarly appropriate if investigated in this way. One wonders, however, to what extent the patient's trouble was really psychosis. The impression

is rather of neurosis with psychotic-like symptoms originally developing under the strain of separation from the mother. The therapist carefully avoided any diagnostic labelling+, however, and might cheerfully agree with our comment. The essential point seems to be that here was a case of family maladjustment++ and the "psychosis" of the daughter, just as the intestinal trouble of the father, was simply a symptom of this. Several kinds of approach could have led ultimately to family adjustment but there would seem to be some advantage in a direct attack on the problem in such cases.

+ One of the rules is that a label must be applied to the whole family, not to an individual.

++ "The one most striking pattern in the research on families has been that of the aggressive mother and the passive peripheral father." Earlier in the project this was described as "The problem of the family is as much an act of omission by the father as it is an act of commission by the mother." (p.164).

. . . . .

Case 69: "Psychosexual Infantilism" - psychoanalysis.
(Fink, 1954)
(Classification 5)

This entire book is given over to the study of a single case, that of a"young Spanish-American whose nom de guerre was Pedro Lavero. At his first interview he was 23 years old, with two brothers, 22 and 21, and a sister 12. His father had owned a large hardware store; but after his death in 1945 (while Pedro was in the Navy) the store had been sold to Pedro's uncle Enrique.

"For the first three grades (he) went to a Catholic grammar school, then to a private school, where there was bickering with other students, since they were Protestant or had no faith at all; he graduated from high school in 1943, then went into the Navy for three years." After that he went to a Los Angeles business college for two years, which he found "both dull and frustrating." His command of English, particularly considering his bilingual background was "exceptional." "Unable to decide what to do, he had approached his psychology professor," who recommended him to see Dr Fink. The professor "had phoned . . . to say Mr Lavero's classroom behaviour was odd, that he spent his time holding hands with one of the more popular girls, and seemed to daydream a lot, for when surprised he was unable to answer simple questions, although his I.Q. was high." Occasionally he went to sleep in class."

Pedro was given a Rorschach and T.A.T., and apparently on the basis of these results he was labelled "ambulatory paranoid schizophrenic", a diagnosis which would appear to have been confirmed in the course of his analysis, during which he is said to have presented delusions of grandeur and of persecution. (p.7)("For obvious therapeutic reasons and to avoid disturbing the patient he was not labelled psychotic in the initial months of analysis, although the significance of this diagnosis had to be brought out when the patient was ready for it, so as to accelerate attitudinal changes and progressive insight into the etiology of his condition.")

He had always been extremely shy, was so bashful at high school that he hated to remember that period at all. During the first interview he commented "Mom is shy like me. She was okay with store customers, but she can't talk freely with us. Perhaps it's because she had no education, for she had to slave all her life. She never

mentions sex, although I think about it twenty-four hours a day. . . " Mom never remarried.

Fink comments (p.8) "Pedro's homosexual trends arose, in part from the domination of a mother who meant well but could not control her brood of four without repression; and, in part, from identifying with a weak father." This statement is, however, somewhat inaccurate. Pedro stated (p.21): "As early as three years of age, I recall Pop telling us what we should do when we grew up. I was to be a doctor, Dom a priest - Lord save us! - and Carl a lawyer. We would play games, acting out the three parts. But I hated these games, since Father ordered us to be these things! Dad pushed us around in other ways too: "Here, eat this liver; it's good for you!" . . . I resented him and planned all sorts of vengeance for the time when I'd reach freedom from his domination." The father apparently died under somewhat suspicious circumstances, Pedro insisting that the doctor had said he had died of arsenic poisoning. Dr Fink took this in good faith (but if one delusion - why not another?) and did not press any enquiry for ethical reasons.

Pedro reported: "Mother once told a neighbour that I nursed too long at her breast. I guess it bothered her, with Domingo on the way. Mom nursed me for six months, she says, and then I took the bottle till after my second birthday or later . . ."

He had masturbated for the first time at eight, when he accidentally found "it was fun to tickle myself, but there was no ejaculation. I had heard something about that from the guys at school, so I felt around the bed in the dark, but found nothing." Two days later he ejaculated, from which time onward he had masturbated "most of the time", though he did not like hearing the boys' terminology. However, "it warmed(him) up, made (him) feel less lonely and neglected." From 11 to 17 he "gratified himself regularly once or twice a day", and from 18 onwards went with girls "while on liberty", though he did not find it particularly satisfactory and continued to masturbate once or twice a week. Around 11 he practiced fetishism with his aunt's underclothing.

"During his eighth year" he and his young cousin had temporary mild homosexual relations. Pedro played a feminine role, "letting him take the initiative." Later Juan "got chicken". When he was 17 a man of 35 had taken him to his home for some fun with some girls.

While waiting for the girls they had undressed and gone to bed; during which time the other male brought him to climax by masturbation and then demanded he do the same. Afterwards Pedro had felt "very guilty and dirty" about what he had done.

He had felt sexually stimulated by his sister, mother, aunt and various other women - with consequent guilt regarding his incestuous wishes. He was also very self-conscious about his lack of height (though he was 5'7").

During his analysis, Pedro recalled "Mom gave me love as a child, but I didn't return it. Pop was man to her by getting on top of her. I was less than one year old when I saw them. I couldn't quite see over the top of my crib, so I had to look through the slats . . . Pop was cruel, so I identified with Mom to save her from him. Reaching two, I slept between them in the big bed till I was three in order to protect Mom by assuming her role with Pop. Sleeping with Pop, I feared he'd discover my penis and kick me out, since he preferred a little girl and didn't want me to take liberties with Mom. I fear Mom, so I want Pop back . . She has a whip over me all the time. I cursed him for leaving me so unprotected. Mom would punish me for the times I separated her from Dad. If Mother had died instead, Father and I could have wept sympathetically on each other's shoulders. I want him to comfort me. I guess I mean 'make love'. Feeling so small and helpless, I needed him badly . . ." (p.200).

"My folks encouraged eating and sleeping, so these were the only functions I felt secure about. I still do too much of both, believing that they will not approve other activities . . ."(p.201)

"I keep up voyeurism to discover woman's 'lost penis'. I want . . to prove that men and women are equally strong, and that there is no more need to fear women . . ."(p.201).

"Mom wanted girls, Pop preferred boys. That was the big conflict, how to please them both. I had to be shy and quiet like a girl for Mom - big, strong and businesslike for Pop." (p.191). Pop "was a man and took the leading role in the family, even over Mother. He was the judge, the supreme ruler." Pop also "had no sense of humour." The family placed great emphasis on quiet, good behaviour and good looks. The father "said he'd lose respect for us if we were not successful. (and to Pedro) I'm surprised at you, you're the oldest boy and should be the leader!" He also said, "Beware of your business partners, for they'll trick you.

Teaming up with your brothers is safer." "I had no desire to learn to smoke. Pop didn't approve of the gang and I didn't want to be like them. The same with drinking. I'd be too mannish if I got drunk.... " "We brothers were taught to love Pop when he came home, so we'd run out in the street to meet him. After a time we avoided this because we had to do it." (p.164) "At eight and nine I spent each Saturday polishing furniture, cleaning the house while my brothers played outside. Mom called me her 'good little housekeeper'. I should make someone a good wife! I ate that stuff up." (p.165) "Mom enjoys being unhappy. She imagines she'll get more attention being masochistic, just like I was." (p.180) "I've hardly admitted my interest in men. Women are a means to an end, to meet men and to compete with them through women. Mom wanted me to be a little girl, so I did her housework. When I was five Mom exclaimed, 'You're so cute, you should have been a girl!' I tried hard to be what she wanted."(p.191). "Eating was the only family recreation, and life centered around the kitchen table . . . I imitated Mom's procrastination, never getting things done on time . . . I rarely smiled, for I never saw them do it. Laughter was unknown at home. If Pop forced a smile it was for business reasons, and he'd freeze up as soon as the emergency was over. There was no relaxation at home, not a book or magazine in the house except my own textbooks."(p.195). "There were two major influences in my life. 'You caused me so much trouble when you were born!' resulted in guilt because Mom had been cut up at my birth (she had a Caesarean). 'You're so good, you're a little angel!" resulted in my perfectionism and self-conscious syhness. . . The more I struggled to ward off guilt the more I was aware of it. So I sank into a lethargic state to escape the terrible conflict. Apathy seemed the only way out." (p.211) "I can't distinguish between kindness and meekness. If a man is kind like you, I figure he has no backbone. If you're mean to people you can't get hurt. If you're nice to them they step all over you. So I figure that the aggressive individual is the strongest... . I'm afraid not to be hostile . . ." (p.215).

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From the above it will be seen that there are strong conditioning factors operating within the environment to mould him into shy, introverted, "feminine" behaviour. An apparently strong sex drive became the focus for his needs for exploration, excitement and acceptance.

He had strong ambivalent attitudes to both parents. Early identification with mother led to many varied difficulties in heterosexual relations, as well as reinforcing his more feminine tendencies. At the same time he learned many lessons from his father only too well: Father's philosophy is reiterated on several occasions, and he apparently also learned expediency and dominant behavioural patterns which were in conflict with his other learned behaviours. Guilt has many causes and was constantly reinforced - he was a boy not a girl; Mother was "cut" through him; masturbatory practices were associated with incestuous fantasies and actual handling of his female relations while they slept. There was a "libidic split" - at one stage he alternately loved and wanted his mother and sister.

His over-eating stems from the family's proclivity for eating. As for his delusions - the only way he could be a full man was in fantasy for a considerable period.

Analysis was brought to an end after 228 sessions. He had actually formed quite a strong heterosexual relationship and asked the girl to marry him. At the time she was still dating another boy as well, and it would seem they probably did not marry, at least there is no mention of it.

In the second to last session Pedro concluded:

"I figured that a person is abnormal if rejected by pthers. Since you accepted me I was okay, and I aimed to become what you seemed to think I was. I that way I struggled to get well. I didn't want to get well for myself, for there seemed no advantage to it. I did it to please rather than disappoint you, since you enjoyed seeing progress. Otherwise I'd still be as badly off as I was at the beginning - or worse." (p.231)

Pedro's early training in trying to please his mother finds its continuance here; at the same time the comment "you enjoyed seeing progress" has overtones of his father's single-minded drive to achievement; which doubtless conditioned Pedro to find motivation in such an aim. The "surrogate father" had also accepted him, so that he had learned what an accepting relationship with a father figure was like.

"Four years after therapy ended a follow-up study enabled the analyst to assess Pedro's current status. . . With greater ease of identification, more and deeper friendships, a sense of belonging, and a feeling of being worth while, he has shed most of his debilitating anxiety and resulting tensions. He now enjoys his day-to-day living, and his social life is exciting and full. He has moved to another State, and realised his dream of becoming a teacher. . . (and is) in the forefront of his school, where he is being considered for an executive position." (p.235)

There would seem to have been here a process of retraining instigated by insights arising from the analysis and a desire to earn the approval of the therapist and reinforced both by the more satisfying consequences and the therapist's manifest approval.

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Case 70: Peptic ulcer and psychoanalysis.
(Grinker & Robbins, 1954, pp.308-310).
(Classification 2, 5, 8a(i)).

"This patient was referred to a psychiatrist by an internist who had been treating her peptic ulcer with good results. He noted that she had recently become lax in following the prescribed medical regime, was irritable with her family, and had considerably more epigastric distress than would seem possible from the improving x-ray findings and other examinations. He learned upon further inquiry that she was leading a progressively constricted social existence and spoke of marked feelings of inferiority. He made a tentative diagnosis of depression, and on investigation found that the patient's symptoms became worse each time her husband left on a business trip or when both left their home town for a vacation. At this point the internist felt that he had neither the time nor experience to treat her psychological problem, and having made an appropriate diagnosis he referred her to a psychiatrist . . . during the course of the subsequent psychiatric treatment the patient continued to follow the medical regime prescribed for her ulcer.

"The psychiatrist having assessed, by means of interviewing technique, the nature and extent of disturbances of her relations to the significant people about her, her prior knowledge of and interest in psychology, her capacity to adapt to a changing environment, and numerous other factors decided that psychoanalysis was indicated . . . It was explained to the patient that she would be seen at regularly specified hours during which she would allow herself the experience of becoming aware of and reporting to the analyst all of her ideas, emotions, feelings, bodily sensations, dreams, daydreams and fantasies. The patient found within the course of weeks that she could do this and the analysis proceeded.

"A definite emotional pattern of tension with tearfulness, apprehension, intense fear of the analyst, and anger toward him developed progressively in each session. The meaning of this phenomenon, which we may designate technically as a transference neurosis, could not become apparent until the patient herself realised that her tears had been coming on for many years and had never been expressed. The emotional pattern seemed

familiar but she could not identify it verbally. Her chain of freely given associations revealed that when she could cry under these circumstances her stomach distress diminished. When she was unable to cry but wanted to, the epigastric distress became severe. In the process of associating present and past events, old memories flooded out with full affect. She claimed that the analyst hated her for being a coward about the analytic procedure, which had first seemed so simple and had now become mysterious and confusing. Needless to say, no such accusation had been made explicitly or implicitly nor had anything been changed in the method by the analyst. After the patient realized this, she was one day reminded of the mysterious and confusing fears of her enforced attendance at spiritualistic, religions seances as a child in a church of a religious sect to which her parents belonged. During such sessions adults were supposed to disappear spiritually and return in reincarnated forms. They were angry with her if she refused to participate in the service and she developed a pattern of covering up her fears and tears by pretended bravery which was highly praised by them.

"However, the mere thought of leaving or being left was intolerable to her both as a child and as an adult. She had been trained to repress her emotions so early in life that it was not until her analysis that this whole complex emotional pattern of response to the stimulus "someone is leaving and will come back only in unrecognizable form' became fully conscious. During the analysis these repressed memories, both visual and affective, came to conscious awareness, particularly following a missed appointment, a vacation, or a business trip. Another major aspect of this case was a fear of being left to the mercies of a mother pictured first as a carnivorous creature with huge fangs. Only later in her dreams and fantasies as in reality the mother was remembered as a rather passive, calm, understanding person who had had to handle feeding difficulties in the patient very early in life without medical help, for the patient had been tongue-tied until she was eighteen months old. With this verbalization, the abreaction of emotions, the recollection, repetition and working through of the pattern in relation to the analyst, the previous unconscious psychological tension was relieved.

"Working through the details of such a pattern as the one cited is time consuming. The patient becomes increasingly aware of the long-buried emotional components

and their re-evocation by specific contemporary stimuli. In the process of being made conscious, the repressed complex of fears and guilts surrounding primitive devouring tendencies no longer requires the unconscious psychological defenses erected against it . . . "

. . . . .

At first sight one might well imagine that this patient was very concerned with the law of talion, and her own behaviour at the breast, (mother was first remembered as "a carnivorous creature with huge fangs") and certainly one may assume that one's "reincarnated form" would be related to one's behaviour on earth. Unusually enough in psychoanalytically-oriented therapists, there is no suggestion that the peptic ulcer was likewise linked to the act of devouring/being devoured despite the feeding problem uncovered; but rather, and more wisely, it is seen as being affected by, if not caused by, the stress associated with the patient's psychological problems.

This is an excellent example of the unfortunate learnings which may, and frequently do, occur as the result of being exposed to noxious stimuli in the form of superstitious, ignorant, inaccurate and mischievous "religious teachings". Based quite probably upon her early non-learning of adequate verbalisation due to being tongue-tied(as well as upon her frustration-reactions to the mother, stemming also from the tongue-tied state and feeding problem), and reinforced by the conditioning to

inhibitory behaviour (in turn reinforced by the reward of being praised and considered "good", thus enhancing self-esteem and promising continuation of "love" and, presumably, of a satisfactory "reincarnation" for herself), associated with the fear-constellation related to uninhibited behaviour; this patient developed a built-in stress system associated with any emotional tension and/or the experience of being left (also doubtless originally associated with her tongue-tied state).

Therapy, as the authors state, has been largely based on "verbalisation, the abreaction of emotions, the recollection, repetition, and working through of the pattern in relation to the analyst." In other words the patient has learned "insight" - the reasons for her fears and behaviour, she has developed "cognitive awareness" based on her own verbalisation and explanation of forgotten events, and reinforcement by repetition be it noted; accepted and approved by an authority-figure who, she has come to realise, accepts without disapproval her verbalisation and emotional reactions. Appropriate emotional outbursts (tears, anger, etc.) act as de-sensitizing, extinction agents reacting upon the circuits which have previously been thrown into action by cues to the whole reference-frame associated with, or conditioned, to fear and conditioned-inhibitory responses.

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Case 71: Depressive reaction; intensive psychotherapy. (Searles, in Cohen, 1959, pp.247-264) (Classification 5, 6b).

"Intensive psychotherapy" was undertaken with a patient who was "a married but childless Southern woman, then 35 years of age, who had just been admitted to Chestnut Lodge in a depressive condition. During the first several therapeutic hours, she spent each session almost exclusively in trying to remember the names of various members of the personnel at the Lodge, including (the therapist) and to remember the growth outlines of her own life history, and in castigating herself for her inability to remember. Repeatedly she would start to say something, forget what she had started to say, develop an increasingly worried and finally very exasperated facial expression, berate herself as being 'worthless . . just a numbskull, that's all!", burst into tears, and then become doubly exasperated and condemnatory toward herself for weeping without, as far as she could see, any rational reason for weeping. Although the bulk of the evidence came to indicate that hers was a severe neurotic, rather than a psychotic, condition, the self-castigation initially seemed psychotic in its degree of harshness, and although she eventually proved to be of normal intelligence and free from organic impairment, her initial difficulty in thinking seemed so marked as to indicate either mental deficiency or organic brain disease.

"The history - as it was obtained from relatives, from a hospital where she had been treated five years previously, and increasingly from herself as her memory improved slowly after about the first two weeks of therapy - showed that a sister had died at the age of three, four years before the patient's own birth. The mother had been in a depression from the time of the death of this older daughter - that is, before the patient was born. When the patient was nine, the mother finally had to be hospitalized amd subsequently committed suicide in the psychiatric hospital. The mother had always related herself to the patient in a solicitous, over-protective fashion, and now the child was suddenly left as the sole surviving female in a family which included four older brothers and an emotionally remote, rigidly domineering father. Only two of the brothers were at all close to her in age, and both rapidly outdistanced her in social and intellectual achievements. She was chronically regarded as 'the stupid one' in the family, and her first breakdown occurred at the age of twenty, while she was enrolled in a small teachers' college where she was not making the grade socially or academically. The details of this breakdown

are unknown, save that she was said to have been 'disturbed and unmanageable.' Significantly, a period of five months' rest in the company of a female nurse, at a mountain resort, enabled her to recover without hospitalization and even to return home a markedly more warm and outgoing person than she had been previously.

"At the age of 25 she married a lumber dealer, a man regarded by her family as being socially and intellectually much inferior to themselves. Toward her husband she maintained, from the first, a clinging dependency, masked behind an almost incessant henpecking of him. Five years later an aunt died, who, in the words of her husband, had been 'like a mother to her.' He said that his wife thereupon showed a marked accentuation of her anxious, clinging behaviour toward him, and began to awake often at night, weeping, without knowing why she was weeping. Her condition rapidly increased in severity so that, one month after the aunt's death, she was admitted to a psychiatric hospital. There she was found to be "confused, disoriented, incoherent, delusional, hallucinatory, continuously weeping without tears." In the course of a period of electroshock therapy, followed by a long series of insulin coma treatments, she reached an inactive, apathetic state in which, eighteen months after admission, she was released from the hospital.

"During the next few years at home, she improved slowly. But then, in a setting - as she eventually brought out in the therapy. . . of increasing anxiety lest she lose her husband, who had never tried to have children by her and who was under increasing pressure from his own family to divorce her, she gradually developed the depressive symptomatology which necessitated her hospitalization at the Lodge. She had evidently not let herself recognise the anxiety as having to do with the threatened dissolution of her marriage; she had only noticed with mounting concern, over the months, that she was gradually losing weight.

"As the therapy progressed, it became increasingly clear that her tendency was to relate herself to other persons, and even to aspects of her own self and to various inanimate objects, in a vindictive, railing fashion. As she had excoriated herself initially for her poor memory and her tears, she later sastigated the nasal discharge, which, for a time, supplanted the tears, and frequently reviled, for example (various parts of her body, or bodily functions, which annoyed her from time to time) . . . She also directed the same kind of vituperation towards inanimate objects . . .which proved to be unsatisfactory to her . . .

"As the months of therapy went by, her deeper-lying feelings of fondness began to emerge - fondness toward her husband, her father, various nurses, certain other patients, and (the therapist). Interestingly, her growing intimacy toward (him) was spearheaded by the same vindictive kind of feelings. After a few months she had improved sufficiently, symptomatically, to move to out-patient status.

"Gradually indications appeared that a long-buried grief about the loss of her mother was at the root of her illness. In an hour during the fourteenth month of therapy this came out in the clearest form that (the therapist had) ever perceived it. After having wept copiously throughout much of the hour, in a spirit now not of self-condemnation but of genuine grief, she spoke of missing her husband and of wanting to be home with him. (The therapist) asked if she had ever missed anyone as strongly as this before. She replied hesitantly, in a childlike, naive way, ' I miss my mother; but I know she can never return, so I think about George (her husband) instead'.

"It was during the month following this hour that she discontinued her therapy here and returned to the home. The indications were that what she was fleeing from, in therapy, was primarily the ancient grief about the loss of her mother."

Dr Searles gamely adds: "My belief now is that I, too, contributed to the dissolution of the therapy, on the basis of my own anxiety about grief from my early life - an area which, at the time, I had not yet explored at all thoroughly in my personal analysis."

. . . .

One sees from Dr Searles' very honest report how one's own needs and reference-frame tend to distort one's perception when trying to fit facts to a particular hypothesis. It seems to me that any unduly prolonged grieving must require a predisposition to depression, no matter what the cause; while the natural concomitant of grief is a longing for what has gone and a wish for its replacement. Usually if a wish or need is frustrated

we find aggression. If, however, there is little likelihood of the wish being satisfied, we may find grieving or depression.

In this particular case there are a number of conditioning factors operating: (a) the child had been conditioned to over-dependence; had been conditioned to expect over-solicitousness and care on the part of her mother; (b) her "model", i.e. the mother, was always depressed; it is conceivable she herself reacted with depression and/or imitated her mother's behaviour; (c) the mother committed suicide, which was conceivably regarded as a "disgrace" by a family such as the one cited - the patient may have considered herself "guilty" about the mother's death; could equally easily have considered herself, by identification with the mother, reinforced by the father's obvious rejection, also a "disgrace" to, and unwanted by, the family; (d) she was conditioned to expect condemnation from her family - later expressed in her own "self-condemnation", (though this, too, could easily be related to guilt); (e) she was conditioned to regarding herself as inferior to the male members of her family, a situation she sought to compensate for in henpecking her husband, probably. When the mother-surrogate, her aunt, also died, she undoubtedly experienced a feeling of abandonment to a potentially hostile all-male world.

There is no clue as to why the husband "had never

tried to have children by her"; nor as to whether she herself wanted children. Therapy seems to have been primarily aimed at clarifying the interpersonal relationships; and interpreting the vindictive behaviour aimed at animate and inanimate objects, primarily in this case, in terms of underlying grief. Vindictiveness would seem to predicate an underlying impotent fury directed against the objects felt to be responsible for the frustration and loss of the beloved - in this particular case, we may suggest that the father was the original person so hated, followed possibly be her brothers. Her marriage could well have been an act of spite aimed at both her family and herself. But, no matter what it was, it could not have occurred if there had not been a conditioning to relatively impotent hate toward the stern, rejecting father.

In therapy the therapist was first related to vindictively; but he maintained his accepting, permissive attitude apparently, so that the patient was able to experience a relationship with an accepting, male authority-figure. In the earlier breakdown the nurse had apparently played a similar female, mother-surrogate, role. During the therapeutic sessions abreaction, or the expression of her rage and grief, had occurred; she was then able to realise that her grief, first for her aunt and finally for her mother, was responsible for her behaviour and her breakdown. This in turn led to her final concern for her

marriage relationship, and conceivably to a desire to see how George was and make sure her marriage did not go completely on the rocks. It seems to me quite possible that the therapeutic result was better than the therapist feared.

. . . . . .

Case 72: Catatonic schizophrenic - Jungian analysis. (Perry, in Burton, 1961, pp.90-123).

Dr Perry is a Jungian - this case is described and dealt with within a Jungian framework. In his general discussion, he notes, for example: "The psychosis is regarded . . . as an eruption of the contents of the deepest layers of the unconscious into the field of awareness, flooding it with images of death, of entering an afterlife state, of descent into an underworld, and renewal or birth in some form, along with ideas of kingship or rulership, and cosmic conflict between political or moral forces." (p.92)

I will illustrate the problem of a mother complex and the manner in which it is handled by the unconscious by presenting a case of a young woman with an acute episode of catatonic schizophrenia whom I had in therapy for several months on an inpatient service." (p.96).

Case History

The patient was "a thirty-year old, single, white woman of a profession associated with the medical field. She was brought in by the police because of bizarre ideas and behaviour.

"The father had died when the patient was six months of age, and the patient later blamed the mother for having forced him to go to work when he was sick and thus causing his death. For half a year, the sixth to

twelfth month, the patient was taken over by relatives because the mother had a 'sort of breakdown' and could not handle the care of the child. During all the rest of her girlhood, the patient lived with her two older sisters and mother under the maternal grandmother's roof along with several other of the mother's siblings: aunts and uncles both. This was a distinctly matriarchal sort of household in which the grandmother kept a controlling hand over the lives of her offspring to the time of her death when the patient was ten. During all these years the mother, a depressive personality, showed little interest in the two younger daughters except in a suppressive, disciplinary way.

"The older daughter made a somewhat comfortable adjustment to the mother by becoming more or less like her. The two younger ones, however, entered upon a mutual withdrawal into each other's secret companionship and into a state of rebellious belligerence toward the rest of the family, especially the mother. Nevertheless these two remained in their later years in a mutual dependence in relation to the mother.

"The patient went through high school and junior college in good health and then enrolled in her professional education; all this time she lived in another part of the country. (She had lived in the city of her present residence for only three years together with sisters and mother; she did not really feel herself at home here, however.)

"Her relations with young women friends have often been warm and close. She has been inclined to react with antipathy to older women, especially in a work situation. She has had a number of affairs with men; but more than once they were married men, and somewhat neurotic and inclined to draw upon the maternal counsel and protectiveness of the patient. One such relationship was sustained from the age of eighteen on - for twelve years.

"She was inclined to use alcohol when lonely.

"In the third month before her present illness she was rejected by a lover and became morose and despondent. She went into psychotherapy not long after, but had only four or five sessions and did not really enter into it fully. Two weeks after admission she was arrested overnight for an impulsive misbehaviour when drunk. She became severely withdrawn at that time and delusional ideas began to form. She became acutely disturbed on the day of admission.

"On admission, physical findings were essentially negative, except for a twenty-pound weight loss which led to the point of severe emaciation."

The patient's delusions were "fairly classical." "She thought she had died, and that she and the others in the hospital were in an after-life state. Crucifixions were a prevalent motif in her drawings. She was implicated in a major world conflict between the forces of communism and those of democracy. Men were to be eliminated and their sperm kept for later use. She believed herself to be Eve in the Garden of Eden, at the beginning of creation; also Queen Elizabeth, the Queen of Peace, now to be married to the Prince of Peace, with a new message for the world, also the Virgin Mother about to give birth to a new Redeemer. She was concerned with the form of a new society in a Heavenly City."

Later, in the course of psychotherapy, on one occasion she said she was "reliving the whole New Testament story . . . 'Christ was born among us and preached love and kindness and goodness, and taught us to love one another and live together in peace. It's the most important thing in life, all this'"; another time she believed the therapist to be her recent lover, Winston Churchill ("we must get to work rewriting the Bible together") and the Prince of Peace. Still later she said she had thought she had created three stars and a moon, and that she was "Mother Earth, the source of all life" apparently "being desecrated by the avarice of men who plunder her of her wealth."

Therapy in this case consisted of both subcoma insulin therapy (which "was begun on the twelfth hospital day, reached a dose of 220 units in two weeks, BID, and with the consequent clinical improvement came down again to 80 units in two more weeks; the psychotic process ceased to progress at the end of the following week, the seventh hospital week) and analytic interviews held concurrently three times a week in the ward, and just following the termination of the morning insulin therapy."

When first seen the patient was in restraint; but she immediately made contact with the therapist by touching his arm and stroking him. Touch was of considerable importance to her; she referred to it later, both with regard to her feeling for the therapist (usually warm, and to whom at one stage she made aggressive sexual advances), and in connection with her mother. She first worked through her delusions and her feelings in connection

with her rejection by her lover, which "was one of the factors precipitating her withdrawal and disorder." Dr Perry comments, " . . . for this kind of personality the difficulty with love is that it immediately awakens the threat of loss; to love is to invite rejection, and the two are so closely bound up together that the one complex automatically induces the other . . This was inevitable, since love and loss both belonged to the mother complex, the basic ground plan for all later experiences of affection, which endlessly repeated the history that her mother had loved her briefly, with snuggly warmth, and then lost interest. Even worse than this, the mother's becoming cold and absenting herself happened to coincide in time with the death of the father, so that again, receiving affection augured a loss not only of the mother but of the father as well. Her mood thus oscillated between love and anger, and docility and hostility. The image of the lover, X, is the image of this complex which appeared in the transference."

Later still the patient worked through her feelings with regard to her professional work, against which she ranted and raved. The therapist, being the interpretor of the symbols offered, suggested that she wanted to "shift emphasis from (her) intellectual, professional life to a more personal, feeling life and to living your emotions - living your own life for yourself." The patient agreed " . . . I sure do! I want love and a family. Is that possible, do you think?"

Dr Perry reports, "In seven weeks' time the patient's unconscious process had run the gamut from the regression to the image of the Great Earth Mother and the First Paradise - that depicting the beginning of creation - to the progressive construction of an image of the Last Paradise, the Bride of Christ - the depicting of the end of creation. . . . from here on there was no further elaboration of such imagery . . . At the same time, her psychosis was beginning to release its grip upon her and she was less prone to insist on her identification with these great divine personages. Her talk in the interviews concerned itself increasingly with personal matters, her present relationships in the ward and her family."

He concludes, "As to the question of the genesis of the disorder, I would put it in terms of her mother-daughter psychology. One could say that she was setting up a symbolic world in which the father was again absent as he was in her early life. Certainly the grandmother had been a matriarchal Great Mother,

powerfully constellating the mother image by way of the mother's mother complex. However, a psychotic turmoil is more dynamic and aimful than merely recreating old configurations of childhood, although these are also present. She had lived thus far as a young woman whose identity was always that of a daughter and maiden, leaving the rest of her womanly nature unconscious and in projection upon the mother and mother figures. The needed development was then for her to explore the meaning of the rest of her feminine nature of motherhood, of the dimensions of love that go beyond sex play, and of creativity, and to assimilate them into her life."

. . . . .

I have quoted so extensively from this paper, because Jungian theory is frequently misunderstood, but mainly because I think this paper clearly shows the learning-processes which are involved in the development and conditioning of such a psychotic state, and in its resolution. Jungians see a psychosis fundamentally as part of the drive to "self-actualisation" using whatever channels and material are available. My major point of conflict with this school might be on the nature of the archetypes and of the symbols.

It is true that there are certain universal experiences which have become symbolised in terms of "Great Earth Mother's", "Hera's", "Virgin Mary's" etc. During the course of our education we learn about a great many of them, which accounts for the particular name or label attached to the symbol, which, in turn, is essentially a complex, a referential system. If I read him correctly, Jung and his followers would see these symbols as genetically

determined, carried on in the memory of the race - I see them as extra-personal: terms, symbols, which are learned as the result of universal experience and verbal conditioning.

It is possible that when we either abrogate control of our behaviour or lose it due to internal pressures, whether externally or internally derived, the cue- or filing-system of memory is what we are aware of - not the later, more sophisticated, more complex verbalisations in which many people think we make our judgments.

This patient had found extreme difficulty in learning to become a mature woman - she had been comparatively rejected by her mother, whose "suppressive, disciplining" attitude was reinforced by the domination of the grandmother; her woman-image or symbol, with which she was partly identified and had learned to imitate, was at variance, or dissonant, with her own warm outgoings. She had undoubtedly learned to relate to males because of the uncles in her childhood household; but her fear of separation, based on the death of the father and reinforced by the mother's aloofness (or vice versa) led, as Perry saw, to her ambivalent attitude.

How many times her self-esteem had been diminished in her previous love-affairs is not noted. One such affair

had lasted for twelve years - longer than some marriages, and we must assume that there would have been considerable stress prior to its breaking-up.

Her mother was "a depressive personality" - any natural tendency to depression after the dissolution of emotionalised relationships, would undoubtedly have been reinforced by the memory of her mother's behaviour in terms of the learned imitative patterns of childhood.

Therapy, in the main, consisted of giving her an accppting listener to her symbolic acting-out of her emotions and imaginings, with its abreactive effect of a lessening of anxiety and emotional reactivity, and a rational interpretation of the visualised scenes and emotional responses. This would do two things: permit at extinction of the emotional responses and their consequent feedback and effect on behaviour; bring about a changed cognitive reference-system, so that rational explanations or informationwere always readily available to assist in the inhibition of maladaptive responses to any appropriate cue.

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Case 73: Psychosomatic pains; Structural (transactional) Analysis. (Berne, 1961, pp.157-159) (Classification 3b, 6b, 5).

Transactional analysts use a language of their own. Before proceeding to consideration of this case, therefore, it is necessary to take a look at their particular reference-frame and terminology:

> "Structural analysis, which must precede transactional analysis, is concerned with the segregation and analysis of ego states. The goal of this procedure is to establish the predominance of reality-testing ego states and free them from contamination by archaic and foreign elements." (p.22).

> "Exteropsyche, neopsyche, and archaeopsyche are regarded as psychic organs, which manifest themselves phenomologically as exteropsychic (e.g. identificatory) neopsychic (e.g. data-processing) and archaeopsychic (e.g. regressive) ego states. Colloquially, these types of ego are referred to as Parent, Adult and Child, respectively." (p.23).

(The particular case quoted here, unlike the case Berne quotes next in his book, is not discussed at all in terms of developmental learnings. The problems dealt with are essentially contemporary.)

"Symptomatic relief was obtained through structural analysis by Mrs Eikos, a 30-year old housewife who had been to many specialists over a period of years for treatment of pains which were repeatedly suspected of being based on organic changes. It was only when everything else failed that she had come to a psychiatrist. It was apparent from the beginning that the initial phase would be the critical one, since her marriage was being precariously maintained only by overlooking certain obvious defects in her husband's behaviour.

"The structural analysis of this situation was as follows. Her husband's neurotic behaviour was highly attractive to Mrs Eikos's Child, since it yielded her large primary and secondary gains. From an Adult point of view, however, it was outrageous. But by contamination the Child kept the Adult from protesting; she offered all sorts of pseudological excuses and explanations for what he did. Decontamination might be a threat to her marriage because an autonomous Adult might not long tolerate his behaviour if it continued unchanged. Also, if she stopped playing the game which constituted one of their chief marital bonds, her Child would feel the deprivation keenly as despair."

She was told all this clearly on three separate occasions, but each time decided to continue with therapy.

"These tests of motivation not only clarified the responsibilities of the therapist and of the patient, respectively, but also initiated the strengthening of the Adult by making the decision hers on the basis of a realistic appraisal of the treatment situation. The transference aspects of this procedure, i.e. the Child's reactions to the therapist's formulations, were segregated to be dealt with at an appropriate time. As she became able to feel and express the autonomous Adult anger and disappointment at her husband's behaviour, the pains gradually disappeared. "

" . . . First, the fact that the disappointment and resentment came out into the open signified that her Adult was now to some extent decontaminated, and she was able to test and exercise her newly found autonomy in other situations. Secondly, now that her Adult was available as a therapeutic ally, the treatment could proceed at a different level. The first hurdle was safely passed, and her marriage survived. She could see that she was actually in a better position than before to ensure its permanence on an improved foundation, if she wanted to, and this gave her new courage. Thirdly, the resentment was itself suspect, since there were in it some elements of child-like ambivalence, and since she had selected Mr Eikos to be her husband from among several candidates, and since it was apparent at this point that her Child had covertly encouraged his behaviour. For all these reasons her expression of 'hostility' was not simply accepted as 'good', but was viewed critically by both the therapist and the patient.

"At this point her Child, deprived of some of the gains she had formerly obtained in her marriage, began to turn her attention to the therapist. She tried to manipulate him as she had previously successfully manipulated several parental figures, including some friends of her father's and an earlier therapist. The analysis of this game disconcerted her, and her productions became less genteel. It was then possible to analyse some of the family games of her childhood, as well as more of her current marital games. As her Child began to experience more and more unbound cathexis, her script came into view and her hours became increasingly stormy. Meanwhile the Adult grew stronger and stronger in her outside activities, while at times it was almost completely decommissioned during her therapeutic sessions. Since she no longer played the marital games, her husband's Child became confused, anxious and depressed, and he also sought treatment (with another therapist.)

"Eventually she began to carry on her life with more energy, satisfaction and equanimity, to the benefit of their three children as well as herself. She was able to discontinue treatment under the following conditions. Changes in ego state were accompanied by tonic and postural changes in her intimate and skeletal musculature. In her Adult ego state she was now symptom-free. If her Child took over, the symptoms recurred, though less severely. By exerting social control and Adult option over incipient games in her family and social life, she was able to abort the dominance of her Child. In this way she could extend almost voluntary control over the occurrence of symptoms. As a kind of bonus, her marriage was, and still is, much improved, in the opinion of everyone concerned."

. . . . .

Of course, the fact that the husband also received some therapeutic help may have affected the outcome of the marriage. But what is so very clearly shown here, is that certain patterns of behaviour, i.e. habits, carried over from childhood, are not just mala-adaptive, but frequently downright disruptive in adult life. The strength of these habits is demonstrated by the power of the"Child" to instigate or interfere with adult functioning.

In the same way the learned response patterns based on parental teachings (i.e. the Superego) also frequently interferes with adult functioning. Marriage is an ideal situation for the development of neurotic or "psychotic" behaviour - two people, with or without their children, are closely tied in such a manner as to frequently give maximum deprivation of certain needs and frustration, highly cathected with "hopelessness" if marriage is regarded as "for ever."

The "games" concept is a useful one - but again both the techniques and the likings/dislikings for certain games are learned.

Therapy would seem to consist primarily of the conditioning of new behaviour patterns based on a change in the cognitive reference-frame and self-concept reinforced by social approval of, and pleasure deriving from, Adult behaviour.

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Case 74: Depressive reaction, psychotherapy. (Reider, in McCary & Sheer, 1955, pp.181-231). (Classification 6c).

"A fifty-two year old successful businessman in the course of a routine medical examination had, for the first time in his life, a blood Wassermann which was found to be positive. He reacted to this discovery with a profound depression, feelings of self-accusation, sinfulness, unworthiness, and the desire to die. He also manifested a strong need for punishment for his indulgence in the premarital sexual affair in which he must have contracted syphilis many years before.

"Detailed study of his case revealed that he had always had a very severe superego which he appeased constantly by a strong drive toward success and that success in turn appeased his conscience by demonstrating to himself his own value and rectitude, thus maintaining his self-esteem. Being successful, according to the pattern under which he had grown up in a small Middle Western farming town, consisted of being industrious, being able to show the fruits of one's labor by accumulation of simple goods, being respected by neighbors, and obtaining simple pleasures only after he had earned them by hard work. Not only did the entire community in which he was reared set this standard, but an additional event in the history of his family had given specific significance to this pattern for him. His father had also been hard working and industrious, but an accident and a long convalescence put him into debt which took many years to pay off. A general atmosphere that some unpredictable event might destroy all that one had labored for pervaded the home and created a feeling of apprehension and of being on guard. After helping his father pay off the debt, he struck out on his own at age twenty and established himself in a small business which prospered. He married, had children, had a relatively happy home life, and prided himself on his ability to send his children to college without their having to work their way through school. He prided himself also on his excellent health and had no knowledge that he had contracted syphilis, which incidentally, was latent and had produced no evidence of body damage. The accidental discovery of positive serology precipitated his depression.

"The knowledge about his illness and personality structure and the evidence of his need for punishment to appease his conscience were used to institute a regime

gratifying this need. At the sanitarium he was treated without any special considerations and given a routine of daily endeavors including, at first, many menial tasks for which, when they were done, he received no especial praise. After about four months of being treated as a sort of hired hand who received only room and board for doing his chores, he felt a little better. Then despite his protestations of inadequacy, it was insisted that he assume some responsibilities in the organisation of several newly begun occupational-therapy projects that involved manual skill and hard work. Gradually he took over. He was commended for his endeavors rather grudgingly. Little by little his self-accusations stopped, and he began to be critical of the management of the sanitarium, made gestures of knowing how to do some things better, and finally demonstrated his independence by renewing his interest in his businsss activities and showing that he was ready to go home."

. . . . .

Here we can again see clearly the conditioning process involved in the development of this man's self-system and ethical-moral-referential-system. Doubtless the knowledge that his Wasserman was positive had revived this man's anxiety associated with his father's illness, when

> "A general atmosphere that some unpredictable event might destroy all that one had labored for pervaded the home and created a feeling of apprehension and of being on guard,"

as well as fear of the consequences to his marriage, when, or if, his wife discovered the truth. (One does not know whether this did occur or not). Therapy was aimed, not at modifying the super-ego (or "conscience" system) in any form; but at appeasing it and his need for punishment for his guilt (conditioning here is the classical example of conditioning to the fear of loss of love for disapproved

behaviour and absolution following punishment, i.e. reduction of fear and a return of love when punishment had been meted out.) As Reider himself puts it,

> ". . . his sense of integrity was dependent upon continued success and meeting his ego ideal. Interwoven into the whole personal system was the value of hard work, of punishment for misdeeds, and of keeping on the straight and narrow path . . his integrity was reinstituted by the sanitarium regime that made him pay for his sins and reintroduced an old pattern supportive in the past, viz. that of industry, which yielded only long-time - not immediate rewards, thus enabling him to pay off his debt and see himself free and independent once more . . " (p.187).

He had learned the hard way that one can pay off one's debts and recover one's self-esteem through his father's misfortune - he paid what he saw as his debt to his wife, society and himself by the menial work he performed in the hospital. This, indeed, is a classical example of a Mowrerian type therapy minus the open confession which, however, is a necessity in Mowrer's eyes.

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Case 75: Hysterical-conversion epileptoid fits; hypnosis, psychoanalytic interpretation. (Dicks, 1947, pp.96-97). (Classification 3b, 3a(ii), 8a(i), 8a(ii)).

(This case is reported in full)

"A very tall and powerfully built girl of 19, with the face of a baby, a factory operative, was sent for the treatment of epileptic fits from which she had suffered since the age of 15. She came from a working-class home, and was the youngest child, the others being two brothers. The father had died a year or two earlier as a very old man, who had had a previous marriage. There was no family history of any fits or other neuropathic or psychopathic illness. The girl was suspected of having a pituitary lesion, but investigation to that effect revealed no abnormality, and her growth was ascertained to be typical of her father's family.

"The fits were described as follows: they would commence with loss of consciousness after a cry, which followed some hours of change in mood. They would often be tonic, sometimes tonic-clonic, at other times quasi-purposive. Thus she might occasionally be observed to be going through the movements of her trade, or to be apparently fighting or even muttering. From time to time she would wet herself and bite her tongue. The fits were unaffected by sedatives like bromide and luminal. She was treated analytically at first, and revealed the following story:

"She had always been very attached to her father, 'who could do what he liked with her,' whereas she had been rebellious and antagonistic to the mother (a very sensible woman in reality) and jealous of her big brothers. She felt intensely inferior on account of her size and early puberty which had made her the victim of many indecent assaults in the dark streets of her little market-town. At 12 she had been seriously assaulted by a boy in a barn, and had fainted.

"At 14, after leaving school and entering a factory, she had come under a strict forewoman towards whom she now displayed her hostility, as the result of which she became a 'marked man'. One day after getting into trouble she had her first fit. She admitted now that sometimes she did not become unconscious, but was aware of all around her but unable to initiate or control her movements. As the fits recurred at her work, she was

removed and lived at home, visiting her father's grave daily, and at times having hallucinations of him calling her to join him. At other times she would brood over his photo until it seemed to come alive and then she would be frightened. At home she was useless, lazy and bad-tempered.

"As an experiment, she was hypnotized one day and duly went into a dissociated state, when she became flushed and rigid. She was commanded to recall what she was experiencing and awakened. She related with great horror that she went through the scene of the assault with the boy in the barn, and that his face then changed to that of her father. She was given reassuring interpretation, but failed to keep further appointments. It was ascertained later that she had become very excited and intractable, and had to be admitted to a mental hospital for a few weeks. She made a rapid recovery, and from that time has been free of fits and apparently well, according to follow-ups over three years."

. . . . .

Dr Dicks adds the following paragraphs (p.97):

"Besides being an illustration of the classical female Oedipus complex as the cause of hysteria, this case offers a valuable commentary on the importance of a psychological approach to epilepsy, even when the fits seem to conform to type, but when they have no ascertainable organic basis. There would appear to be very little gradation in the severity of the dissociation from the tantrum to the true 'idiopathic' attack. It has seemed to me that the nearer the true epileptic attack the manifestations are, the more primitive aggression is present, so that idiopathic epilepsy may, after all, be a regression to the massive tension - discharge of infantile rage.

"Returning to the question of dissociation we are bound to conclude from the above-mentioned case that while there is a distinction in degree, there is no difference in kind or in purpose, between morbid repression and dissociation; both subserve the function of a 'cut-out' and will act in either direction - permitting or prohibiting the expression of the offending impulse; only dissociation is the more forcible, and, in a sense, the more naive manoeuvre. It has been asserted that it is the method of lowly human types. To this it is impossible to agree."

. . . . .

Apart from the psychoanalytic reference frame there is no reason to suggest that here is proof of "the classical female Oedipus complex as the cause of hysteria", although there are undoubtedly sexual components in the case. Insufficient developmental history is present to be sure of all the factors operating. Why the antagonism to her mother, jealousy of her brothers (possibly interlinked), and fixation on her father (was there perhaps an actual incestuous relationship?). It is not possible to trace the conditionings or learnings which have taken place, except to note that the epileptic-type fits appear to be related to the conditioning relating to the experience of assault in the barn when she fainted. Obviously the act of going, or state of being, unconscious after the sexual attack was found to be rewarding as a means of escape from a dangerous situation and there is little doubt that she wished to withdraw either from the possible response to her own hostility, or from a possible outbreak of her own forbidden hostility, and/or it was rewarding to punish the feared/hated-object by becoming unconscious ("See what terrible thing you have done to me"), as well perhaps as punishing herself for her own forbidden impulses (to accept the boy's sexual advances, to want the love of the mother-forewoman, to sexually desire/hate the father). Nonetheless all these reactions are learned responses to experiences which have occurred in the past and traces of which are operating in the present.

It has been suggested (Eysenek, 1957) that the hysteric either has an insufficiency of super-ego control (or over-sufficiency of emotional activity) and/or has an element of conscious control over the channelling of "libidic impulses". At the same time there is quite an element of "acting-out" which suggests either highly imitative behaviour or a "dramatising" or sharpening of affect and cognitive awareness. We may, therefore, assume a heightened level or arousal, which in some persons could well bring about epileptoid behaviour; while at the same time we know that too high a level of arousal flattens or inverses the learning curve, thus undoubtedly affecting the last or least learned element of control by the so-called "super-ego" reference frame.

So far as psychotherapy is concerned, abreaction under hypnotic recall seems to have been insufficient to extinguish the fear responses and epileptoid attacks; indeed it apparently produced a manic reaction. One cannot be clear whether the elapse of time between the experience and the inhibition of the related affective responses, or fear resulting from the "punishing" experience of being confined to a mental hospital, or insight and a changed cognitive reference-frame, was the major factor in the extinction of the maladaptive responses; possibly it needed a combination of all three. Theomanic or excitatory

reaction and length of time required for inhibition or extinction is conceivably related to such findings as Eysenck's (1957) that hysterics condition only with difficulty, which in turn must refer to the level of cortical excitation and rate of functioning.

. . . . . .

Case 76: Hysterical conversion symptoms and stress; change of job.
(Main in Rees, 1949, 397-413).
(Classification 5, 6c, 8b).

"A rugged-looking miner of 26 years of age, with an intelligence quotient of 100, an ordinary man with powers and characteristics that were unremarkable, complained of rheumatism in the back. It had kept him off work for four months despite physical treatment and reassurance. The condition was hysterical, and behind the symptoms lay a work-conflict. He had a job at the coal face as a hewer and it held certain fears for him. His father had also been a hewer until eight years before, when a fall of stone had broken his back and had left him a cripple. The patient's loyalty to miners and to underground work was high, but he was very much afraid of falling stone. His fiancee also admired the courage of underground workers, and to retain his own and her esteem he could not accept the offer of his employers of an easier job at the pit head. His back hurt him too much, and provided a face-saving solution to his dilemma. Discussion of his fears and hopes and his superficial conflicts produced the fact that he would like to work underground as a pointsman away from the danger of loose stone, and that the slightly lower wage would be acceptable. After such a job had been arranged by the pit medical officer, the rheumatic symptoms disappeared with reassurance and suggestion in one session. He began work and six months later he was still at work - as a pointsman." (p.398).

Here we see an almost complete identification by the son with his father. Conditioned to a rational fear of falling stone, by the accident which had befallen his own father (and doubtless by other accidents as well), and with whom he identified closely, as witness his pain in his back; the young man also demonstrates a conditioning to social acceptance and to a self-esteem based on socially admired behaviour. Reassurance, suggestion AND a safer job which still permitted him to stay underground and retain his own and others' esteem, were apparently harbingers of complete cure.

. . . . . .

Case 77: Shyness and sociodrama.
(Sarbin, 1943, in White, 1956, pp.375-6).
(Classification 5).

"A seventeen-year old high-school boy seemed quite incapable of social relationships. Listless and shy, he stayed by himself most of the time, but from interviews and tests it was clear that he fantasied himself as a popular high-school boy. He was first asked to participate as a spectator while other patients acted their psychodramas. Then he was asked to prepare a short scene of his own for a subsequent session. He chose the role of a radio commentator and gave a simple scene that required no supporting characters - altogether a safe and undemanding performance. At the next meeting he was requested to serve as a minor character in a drama being enacted by other patients. He was the buddy of a soldier who received abusive treatment from a tough sergeant. He was able to imitate freely the actions of his buddy and even develop them in his own way. For his next assignment he prepared an original scene calling for several supporting characters. For the first time he was able to act without self-consciousness, genuinely absorbed in the drama. Next he took the part of father in another young patient's drama. This role proved highly congenial, he 'stole the show' as he acted out what were unmistakably his own father's attitudes toward him. Only after this success was he requested to enact what corresponded to his own most cherished fantasy. He was asked to depict a day in the life of a high-school boy. Choosing various characters to represent his parents and his fellow students, he put on a spontaneous drama remarkable for its animation and conversational freedom as well as its revelation of his emotional difficulties at home.

"There were various other sessions, but what concerns us more is the patient's off-stage progress. Instead of sitting alone he began to come into the center of the group. Instead of retiring between scenes he began to use these intervals for conversation with others. Listless shyness gave place to more alert participation. The parents were surprised at the rapid increase of interest in people and events and at his spontaneous seeking for companionship. The patient even gained weight while these improvements were going on. In the realm of psychodrama he had become able to behave in a way that corresponded to his ego-ideal and that gave him self-esteem. The change carried over into new behaviour in everyday life."

. . . . .

We are left in the dark here regarding the conditioning stimuli which operated to bring about such a degree of shyness in the boy in question. But the conditioning involved in the therapy used is quite clear. As White comments in his general discussion (p.376), "psychodrama bears particularly on the expression of feelings and on new behaviour." Those taking part learn (a) how to express their thoughts and feelings in manifest verbalisations and actions, and (b) how to react overtly to both similar behaviour and the responses of others. This is, of course, carried out within a permissive environment, which acts as a reinforcer of such behaving.

The report states clearly that there were emotional difficulties at home, and these undoubtedly were at least partly responsible for his fear of approach-behaviour in social relationships; while his listlessness could either have been a mild depression or a type of miserable apathy due to lack of stimulus, or both. The fact that he put on weight so readily, would appear to show greater excitation and general wellbeing.

. . . . . .

Case 78: Autistic Child, folie-à-deux; psychotherapy of mother and child.
(Pavenstedt, in Caplan, 1955, pp.379-405)
(Classification - Child 4, 5;
Mother 3b, 5).

This is the story of a child, first seen at age four, and apparently last seen when the boy was between nine and ten, who demonstrated "psychotic", "autistic", "a-typical" behaviour.. Dr Pavenstedt concludes sadly in her final paragraph, "We feel that the well-known concept of folie-à-deux is essentially what we see here, at least from the time Brad reached the latency period. The mother, being the older and stronger person, is still able to maintain her surface adjustment. With sufficient additional help in school and in therapy, it is conceivable that Brad too may achieve this." It is essentially the story of a child, dominated and cowed, by a hating, fearing, mother.

The child was reared in American "middle-middle-class" home by his father, mother and maternal grandmother. The father was an extremely passive member in the marriage relationship. Although the wife felt they had been "happy together because he completely accepted her and never argued . . . she had sores in her palms from digging her nails into them in her impatience with his slowness." He had had a very poor family background himself - mother died of t.b. when he was four, later he "had a 'classical' stepmother," who terrified him with "frequent beatings", and who, after she had a baby of her own, forced him "to perform such menial tasks for the child that he ran away from home. From the age of fourteen he lived with his grandparents, devoting himself to his schoolwork. He put himself through an advanced education and attained moderate success in his career. Always very retiring, he never allowed himself to be drawn into arguments or fights... "

The grandmother lived part of the time with Brad's parents, part of the time with her other children. She was "a gentle, resigned, elderly lady who was concerned about her daughter's distress, encouraging her to seek comfort in prayer." When Brad was a baby she had "cuddled and rocked him." This sometimes angered Brad's mother, who would then put a stop to it. Later she also read to the little boy "by the hour"; but she always, like the child's father, "kept the peace by going along with all of the mother's decisions and plans without a murmur."

The mother told the therapist of "having manipulated her parents from childhood on with her temper and fainting spells; about her hostility toward an older sister, and her domination of a younger brother ... In adolescence she lied to her father that the neighbourhood boys were following and molesting her, so that he would be more protective. Accounts of tragedies she had witnessed while growing up, and especially a long dramatic account of her father's misfortunes late in life and of his sudden death, revealed her paranoid tendencies and the primitive quality of her feelings. (She) had been so upset at her father's death that she didn't know what she was doing for a while. She broke an engagement with a man her own age because she suddenly felt she couldn't stand him . . . Fully five years later (when she was 25) she married Brad's father . . . "

It was not until after three years of marriage that "she finally conceived, only to lose her fetus at three months. She had fainted a great deal during pregnancy." Following this she was depressed but claimed she was over her depression when she conceived Brad three months later. During this pregnancy she vomited "almost continuously." Birth was "by simple breech extraction through median episiotomy, forceps to after-coming head, cord prolapsed. Seconal and scopolamine alangesia were given. The baby cried and had good color, so no resusciation was needed. He weighed six pounds, fourteen ounces." According to the pediatrician he was quite normal at birth. But, "the mother never denied that she was bitterly disappointed about his being a boy - on the contrary she affirmed it over and over . . . . There is ample evidence that she tried, from the time Brad was born, to have another child - a girl."

"The mother made the direct statement that she never planned to breastfeed Brad because nursing was repugnant to her." She also said "that she didn't cuddle (him) because she didn't want to spoil him and held him only rarely when feeding him. Bottles were given in his crib." As stated above, the grandmother, however, cuddled and rocked him; but this was soon stopped by mother. "The grandmother was in the home during the first month, then away for three months, and back for most of the next few years."

He was said to have been "a very good baby", and "the neighbours commented on his sunny disposition." However, from his fourth month the mother "began to force pablum down his throat by holding his head and pushing it down until he vomited," and this "continued until he was two". "At six months, he began finger sucking, and this became almost constant in the daytime after he was weaned

from his bottle at eight months." This particular habit was broken when he was 18 months, "after his mother had put bitter fluid on his fingers and slapped his hands"; and apparently "handshaking started then." (She had failed to break it at 13 months when she "forced him to wear metal cuffs" and strapped his hands.)

Somewhere between the sixth and eighth month "his mother sat him on the toilet seat until he performed." "At twelve months, bladder training began in all seriousness. The mother said to the social worker that she was terrible; she took Brad to the toilet every two hours, and by the time he was fourteen months old, she spanked him hard each time he wet. He responded by giving up wetting in the daytime, but continued to wet his bed until the age of two years and nine months. The mother felt that Brad never went on to the next stage of his development unless she forced him to."

The child "crawled from the age of eleven-and-a-half months. He sat but wouldn't stand, and his mother told us how angry she was because of this. She took hold of him and shook him and stood him up, and from that time on, he did stand . . . The mother never could leave Brad alone - he had to do just what she wished. She said desperately that she couldn't help it. She thought it best for him to be brought up that way. 'I guess I just couldn't stand Brad because he was a boy, whereas anything Betty does is all right, because she's a girl!'."

"At thirteen months, when Brad began running, he had to be tied so that his mother could keep track of him." "At fifteen months he could say clearly "dada", "mamma", "nann" - "and at eighteen months said "caca" for car and "baba" for baby."

At fifteen months the pediatrician noted that the child "was 'acting up': vomiting easily, spitting food, and refusing to feed himself. A month later, a series of gastrointestinal tests was done because of the vomiting. The roentgenologist reported that the only thing wrong was that the mother was forcing food on the baby."

At 21 months the child had a severe attack of diarrhoea and a rectal prolapse, following which the mother kept him "flat on his back for six months for his nightly bowel movements." This the child accepted without protest. "Following this experience, he was

not only inhibited by his mother's controls but began passively to resist any encroachment on himself. He withheld his speech and his bowel movements, withdrew into unresponsiveness and negativism, and shut himself off from any suggestion. He was over two before he finally fed himself, and he refused to dress himself until he was well over five. The only release for his pent-up aggression was his constant handshaking. He carried on his mother's activity in some of his play, but only timidly or inadvertently included her aggressive behaviour in it. His many fears, sleep disturbance, nightmares, and dread of change were evidence of the hostility he anticipated on all sides, having experienced it so often and forcefully from his mother. We saw him identify with inanimate machines - planes, bicycles, pianos, radios, carousels - in flight from expressing his identification with so threatening and hostile an object as his mother."

The child was taken into therapy when he was four years of age, together with the mother. There were many difficulties. The mother, for instance, at first "could not tolerate his doing with others things he feared to do in her presence." Then she "became quite absurdly permissive"; but the child improved immeasurably both in his relations with her and with others, including his father. "He wanted to touch people in the streetcar, as though to feel that they were real. In situations that he previously would have avoided because they frightened him, he now used his teddy bear to lead the way. He even dared, for the first time in three years, to lie on his back."

However after four months he started to insist that "he wanted to throw his legs away, to walk with the therapist's or the teacher's legs. There soon followed compulsive touching rituals. The mother, however, was radiant because she was pregnant and felt fine for the first time . . " And then the final tragedy occurred. The mother "fell on the kitchen floor, which had been inundated by Brad, and bruised herself, and when she subsequently miscarried, she made no attempt to spare him as she went completely to pieces." So, of course did the child - "His rituals . . increased, he became destructive, . . . withdrew from contact and was absorbed in flushing things down the toilet."

After her convalescence, once she had talked things out with the social worker, the child's panic also calmed down, and, with his mother's encouragement he tried to "comply with social demands", and managed this to quite a degree. However, mother's attitude to the therapist became increasingly ambivalent and

therapy proved impossible for the remainder of that year. The mother first sent the child to a private teacher, then, for the next three years, she insisted on his attending public schools, "although he was learning nothing. His teachers found him too subdued and compliant. He retreated from the other children for fear of their teasing . . . He seemed to be living to please his mother . . ." When the child was eight the mother finally had her longed-for "beautiful little girl", and "her guilt feelings toward Brad were redoubled" and she asked that he should be taken back into therapy. This was done - at eight; he was found to be "an extremely disturbed boy, anxious to the point of agitation, almost paranoid in the degree of his distrust and ambivalence." He was "actually in terror of the therapist, as he was of the whole world, and it was important to help him deal with this fear." Gradually the mother was "helped to allow Brad some degree of assertiveness and independence. Her aggressive outbursts toward him were interpreted to her as a recurrent need to test herself out, to prove to herself that she would not actually kill him; she was reassured that she need not test herself in this way."

After the teachers in the school insisted he was unable to continue with him, and another violent outburst from mother, an elderly woman tutor was obtained for him. But, "besides his aggression, Brad's increasingly uninhibited sexual overtures became extremely difficult to deal with. As his mother became more aware of this, and she was advised to set some limits, she gradually revealed that she had been very seductive with him over the years." He was then sent to "an excellent remedial day school" where his teacher, "who had handled many psychotic children, considered him the most negativistic child she had ever seen." "All pressure was removed and he was allowed to grow into the learning situation very slowly. In his second year at this school now he is reading third-grade material and achieving well with fourth-grade arithmetic. He can work by himself, is responsive to questions, and has finally stopped waving . . . He accepts the other children, but has not learned to relate to them."

. . . . .

Apart from two important facts which Dr Pavenstedt does not appear to have realised, the learning situation, and the conditioning to fear and withdrawal, is quite clear. I have not included here

the author's discussion regarding the possible genetic components; I think, however, we may with reason postulate that the child was born with a predisposition to compliance rather than aggressive behaviour. At the same time the neonate was rarely cuddled or fondled by the mother - if it had not been for the grandmother the child might indeed have become marasmic. The child's difficulty in relating to others probably stems from the conditioning (or lack of it) involved here. The second point De Pavenstedt does not make, is that Brad's "wanting to throw his legs away" and the beginnings of his compulsive rituals would appear to coincide with mother becoming pregnant again. Again it is not possible to bring proof, but it would seem highly probable that the little boy was, if not once more subtly rejected, at least sufficiently intelligent to realise that when the baby was born he might be rejected again. At that time "Brad and (his mother) studied his 'baby book' and (she) declared that not only was he discovering his past but was looking forward to his future by announcing that he wanted to be what his father was."

The precise nature of the therapy is not stated but the major point seems to be a change in the social environment of the boy. This was sought in the first place by attempted modification of the mother's attitudes but was finally attained only by removal of the boy to school where an understanding teacher was able to provide both remedial education of the academic kind and act as parent surrogate.

. . . . .

PART SEVEN

LEARNING, AETIOLOGY AND PSYCHOTHERAPY.

I. Aetiology:

The following classification of learning disorders was formulated as the result of the case study reported in Part Six and theoretical considerations arising therefrom. It is also related to the account of learning principles and processes which I have given earlier (particularly pp. 92-95).

The numbers following each classification refer to the Case Nos. of the previous section. Asterisks refer to double entry. As will be readily seen, many patients suffer from a number of different learning disorders.

.. ..

1. Retarded or impaired learning due to
   (a) physiological deficiencies such as brain damage, tissue deterioration, early perceptual deprivation, etc.
   (b) Environmental deprivation.
2. Maladaptive habits. Many of these are quite simple in nature and not necessarily tied to deeper disturbances. As instances we may quote thumb sucking, nose picking, enuresis, nail-biting and non-verbalisation. Some of these may be initiated and aggravated by emotional disturbances, but may persist when such causes are no longer important. (Cases 40*, 49*, 70*).
3. Abnormal Conditioning of affect and drives. (Note: An

affect must be related to a particular drive, therefore to speak of one is of necessity to infer the other.)

3a(i). Classical. Abnormal fears and fetishes are outstanding examples of this kind. Twelve cases in the survey seem to come within this category. (2*, 14*, 18*, 24*, 25*, 26*, 27*, 30*, 21*, 49, 55*, 64*)

3a(ii). A special form of this conditioning involves what I would call "dissociated affect". These are the product of traumatic experiences where intense emotional response has prevented integration of the cognitive aspects within the cognitive reference frame or repressive influences (e.g. guilt) have operated to produce this end. Disorders of this kind typically yield to abreaction, which should be carefully distinguished from catharsis. The latter need not involve abreaction at all. This is well illustrated in play therapy techniques which are frequently very successful with children. (Cases in this category are - 1, 2*, 6, 11*, 15, 25, 35*, 54, 64, 67*, 75).

3b. Operant. This provides us with useful forms of response for the securing of drive satisfaction, but many maladaptive forms of response can also be acquired in this way. The survey yielded the following types:

alcoholism (45*, 57)

gambling (19)

evasion (38, 60*)

refusal to eat (28*)

manipulation techniques (8*, 9*, 73*, 75*, 78b)

anti-social behaviour (35*)

kleptomania (52*)

4. Abnormal conditioning of affection. This drive is so intimately related to social functioning that abnormal conditioning can produce a wide range of maladaptive behaviour particularly in regard to

marital relations (Cases 36*, 50)

family relations (12*, 13, 32*, 33*, 35*, 41*, 49*, 51*, 53*, 58*, 59*, 60*, 62a*, 75)

peer relations (Cases 22*, 32*, 34*, 35*)

Of particular importance here is the widespread effect of parental rejection, real or imagined. Abnormal patterns of response built up during childhood may produce social maladjustment in later life, but it may also have many indirect effects due to the disturbed situation of the child within the family. In this connection it may be noted that the therapist may often be concerned not so much with redressing the effects of undesirable learning but of changing the conditions which are still operating to produce such learning.

5. Abnormal conditioning of drive-traits. All drives become the basis of major traits. When these are exaggerated or perverted we get important forms of maladjustment. Examples are

anxiety (Cases 3*, 4*, 11*, 34*, 40*, 42*, 48*, 49*, 54*, 62*, 65*, 66*)

dependency (58*, 68*, 73*)

sex (16, 29, 41*, 45, 47, 48*, 51*, 59, 61*, 63*, 64*, 67*, 69)

aggression (5a, 56*, 59, 71*)

withdrawal (5b, 22*, 62c, 77, 78)

grieving (4, 71*)

empathetic behaviour (6)

self-sufficiency or "masculinity" (50*)

6. Distortion in Ego-structure components.

6a. Ego-control. This may be inadequate or too rigid, but note that the adequacy of control here will be related also to the strength of emotional reactivity. (Cases 3*, 10*, 17, 23*, 28*, 37*).

6b. Ego-ideal. Both the material ego-ideal (or self-sentiment as it is described in the factorial study in Part Five) and the moral ego-ideal, may be unrealistic or inadequate. Lack of goals or striving to retain unrealistic goals may be a source of unmanageable psychological strain. Inadequate development may produce delinquency and/or lead to social maladjustment. (Cases 22*, 32, 42*, 44*, 50, 61*, 62b*, 71*, 72*, 73*).

6c. Super-ego. The highly irrational nature of this reference-frame makes it a potent source of trouble. When its unrealistic requirements cannot be coped with, the individual may experience intense depression.

Mowrer's recent emphasis (op. cit.) already described, suggests this is a major form of maladjustment. (Cases 2, 10, 14*, 16*, 20, 21, 31*, 33, 43*, 46*, 53*, 62b*, 63*, 74).

7. Distorted cognitive reference frame. Since so much of our behaviour depends upon our understanding of reality any misunderstanding can be productive of maladjustment. The case survey presented twelve cases where the focus of difficulty appeared to lie in cognitive misunderstanding (Cases 4, 23*, 31*, 33*, 36*, 40*, 44*, 49*, 53*, 56*, 66*, 72*).

8. Abnormal physical symptoms.

8a. Incidental.

(i) These comprise the numerous psychosomatic effects which can only be regarded as secondary to some psychological maladjustment. It should be noted, however, that some persons will develop such effects from psychological disturbances which for others would be insufficient to produce either physical symptoms or obviously important psychological effects. Some hallucinations will come under this heading. (Cases 3*, 24*, 34*, 56*, 62*, 65*, 70*, 75*).

(ii) Hallucinations due to sensory deprivation or undue level of arousal.

8b. Instrumental. This covers the wide class of "conversion" symptoms where the physical disorder serves

the purpose of acting as a solution to the psychological problem. Typical of these is the classical example of "shell shock". (Cases 7, 8*, 9*, 18*, 26*, 27*, 30, 39, 76, 77*).

9. Maladaptive defence habits. ("Ego-defence mechanisms"). Here we have the many manoeuvres resorted to in order to avoid ego-deflation. They include:

Projection (Case 33*)

Identification (17* and 68*)

Displacement

Compensation (17*)

Devaluation ("sour grapes").

10. Psychotic reaction. When the competing psychological tensions become too great some major cracks may develop in the personality system. I would postulate that this may occur either as the result of acute or prolonged psychological stress or as the result of physiological changes which themselves produce such psychological tension. I would therefore expect that some psychoses would be very little amenable to psychological treatment, but that it may be very successful when applied to those of psychological origin.

The central effect in the psychotic reaction can be regarded as cognitive distortion, but it goes beyond what has been described in this connection. It involved a major, systematic break with veridical perception. Adequate tests of reality have now been abandoned and the cognitive system

is free to develop out of relation to reality. The major forms are:

10a. schizophrenia (Cases 16, 32, 43*, 46*, 48*, 63*, 67*, 68*, 72)

10b. paranoia (35*, 61*)

10c. Manic-depression.

11. Frustration due to environmental pressures and/or lack of inadequate avenues of "effectance" or achievement. (This relates to the ego-ideal, but demands a separate category). (Cases 9*, 37*).

12. Anomie, or lack of adequate life-philosophy. This relates to the ego-ideal and super-ego.

.. ..

II. Psychotherapy:

If, as I assume in this thesis, "mental disorders" are best conceived of as learned or "learning" disorders, i.e. stem from or are related to the learning process and its function, it should follow that psychotherapy should itself be based upon, and utilise, learning theory. Eysenck's (1958) suggestion that such therapy should be called "Behaviour Therapy" has much to commend it, as we are indeed concerned with changes in behaviour through the unlearning of maladaptive, and learning of adaptive, behavioural patterns. Nonetheless, as I have stated earlier (see pp 3-4), in my opinion the Behaviourists do not extend their consideration of the application of learning-theory sufficiently widely.

1. Therapy and Re-education: Myriads of acknowledged authorities

and lesser writers have agreed that psychotherapy generally is educative or re-educative in nature, and some, more specifically, that learning-techniques are involved, (cf. Alexander, (1950), Freud (1940), Misbach (1948), Rogers (1951), Sanford, Hunt, Estes & Wyatt (1948), Snygg & Combs (1949), Thorne (1948 and 1955), Dollard & Miller (1950), Mowrer (1956, 1961), Snaffer (1947), Shoben (1949), Sheer (1955), Stein (1961), Kraines (1948).

The doyen of psychoanalysis, Freud himself, understood the nature of the process, even if he had to dress up his description in his own jargon. For example, in his Outline of Psychoanalysis, (1940, p. 47) he had this to say:

> To begin with, we induce the patient's thus enfeebled ego to take part in the purely intellectual work of interpretation which aims at provisionally filling the gaps in his mental resources, and to transfer to us the authority of his super-ego; we stimulate his ego to take up the struggle over each individual demand made by the id and to defeat the resistances which arise in connection with it. At the same time, we restore order in his ego, by detecting the material and impulses which have forced their way in from the unconscious, and expose them to criticism by tracing them back to their origin. We serve the patient in various functions as an authority and a substitute for his parents, as a teacher and educator; and we have done the best for him, if, as analysts, we raise the mental processes in his ego to a normal level, transform what had become unconscious and repressed into preconscious material and thus return it once more to the possession of his ego.

What he is saying, very briefly, is: analysts require to assist the patient himself to find out what are (a) his needs, (b) his wishes (or drives), (c) what experiences in the past have interfered with the fulfilment of these, i.e. what maladaptive learnings or conditionings have occurred, what

adaptive learning has not yet taken place; then help his rational self to take the necessary steps to fulfil his needs and satisfy his wishes/drives. In doing this it is necessary to help him understand and evaluate the moral imperatives he has learned.

The "brouhaha" Mowrer, for one, raises about the "reduction of the super-ego" ~~and~~ has no basis in Freudian theory unless he demands the super-ego system should remain quite unchanged. Admittedly his present stand is merely an elaboration of his 1950 contention that neurotic symptoms were due to a deficit in learning societal codes and moves. The difficulty now appears to be his alignment with, and implicit acceptance of, specific but changing codes and demand for a rigid super-ego. Freud himself commented,

> The new super ego now has an opportunity for a sort of <u>after-education</u> of the neurotic; it can correct blunders for which his parental education was to blame (<u>ibid</u> p. 39)

And he warned that the analyst must be careful in his own approach to the patient, or

> He will only be repeating one of the mistakes of the parents, when they crushed their child's independence ..... In all his attempts at improving and educating the patient the analyst must respect his individuality. (<u>ibid</u> p. 39)

2. <u>The Therapeutic Situation</u>.

Some, such as Thorne (1955) and Sheer (1955) have also made explicit reference to the therapeutic situation:

> ... all effects of psychotherapy may be classified under either of the two general headings: <u>establishing suitable conditions for learning to take place</u> and <u>providing suitable</u>

> training situations according to the psychology of learning, so that reconditioning actually takes place and is translated into action. (Thorne, ibid. p. 243).

The analytical emphasis on the transference situation is conceivably an intuitive and experientally-based acknowledgment of the fact that the early learning situation and the learnings which occurred are indeed the basis of most mental disorders. Furthermore, the ideal prototypical learning situation, of a warm, secure "home" environment with fully accepting parents, is the situation in which optimal learning can occur and from whence exploration can begin. This is the situation supposedly found in the therapeutic milieu.

> In the patient-therapist relationship, therapeutic techniques are directed toward the provision of the most favourable conditions in which learning and reintegration may take place. (Sheer, 1955, p. 372).

But, unfortunately not all psychotherapists, and this applies particularly to the analytic school, realise the importance of the inculcation of new behaviour patterns and the necessity for many of them to be habitual. Many of us have been grossly conditioned by past experience with authority, or theological precept, to believe that man must always be "free". The idea of "automatic" behaviour is accordingly anathema to some people.

3. Re-education and Habit Formation.

Thorne, a Professor of Psychiatry, as well as the editor of the Journal of Clinical Psychology, is one who sees more clearly:

> But analysis and emotional release and the acquisition of insight are often not enough and do not inevitably

> result in cure. It is then necessary to undertake the second part of therapy, which involves an active reconditioning process that must not be considered complete until insights are actually translated into action. Much of the psychotherapy of the past has failed because the therapist and client did not work hard enough in practicing newer patterns until they were actually mastered..... (Thorne, 1955, pp. 243-244).

Kraines, who followed Meyer at the University of Illinois, pointed out at least fifteen years ago that:

> Man has learned to make habitual many activities, so that he is more free to focus his attention on objects of interest. Habitual responses require almost no thought, and are automatic and reflex-like in character ..... It is desirable that much of one's life be automatic - provided the habits thus carried out are energy-saving ones ..... Habit has no value other than its pragmatic worth ..... In the same way <u>much of what a person thinks and feels is automatic</u> and habitual, the pattern often having been laid in the forgotten past.... (p. 48)

And, in relation to psychotherapy, he admonished:

> ..... the fundamental treatment of neurotic symptoms should be directed at: (1) removing excessive stress, (2) eliminating immature and unhealthy personality traits, and (3) substituting mature and healthful reaction patterns with which to meet future stresses (p. 123). (2) and (3) were to be obtained by changing attitudes and behaviour as the result of "(a) intellectual understanding of the <u>cause</u> of the attitude; (b) desensitization toward the old and emotional acceptance of this newer outlook, and (c) conscious redirection of thought and action processes so as to break unhealthy <u>habits</u> of thinking and feeling and instil healthy ones" (Kraines, op. cit. p. 131).

4. <u>Curative Elements in Analytic Therapy</u>.

Kraines, after noting that psychoanalysis was no more successful than eclectic psychiatry (for confirmation, see for example, Landis, 1937; Wilder, 1945), points out that what cures psychoanalysis does obtain are in effect based on acceptance, catharsis, desensitization, loss of guilt and learning to view symptoms rationally as relating to emotional

problems.

What Kraines refers to as "desensitization" may also refer to the principle I have called "satiation", for the patient has iterated and reiterated his experiences and problems many times in many different ways. To this principle I shall return again shortly.

5. Therapy and the Interview Situation.

Wolpe (1958) has also considered the therapeutic elements in "therapy without reciprocal inhibition procedures", under the headings of "Interview-induced emotional responses" (which I would call "catharsis"), "Abreaction", "Fortuitous Therapeutic Effects in life", "correcting misconceptions", "thought stopping", and a factor not considered in this thesis, "the use of drugs" (Ibid, Ch. 13, pp 193-203).

6. Learning and Current Therapies.

In the now classical exposition of Bandura (1961) the following points emerged:

(1) Psychotherapy is a learning process

(2) Some authorities (cf. Dollard & Miller, 1950; Dollard, Auld & White, 1954; Shoben, 1949) have simply translated psychoanalytic theory into learning theory terminology, which is by no means the same thing as considering psychotherapy as learning and unlearning.

(3) Most psychotherapeutic theories (cf. Dollard & Miller, op. cit. Fenichel, 1941; Rogers, 1951; Sullivan, 1953) emphasise discrimination learning

believed to be accomplished through the gaining of

> awareness or insight (which causes the patient's behaviour to) become more susceptible to verbally-mediated control. (Bandura, ibid p. 147).

(4) There is a tendency to develop "schools of therapy" -

> Wolpe, for example, has selected the principle of counter-conditioning and built a 'school' of psychotherapy around it; Dollard & Miller have focused on extinction and discrimination learning; and the followers of Skinner rely almost entirely on methods of reward. (Ibid, p. 154).

(Bandura, himself, however, has concentrated on the development of social imitation as the major therapeutic adjunct. *)

(5) He, himself, after (Adams, 1957; Erikson, 1958; Razran, 1949) doubts the effect of awareness on the acquisition, generalization, and modification of behaviour (Ibid, p. 148).

Reference has already been made to consciousness (see Part III) and to the importance of attention in learning, which implies a certain degree of consciousness or "awareness". The term can only be taken to mean "being conscious of/attending to/conscious focussing" or "being aware of the implications".

Camilla Anderson (1957), argues in somewhat similar fashion to Erikson (op.cit.) who contends awareness cannot exist at levels which cannot be verbalised (I assume he means in adults). She says,

> Getting an experience integrated with the proper verbal symbols constitutes the process of bringing it into conscious awareness. (Ibid, p. 91).

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* Personal communication; August, 1952.

Metzner (1961), in an equivalent English attempt to consider learning theory and the therapy of neurosis, based his discussion in the main on the question of extinction; though he discusses also the transference situation in relation to reality-testing, as well as the role of insight.

Although he realises that reality-testing is usually done at the verbal level Metzner pays little or no attention to verbal conditioning as such possibly because he has only considered theories derived from animal studies nor does he realise as Anderson (op cit) appreciates that "reality-testing" in the child is unfortunately frequently the testing of the responses of the "significant other". Again, unfortunately such testing is sometimes found in therapeutic situations with the subsequent reinforcement of irrational conditionings. He contends that

> there are two types of cases in which psychoanalytically orientated psychotherapy is most useful: 1. Where fear is primarily evoked by verbal stimuli and generalized (often unconsciously) by verbal cues, in the manner extensively described by Dollard and Miller. Psychotherapy here - besides the verbal reality-testing already discussed - would include the correction of faulty ways of thinking, the allaying of misguided fears and the reinstatement of rational planning procedures. 2. Where detaching the anxiety from the CS is insufficient because the traumatic US is of the kind that is likely to recur frequently. This is presumably the case in neurotically predisposed persons with a low 'toleration threshold'. Psychotherapy here takes on the function of changing the whole personality so as to make it more stress-resistant. In some cases this may be necessary; in other cases it is based on a value decision that has to be made and which involves questions of the philosophy of treatment. (pp. 23-24).

One has only to read Metzner's sentences carefully to realise that one needs to take note of (a) the effects of verbal-

conditioning; (b) the fact that both anxiety-reduction and reward, as well as goal-setting, are involved in the psychotherapy he has in mind; and (c) that, although he has discussed it, he has failed to appreciate the value of Wolpe's de-sensitization of anxiety-conditioned responses by discrete steps (cf. Wolpe, 1958).

The re-learning and un-learning techniques which have been used therapeutically have been summarized by Rachman (1963):

1. Desensitization based on relaxation (Wolpe, 1954, 1958, 1961; Bond & Hutchison, 1960; Lazarus, 1963; Rachman, 1959; Hussain, 1963; Clark, 1963; Walton, 1960, 1963; Meyer, 1958).
2. Operant conditioning (Ayllon, 1960, 1963); Lindsley, 1956, 1961; King et al., 1960; Brady & Lind, 1961; Ferster & de Myer, 1961).
3. Aversion conditioning - chemical or electrical (Wolpe, 1958; Blakemore et al, 1963; Freund, 1960; Raymond, 1956; Franks, 1960; Max, 1935).
4. Training in assertive behaviour (Salter, 1950; Wolpe, 1958; Lazarus, 1963).
5. Use of sexual responses (Wolpe, 1958; Lazarus, 1963).
6. Use of feeding responses (Jones, 1924a, b; Lazarus, 1960).
7. Extinction based on negative practice (Yates, 1960; Jones, 1960; Williams, 1959).
8. Anxiety-relief responses (Wolpe, 1958)
9. Avoidance learning (Lovibond, 1963; Jones, 1960).

(Rachman, ibid, pp. 3-15).

7. "Learning" Therapy.

I have based my own approach on the learning and unlearning principles I have enunciated in Part IV as well as the theory regarding ego reference systems, set out in Part V.

So far as psychotherapy per se is concerned I contend:

(1) While all behaviour is based on innate neurophysiological processes in interaction with maturational development and learned activity (which infers interaction with the environment), the psychologically-oriented therapist is concerned with the learning process.

(2) Human learning is basically "simple", i.e. conditioned by contiguity or association and generalisation; but can also be regarded as "complex" for it encompasses, via the conditioning dependent upon all the feedback and intra-communication processes, incentive, probability and/or relational learning as well as reference systems. These are essentially dependent on what Mowrer (1960b) called "the symbolic processes", or Pavlov, "the 2nd signal system".

(3) All learning is reversible over time even if some of it may be difficult to extinguish, particularly when symbols are attached to fundamental drives, as Sullivan saw in regard to homosexuality (see pp. 196/7)

(4) All learning can be modified through the symbolic system as well as via the purely sensoric processes.

Bearing in mind these four principles, consideration of therapeutic

procedures based on learning principles may be subsumed under the following headings:

A. Type of Learning Process Involved.

1. Cue conditioning, and counter-conditioning. In principle these are the same but for the latter some special refinements in technique may be necessary. During the early stages the drive which is to be replaced must be only mildly stimulated while the new drive which is to replace it must be stimulated with greater intensity. By degrees the ratio is changed until finally the new drive attaches to the cue and "reciprocally" inhibits the old one. The case quoted from Watson & Raynor on p. 54 is a classical instance.

2. Operant conditioning. This is operating in many forms of therapy. In various ways (see Below) the patient is instigated to make new responses or types of response and these become reinforced and so satisfactorily established. The fact that several forms of therapy all produce satisfactory outcomes may be accounted for by the fact that they all succeed in instigating the emission of suitable responses which then become reinforced, The methods of Moreno, Freud and Rogers all illustrate this type of learning.

2(i). Incentive Learning. This is the association of particular degrees of reward with particular "performances" as Tolman terms them, thereby distinguishing between a mere series of muscular movements and an actual manipulation of the environment. Incentive learning is an essential part of motivated response learning. This is the source of the

dynamic element in the learning. I would argue that learning as such does not require reward or punishment to reinforce it, but that any form of learning which is to have inherent dynamic quality must in some way be linked with a drive. A major problem in the application of therapeutic conditioning is to find suitable forms of incentive reinforcement.

2(ii). Probability assessment. Operant learning involves an appreciation of the degree of probability. It is this aspect which makes the difference between the effects of regular and partial reinforcement. As we have seen (pp. 62-64) this is an important aspect of "hope".

3. Satiation. This must be distinguished from extinction which may be the result of expectancy modification rather than satiation. I may cease to go to the fruiterer for strawberries not because I have been satiated with the fruit but because I have zero expectancy of finding strawberries available. One might postulate a law of decreasing affective returns in this connection. Whether it is due to a positive decline in the experience of reward or whether it is due to the building up of a negative counter-effect (re-active inhibition) is a matter that may be left to learning theorists to elucidate. It may be noted, however, that the long-term effects of satiation depend upon conditioning and Hull's concept of conditioned inhibition is clearly applicable in some form. The rate of responding is very important in this respect. The more

rapid the responding the less rewarding the responses will be so there will be a decline in incentive value. It is possible also to choose optimum periods for such satiation. If strawberries are presented only when the subject has eaten to repletion and he is caused to eat them, incentive may be reduced although few strawberries have actually been eaten while foods presented usually when hunger is high will gain high incentive value.

Habits such as nail-biting may have value as an outlet for aggressive tension but if pursued long as a conscious response may become positively distasteful and such a procedure may produce a high degree of conditioned inhibition.

4. Extinction. As already noted this may occur while the organism still retains both the response pattern and a strong urge to employ it. Responding has ceased because of a change in expectancy and such a change can be greatly accellerated by insight. The actual impulse to respond is still present but is positively inhibited as Pavlov has shown and as Diamond, Balvin and Diamond (1963) repeatedly stress.

The conditioned attachment of inhibition to stimuli in this way makes possible a secondary reinforcement approach to extinction. A stimulus which has acquired conditioned inhibitory strength may be used to attach the same quality to another response. In practice this does not appear to have been systematically exploited but the

use of the word "no" by parents to prevent their children from engaging in undesirable behaviour could perhaps be regarded as a form of such conditioning. The condition effect here, however, may arise via the stimulation of fear and so be better regarded as an example of reciprocal inhibition.

5. Reciprocal inhibition and conditioned inhibition. Wolpe (1958) makes reciprocal inhibition the focus of his therapy but in practice he makes use of a wide range of principles and methods. To some extent it enters into a great variety of situations and may indeed be an aspect of all learning. Counter-conditioning has already been referred to. This involves the application of a more dominant stimulus which draws a response which reciprocally inhibits that of the weaker stimulus. Strictly we should insist that reciprocal inhibition apply only to this transient effect. Permanence can be given to this effect either as the result of the cue concerned becoming positively conditioned to the new response or by its acquiring conditioned inhibition. Usually both effects are likely to be involved and difficult to disentangle since inhibition will be present in both cases either as a direct or indirect effect.

The normal process of extinction probably involves two sources of inhibition: that generated by negative expectation and that arising from the reciprocal effects of competing stimuli. With more primitive forms of functioning it is possible that the latter is more important. When it derives from a variety of sources the conditioned inhibitory

effect may be much more important than the acquirement of any new positive response by the cue, indeed there may be none. But where a single insistant drive response is competing the new positive conditioning may be the major outcome. This is exemplified in Wolpe's own experiment (1958, 50-54) and typically in the Pavlovian cortical switching experiments (cf. Yu. N. Dan'ko, 1961). On the other hand his relaxation technique would seem to emphasise the conditioned inhibition aspect.

The point I would make here is that the reciprocal inhibition approach is only <u>partly</u> a conditioned inhibition technique and furthermore that conditioned inhibition may be used without the inhibition being reciprocally derived. Extinction and differentiation may both be sources of such inhibition and be used in conditioned inhibition techniques.

6. <u>Cognitive or relational learning</u>.

Behaviouristic therapists have tended to neglect or even oppose this but it is certainly a form of learning. I have already argued that it operates in more complex fashion than simple conditioning. It calls for the operation of intelligence and the use of symbolic constructs such as language. Moreover there may be no need for repetition of the conditioning situation since the learning involved meshes in, as it were, with the already developed systematic reference frame and so has the support of previous conditioning. It is this latter fact which tends to obscure the fact that conditioning is involved.

Cognitive learning does not directly involve the motivational structure but it is very important in two ways. In the first place it provides the map of reality in accordance with which drive satisfaction is sought. A man does not seek to buy a drink from a hotel which in his belief does not exist. Modification of this reference system is likely to have continuing effects on behaviour. In the second place modification of the cognitive reference system may have important effects on current behaviour and so influence drive conditioning which will become a more or less permanent part of the motivational system. Cognitive change thus becomes an important form of what I next deal with; behaviour instigators.

B. Current Behaviour Instigator.

In the case of cue-conditioning no behaviour is called for. The cue is presented in conjunction with drive activation and the bond is bdtween cue and drive but in operant conditioning behaviour must be 'emitted' before any conditioning can occur. Psychotherapy makes use of a variety of techniques for so instigating behaviour:

1. Role playing. A patient may be required to act the part of a character according to the supplied script, may be directed to improvise the part of a described character or may be set to play a given type of role in real life. This last approach has been used by behaviour therapists such as Salter (1961).

2. Imitation. Bandura and Huston (1961) and Bandura, Ross

and Ross (1961) have demonstrated the effect of aggressive models in fostering aggressive behaviour. It seems very likely that the role of the model here is to suggest appropriate means of behaviour for the attainment of ends already important to the subject. The subject is thus led to experiment with such behaviour and becomes reinforced in the usual way. This is directed operant conditioning where the emission of suitable behaviour for reinforcement is greatly speeded up.

3. Counselling. The therapist may act directly as an instigator by verbally advising the patient to try certain forms of behaviour and using his own prestige, the painting of favourable outcomes and direct suggestion, to persuade the patient into the required effort. In so far as real learning takes place only as the result of appropriate reward, this is still a learning technique.

4. Revised cognitive reference. A major value of inducing greater "insight" in the patient is that it alters expectations with regard to the possibility of changing his behaviour and to the probability of punishment ensuing therefrom. If, for example he can be led to believe (whether or not it is in fact true) that he has been shy in the past because of the way he was treated by his mother he will more easily be persuaded that there is no longer any need for him to be so influenced by his mother and he will be more ready to attempt a new behaviour pattern. The

fact that any rationally acceptable explanation of past behaviour can play this sort of role helps to explain why divergent theories of therapy have produced actual cures in practice. A further point is that this may reduce dissonance within the reference system.

C. Reinforcers.

In order to bring about operant conditioning suitable reinforcers must be found. The ingenuity of the therapist may turn up many forms but most of these will fall under one of the following headings:

1. Natural consequences. In many cases appropriate behaviour will automatically be reinforced. The painfully shy individual who is induced to be more outgoing is likely to find his success so satisfying that he will be led to continue such behaviour. The problem is one of instigation rather than reinforcement. New behaviour resulting from "insight" tends similarly to be reinforced and in accounts of such cures the conditioning process is often overlooked.

2. Approval and disapproval. This can be controlled directly by the therapist and can be brought into operation before the patient has appreciably experienced natural reinforcement. It can also powerfully strengthen the natural effects by directing the patient's attention to his own success and can methodically boost his self-esteem. It should be noted that the so-called transference situation, where a bond of affection has been established between patient and

therapist, leads to the patient having a strong desire to please the therapist so that the latter's approval becomes reinforcing through the satisfaction of the affection drive.

The therapist is not restricted to verbal statements in expressing approval and disapproval, but may use more subtle methods: smile, frown, gesture, change of subject, obvious enthusiasm, etc.

3. Environmental change. It is often possible to change the environment and so bring new reinforcers into play. A child removed from a home where he has experienced rejection and where his good intentions are never rewarded may rapidly change when moved into a suitable foster-home. A child transferred from a class where he is unable to cope with the work to one where he is able to make progress and gets consequent approval may soon build up a healthy self-ideal and change his general attitude to life.

Such an environmental change may sometimes be brought about without geographical change by suitably instructing parents or teachers. A considerable amount of child therapy can be carried out via the parents.

4. Artificial. Often the therapist can make use of laboratory-like reinforcers. For aversive conditioning he may resort to electrical or chemical means. The treatment of alcoholics by administering of apomorphine which results in the imbibing of alcohol causing nausea is a classical example of this type of reinforcer. Monetary rewards, toys,

favourite foods, etc., can be used with children in somewhat similar fashion. A case in an American hospital of which I heard was treated for anorexia nervosa by making eating a conditioned response. The patient was kept in a bare room without company but was allowed a radio programme or human contact as the reward for eating. A woman who had become virtually a living skeleton was thus induced to put on several stone and became able again to participate in ordinary living. The conditioned response so established maintained itself outside the hospital situation. Unfortunately treatment along similar lines for obesity was not found to give permanent results.

5. Hypnotic suggestion or fantasy. Freytag (1959) (see case 20) describes a procedure which involves reliving crucial experiences but with appropriate modification so that a rewarding situation is substituted for a punishing one. This is carried out under hypnotic suggestion and thus applies a very subtle form of reciprocal inhibition. A similar approach with hypnotic suggestion is used by Wolpe (1958) and Salter (1961). Related to this is the "direct analysis" of Rosen (1953) in which he converses with schizophrenic patients in the role of the relevant person. In the role of father he assures a patient with a strong castration fear that he loves him and will not punish him although he knows all about his misdemeanours. (Case 43).

D. Area of learning involved.

1. Conditioned drives. The simpler forms of conditioning

will relate directly to drives. The extinguishing of maladjustive cue conditioning (e.g. phobias) and the building of new response patterns or "performances" are major forms.

2. Ego-structure components.

   a. Ego control

   b. Self sentiment

   c. Ego-ideal

   d. Super-ego.

Modification of these reference systems may often be the essential part of therapy and it must be recognised that the methods employed for D. 1 may be quite unsuitable for this more complex problem. Some form of analytic type approach may be very effective from the anxiety hierarchy type of analysis of Wolpe's to a more loosely constructed analysis of behavioural components. It is important to bear in mind that one is dealing with a systematic structure and not just a simple unit; nevertheless one may sometimes be concerned with a simple part of the whole, e.g., an old-fashioned conception about the right use of the Sabbath.

3. The cognitive reference system. I have already indicated how modification of this may be important with regard to therapy.

E. Techniques concerned with the Facilitation of Learning.

These may be of particular importance in the therapeutic situation:

1. Relaxation techniques. These may play a double role. They may be important for reciprocal inhibition procedures

but they may also serve a more general purpose in bringing the disturbed patient into a more suitable state for treatment. I have found that relaxation has often released a flood of memories which have proved very important in providing the insight on which new behavioural patterns could be based. It has thus been a means of facilitating learning in two different ways: guiding the direction of learning and making the conditioning procedure more effective.

Jacobson's (1929) book on "Progressive Relaxation" has been of considerable influence in this connection. Brown (1938) made early use of this technique and Wolpe (1958) has regarded it as a major tool in treatment. Kraines (1948) stresses that "the patient must learn to relax".

2. Abreaction. This calls for special consideration. What we have called "dissociated affect" may resist extinction indefinitely because it is operating out of context with the cognitive system. Brown (1944), inspired by McDougall's drainage theory, explains the dissociation in terms of reciprocal inhibition but it is probably simpler to think in terms of the high emotional response interfering with cognitive integration or recall. In connection with a study of perception (1961) I advanced the hypothesis that "electric shock, at the limits of tolerance, concentrates all the S's attention on itself. Instead of bringing the to-be-conditioned stimulus into its aura and endowing it with its own attention-getting qualities, it takes attention away from the stimulus and so results in negative

conditioning." (P. 36). This hypothesis, only a minor one in this research, was significantly confirmed. I would suggest that it is this narrowing of attention or, in Pavlovian-Sullavanian terms, this conditioning to "selective inattention" which is responsible for the phenomenon of dissociated affect since the traumatic experiences involved are usually much more intense than the electric shock used in laboratory experiments.

Perhaps this is just saying the same thing in another way but whatever the neural process may be there does appear to be a divorce of the experience from the normal memory system and it is the apparently irrational source of the behaviour which makes it so difficult for the patient to cope with it. Abreaction appears to provide a means whereby the experience can be brought back within the cognitive system whereupon it becomes subject to various factors which will result in its extinction.

It must not be overlooked that active repression may also produce the dissociated affect. In the famous River's case it was the fear of parental disapproval which resulted in repression and it could be expected that super-ego repressive effects would frequently be operating in the war cases which provide the majority of instances of successful abreaction. (cf. Case 55).

3. Catharsis. I have already distinguished between abreaction and catharsis. They do have something in common: intense emotion which needs to be dissipated. In the case of

catharsis this effect is produced by displacement. The patient is given other opportunities for emotional expression. Repressed anger can be directed towards the ill-treatment of a doll, breaking of toys, etc. In these situations it is not so obvious how learning takes place. On the face of it one would expect no permanent effect at all. It can only be assumed that the improved emotional conditions permit more satisfactory behaviour which in turn leads to the learning of more satisfactory forms of adjustment.

4. Scheduling reinforcement. Ferster and Skinner (1957) have shown the great importance of suitable scheduling of reinforcement. Fixed-and-variable-ratio and fixed and variable interval reinforcement have different values. In general partial reinforcement is much more resistant to extinction but on the other hand it is slower in producing conditioning so is not necessarily to be preferred. Choice in this respect (where choice is open to the therapist) must be made in the light of the total situation and the aim in view.

5. The length of time between response and its reward or punishment. This can be of considerable importance in the conditioning, reinforcement or inhibition of behaviours. Spence (1956) contended that immediate reward learning is more efficient than delayed reward learning, postulating that in the latter there is more likelihood of the arousal of competing responses which would interfere with the learning. Terrell & Ware (1963)

in a study relating to emotionality in a group of kindergarten and 1st grade children and delay of reward, considered that greater emotionality was induced by delayed than immediate reinforcement (p. 501).

Walters & Demkow (1963), again using kindergarten children, found that early punishment had been somewhat more effective than late punishment in producing response inhibition in boys. There were also indications that response inhibition is more readily produced in girls than in boys. (p. 214).

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PART EIGHT

LEARNING AND UNLEARNING IN PRACTICE

The following series of case studies was undertaken in England. In each of the ten cases I report "learning therapy" techniques of various kinds were utilised. These varied considerably according to the presenting symptoms and my perception of the needs of the particular individual, and included such things as efforts to change the environment and modify the behaviour of "significant others", "reciprocal inhibition therapy", catharsis and abreaction.

Each case was investigated as fully as circumstances would permit. Therapy was given without charge, and the people involved were informed that this was a research series. Names, geographical locations and relevant minor details are changed, however, in order to ensure the patients and their families as much privacy as possible. Where discretion would warrant such action, suitable cuts have been made in the record. The full records are on confidential file in the Department of Psychology, V.U.W., and may be consulted by academic staff, research workers, or other suitably accredited persons.

The cases are reported as fully as possible (see discussion of this point below), but are not discussed other than in regard to the variables I could hold reasonably constant or situations in which I was involved. Some of the cases do, however, illustrate very clearly the environmental pressures to which so many people are subject, as well as the effects on the environment and the

patient of change induced by the therapist.

.. ..

1. The Therapist. Many authorities have mentioned the personality of the therapist as being of importance in regard to his particular utilisation of various techniques or interpretations and/or in regard to the therapeutic relationship itself (vide Knight (1954), Atkin (1962), Steinfeld (1951), Strupp (1958, 1960), Alexander (1960), Stein (1961), Sheer (1955)). But, to my knowledge, no mention has yet been made of the therapist's own models. From my study of the records presented here, I have come to realise just how clearly I myself reflect (though necessarily, to different degrees, in different situations) the most important of my own female models as well, to some degree, the behaviour patterns and values of those (unfortunately all male) therapists I know well. Another related variable I suspect to be operating and which could well stand study, is the degree to which particular models influence the therapist's (or, for that matter, any human being's) behaviour with different age groups. It is quite customary to speak of the introduction of parent's values and the imitation of their behaviour; but one variable which shows up in all therapeutic situations is that model-imitation occurs whenever, through shared-interest or the affectional drive, another influencing or suggesting stimulus (in this case, the complex stimulus of another person) is present.

No published study of which I am aware has included

a report on the personality of the therapist. Nor, at least at this stage, do I propose to reproduce a full assessment of my own. It may, however, be noted that on the Myers-Briggs Type Indicator (1962), my scores place me in the INFP group (i.e. Introverted-Intuitive-Feeling-Perceptive type; (the direct opposite of which would be Extraverted-Sensing-Thinking-Judgmental).

There were also three personal variables which were constant during the period of therapy, and easily verifiable, viz. my age, weight and height. The first two were of direct consequence in at least one therapy session; while my height (or lack of it), and experience of my own anxiety-conditioned reaction to people much taller or larger than myself, was undoubtedly responsible for the practice I occasionally adopted, at first intuitively, later deliberately, of sitting on the floor, or at least near to or below the eye-level of my child patients, when they were apparently anxious or confidential, and in need of support or acceptance. This, however, is a variable I did not hold constant - there were many occasions when the child sat beside me, with or without my arm around her/him, or even on my lap. In this particular respect I usually acted spontaneously in immediate response to my perception of the child's need or wish. An unfortunate consequence of my own behaviour here was that I disrupted my reportage of events.

2. Reporting of Cases. It is my considered opinion that no complete experimental or objective study of psychotherapy

will be possible until every session is taped and cinematographically recorded through a one-way screen so that the patient and therapist is not immediately aware of what is happening. An attempt was made at tape-recording the current interviews, but it was found to be too disruptive. (One child said, "No! Take it away! It makes me make mistakes!" after he had demanded, and heard, a play-back of the first attempt. Another child complained of my paying "it" attention, while a third simply became negativistic). As I am an experienced and rapid shorthand-writer, and accordingly use pencil and notebook "naturally", almost as though they are merely an extension of myself, I recorded all sessions verbatim wherever possible, as will be noted in the record. It was found, however, that even with this method, the children would require me to play with them or give physical support, while the older patients frequently tended to become either defensive or attention-demanding, so that I was forced to put my pen down and fill in the gaps from memory. On a number of occasions, too, material which was of importance was not mentioned until for some reason or other I had put my pen aside; or else my undivided and continuing attention and/or response was demanded by unduly rapid or agitated verbalisations or movement, or questions. This particularly applied to Jennifer (Case 8) and Mrs. Sylvia Thompson (Case 10).

3. Difficulties of Research Situation.

As this was a research series and therefore dependent

on the goodwill of parents and/or patients beyond that normally given in a deliberately sought-out therapeutic situation where authority is at least tacitly accepted more or less without question, a number of difficulties presumably arose. Conceivably I may have been too concerned lest I offend the parents (this particularly applied in the cases of James Barrett and Caroline Quirke); while, rightly or wrongly, in the main I conceived all responsibility to be entirely my own (and not, in part, that of patient or parents). All factors considered, it is most unlikely that I would have acted otherwise at many points in any case; but one cannot be entirely sure of these things. I do know for certain that my dislike of a particular adult was a factor in my not visiting the home of one child earlier than I did. Deriving from this experience, I would draw the conclusion that the question of authority and the wielding of power is one variable which requires consideration. It is I am quite sure, a factor in the therapist's personal reaction to the utilisation of any technique which might be perceived as "punishing", though it might not necessarily in fact be so.

4. Behavioural Limits.

In therapy, as in all educative processes, love unfortunately is not enough (cf. Bettelheim (1950), Redl & Wineman (1952). Love is perhaps a major prerequisite, as is the provision of appropriate materials, etc., but the drawing of limits with regard to behaviour is likewise a necessity. Furthermore, what one individual regards as "punishing" is

not necessarily so regarded by another. To re-state the point more clearly, as McDougall (1908) in his Introduction to Social Psychology, also saw, it is essential that the child or disordered adult shall experience being controlled before it can learn (again) to control itself. In learning theory jargon, a child must be conditioned to accept, and set, limits to free behaviour. Such limits must be set as widely as possible; but the anxious child requires a certain amount of routine, and at least some knowledge of what is expected of him, before he is once more free to explore and to learn. But individual differences must always be taken into account as regards limits, rewards, punishment or any other variable. These factors were of some importance in Case 4.

5. Milieu.

The therapeutic milieu is another variable which doubtless affects both therapist and patient. As no clinic was available in the area where the children resided therapy was undertaken in such places as the "Medical Room", or sometimes due to force of circumstances, in the Staff Room, of the school which two of the children attend; one child was seen at first in the office of the supervisor of the Occupational Centre; another child and one of the adults was seen in my home where therapy was usually carried out in my study unless the child voluntarily removed himself elsewhere; while others were seen in whatever staff study was available at the time of the interview. This variable, as will be reported later, did affect one boy quite considerably, but

in the main, it is probably the amount and type of equipment or extraneous attention-getting stimuli, and the number of interruptions which are the major deleterious factors involved in this situation.

6. Duration of Programme.

A variable peculiar to the circumstances under which much of this series was conducted was the linking of the therapy sessions with the school terms. It was not my original intention to do this, but in order to offset incipient and expressed anxiety in the teaching staff and/or parents and separation anxiety in the children, all children were usually seen only during the school term and until the final week of any particular term.

7. Somatic Features.

Three of the cases are of particular interest because of the somatic features involved. Caroline Q. (Case 5) and James B. (Case 6) have both been diagnosed as "brain-damaged". Both have completed the Goldstein-Scheerer cube and stick tests correctly. Both have language deficits, and Caroline has a definite speech defect. Bearing in mind the views of people such as Travis (1943) that lack of dominance of one of the cerebral hemispheres may be the cause of language deficit or speech defect, it is interesting to note that both children have a tendency to ambidexterity, Caroline particularly so. Jennifer J.'s (Case 8) presenting symptom was the psychosomatic complaint of "blotching". Alexander, in Psychosomatic Medicine, (1950, p.165) has approvingly quoted Klauder (1935) to the effect

that "the psyche exerts a greater influence on the skin than any other organ.....The skin is an important organ of expression comparable only to the eye."

8. Communication.

It is quite clear that, while a specific technique may be the primary mediating influence responsible for therapeutic success, a number of other factors are also involved, e.g. the therapist's "permissiveness" or acceptance of all manner of verbalisations and behaviours in the interim period while therapy is being carried out and/or the lines he may draw in connection with them. And I would postulate that many "lines are drawn" inferentially without the therapist even being aware of them, once rapport is established and therapy under way. A study by Cameron (1958) of "ultraconceptual communication" demonstrated very clearly that not only is there a considerable range of communicatory signals (11 sub-groups of verbal signals alone are listed), but that sometimes they are not conceived as such by the signaller and may be misunderstood at the same, or varying, times by "signaller" and "receiver". Furthermore

> It was also found that a group of therapists listening to a communication would all pick up many of the same signals, but that in addition there would be quite a number of signals which some therapists would pick up and others would not (and often could not)....Indeed we have a few recordings ....(where)....no agreement whatsoever can be reached as to their significance. (pp. 21-22).

I was as permissive as possible; but I "talk" kinaesthetically as well as verbally. It was impossible here to note either all stimuli observed or my own reactions thereto.

9. Spontaneous Abreation.

Abreaction which may occur as the result of spontaneous associations and verbalisations in the interview situation, or in conjunction with or resulting from the utilisation of specific techniques within specific situations, is another factor to be taken into account in any final assessment of the total clinical picture, as Wolpe, for example, has noted on more than one occasion (e.g. Wolpe (1958 pp.113, 195-198). It will be seen that this occurred incidentally in a number of the cases quoted (see 1, 3, 8, 10).

10. Incidental Learning.

Furthermore, during the attempts at induction of other responses ("assertive" instead of "timid" responses, for example) we find the factors operating must include such things as the learning or acceptance of the therapist's views on what is acceptable behaviour; the approval or disapproval (symbolic reward or punishment) of the patient's behaviours; reward or punishment stemming from the new behaviour pattern in interaction with others. The influence of all these factors is frequently very subtle; but we cannot claim success for certain methods without at least noting the multitudinous other factors which are also operating to reinforce or change response (and, therefore, "stimulus" so far as others are concerned) patterns and bring about the desired habitual behaviour. They obviously played a considerable role in the cases reported.

11. Deprivation in Infancy.

In particular connection with Cases 3 and 4 although they

(they) have many years to go to reach adolescence, it is interesting to note that Peck & Bellsmith (1954) in a study of over 1000 cases of delinquent adolescents found:

> First, as infants they experienced the deprivation of such love manifestations as handling, fondling, kissing, parental attention, as well as more specific basic biological lacks in food, warmth, and opportunity for motor activity. The absence of any of these essentials constitutes a defect in the basis for the infant's growth and security. Second, during the period from 3 to 6 years of age, the child's deprivations stem from the inadequacies of the interpersonal relationships within the family constellation....he must still depend largely on adult consent and support for his actions... Third, from the age of 6 on, the most significant deprivations for the child seem to be related to interference with his accelerated needs for social expression.

12. Relaxation Techniques.

Deriving in part from my finding it difficult if not impossible with the children to utilise Jacobson's relaxation technique (1938) as utilised by Wolpe (1958), and in part from Waal's (1958) report of the use of stroking and bodily massage with an autistic child, as well as such reports as that given above, some stroking and massage were used as relaxing techniques. I would also occasionally put my arm around a child, or tousle his hair slightly as a gesture of acceptance, support or affection.

13. Tests.

The following tests were administered either singly or in different combinations to the children and adults involved in this investigatory series:

(1) the Illinois Test of Psycholinguistic Abilities (Kirk & McCarthy, 1961)

(2) the W.I.S.C. (both in full, or in "modified" series) (cf. Jones, 1962)

(3) The Rosenzweig Picture Frustration Test (Children's Form) (Rosenzweig, 1948)

(4) C.A.T. (Bellak & Bellak, 1948)

(5) P.F. 16; I.P.A.T. H.S.P.Q. (Cattell et. al., 1957, 1958)

(6) E-S Scale (see Part V.)

(7) the Myers-Briggs Type Indicator (1962)

(8) Goldstein-Scheerer Cube and Stick Tests (1941)

(9) M.M.P.I. (Hathaway & McKinley, 1951)

(10) Allport-Vernon-Lindzey Scale of values (3rd Ed. 1960)

(11) The Willoughby Personality Schedule (1932, 1934)

The Pickford Projective Pictures were used as stimulus material and not as a diagnostic aid (Pickford, 1963).

In line with the official practice in both the Illinois U. Psych. Dept. and Illinois Student Counselling Service, as well as with the current knowledge with regard to the validity of such tests, no attempt was made to administer projective tests such as Rorschach and T.A.T. (Eysenck (1953). Nor were any interpretations attempted in line with classical analytical theories.

The tests were administered either to assist in the diagnosis of areas of (non-) development requiring remediation or to give additional correlative material with regard to the personalities and behavioural-trends of the people concerned;

or where family units were concerned, to give some picture of the possible pressures and points of conflict likely to occur.

My experience with the test material would lead me to refuse to accept any test result whatsoever (whether in single, or battery form) as absolutely valid. As will be seen from the cases given, the I.Q. testing of disturbed children is particularly prone to distortion. It is also quite self-evident that the Goldstein-Scheerer tests relate only to certain types of brain damage or malfunctioning.

I first heard of the I.T.P.A. at the University of Illinois itself and was fortunate enough to attend the relevant seminars held in the Exceptional Children's Clinic where one of the co-authors of the test (Dr. Sam Kirk, Director of the Clinic) or his assistant, Dr. Corinne Kass, lectured on, and illustrated its use.

The test was designed as a diagnostic tool to assist in the remediation of psycholinguistic deficits in children. It is based on the theories of Osgood (1957 a and b) and Wepman, Jones, Bock & Pelt (1960), both of whom postulate three levels of function or organisation in the use of language or in a behavioural act mediated through language though their concepts are somewhat different. Osgood speaks of projection, integration and representation or cognitive, levels; while Wepman et al speak of conceptual, perceptual and reflexive levels. Kirk & McCarthy (et. al) consider

their three dimensions in terms of "(a) channels of communication, (auditory input, vocal output, and visual input, motor output); (b) levels of organisation (automatic-sequential incorporating memory and imitation factors, and representational, i.e. meaning); and (c) psycholinguistic processes (decoding, association, encoding)."

Corinne Kass (1962) has criticised the test for its lack in certain areas, and her study involved the addition of such sub-tests as "a closure task in the visual area","a test of auditory fusion (sound blending)." (p. 20). The authors indeed admit its lacks and the test itself is scheduled for revision within the next three or four years*, though it may be noted that it went through three major revisions before the Experimental edition was published, and it was standardized on 700 children between the ages of $2\frac{1}{2}$ and 9, the sample being taken from the city considered to be the most "average" in its population.

There is, of course, no question but that such a standardisation must be carried out in New Zealand before it can be assumed to be valid for local application. Nonetheless, as a diagnostic tool and an aid in the setting up of individual remediation programmes, it has considerable face validity, and it would appear to throw at least some light on the difficulties of the children concerned. 4 specific cases are reported in Kirk & McCarthy and I understand that others have since been reported in Exceptional Children, while Smith (1962) of Peabody College found that the language

*Personal communication from Dr. Kirk, University of Illinois, 1962.

age of mental retardates measured on the I.T.P.A. was increased with an intensive group language programme aimed at developing the child's general ability to decode (receive visual and auditory cues), to associate, and to encode (express verbally or through motor responses) linguistic symbols, (Smith, p. 21). Deriving from this work use was made of psycholinguistic conditioning techniques such as miming, naming objects and pictures, word games, making words from letters, etc.

The Myers-Briggs Type Indicator (1962) is a new test, based on Jungian typology (1923), and the theory that there are (a) two ways of perceiving - directly by sensing and/or indirectly by intuition, i.e. by sensing + association of ideas; (b) two ways of judging - by thinking or by feeling, the former a logical, impersonal process, the latter, a subjective process of appreciation; (c) two major orientations to life - the introverted (whose main interests are in the inner world of concepts and ideas) and the extraverted (concerned with the outer world of people and things); and (d) two attitudes for dealing with the environment - the judgmental or perceptual. Mrs. Myers postulates that each individual has a "preferred" way of behaving depending on the combination of these choices. In other words, the tendency to utilise any of these ways of behaving will become habituated and integrated into a personality type. The test is apparently in use in the Institute of Personality Assessment at the University of California at Berkeley (where I first learned

of the test's existence in August, 1962); and was also being used by Dr. Jonietz of the University of Illinois Student Counselling Bureau*.

The Ego-Structure Test is discussed fully in Part Five, while the remainder of the tests referred to in the cases reported are well-known and require no further amplification.

14. Games.

The educational games referred to are:

(i) "Teachatot" Spelling and Arithmetic game, consisting of interlocking cardboard pieces on which there are printed numbers, arithmetical signs, letters, and named pictures.

(ii) Educational Blocks for Children - wooden blocks on each side of which are numbers, letters, or unnamed pictures.

(iii) Educational Card Games (the series used were produced in New Zealand by Tanner Couch Ltd.): "Animal, Bird, Fish" Game - each card with an appropriate named picture; "ABC" Game - each card bearing a capital letter or number on one side, with a picture beginning with the particular letter, or relating to the number, on the reverse side; "Rootie-Kazootie", with named and lettered pictures.

Appropriate children's toys, model kitchen utensils and tools were also provided for the children; as were also coloured pencils, crayons, chalks and plasticene, and children's books.

.....

*Personal communication, October, 1962.

Case 1:

The patient was a married woman of 44, who had suffered from extreme depression, obsessions and multiple phobias for many years. Desensitization therapy had resulted in lifting of the depression and the extinction of most of the obsessional behaviour; but the phobias still remained. "Satiation therapy" was used in regard to her lift phobia, with considerable success; it resulted also in some degree of abreaction and the recovery of other previously unadmitted material. Desensitization of her phobia with regard to the preparation of meals was brought about by means of support, verbal conditioning, increase in motivation, and practise of habits conditioned earlier in life.

In terms of the discussion and classification developed in this thesis, the patient had suffered from abnormal classical conditioning of fears, and dissociated affect; the development of maladaptive habits; a deficiency of ego control and distortion of the ego-ideal; and environmentally-induced frustration.

....

Mrs. Yates was seen by me during the period I was assisting in the work of a hospital out-patients' clinic.

At the time I first saw her she was an out-patient of the Summerfield Hospital, where she had been hospitalized some two years previously. Her symptoms of extreme depression, obsessions and phobias had been systematically treated and very largely desensitized with reciprocal inhibition therapy; but she was still extremely phobic in regard to lifts, trains, aeroplanes and fog; and was unable to put meals on to cook unless her husband were at least in the house, and preferably with her in the kitchen.

She told me on this occasion that she was 44 years of age and that she had led an odd but extremely sheltered early life. "My parents took me everywhere with them right up until I was about 19." It was, however, a strange triangle. "Sometimes my father would pay for me and

himself, sometimes my mother would pay for me and herself. They never paid for each other. There were always quarrels going on, all the time. I was always dominated by my mother. I've been much better since my mother died." (This was confirmed by Dr. X.) "I always used to side with my father and I was very upset when he died - about six months after I was married. It was my fault, I suppose. The neighbours told me he just went to pieces after I left home. My mother used to insist my father give her her allowance every night (he was a waiter). She was always claiming that my father was well behind with his payments, but after her death we found she had a few hundred stashed away." When queried about her husband she replied, "Ooh I suppose he's all right. But he always annoys me. He never understands anything; he's very slow to catch on." She had had two major "breakdowns", and at one stage "used to vacuum a tiny corner of carpet for hours on end because I didn't think it was clean."

There were no children to the marriage, a fact which seemed to have bothered her at times, though she did not like the idea of adoption when I suggested this to her. At this time she was working in an office and enjoyed the work. She gave the impression of being in good physical health, was neatly but not well dressed, verbalised readily and smiled and laughed quite spontaneously, and was on sufficiently friendly terms with her therapist to "do her scone" when she felt like it.

Desensitization of her fear of lifts was being carried on by taking her to the lift, riding up and down between floors, in discrete steps, as regards length of stay in the lift, and accompanying the experience with bandinage, jokes and pleasurable verbal associations and discussions.

She was always extremely tense on entering the lift, which she frequently appeared to do against her own wishes; but if, and when, she gave all her attention to the conversation (which, of course, unfortunately fluctuated in interest) the tenseness would temporarily disappear.

Attempts were also being made to discuss and resolve her present emotional conflicts, which appeared to be centred around her husband of whom she was frequently complaining, and sometimes of divorcing. Dr. X. considered this possibly an essential for further progress. When Dr. X. and I worked out a repertory grid (Kelly, 1955), however, it became clear that her husband had a predominant number of characteristics which she most admired.

When I took over administration of her therapy sessions on December 22nd, it was decided that our two immediate aims would be (a) de-sensitization of the lift phobia and (b) the re-learning of the ability of being able to peel the potatoes and place them on the stove before her husband came home. It was clearly stated and understood that I should only be in Manchester for approximately two months; and I think that this time limit, taken in conjunction with the excellent rapport we established and maintained, assisted in what therapeutic results were obtained.

Mrs. Yates was supposed to come for therapy once a week for 50 minutes. She failed to come on one occasion "because of the fog"; and on a second occasion because "she felt terrible." On the sessions I conducted myself I placed no limits on length; on one occasion she stayed nearly two hours "just to talk"; while on a further occasion she stayed 35 minutes late to complete the repertory grid for me. She kept reiterating that she was "fed up", she "had been ill for 18 years or more - when was she ever going

to get better?"

After the Christmas holiday period during which Mrs. Yates had been involved in some family unpleasantness, Mr. Yates was also called in for a general consultation, primarily to get his views on her progress and the present marital situation. (Sexual relations had originally been poor; but had become "good" after reciprocal inhibition therapy). He was a frank, pleasant person, and did not appear to be so "submissive" as his wife had led us to believe. What does seem to have occured, is that his initial comparatively unsympathetic attitude was overcome by his being taught that his wife was "ill", and accordingly he did not place the limits on her behaviour which his wife felt a "masculine man" should; at the same time, due to her own past experience with an extremely dominating mother, she could not stand any suggestion of domination. He thought that, although she had improved considerably over the entire period therapy had been going on, she did not seem to be getting any better at present; but he thought their own relations quite good.

Following a similar practice which had been utilised before to help her carry out various household chores, a regime was instituted whereby I telephoned Mrs. Yates at a certain time each day when her husband had not yet come home, we chatted spontaneously (usually about her problems in connection with her job, the weather, New Zealand, travel, books, t.v., etc.), and when she sounded sufficiently relaxed, I would send her off to peel a potato, following which she would return to the 'phone,Ialways told her she was "a good girl" and would congratulate her on her speed if she were quick, joke and instruct her to take her aggression out on the potatoes if she seemed anxious or slow; and finally end the conversation on as light and

pleasant a note as I could. By the 7th session she was spontaneously peeling two potatoes at a time; it took a further 12 sessions before she could manage three at a time; and in the last week I was there she triumphantly managed four (the total required). This, however, was initially done on a day when she knew I was in a hurry to keep an appointment; a wish to be helpful (which was one of her characteristics), to please me, and perhaps to make me a gift (which she did in actuality on the day I left) conceivably supplied the necessary motivation or arousal to permit this behaviour. This was maintained for the next two days until I left; but I have no information as to what has happened since.

De-sensitization of her lift phobia seemed to be making little or no headway; in fact on one occasion she insisted she was worse. Somewhat in desperation I decided to use "satiation therapy" (cf. Stampfl and Malleson (1959) Salter (1961)). (see p. 356) I carefully explained the rationale and procedure to her first; then took her into the lift, put my arm around her for support, and instructed her to imagine that she was "so scared she might die", at the same time I reinforced this with verbal suggestions as to how she was feeling, how frightened she was, etc. She started to shake and then to cry, so I immediately stopped the lift at the nearest floor, and took her out, comforted her both verbally and from maintaining my embrace. We then went back to the interview room and when she was composed I asked her for her associations. She told me (a) she was reminded me of an incident (of which she had previously spoken several times) wherein she was in a train, when another train passing by was hit by a V-2; (b) of the small bedroom where she and her sister as well as her parents had slept when she

was a child, and (c) that she had had homosexual relations during the war.

Thinking in terms of the "primal scene", during the next three sessions I endeavoured to obtain further association to the bedroom scene. She insisted, however, that she was not concerned either with guilt or fear about her parent's sexual relations; but she had been intensely ashamed because they could not afford to have two bedrooms. She elaborated this to a considerable extent; telling me of various experiences connected with her schooldays during which she was frequently ashamed of her family's social status and behaviour, and finally relating it to her present attitude to her sister and brother-in-law (who are in considerably better financial circumstances than herself), though she insisted she would sooner have her own husband and her own way of living.

Mrs. Yates appears to me to have quite a high intelligence - and one which has not been able to reach full development due to her lack of higher education and environmental pressures. It seems to me to be one of her present problems, which is unfortunately reinforced by her husband's non-intellectualism. I urged them both to join a choir (they are both interested in music; indeed her husband's desire to be a professional musician which he was unable to fulfil, again because of environmental circumstances and pressures, conceivably still remains one of his problems), but they both seem to lack initiative and drive (conceivably due to, and circularly reinforcing, depression and/or lack of positive reinforcement) and I doubt if this was done. At my suggestion, however, she was beginning to read biographical material of successful women.

From the interview material it appeared that Mrs. Yate's main anxiety, apart from the phobias and social status or approval, was connected with "religious truth", the possibility of a "hereafter", the reality of "God".

As is my constant practice, I presented all the known facts and rational explanations of which I was capable, and reinforced as much as possible her own tendency to seek such things. I followed the same course with respect to her homosexuality, about which she admitted some guilt feelings, but denied any present wish for further homosexual relations.

On being asked to rate herself on a 100 point scale as regards her anxiety on entering and being in the lift, Mrs. Yates claimed that at first she was 98 percent anxious, but that, after two "satiation" sessions this had been reduced to 60 percent. It is extremely unfortunate this therapy could not have been carried on for a longer period.

After I left England I received a letter from Mrs. Yates telling me she was busy writing the history I had asked her for, and that, after she had had a talk with Dr. X., she had decided not to go back to the clinic again "at least meantime". The history, however, has not come to hand, and apart from a Christmas card and a message of greeting, I have not heard further.

.....

Case 2:

A woman of 45 suffering from the maladaptive habit of nail-biting, was given massed practice, i.e. a form of "satiation therapy". The habit disappeared after two sessions, but reappeared with lack of therapeutic support. It finally disappeared when she terminated one affaire (which, in one aspect, had brought her loss of self-esteem) and engaged in and concluded another affaire with a younger, married man. The latter affaire was said to have overcome the hurt to her pride (i.e. ego-ideal) caused by her husband's desertion for a younger woman.

....

Mrs. Allen was a woman of 45 years of age, divorced, with a daughter of nine. The finger-nails of both mother and daughter were bitten to the quick, but the mother claimed she did not know the reason for the practice.

A survey of her history, however, soon dated the onset of the practice. Mrs. Allen is one of two siblings, her brother being younger than she. Her childhood was a very happy one, and she, herself, had been particularly close to her father. Her mother died at the end of the war. It was understood that her father had had extra-marital sexual relations because of her mother's relative disinterest in sexual relations, and he had indeed insisted that his children understand the nature of the sex drive and be completely "natural" in their sex relations; undue promiscuity was frowned on, but sexual relations with a loved or very-much-liked person were acceptable provided these were carried on openly.

Mrs. Allen had married a Canadian, whom she had met and nursed in a military hospital during the war. She had approved and helped him through his post-war teacher-training, and had felt their marriage was a happy one.

Some three or four years previously they had gone to Australia, where Mr. Allen had obtained a teaching-post. It was just when they had been buying household goods for a new house, that he broke the news to her that he was in love with another woman and wanted a divorce. After an abortive attempt by him to break off the affaire, and considerable mental turmoil on her part, she had taken the necessary steps to divorce him. He had remarried immediately afterwards and gone back to his own country. She herself returned with her daughter, to her father's home in Manchester and remained with him until he had died suddenly about eighteen months previously. Both she and her daughter, who had adored her grandfather as well as her father, were extremely griefstricken. The father had left his children "in confortable circumstances", and Mrs. Allen retained the use of the family home. There had therefore been no pressure on her to obtain employment, or otherwise take her out of her grief and depression.

After her husband's "betrayal", Mrs. Allen had felt "completely rejected as a woman", "undesirable" and "without sex appeal". Some time after her father's death she had begun an affaire with a tradesman, of whom her father had approved, and who had originally come to do some service for her. However, although he was "very kind", "always helpful" and wanted to marry her, and her daughter liked him and urged this upon her, she was ashamed of their relationship because he was relatively uneducated and uncultured. It was sometime after her father's death that she had begun to bite her nails, and this had become worse after the commencement of the affaire.

I again used a type of "satiation therapy". Basing the procedure on Salter's practices (1961) as well as the Maudsley practices in connection with tics, I instructed her to deliberately practice biting her nails for ten

minutes at a time. Two deliberate attempts were sufficient to inhibit the practice for the period I was in Manchester, during which time "supportive interviews" and rational explanations for various behaviour patterns (including her husband's) were also given. However, after I left England she again began to bite her nails, though she claimed not so much as previously. The habit finally disappeared completely after her shame-producing, i.e. anxiety-provoking, affaire, was finally broken off as the result of a temporary affaire with a younger married man, which she said she knew she was bound to end but was "short and sweet", and which she claimed restored her belief in her own attractiveness and thereby restored her self-esteem. In her last communication she was making plans to start a private nursing-home.

The daughter is said to "always have bitten her nails" and it was not possible to date the beginning of the practice. She refused to practice biting them, but promised to "try to stop if Mummy did". The mother was advised to buy the child a manicure set and, if necessary, make arrangements for a professional manicure to be done regularly so the little girl would begin to take an interest in, and be proud of her nails,* but no report has been vouchsafed as to the success or otherwise of this treatment.
(* This therapeutic regime was instituted by Dr. Sam Kirk some years ago with some small nail-biting girls, with complete success - personal communication, U. of Illinois, November, 1962).

Case 3:

A boy of 3 yrs. 9 mths. was referred because of highly disturbed and aggressive behaviour. His nursery school environment proved to be both ameliorative and therapeutic; emphasis was accordingly placed on "environmental manipulation" so far as the home and family-relations were concerned. The child was subjected to traumata from birth itself right through the therapeutic period. Mother received unsought therapy as the result of my interaction with her, reinforced by the verbal conditioning and behaviour of the nursery school supervisor. Abreaction occurred with regard to the mother's grandmother's death and the father's former infidelity; considerable semantic conditioning was given with regard to love for the child and healthy intra-familial relationships and behaviour.

... ...

Larry Johnson was referred by Nurse Peters, the visiting school nurse, who had seen Larry at a kindergarten he had attended earlier, and at the presently-attended kindergarten. This latter "kindergarten" is actually a nursery school (the only one in the district), taking children from 8 a.m. until 5 p.m. Nurse P. contended he would be a considerable problem when he entered primary school, his behaviour then being both highly disturbed and aggresive.

With the permission of the principal of the kindergarten, Mrs. Y. (of whom I cannot speak too highly), I observed Larry for half and hour. Larry, mesomorphic in build, was dressed neatly and warmly, and though it was a cold day (even in an overcoat I was shivering the entire time), he played outside for the entire period. In the main he played on his own, though he followed a boy, Peter (aged 5), about for a few minutes. On this occasion he spoke to the other children only when they spoke to him. At no time did I see any aggressive behaviour. Mrs. Y. gave him a box to put rubbish in, but when Peter said he wouldn't help, Larry left it alone too.

Mrs. Y. advised that Larry was much quieter now than when he first came to the kindergarten. When he first came "all you could see were two little dark buttons of eyes staring out of a stolid face". He never smiled, never spoke. He did not want to eat his meals, but he had finally been told, "Very well, if you don't want it, it will be thrown out." He then went in quietly, and now there was no trouble at meal-times. He preferred to play outdoors, and this was permitted as much as possible. Larry's best friend at Kindy was Peter, who was tall for his age, and a very aggressive child. Peter had also been a considerable problem when he first arrived. Larry was usually taken to and from Kindy by his grandmother, who openly preferred Larry's younger brother, saying such things, as "This is the good boy," etc. Larry would lie quietly at rest periods, but did not sleep easily.

I made no attempt to speak to Larry on this or the following occasion, and at first he took no apparent notice of me. Just as I was leaving he did look at me, and, indeed, all one could see were "two little dark buttons of eyes staring out of a stolid face".

On Thursday, 1st August, I again visited the kindergarten and observed Larry for 1 hour. The record is as follows:

9.30 a.m. Larry outside. Warmly clad. Larry was playing with Peter who was pushing a stick into muddy manhole. He then played on his own with a tyre and stick; then talked to his friend, standing by the manhole. Watched other children. Appeared quite at ease. As on previous occasion looked at me, but did not smile, or speak.

9.40 a.m. Knocking off pieces of protruding concrete around hole in foundation of building, with iron bar. Peter took it from him and

continued; no reaction from Larry.

9.45 a.m. Peter still using iron bar; Larry playing with stick in garden nearby.

9.50 a.m. On Larry's instigation, he and Peter playing soldiers. Peter laughing, with bar over shoulder. Now running round with bar in hosepipe. Third boy arrived. Peter's behaviour aggressive; inclined to bully somewhat. Grabs stick and throws stones.

10.0 a.m. Peter playing in garden on his own. Peter still trying to lift cover off sump. With other children, Peter finally succeeds.

10.5 a.m. Larry and other children play with sump - stopped by teacher. (Children obey her verbal instructions, which are accompanied by explanation as to why they must do so.)

10.10 a.m. Larry playing with hoop. Other children about, but Larry really playing on his own.

10.15 a.m. Larry still playing with hoop.

10.20 a.m. Larry playing up in garden. Boy in green jumper hits at him with stick. Peter joins in. Short fight, Larry runs into bushes.

10.30 a.m. Peter and Larry play with sticks and ball; then Larry runs up into bushes in garden again. Peter playing shooting with "gun" (stick). Larry comes down and follows; then goes back to garden. Climbs tree.

10.35 a.m. Peter starts throwing stones. Larry goes into Mrs. Y. who gives him tricycle to play with. Peter and Larry have argument over tricycle and Larry gives it to Peter. When Peter gets off Larry has it again and refuses to give it to another child. Then plays happily by himself again, riding tricycle up and down path.

Because of the information obtained from Nurse P. and Mrs. Y. that

Mrs. Johnson was working as an aid in the hospital, I visited the house at 5.30 p.m. Mrs. Johnson had just arrived home. She was not very gracious, but invited me in when I explained that I was a psychologist who had been asked to "have a look at Larry" (it is an observation of mine, that the more colloquial the language you speak, the less afraid people are of you), and that the educational authorities were concerned about his behaviour and I wanted to see if I could help. (Later, inside, in response to a comment by Mrs. Johnson, I explained that I was actually doing research for my Ph.D. thesis; this and its implications has been explained again several times, but the family seem to continue to expect free therapeutic service and advice from the Department of Education, or the University, as a matter of course.)

Apart from the parents' bedroom and lounge (which actually included a quilted movable cocktail bar), the house was quite sparsely furnished. I was taken down to the "living-room". The grandmother was lying back on a bed there, smoking. She was dressed in slacks, and frequently lay on her back with her feet up on the bed while talking in a somewhat raucous, dominating voice. Mrs. Johnson on the other hand was neatly dressed, quietly spoken, in response, but highly verbal and quite excitable when she is talking normally, and with a pleasant personality. She is inclined to be plump, but has a good figure.

We sat around the table, Larry running in and out of the room. This time when I smiled at him he smiled back, but immediately appeared to become shy, and ran away.

Mrs. Johnson told me: "Larry was born with high forceps delivery.

He was terribly bashed around." She "had had a normal pregnancy; brought Larry out of home 10 ozs. under birth weight. We were only home two weeks when he started vomitting - the nurse changed his milk. Then he started taking convulsions; had them during the night; they admitted him to the hospital in the end for a week; sent him home on another milk liquid, which was no good and he kept vomitting. He was referred by Dr. Y. to Mr. Z. who sent him to the Children's Hospital where he was put on Bengers' food. He was up there for a fortnight and they started him on tranquillisers, and kept him on Bengers. He was a bad sleeper; only since going to Kindy has he slept all night. He used to be up all night; he either had too much tranquillisers or something - he had seemed to react to them finally like a wild animal, and he had to be taken off them. He has only just gone down for the whole night from 7 to 7. He has been in good health, though he had dreadful hives. He is very defiant, though not quite so bad now. (In response to my query:) Kevin, the baby is 17 months old. Larry seems to love him, "but we never have any trouble with Bubby."

I suggested that Larry was a very nervous and anxious little boy, and needed a lot of love and attention, perhaps more particularly to offset any feeling of rejection he might have due to the attention paid the baby. Grandmother (interrupting): "She was married 5, nearly 6 years, up till the time she had him. When he came, he was the only grandchild, everybody spoiled him. Everybody."

I suggested that this could have made him feel even more left out, feel that his "nose was completely out of joint", after Kevin was born, and

pointed out that little boys do not understand what is going on in the way that adults do.

Mrs. Johnson : "Larry used to stand and scream; he would not wait or stand up in the bus. He hit a lady because there was no seat. He did not go without attention when the baby came. We had two boarders living with us before Kevin came and they looked after him. But after he was dumped in hospital he stopped walking and talking for a while."

("When was that?")

"When he was between 12 months and 2 years; about 17 months old. I went to get him one morning, but he wouldn't stand up. He didn't seem to be able to move, not even his head, which seemed to go to one side. He would only move his eyes. Dr. Z. or Dr. X. came and sent him straight to hospital. He was there for a week but they didn't seem to know what was wrong - sent him home at the end of a week, all right. Then he fell off a concrete wall last Christmas; but that's all that's been wrong with him."

Mrs. Johnson added that she is 27, and was married at 18. Her husband is 28. He has two jobs - is a partner in a small business. They have to pay (an exceedingly high rental) per week for the house (in Sanditch, a working-class suburb) which she showed me they were painting inside. She was working, "but just for a while", because her girl-friend was getting married and she was giving her a reception and wanted a new dress. She had lost nearly all her girl-friends because of Larry's behaviour in the past. Larry had played up so much one day her girl-friend had walked out saying she wasn't going to have a little two-year old b.....d treat her like that. She herself was very nervy and on tranquillisers.

The grandmother added that Larry seemed much better since he had been at Kindy. But her daughter had been "an absolutely perfect child -you could tell the time by the time she would come home from school and she would do everything." (During this Mrs. Johnson stood with eyes downcast). "She was an only child." She, the grandmother, was staying with the Johnsons at present "because her husband was in hospital". She then told Mrs. Johnson she "had not got the tea on because she had left it to her".

During this long conversation Larry wanted to go outside, but was not permitted to. As an aside to me, Mrs. Johnson said that he liked to be outside all the time, in all weathers, so long as other children were there too. At weekends his father takes him to the business with him. Larry continued to pester his mother for permission to go out, but was again refused. Then he ran off and started playing with his toys. Both children began to grizzle with hunger, so I left. After my again strongly-expressing the concern felt for Larry's welfare, and explaining the needs of children to her, Mrs. Johnson promised to give Larry more love and attention, and stated she was going to finish work the following Friday, August 9th. I instructed her to call me if there were any problems or any way in which she thought I could help.

.....

At this point it was my considered opinion, shared by Mrs. Y., with whom I discussed the matter at some length, that the best "therapy" for Larry was to leave him to experience the love and discipline (which I observed to be firm, but never harsh; and always expressed in terms of verbal

prohibitions, removal of dangerous objects or of the child from a particular scene, and redirection of the child's attention to other activity, acceptable in terms of the child's interest and needs, or, if necessary social needs) given him at the kindergarten, plus the learning of various educational activities and social relatedness which was a constant part of his total experience in that milieu; while at the same time supporting the mother and re-educating the family as occasion required or permitted.

From that time on, until Christmas, it became my practice to call into the kindergarten fornightly, or weekly when the necessity arose, in order to check the situation with Mrs. Y. and to observe Larry myself. On such occasions I might only smile at Larry, but I always established some contact with him, unless he happened to be asleep.

13th August: I checked with the kindergarten on this occasion to see if Mrs. Johnson had actually left work and was bringing Larry to kindergarten herself. Larry, with the other children, was asleep when I arrived at approximately 12.30 and was still asleep when I left at 2 p.m.

During my long discussion with Mrs. Y. she advised that Larry was still being brought to Kindy by his grandmother, he was relating better to other members of the staff, but still seemed very dependent on Mrs. Y., but she might not be at this kindergarten much longer (fortunately the change she was contemplating did not occur).

3rd. September: I had already made arrangements (still unknown to Mrs. Johnson) to call at the Johnsons' house this day as I had been unable to establish telephone contact. However, at 8.30 a.m. I received a telephone

call from Miss X. of the Family Protection Society. Nurse P. had asked her to call and see Mrs. Johnson about Larry as she had heard that the Johnsons intended moving to a district from whence it would not be possible to get Larry to a kindergarten. I gave Miss X. all the available information, and it was arranged that I should then make an appointment with Mrs. Johnson to bring Larry to see me, and Miss X. would call unexpectedly on her later in the morning and try to impress on her (a) the need to take into account Larry's needs, and (b) that she herself apparently had problems which were affecting her relations with Larry and which might bear being talked about with one of the professional people concerned in the matter. (Nurse P., Mrs. Y. and Miss A. were all of the opinion that I should "take her into psychotherapy" - as her husband also later suggested - but this could not, of course, be foisted on her.) As things turned out she would have been unable to spare much, if any, time; but, after observing her high defensiveness and the effects of her anxiety on Larry, I concluded that a more casual, "chatty", approach, unless or until she decided she wanted "help" in this form, would be of more help to the entire family.)

I rang Mrs. Johnson at 10 a.m. She was very voluable, and I had considerable difficulty in terminating the conversation 15 minutes later. She explained that she and her husband were endeavouring to buy a house, which they could get cheaply because the builder had gone bankrupt, and were trying to raise a mortgage. She claimed her pram would not go on the bus, and she would not be able to get down to the kindergarten herself; but Mrs. Y. would try to see if someone could bring him down, in which case she, Mrs. Johnson would be willing to pay for the petrol if some mother would bring her child down by car. Mr. Johnson works every second night

at the skating rink and often is not home until around 9 p.m. for dinner, so he could not pick Larry up from Kindy.

Somewhat defensively, she went on to say that Larry could not be considered a problem child at home any longer since attending this Kindy, though he always wants to play outside and often they had a terrible time with him if he wanted, or didn't want, something. (I suggested she treat him much more casually and not have a conflict of wills, except in terms of his safety.) All the children in the street are too big and won't play with him, though he tries to join in their games. Bubby (i.e. Kevin the baby) is too small. He was still asleep then - he had been out with some of her friends all the previous day and had a wonderful time - so tired last night he was asleep on the sofa, fully clothed, when she arrived home from seeing someone else.

Larry is asking more questions all the time now - and discovering parts of himself. He had wanted to know the previous day 'if he had a name when he was borneded', and was very puzzled when she had replied 'After 5 years I should think you did,' by which she had meant that they had been waiting for a child for 5 years and certainly had a name ready for him."

I explained that Larry seemed to talk very little and I wanted to test him to try to see if anything was wrong, though I thought there wasn't anything to worry about. She agreed to bring him to my home at 11 a.m. the following Thursday, to be tested.

.....

5th September:

Mrs. Johnson and Larry arrived half an hour early. I had considerable

difficulty in administering the test. The mother was extremely nervous; and there was a frequent clash of wills between mother and child, who was very restless, and refused to do either as he was requested or ordered. (Later he ran outside and repeated the same refusal pattern with my husband, who was mending a fence. My husband, however, controlled this behaviour by repeating the same request firmly several times; Larry obeyed and finally appeared to enjoy himself very much "helping".)

I finally coaxed the child onto my knee speaking quite firmly, but with my arm around him, and we worked through the I.T.P.A., albeit with many interruptions when he ran off to look at or play with something he saw, though he always returned to my side. The results, given below, must be regarded as indicative only; but they did help me conclude that he was much more intelligent than generally realised.

I.T.P.A. Results:

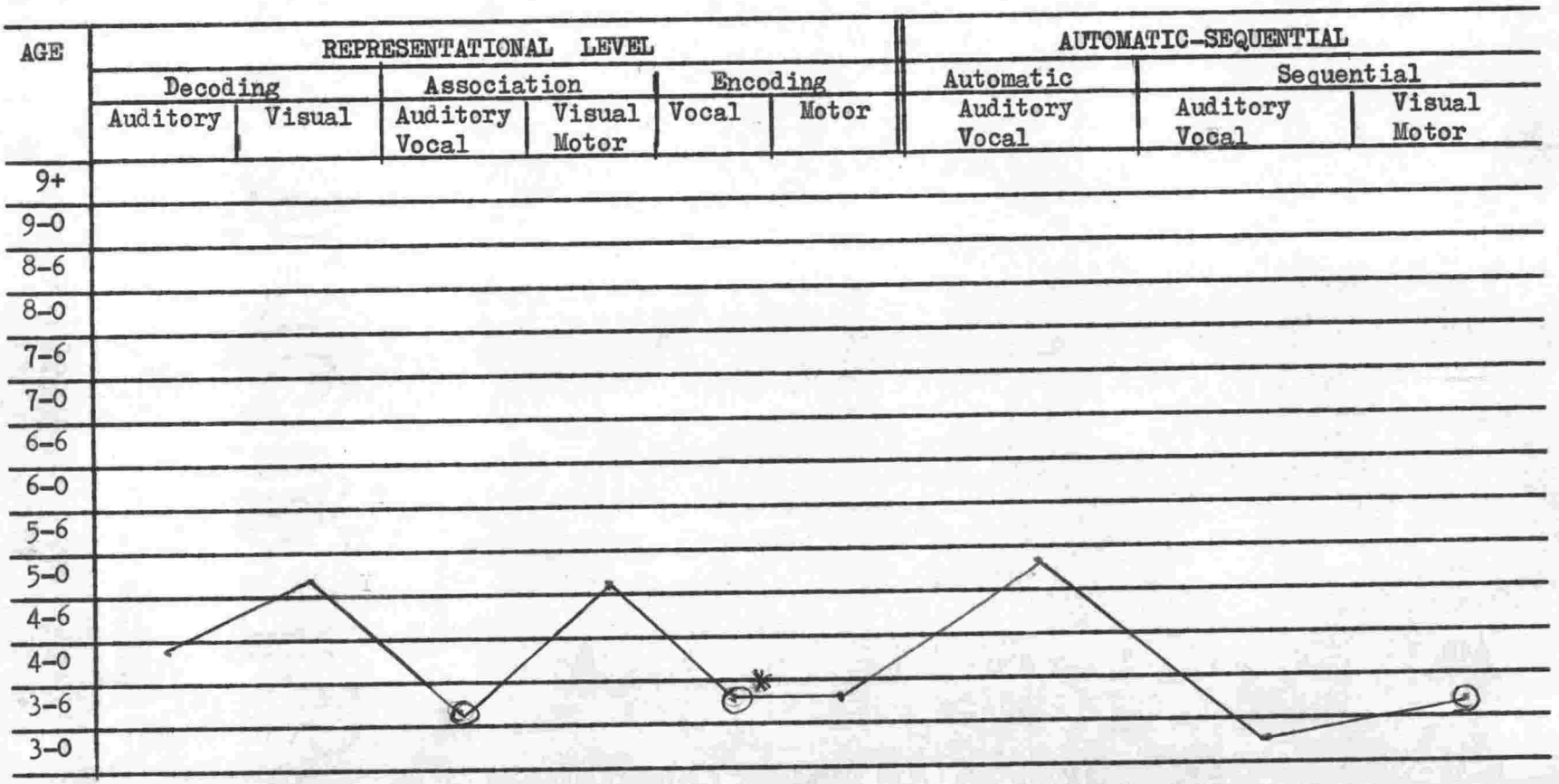
The profile is reproduced on the following page (406).

No function is significantly below average, even though the child could not be regarded as working at capacity, and some are well above average. Three scores are above the 5-year level: visual decoding, visual motor and auditory vocal. The test material for each of these seems such as would probably be influenced by general intelligence, and the high scores here may merely reflect his intellectual level.

THE ILLINOIS TEST OF PSYCHOLINGUISTIC ABILITIES

Language Age Scores

Name: Larry Johnson **Age:** First test - 3yr. 9mth **Retest:** - -



Note: 0 - Scores deflated - tired; difficult to keep attention

0* - " " "

I asked Mrs. Johnson if she would also do some tests for me, and gave her the Willoughby and P.F. 16 forms. She appeared willing and co-operative, but her anxiety was pathetic. Every sentence of the Willoughby had to be explained; she "didn't understand", or "misread" what she saw. The score is useless; it is quite obvious she did not know what she was doing. When she finally put her pencil down after completing this test and made no attempt to go with the P.F. 16, I did not force the issue. Her voice was quavering, but this disappeared when she began to talk spontaneously.

When Larry ran outside she became more animated and highly vocal. Much of her spontaneous conversation was about trivia, the girl-friends, the wedding, what she wore, etc., etc., but carefully inserted questions brought the information that her father had been "no good", he had been in gaol, and her mother had worked to support her. They had lived with the maternal grandmother whom Mrs. Johnson had loved even more than her mother, and who had died a few months before Kevin was born. (Mrs. Johnson cried for a few minutes at this point). Mrs. Johnson goes to the grave every Sunday - takes Larry too, "and on Grandmother's birthday, and at Christmas, Larry has his own little bunch of flowers." Her husband says she should "let the dead alone" but she thinks she should show her love and respect (and her voice was decidedly hostile at this point). She still misses her grandmother and wishes she were alive now. When she died she, Mrs. Johnson had a "kind of nervous breakdown herself, losing all her hair". (Mrs. Johnson became increasingly emotional as she was talking here.)

I told her I quite understood, I had had a greatly loved grandmother too, who had helped bring me up; but she was now losing her memory and perhaps

her own grandmother had suffered less by dying when she did; while we perhaps owed much to such people we did their memories more reverence by teaching our children love and respect for the living. She made no reply to this, but she did become calmer and she moved her head as though in agreement.

I again reiterated my previous advice; not to smack Larry, to give him as much love as possible; not to have a conflict of wills with him if at all possible; to treat him more casually; and I added that I was sure she had been a good nurse and she should treat Larry more as a patient than as someone for whom she was very much afraid.

Her response to this was, "He is all right, isn't he? He isn't mental or anything? I was afraid he might be - or no good - but I don't think so. (And, very anxiously, almost pleadingly) He seems all right."

I stepped up my level of reassurance, saying, as indeed I believe, "Of course he's all right. He's a very intelligent little boy, and intelligent children often bring us more problems than dull ones. He is just going through a period where he is learning to be independent and must show that he has some self-will. He is not trying to take things out on you; he is learning how to be an individual like we all must do. Don't fight him where it isn't necessary. Be proud of him. Everyone loves him at the kindergarten. He is a darling little boy." She repeated to herself, "Intelligent, darling little boy" and went out smiling.

....

9th September:

I received a frantic phone call from Mrs. Johnson, who sounded semi-

hysterical, and, for a time, was only partially coherent. Would I please take Larry to the dentist on Thursday week (the 19th). They "had had a terrible performance at the Dental Clinic that day", and it had been suggested it might be better if a stranger took him next time.

To be associated with particularly painful experiences is not the aim of any therapist, but to do as requested seemed the lesser of a number of possible evils: the child already reacted to mother's anxiety, he might learn to always act in this way; mother was already too much associated with punishing situations - he might fear and want to aggress against her even more; the mother obviously would be even more anxious herself. I therefore agreed, and she immediately calmed down, and proceeded to tell me that Larry was "much better, e.g. he had walked in with the bucket and said he was going to pee in it; she had simply said (instead of screaming at him to put it away) 'All right, little feller, if that's how you feel'. He had thereupon gone and put the bucket back and gone to the toilet as usual."

A similar incident reported to me in December bears out the mother's improvement, as well as the child's. Larry had become intensely annoyed because he was not permitted to do something he wanted. He told his mother, "I'm going to smash all the winders, so there," to which she replied, "All right, little feller, go and do it then." Grandmother, who was present at the time, "had a fit" and said, "That's not the way to talk to a child. You want to give him a good hiding." Mrs. Johnson however (to grandmother's chagrin and amazement, I should think) simply laughed. Larry stared at his mother in amazement, then grinned and walked off.

Tuesday, 17th September: I called into the kindergarten, and was told

that, since the visit to the dentist, there had been "a screaming match" each time Mrs. Johnson had left him at the kindergarten gate. Mrs. Y. had persuaded Mrs. Johnson to stay with him for a while that morning (as she also did the following morning), and he had been "fine" when she did leave.

Larry, however, "had gone off his food again". He ate a little of his dinner for me, but kept asking me for his pudding. Mrs. Y's rule, however, is "dinner" (i.e. meat and vegetables, or just vegetables) not all eaten, no "pudding". Larry came and sat by her, and allowed her to feed him, particularly when she placed "Humpty Dumpty" (a piece of bread) on each spoonful. He was then given his pudding, and proudly pushed it aside to show me the picture of Humpty Dumpty which was actually on the plate.

He smiled at me spontaneously when I went in, and finally looked at me with friendly, wide-open eyes instead of the "hard little buttons" which I usually saw.

Thursday, 19th September:

As I could not yet drive the car, my husband and I met Mrs. Johnson and Larry at a meeting-place convenient for all concerned at 8.45 a.m. She was in a state of high tension, and was walking agitatedly up and down when we arrived (2 minutes early). She told me Larry had been "tranquillised" (her G.P.'s preseription). We put Larry in the car - he chose to ride alone in the back-seat instead of sitting on my knee - and left immediately. He turned once to look back at his mother, but immediately became interested in the car and traffic, verbalising more than I had previously known him to do. He looked a little hesitant as I took him into the Dental Clinic ("Yes, he knew where to go"), and was perfectly behaved until he was actually in the dentist's chair and the nurse had looked in her mirror and started probing

a tooth. He started to become stubborn; no amount of persuasion would get him to open his mouth. Two other nurses came, but no persuasion helped. He started to cry very loudly, calling "Mummy! Mummy!" in loud wails. As he was upsetting the other children, arrangements were made to transfer him to a single room. I carried him, soothing him as best I could, and distracting his attention as much as possible. But here he really started to fight, screaming extremely loudly and struggling in the chair. I explained the necessity for looking at the teeth, praised his bravery, told him stories; but each time the nurse's hand went near his mouth he screamed piercingly, and it took the three nurses to hold him. The sister in charge was sent for; but meantime he worked up into hysterical crying. I took him from the chair, rocked, cuddled and calmed him. Finally he went back into the chair, apparently quite willingly, but, even with Sister's exceedingly calm presence, he started to fight again. While the three nurses held him down the Sister finally held his mouth open and managed to look at the teeth and get some of the terrible decay out. To my eyes this tooth was just a mass of moving pulp. Larry, however, was fighting even more furiously, and his strength was extraordinary.

The dentist in charge of the clinic then came on summons. He was also very calm and tried his best to handle Larry gently and calmly. Larry refused to open his mouth until two nurses and I took his coat off and the two younger nurses admired his new T-shirt and talked to him about the pictures on it, while Sister and I moved to one side, talking together in low voices. He swivvled his eyes around apparently to see if I were watching, (or if I were there) but I pretended not to be interested. The dentist again told him he

only wanted to look, and finally, to the dentist's command, Larry opened his mouth and the child's teeth were fully examined. A further attempt to probe, however, brought fresh resistance; and it was decided, by unanimous agreement, that (a) the teeth as they were must pain the child very considerably; (b) they also constituted a considerable health hazard; (c) to do any work at all on the child an anaesthetic would be required. The dentist then arranged an appointment at the local hospital for the following Monday at 10.45 for the extraction of four or more teeth.

The Sister and senior nurse both affirmed that Mrs. Johnson was extremely hysterical herself, and had kept saying in front of Larry how frightened she was when she had had to go to the dentist.

I then took Larry (now perfectly calm) back to Kindergarten. His behaviour was excellent. He chattered about the things he saw from the bus window, asked where "the man" ("Dr. Adcock", he reminded himself later) had gone to; and wanted to show Mrs. Y. some marbles and the bus tickets I had given him. When he unfortunately lost the top from the autogyro which his mother had bought him specially for the occasion, he only said, "Oh, perhaps Mummy will buy me another one," when our search had failed to find it. Once at kindergarten he immediately ran to Mrs. Y. to show her the tickets, sat down quietly at her bidding to listen to a story, and then went off playing by himself. Mrs. Y. told me that on the previous day Mrs. Johnson had been talking agitatedly in front of Larry about his having to go to the dentist.

On Mrs. Y's suggestion I decided not to tell Mrs. Johnson the date of the next appointment until the night before; unfortunately this advance

information was essential because the dentist's instructions were that Larry was to have nothing to eat or drink from 6 p.m. of the evening previous to his appointment (at 10.45 a.m.). When I did tell Mrs. Johnson over the 'phone there was immediate emotional disturbance; first sympathy uttered in tones of anguish "Poor Larry! Poor little feller!", followed by panic about how she was going to keep him without food and drink all that time, then by anger about his possible aggressive behaviour in the face of this frustration. All this was expressed at the top of her voice with Larry playing somewhere in earshot in the background (I could hear him talking at times).

Suggestions were given her to assist in coping with Larry's food-frustration (which must have been considerable), and I again calmed her by reminding her that as a nurse she knew what to do and how to behave, and repeating several times that she must not let Larry see her upset as this would upset him too. This was met by the response that "the little dear had asked her what the matter was when she had had a headache recently." The "dear wee boy" had spontaneously gone and got her a glass of milk, rubbed her head, and told her "Mummy better now".

23rd September:

Mr. Johnson (this was the first time I had met the father) brought Larry to the hospital, where we met at 10.40 a.m. When Larry first saw me he ran behind his father, but when I said, "Hullo, Larry" and gave him the autogyro I had bought to replace the one of which he had lost an important part, he came to stand beside me, and let me take his hand as we went into the hospital. Here (with the child both hungry and thirsty) we were forced to wait for more than an hour before the child was even taken from the

waiting-room. The child became more and more restless and anxious as the time wore on, and practically reached a state of panic when another child's violent screams became audible.

The interval, however, gave me the chance to learn something of the father, a well-built, good-looking young man of medium height. He was quietly spoken; not so well-spoken, nor perhaps as well educated, as his wife, grammatical errors were many and obvious. We talked first of Larry and his mother, whom the father described as "very nervous" and "often squashed by the grandmother, who caused most of the trouble". He was sometimes glad he didn't have a mother; she had died when he was "six or eight" and for "six or eight" years he had been in an orphanage, which he had hated. He had then gone to sea. He quite liked it but sometimes he had been lonely. His father had remarried again "six or eight" years later (i.e. apparently after his mother's death). He thought his marriage was happy, but his wife "could be very difficult". He thought it would do her good to talk with me.

While this conversation was going on Larry was either sitting on the floor playing with his autogyro, or watching a little girl play with her mechanical toy (it was the screams of this little girl which later caused Larry to become increasingly difficult), or running in and out of the waiting-room. He sat reasonably quietly for some 15 minutes or so, then started asking, "When can we go? Can't we go now", which increased to, "Let's go home, Daddy," and finally, sobbingly, to "Mummy! I want my Mummy!"

When we were finally sent for Larry pulled away, but I took him by the hand and said firmly, "Come along Larry", and he then went quietly, with

his father close behind. The father showed concern in his eyes, looked awkward, but stood still and said nothing. The child was picked up and put in the chair by the Nurse with the dentist in close attendance. Larry struggled a little but with a little forcing, his mouth was opened and the doctor surveyed the mouth; almost immediately, while the child whimpered "Mummy! Mummy!" a mask was placed over his nose, and he was instructed to breathe in. He did so obediently, several times, his eyes closed, and everyone noticeably relaxed. Suddenly the child's eyes shot open, he turned his head toward me, and started to scream with all the power in his lungs. Amid screams, interspersed with cries of "Mummy! Mummy! I want my Mummy!" the doctor and sister worked over him and he started to fight furiously.

Finally the doctor informed us that they could do nothing as the boy seemed to have an obstruction in his throat and was not getting the gas properly; we should have to make another appointment and bring him back again as no anaethetist was then available.

It should be noted that, when Mr. Johnson and I returned to the surgery, Larry had ceased screaming. He was sitting in the chair, with tear-marks on his face, but otherwise quiet, unexpectedly and unduly so. It may have been due to shock; but from the expression on his face I could not but wonder if he had felt this had been another tussle of wills and he had won again. He came into my arms willingly, and I lifted him down from the chair. His father buttoned him into his overcoat and we were quickly ushered out. Larry stood quietly with me, whirring his autogyro. which he had demanded as soon as he was out of the chair, while his father

sought to make another appointment. This could not be arranged immediately as it was not known when the anaesthetist would be available, the mother would have to 'phone again later.

We left the hospital and the father asked what should happen now. I suggested Larry might like to go to Kindy (which was nearby) now to see Mrs. Y. He appeared undecided, but finally shook his head in negation. All speech seemed inhibited at this juncture; he communicated by nodding or shaking his head in answer to queries. However, he sat quite happily on my lap when his father drove me home and waved Goodbye spontaneously, though again without speaking.

That afternoon I rang Mrs. Johnson to find how Larry was standing up to all the stress he had endured. Mrs. Johnson needed someone to talk to, also. For some twenty-five minutes she explained in minute detail how hungry he had been, the efforts she had made to keep his attention on other things, the preparations she had made for his return, how upset she had been, how angry she was, all interlarded with sympathetic ejaculations of "the poor wee man!" Larry had evidently eaten his lunch, had played with "Bubby" but had also kept close to his mother, and was then (at 5 p.m.) asleep; nor were the child's troubles at an end. Mrs. Johnson went on to say that her "girl-friend had just gone into the maternity hospital and she was going to look after her 18 months' old baby until mother and new babe came home". The baby's father was going to take Larry to Kindy in his car, as, of course, she would be unable to take him herself.

There were occasions when Mrs. Y and I, not to mention Nurse P., who thinks Mrs. Johnson is "not very bright, still wants to play and doesn't want her children", were extremely displeased with Larry's mother. I asked

her to try to make sure he wasn't ignored in favour of the friend's baby. Unfortunately I was unable to visit the Kindy again that week.

Saturday, 28th September:

Mrs. Johnson rang me at 9 a.m. She was very voluble, almost semi-hysterical. "They had had a terrible week. Larry would not go with the father of the baby to Kindy. He kept saying he wanted to see Mrs. Y. Yes, No. Then would cry and not go. Then he said he didn't want to go and see 'that lady' (assumed to be me). They couldn't even get him in the car - he woke up every night screaming, really frightened. He had come into their bed that morning at 3.15 a.m. No more sleep for them."

"Dr. Smith had come to see Larry last Monday night - hardly stayed five minutes and was out of the door before she had finished talking. She had asked him if it would be possible to have Larry's teeth done at the same time as his tonsils and adenoids, of which she had actually complained to him previously. He said he didn't know but would see, but so far he had not replied to her. Larry was now completely covered in hives and had been the whole week."

She told me she had "taken Larry to Kindy herself on the Friday, but he had screamed the place down and wouldn't stay. The baby had actually gone home on the Thursday. They could help it or him being frightened."

At this point she sounded as though she were in tears. I gave her verbal support, approved the idea of helping friends in need, and pointed out that the situation at the dentists' was due to no shortcoming of hers. Then I again explained how Larry, already a very anxious little boy, would be upset once more by there being another baby in the house just at a time when he had had a very unpleasant and frightening excuse and needed all her

love and attention. She replied that she realised now what they must have done with Larry - spoiled him too much at first then "put his nose out of joint", and she had warned her girl-friend not to make the same mistake, she was to cuddle Bubby* when she fed the new baby.

(* This term seems to be applied indiscriminately to any small child. Mrs. Johnson always used it with an expression of some warmth in her voice.)

I repeated what I had said some time previously, that Larry was a dear little boy and everyone loved him; certainly he was highly-strung but many intelligent children were. She made pleased "Mmmmmmmm-ing" noises in response.

However, in response to my query about the housing situation she again became excited. They were "not able to get the necessary mortgage". She then gave me information as regards their financial position, in considerable detail. Actually the housing situation was one which caused her much trouble and worry. The Johnsons were most unfortunate. They did manage to raise the necessary down-payment, only to have victory snatched from their grasp. At the last moment the bankrupt builder managed to pay some of his bills and retain the house for himself. Shortly after this the Johnsons were given notice to get out of their house by Christmas; on several occasions they saw houses they wanted to buy, only to find they could not raise the necessary mortgage. This carried on right up till Christmas when I last saw Mrs. Johnson and Larry. At that point they were still in the same house, with the owner still wanting to move in himself, and with nowhere else yet to go.

While Mrs. Johnson was telling me about the then situation, Larry went into the house and she asked him if he wanted to talk to me. I heard, "Who

is it?" "The lady who gave you the helicopter." The next moment, with no sound of hesitation, fear or dislike, a cheerful little voice, said, "Hullo." "Hullo Larry, how are you?" "All right" (followed by something unintelligible.) "What have you been doing?" "I've been up the hill, playing up the hill." "That was nice. What are you going to do now?" "Going outside," and he went.

Mrs. Johnson then informed me her mother was coming in the gate and she would have to go too. I told her that, if Larry appeared afraid to go to Kindy on the coming Monday because I might come and take him away (as she had inferred) she was either to get Mrs. Y. to ring me or ring me herself. I would then talk to him on the phone and tell him where I was so as to reassure him. She promised me, in response to my urgent request, that she would take Larry herself and would stay with him. She said also she would get her mother to look after "Bubby" (i.e. Kevin) the next time, and take Larry to the hospital herself.

Monday, 30th September:

I rang Mrs. Y. at 9.15 a.m. Larry had not yet arrived.

Mrs. Y. told me Mrs. Johnson had rung her last week and told her that when the baby's father had come to take Larry to Kindy he had lain on the pavement and screamed and kicked and insisted he wasn't going. Mrs. Y. had said, "No wonder - he was objecting because he was already jealous, she had the other baby there and he was being bundled off with a comparatively strange man." Mrs. Johnson then suggested that it was because he was frightened of meeting Mrs. Adcock again and being taken to the Dental Clinic. Mrs. Y. had told Mrs. Johnson she did not think that at all. After reporting this Mrs. Y. added that she herself was quite sure of this and was even

more certain when Mrs. Johnson did take him to Kindy on the Friday afternoon. He was quite happy with Mrs. Y. - had shown her some pictures he had, etc. - but when mother moved to go he clung to her tightly. There was no antipathy to anyone else - only fear of mother leaving him.

Mrs. Johnson rang later to say she had taken him down and stayed some time with him. She had left him when he wasn't looking.

Tuesday, 1st October:

I called at the kindergarten at approximately 12.15 p.m. to check the situation for myself. I was seated talking to Mrs. Y. when Larry came along. He saw me, smiled, looked shy, and stood just around the corner from the door where I could not see him. I went out, said "Hullo Larry, how are you?" "All right, thank you." "What have you been doing?" "Playing". "That's good" and I went back inside to Mrs. Y. A few seconds later Larry came in and showed me his little yellow truck from which he said he had lost the wheels (a hint for me to get him another one?) He was smiling, eyes wide open, and seemed happy again. Later he took me and showed me the toy animals in the kindergarten zoo. At no time did he evince the slightest fear or dislike of me.

Mrs. Y. told me that the previous day Larry had been all right when his mother left, but this morning there was a real temper tantrum. Mr. Johnson had brought them down in the car because it looked like rain, and Mrs. Johnson insisted that she, therefore, couldn't stay. Larry immediately started to scream, and finally Mrs. Y. had picked him up, taken him inside and shut the door of the room into which she had carried him. He kept insisting he wanted his Mummy and going to the door. Mrs. Y. had started looking at a book, finally found a picture of a dog, and said "Isn't this like

(Name of Larry's dog)?" "No, it's not", said Larry and the tantrum was over.

.....

I rang Mrs. Johnson at approximately 5 p.m. that day, with the intention of commending her for having stayed with Larry the previous day and persuading her to continue the practice, and also to support her in connection with Larry's forthcoming teeth operation about which she was to have made arrangements that day.

She told me (inter alia) Larry could not have his teeth out at the same time as his tonsils, reason unknown; the doctor was coming that night or the following day because Larry now had a cough and this might mean postponement of the operation, the dentist's nurse was away and he might not do the operation until she returned next week anyway; Larry's pillow sometimes showed signs of dribble and blood, evidently from his teeth; Kevin has perfect teeth; "the other little feller (i.e. Kevin) is really perfect, why couldn't Larry have something right, do something right?" (Larry was within hearing distance according to the noises I heard on the 'phone.) I reiterated that Larry was a dear little boy, he might be difficult and have many things against him, but she did have reason to be proud of him. I warned her not to say "Poor little boy" to him, but to keep telling him what a good thing it was to have those bad teeth out, etc.

She immediately responded by a fresh outburst of stories about how he had reason to be afraid of the hospital; he had had six stitches in his head when they first shifted into this house, then he went down the back of the house and had about 30 stitches in his hand. He had four teeth out at the age of two. Kevin at 20 months has nothing wrong.

(It should be noted that much of this was new material of which I had previously not been told. I was concerned lest Larry should hear all this and respond with anxiety or guilt (or reinforce such patterns), but there was no stopping her unless I had abruptly ordered her so to do, and this I did not want to do, thinking it better to let her verbalise to me her own anxiety and aggression as much as possible and gain at least some abreaction in this way.

She then reverted to Larry's playing up at Kindy. How naughty he was. Why? why? why? But he had had his first full night's sleep last night (Monday) for some time. I pointed out once more the trauma of the dental incidents, his great need for activity in a social situation where he had friends of his own, and the fact that doubtless the strange baby had upset him - that small boys do not understand like adults. She immediately became defensive: "It was only for four days". I pointed out that one day is like a year to a child - time has a different meaning for them. I told her once more that she would help by staying with Larry at Kindy for a while, making the period less each day. She retorted that she "couldn't just run her life around Larry, she had other things she had to do." I tried to ease the hostility from Larry and finally changed the conversation. The house then became the topic for a fresh verbalisation of anxiety. The conversation finally finished with Mrs. Johnson at least not sounding so emotional.

Thursday, 3rd October:

Mrs. Johnson rang - 20 minutes on the 'phone. The only important comments were that there was still no anaesthetist available to do Larry's teeth; she had stayed at Kindy until 9.30 the previous day, and Larry had

been perfectly O.K. until a lady had taken him up the street after his mother to recover a toy she had inadvertently taken with her. Then there had been a temper-tantrum, he had lain on the pavement, screamed and kicked. Finally she had put him inside the kindergarten grounds and left him.

(It will be seen that Mrs. Johnson seemed to be building up to a crisis of some sort; she was more openly rejective of Larry, more given to openly comparing him with the younger child. At 12.15 that day some of the pieces clicked into place.)

12.15 Mrs. Y. rang. She had learned indirectly that Mrs. Johnsons' father had left her mother many years before and gone to Manchester where he had been involved in a shooting affair there with another woman. He had been allowed out of prison to marry the woman and had written to Nancy (Mrs. Johnson) inviting her to attend the wedding. On top of that Mr. Johnson had been involved in an extra-marital affair with another woman who had his baby. Mrs. Johnson had gone to the Church and gone up to her and said, "I hope someone tries to break up your marriage like you tried to break up mine." Her marriage was "rocky" again now.

Mrs. Y. and I discussed this at some length, and it was finally agreed that I should call on Mrs. Johnson and broach this subject myself as we both considered she would not tell me herself unless she were under extreme tension, (because she would feel guilty) by which time it might be too late to help.

<u>11th October</u>:

I called at the Johnsons' unexpectedly at approximately 11 a.m., when I expected Larry would be at kindergarten and Mrs. Johnson would be home alone,

but for Kevin. She had been doing some housework, was apologetic about her appearance and continually wiped her hands on her dress. She took me into the "lounge" where I sat down; she remained standing for most of the interview, which lasted nearly 2 hours.

She asked me what was wrong, and I responded by telling her that "we had heard indirectly that her marriage wasn't very happy and were concerned about its possible effects on the children. Could I help?" Her reply was immediate, "Oh, it's all right now", then showed that she had suddenly realised she had given herself away. She coloured slightly, and looked confused. I said as gently as I could, "Yes, I know. Won't you tell me all about it?"

With that she started to cry. I have not got a shorthand report of what followed, nor did my memory permit me to make an exact record. Amongst the information she gave me, however, were the following facts: Her husband was the only man she had ever been in love with; once she had met him she refused to go out with anyone else, she just didn't want to, she had thought everything was wonderful, then suddenly the other girl came and told her she was going to have his baby and wanted her to divorce him. Everybody said she should divorce him, but she wouldn't because she loved him and wanted him herself, and it was then she decided to have another baby herself, "which is how Kevin came." (This places the event at occurring approximately when Larry was about 18 months' old; but I have never been able to get an exact date. Was it perhaps related to Larry's strange episode when he couldn't stand up? I can't tell; but it will be recalled the birth of Larry was followed only a few months later by the death of

Mrs. Johnsons grandmother, Mrs. Johnson was accordingly very stressed during Larry's infancy and early childhood.) The other girl lived in the same district and had continually flaunted the baby when it was born, and jeered at Mrs. Johnson that if she would only go away she (the girl) would soon have him back. The Johnsons had born the cost of the birth, layette, etc. as well as maintenance, and it had cost over £400, and Mrs. Johnson had been very hurt when her own children had had to go without for the other one. She wouldn't have minded so much if the other girl hadn't been "just an old bag"; it made her feel dirty herself. Fortunately, just lately, the girl had got married and moved away and the man was going to adopt the baby, which would ease the financial strain.

All this was told with a wealth of detail and tirades about and abuse of the girl, and almost continuous crying. After she appeared to have cried herself out, I directed the conversation into a verbalisation of her present attitudes to her husband and their relations. She insisted she had forgiven him a long time ago, but she could not always forget, though she was getting better at it. Their sexual relations were good and she thought the marriage was all right now. Her husband was different altogether; he "had had a real scare."

I gave her as much support as possible, praising her maturity of outlook, and pointing out how much children need both parents, leading from there into a discussion of Mr. Johnson's early childhood which I pointed out could well have led to personality problems of his own and some difficulties in relating to women properly. (He had told me how badly he had hated the convent-orphanage, and it will be recalled that, following his years there, he had gone to sea in an all-male company). I pointed out that she should not

feel her own self-esteem had been lowered; in fact it should be increased because of the manner in which she had dealt with her problem. This, together with the rational (possible) explanation for her husband's behaviour, led her to smile and speak more naturally; her speech had been somewhat stilted though prolific. Thinking that, as her husband had been educated in a convent, she might have religious affiliations, I suggested that she should try to follow the Christian ethic and try to forgive the girl also; she would feel better if she did. I pointed out that there must be an explanation for the girl's behaviour also. Mrs. Johnson agreed, but doubted if she could forgive her, though she would try.

At this point the husband had returned home for a meal, and she went out into the passage and spoke to him. What she said I don't know, but he did not look me in the face when we met in the hall a few minutes later.

As I left Mrs. Johnson wanted to know how I knew, "because if they knew down at the kindergarten she could never go there again, could never face them." I evaded the question by telling her that the Education Department and the social workers were always very concerned about the welfare of all children, legitimate and illegitimate. She promptly linked the passing on of the information with someone she knew who did social work and knew all about her case, but she "didn't mind, just so long as the kindergarten people didn't know." I told her that the staff there would undoubtedly be extremely understanding; she had no need for concern there whatever happened.

She thanked me very sincerely as I left; the result was somewhat unexpected. From then on she appeared to accept Larry fully, staying with him at kindergarten in the mornings for a while, until the next blow fell- (Kevin developed pneumonia and was very ill indeed) reporting to me how she

had stopped various members of her and her husband's family from making a fuss of Kevin until they had first talked to Larry, and constantly talking of him as "the wee man". It was only when the house-hunting became urgent and she saw several houses in areas where Larry could not reach the kindergarten and the pressure was on her to reject what she so badly wanted ("a really nice house; I think I deserve something decent for a change" was her constant cry) in order to have regard for Larry's needs that she became somewhat irritated ("Why should everything happen to me? What have I done to deserve all this?") Again she was supported with praise and rational explanations.

October 18th:

Mrs. Johnson phoned to say Larry had a cold; his teeth operation had been postponed again. It was a brief, light conversation.

I continued to call at the kindergarten periodically from then until it closed for the Christmas holidays. Larry was usually happily playing, eating or sleeping. He invariably greeted me with a very shy smile, but rarely talked much. I was told he had had quite a bad cold, and suffered periodically from toothache. (This may have been constant, but he only mentioned it periodically.)

October 22nd:

Kevin developed pneumonia, and for the next six weeks Mrs. Johnson rarely went out of the house. She showed herself completely at her best, nursing the child night and day, and, to my knowledge, at least, never complaining. Larry was taken to kindergarten each day by a friend (who also drove her own child there), with no bother whatsoever. Larry was relating better with the other children, even demanding packets of raisins for the

other children as well as himself, and greens for the Kindy guineapig.

December 3rd:

Larry finally had his teeth out. The grandmother had looked after Kevin in her home and Mrs. Johnson took him to the hospital herself. She telephoned me as soon as she had got him into bed and asleep. Once more she was close to hysterics. For 45 minutes I alternately soothed her and listened; her level of identification with the child seemed extraordinarily high. With her usual obsessionalism she examined each minute of that long day; finally once more in tears she told me how terrible it had been coming into the empty house and thinking, "There's no-one here, no-one." Intuitively I felt she was expressing a wish or need for her own grandmother; I was aware of my own voice deepening as I said, to my own surprise, "Yes, I know. I wish I were there to put my arms around you." Her hysteria snuffed out immediately; she stopped crying, spoke normally, and two minutes later she followed my advice and went to make herself a cup of tea.

Despite having seven teeth out with gas (heaven knows what happened to the anaesthetist), Larry was quite recovered the following day, and returned to kindergarten the day after that.

When I next called at the kindergarten Mrs. Y. was once more perturbed because the Johnsons were again considering buying a house, this time in Finchly, where again Larry could not reach or at least obtain entry to a kindergarten. Because Mrs. Johnson had never returned to her practice of taking Larry to the kindergarten and seemed somewhat evasive on the subject, Mrs. Y. was concerned lest she would not come and see Larry in the special

Christmas pageant which the children were presenting, and for which Larry had been practising singing so hard.

I again went to the Johnson's. I was met with considerable friendliness and when I explained the purpose of my visit, she promised to go to the Pageant, provided they weren't shifting that day. She was already packing to some degree, and they hoped they might be getting another house. Once more we discussed the needs of Larry and Kevin as regards social contacts with their own peers and suitable activity.

December 23rd:

Both Mr. and Mrs. Johnson went to the Pageant with Larry. She looked very unhappy and told one of the staff members they had had to let another house go because of Larry. (We suspected the mortgage had also proved a difficulty.) I praised her for her concern for Larry and Mr. Johnson, finding his own tongue for once, commented spontaneously that he thought Larry needed the kindergarten and he was sure they were doing the right thing in making sure he could get there. Again I pointed out how important it was that Larry should feel they were interested in him and his activities, and thanked and praised them both for coming that day. The father looked pleased, but Mrs. Johnson looked, if anything, more sad.

Having mistaken the date the kindergarten closed for the holiday period and having planned to give Larry a Christmas present I paid a final visit to the Johnson's. (Mrs. Johnson actually "beat me to it"; a present "from Larry" was in the postbox as I left to see him). Knowing how Larry loved cars I took him a friction model car; but the problem of Kevin then confronted me; should I or should I not give him a present too? How would

Larry feel and react? I took Kevin a small rag book, and two bubble pipes, one for each child. Mrs. Johnson more relaxed than I had ever seen her, met me with enthusiasm at the door. Larry arrived almost as promptly and came to sit with us in the lounge. At the moment there was no prospect of any house, but Mrs. Johnson said she had given up worrying, they would get out as soon as possible, but meantime she didn't think they would be put out in the street. She agreed quite happily with me that it might be better to put off thinking of the better-class house she had set her heart on until the children were older and not so likely to damage things and they could afford a better one. (A poor rationalisation, perhaps, but it helped.)

Larry looked at my parcels but said nothing and did not try to touch, nor did he ask for anything. Finally, after I had been shown their 18" high Christmas tree I suggested Larry might like to put the parcels under it; but this was naturally too much for a small boy. He begged to be allowed to have a look - who were they for? Was one his? Kevin was now also in the room. Finally both children were given their presents. Larry obviously adored the car, stroking it, patting it, moving it backwards and forwards. He didn't bother about Kevin's book, but demanded to know what the pipes were for. When told he took his, went to the bathroom, and came back blowing bubbles (he had made the soapsuds without being instructed) and laughing gleefully. Then he returned to sit at my feet. While his mother and I were deep in conversation (they have a friend, interested in psychology, who "just goes and sits with the alcoholics in the hope of helping them"), Larry suddenly looked up and said to me, "Thank you, Nana."

Both exceedingly surprised his mother and I looked at him and laughed, and I told him that I was afraid he had made a mistake, I wasn't Nana. He looked at me, got up and left the room, returning a few seconds later with an engaging smile, "Thank you Mrs. Adcock I mean." This was the first time he had ever called me by my name unless directed to do so by his mother. He again went from the room, returning sometime later with both bubble pipes in his hand, one broken. He insisted the broken pipe was Kevin's and had been broken by him (Kevin). This seemed possible but Mrs. Johnson told me that "sometimes he tells fibs now." I told her that many small children went through that stage and explained the developmental problems to her. I took the opportunity to query her handling of the masturbation problem; she said she had growled at him until the doctor had told her not to, "it is better for him to do it now than later." But he masturbated only rarely so far as she knew.

Larry now returned and insisted on monopolising the conversation. For the first time since I had known him he talked spontaneously for a considerable period. Did I have a little boy? "No, just a lot of little girls and boys like you," whereupon he actually blushed. Were the other little boys good? Where was the doctor-man, was he all right? Then he followed this up with a long report of a fire and fire-engines which he had witnessed. When I finally left everyone seemed happy, and Larry waved Goodbye of his own accord. It was an extremely pleasant note on which to leave this family; but, in the light of its history and problems, one can hardly be optimistic about its future.

.....

It will be seen from this somewhat lengthy history how the maladaptive patterns of parents and child act circularly, to reinforce each other and create fresh problems. This is very much the pattern, but not the emphasis, of the so-called schizophrenogenic families (c.f. Clausen & Kohn, 1960) Although I have little objective data, apart from the observations reported here, the mother in this case would appear to have high autonomic lability. One would predict a high "neuroticism" score on the M.P.I.; but she is also somewhat of an extravert and concerned with social approval. On the Willoughby scale she rates low in shyness or lack of self-confidence, and her responses also show that she does not cry, but is very much afraid of authority.

From birth onwards Larry has been constantly subjected to traumata. The school pediatrician (formerly in charge of a children's hospital) confirms Larry's early medical history. Despite it there has not, however, to my knowledge ever been any attempt to describe him as "brain-damaged", which, bearing in mind the forceps delivery and "bashing about", might well have been suggested as an explanation for some of his earlier behaviour and temper tantrums.

It is conceivable that he has inherited his mother's autonomic lability. His extraordinary shy smile would seem to betoken a liking for, and moving toward people who recognise him, but it is allied with some fear of what unpredictable adults (particularly women) may do or be associated with. It would seem that we have a child who was spoiled very considerably in the first place, with a mother who, recalling her own fears and pains, identifies closely with the child and reinforces his anxiety through hers. Furthermore the child has undoubtedly been conditioned to being highly

vigilant for possible physical and psychological dangers; the death of his great-grandmother; the tremendous stress imposed on the mother as the result of the father's infidelity and its unfortunate results, which, in turn, has I think, conditioned the father to fear of provoking his wife, the birth of the flawless sibling, whose quiet, conforming "good" behaviour brought praise on all sides and an undoubted sense of rejection to Larry, have all brought great pressures on the child, who in turn has produced behaviour causing great pressure on already stressed and anxious adults.

It will be noted that the father's infidelity mirrors to some degree the infidelity of Mrs. Johnson's own father. It is possible that memories of her own childhood acted as a drive to reinforce Mrs. Johnson's own love-object wishes to keep her marriage intact, as well as her need for social approval. It is this need for social esteem that I have endeavoured deliberately to build on - Mrs. Y. and I constitute two of her reference-agents; our approval or disapproval of her behaviour, taken in conjunction with the verbal conditioning assiduously carried on, has, I suggest, helped her to control, or has at least offset the violence, of her need for "something economically better", of her wish to become socially superior. "I deserve something better/good/new" tends to be replaced with a genuine concern for the children.

One cannot but feel sympathy with Mrs. Johnson in her cry "Why should it happen to me?" She was not responsible for her father's behaviour, her childhood environment, Larry's forceps delivery and difficulty in feeding, and only partly, if at all, responsible for her husband's infidelity. (According to her story, which could, of course, be rationalisation, the girl worked late at night and used to call in wherever Mr. Johnson was working,

often at two and three in the morning. She offered "it" to him, and he "just fell".) The conditioning and reinforcement of her own anxiety to/of behavioural patterns imposed on a low frustration tolerance and high emotionality created stress for herself and the entire family.

The abreaction which she appeared to experience in the incident where unexpected confrontation brought a spontaneous reactivation and expression of the emotionality and fears associated with her husband's affair, reinforced by my verbal conditioning of self-esteem to her behaviour then, and a rational explanation of her husband's behaviour, does appear to have reduced her anxiety level very considerably and helped in her acceptance of Larry's difficult behaviour.

"Therapy" in Mrs. Johnson's case, unsought and conceivably unacceptable in its official form, consisted of verbal support reinforced with what warmth I could imbue it, verbal conditioning, both in the form of direct statements and indirect suggestion as well as rational explanations; "reward" and "punishment" in the shape of approval and disapproval by Mrs. Y. or myself administered as promptly as possible after her statements or behaviour which we considered needed adjusting; providing models (both in percept and practice) for her behaviour towards Larry; education in regard to the normal developmental stages of a child; abreaction.

In Larry's case the major therapeutic agent must be considered the kindergarten in general, and Mrs. Y. in particular, allied with, and reinforced later by, greater acceptance by and better social relations with his mother and family. In other words "environmental manipulation" has been the major technique. Mrs. Johnson incidentally, seemed to throw off the yoke of the dominating grandmother (which had galled the husband very

considerably); and from the time when ventilation of the marital problem occurred the great emphasis on "girl-friends" seemed to disappear, they were mentioned only in passing. The mother had also learned to expect some behaviour problems in the children and not to react towards them with hostility. Her final comment to me, offered at the gate was, "Oh, you know the girl who called Larry a little b. because of his behaviour? Well, her little boy is getting even worse - he's a real terror. I told her it was just natural, and she'd just have to love him and put up with it. I think (pointing to Larry) he's just normal, that's all. He's not bad at all."

And there, I think, is a hint of yet another conditioning factor in the entire problem - Mrs. Johnson conceivably was afraid Larry was going to be "just no good" like her own father and, as she possibly sometimes thought or felt, like his own. She has not yet learned to place responsibility on herself; but she has, I hope, at least learned to act with some degree of it.

.....

Case 4:

Jack King, a seven year old boy was referred because of "odd" and aggressive behaviour in school; he was retarded in his school-work generally, and particularly in his reading, having been held back in p.4 for the second year. Enquiries showed that the parents were legally separated, the boy's father having "walked out" on the family "some two years previously", and this lad had been the one most upset, apart from the mother. The mother admitted that she had "let herself go" for eighteen months or more, until she had finally met an old school-friend, Harry Smith, who had come to live with the family as a boarder. (Marriage may take place when the divorce is eventually finalised). Jack frequently spoke of Harry as "me farver", and his presence undoubtedly had a helpful effect. There were two older sibs, girls (11 and 16), and one younger, a boy, who appeared to be the mother's favourite. The oldest sib, Maggy, aged 16, was highly aggressive and punitive toward the younger children; according to Jack she had been his father's favourite and was also given much latitude by Fred. Jack's jealousy and resentment was directed towards the older children; towards the younger boy he seemed highly protective, perhaps because he was frequently responsible for looking after him. The household was very poor, though a television set was finally acquired, "on the never never".

Jack may be said to suffer from; (a) retarded learning as the result of environmental deprivation and pressures; (b) abnormal conditioning of affection within family and peer relationships; (c) abnormal conditioning of the drive-traits of anxiety, aggression, possibly to some degree, withdrawal, and I would postulate, grieving; (d) inadequate ego-control; and (e) a distorted cognitive reference-frame.

Environmental manipulation was attempted as much as possible, and the mother's attitudes and behaviour modified; she in turn promised to modify the older girl's punitiveness. Therapy initially based on the I.T.P.A. results (see below) was directed mainly in three ways; (a) to motivate him and help him with his school-work; (b) to build his self-esteem, give him a feeling of acceptance and an environment from which he could once more explore and learn about his world; (c) to correct his mistaken inperpretations of events.

Tests:

At the first interview the I.T.P.A. was administered, and a re-test carried out 26 interviews later. The profiles and discussions are presented on the following page.

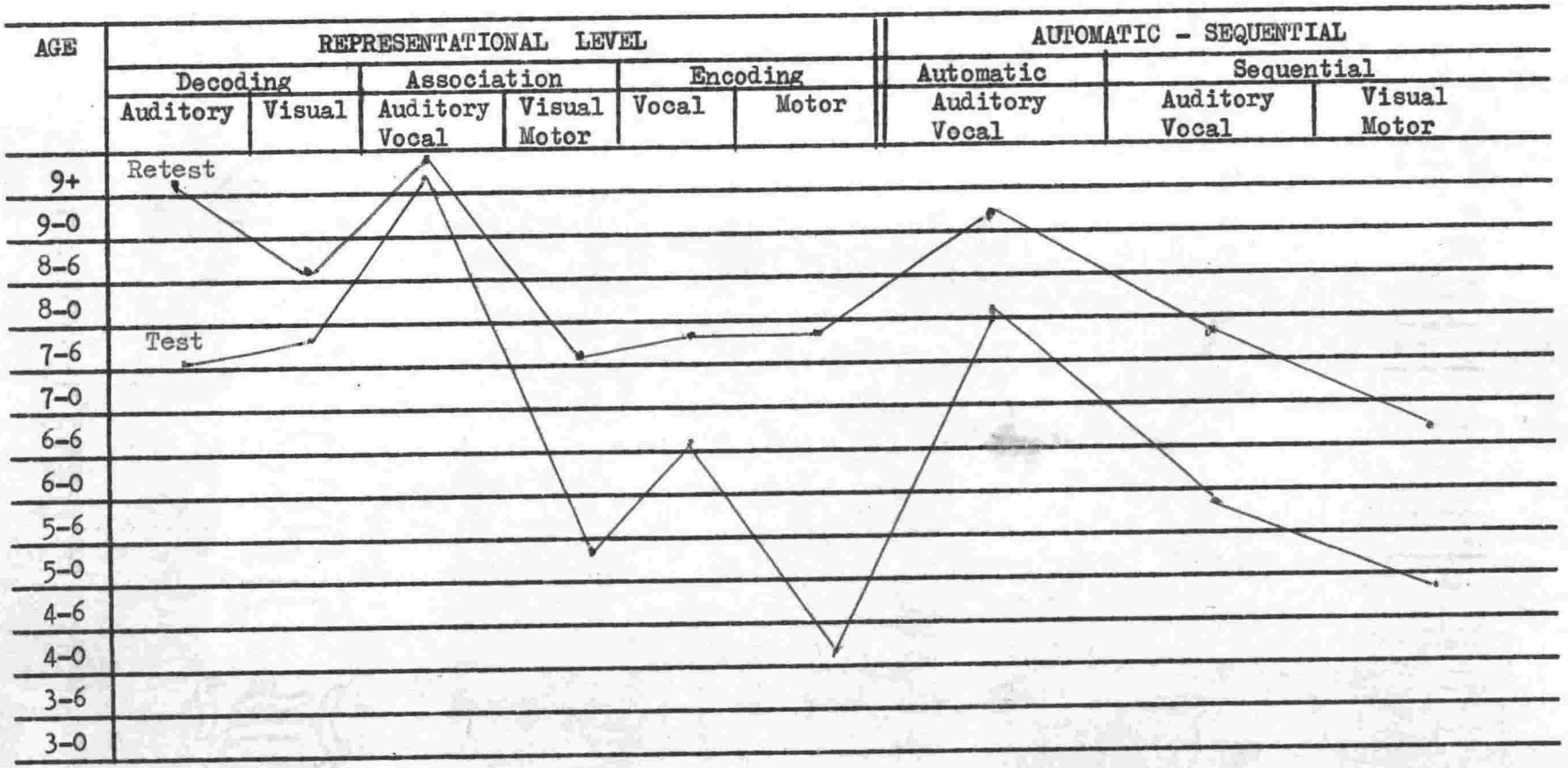
At the second interview, the C.A.T. was given. The results showed only apparent lack of imagination, matter of factness and/or stimulus- (or reality-) binding.

As he was said to be unduly aggressive, at the third interview the Rosenzweig Picture-Frustration Test (Children's Form) was administered. The scores showed a distinct tendency to be extra-punitive rather than impunitive or intra-punitive; this confirms the conclusions to be drawn from the case-history. It is a reflection of the behaviour he has learned in the home as well as his own frustrations. The scores also show low need-persistence, but this is not so pronounced as the extra-punitive attitude,

THE ILLINOIS TEST OF PSYCHOLINGUISTIC ABILITIES

Language Age Scores

Name: Jack King **Age:** 7yr. 9mth. **Retest:** 8yr, 3mth.



Discussion appears on p. 438a following.

I.T.P.A. Profile:

The initial test shows large deficits, the three greatest being motor encoding, ($-3\frac{1}{2}$ years), visual motor sequential (-3 years), and visual motor association ($-2\frac{1}{2}$ years). Much of this might be explained in terms of the cultural background.

The motor encoding test, which was the most depressed, would appear to reflect the restricted environment, as well as a generalised inhibition of all motor activity other than sport or "playing". It could be argued that this is related to his general emotional inhibition (apart from aggression). Miming, which was introduced to assist in conditioning motor activity, was regarded as "sissy", as indeed are gestures generally (other than kicking or punching), as well, for example, as tears.

It will be seen that Jack's comprehension of language is high, as, in fact, is his general knowledge. This is related to his capacity to decode auditory stimuli. His reading retardation was undoubtedly associated with his deficit in visual motor capacity.

His re-test shows a marked improvement in all scores, particularly motor encoding, which shows a gain of over 3 years in language age.

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i.e. he is both more obstacle-conscious and more ego-defensive.

The shortened W.I.S.C. (see p. 380) was given in the sixth session. Although rapport in general was good, on this particular day Jack was at first very disturbed. His work on the Performance test was so extraordinarily poor (nil right) I put it aside and with some difficulty and much shoulder-shrugging from Jack I finally elicited the information that "me grandfarver (actually Harry's father) died yesterday". I put my arm around him, soothing him, and after talking about death as sometimes being the best thing for old people, and something which rarely came to small boys, as well as promising to tell his teacher (who had complained most bitterly that morning about his work), I gave him the test again. After proration, Jack's scores gave him a Verbal I.Q. of 119, a Performance I.Q. of 125, making a total I.Q. of 118. Actually, as his teacher admitted and he later showed in his actual school work, Jack had a wide general knowledge and considerable vocabulary. When reading anything, however, he would not read the words before him, but would guess, supplying some synonym or a word he thought referred to the meaning of the sentence or story. Fortunately, in the second term during which I saw him, a remedial reading class for Infants was instituted, and Jack made considerable progress within this class.

The child had a very great need for love and acceptance, or at least its surrogate, attention; he also had some sense of guilt regarding his father's departure from the home. Jack had evidently loved his father very much, though he apparently experienced (and resented) some rejection in favour of the older sister, a pattern repeated later with Harry. I suspect Jack was also quite aware of the social irregularity of Harry's relationship with his mother, and his initial insistence on referring to him as "me farver" both constituted a defensive denial and a wish.

....

Jack King was seven years nine months when first seen. The Area Organiser for Special Classes had suggested to Mr. Younger, Headmaster of Bermondsey School, that any "problem" or "retarded" children who were particular nuisances should be referred to me for inclusion in this series of studies. The welcome and co-operation I received from this headmaster and staff (as indeed from all officer of the Education Board and of the Education Department with whom I came in contact) was considerable, tempered though I occasionally found it by lack of understanding and overwork.

Mr. Younger then referred Jack and another small boy, Robin (who was transferred to an outlying school after I had commenced working with him, and with whom I eventually lost contact, so that his case is not included here), to me. Arrangements were made whereby the children were to be released from class when I asked and were to be seen by me weekly in the School Medical Room (or in the Staffroom when the Medical Room was otherwise in use). (I actually saw them twice weekly for a start.)

Jack was disliked, and a little feared, by most members of the staff. Nobody wanted him in his/her class. He was regarded as "surly", "stubborn", "aggressive", "horrible", "stupid". The headmaster considered him of low intelligence - and I later had the utmost difficulty in persuading him otherwise - and, at best, "difficult" and "not a likeable boy". His own schoolteacher "quite liked him BUT!.....". One of the difficulties I encountered was the attitude of the entire staff: "What on earth can you do with <u>him</u>? He's no good" (which I assumed to mean, "stupid"). Whenever I encountered with difficulties I was asked, "Do you want to <u>still</u> see him? Do you think you're getting anything out of it?" Accordingly each morning-tea period when I was in the school I would explain what I could of the causes of his behaviour and his needs. Finally from grudging sympathy to very considerable helpfulness from the two teachers most involved with him, to, "You know, he's not <u>really</u> Special Class," "He's really quite intelligent", I managed to bring about some change, not just in Jack's overt behaviour, but in the expectancies and evaluations of such behaviour by very "significant others" in the persons of his school-staff.

When first seen he was given to standing up in school assemblies and in class making noises and inexplicable remarks. His own teacher found

him unmanageable. He lacked attention, hit the other children. He was in p.4 for the second year in succession; his reading ability was practically nil, and he simply refused to take part in class work, even sitting down during musical games. When I finally managed to make verbal contact with him I discovered he labelled these as "silly" and "sissy".

When I visited the house, on the first occasion the mother was away at work, but I could smell the dinner cooking, and Jack and his younger brother, were at home alone. This apparently was quite a common pattern. She has a part-time job and is at work from 10-12 and 3-5. On the second occasion I was invited into the "sitting-room" which was scrupulously clean, as was the rest of the house, sparsely furnished though it was. The garden, however, was a wilderness, Harry apparently taking no interest in it. There were only two children's books to be seen and no adult's books at all, although some magazines were on a table. There was, however, an old upright piano which the mother plays.

The mother was strident, highly verbal and intelligent. Indeed she appeared to have had a better education than one would have expected. She told me, inter alia, her husband had left her suddenly, without any money until she "caught up with him", "and put the authorities onto him". He had always been inclined to "go on the booze", and would frequently change his jobs. "Things" had always been difficult, but he had apparently loved his children and "been very good with them". This had helped to make his disappearance inexplicable, until it was found he was living with another woman, who was described as being of inferior social status.

According to her view, Jack was "an introvert like her own father"; she had just left him alone; he didn't have many friends. He was usually

quite a good boy. He had, however, been most upset when his father left, even running out on the road in front of passing cars and screaming, "You bring me back my father, you bring me back my father," which, of course, she had been unable to do.

She had heard there was a suggestion he should be put in Special Class, and was most upset about this. She had little money and it was essential the children got the maximum education before it was time to leave school. I pointed out to her that, in part at least, Jack's retardation and learning difficulties were due to his emotional problems and lack of a feeling of acceptance; could she not "love him more", and "assist him in his schoolwork more". She claimed "he's loved all right", but promised to help him more.

I discovered very early that he had few, if any toys. (Indeed, although I have been in the house twice, and there is another younger sibling about 3 years of age, I recall having seen no toys lying about or in use.) It was apparently "marble season", but when I asked him how he liked the game, he responded, with an excellent display of indifference, that he didn't have any marbles. I suggested that perhaps I could give him a marble every week he was "good" and I didn't have any complaints about him, and asked him "How would that be?" He nodded his head, and even smiled very slightly. Accordingly I instituted a regime of "reward" and "punishment" (no marble). The "reward" had the advantage of being related to the child's own experienced needs, and being, to some degree at least, chosen by himself. The disadvantage was that I always felt guilty: the "reward" seemed so paltry and "mean" to me (the marbles were a few pennies a packet), but I

forced myself to try to think in terms of the child's own environment and the possible effects of my behaviour upon his interpersonal relations, both with sibs and mother.

I was so very glad when I found reason to raise Jack's reward that my joy seemed to communicate itself to him, and, as it happened, he seemed to read it as my additional pleasure in his changed behaviour. Quite without intention on my part, this in fact seemed to increase motivation on his; it was by no means always, but there were times, when he did indeed try to please me.

At the beginning of the following school term, I was still receiving complaints that he "would not take part in the school work, particularly tests," though his general behaviour was much better. I accordingly asked him one day, "Jack I'd like you to help me about something, would you do that?" His response was pathetically eager - he actually ran to my side. But his face fell when I explained that I "wanted him to help me find a way to help him do his work in school; I was stuck, I just didn't know what to do". I put my arms around him and asked him, did he know? He shook his head. "Well, for a start, how about my giving you two marbles each week, one for good behaviour and one for doing your school work?" "Do you think that would help?" He nodded his head, and so it was arranged.

The question of partial reinforcement arises here. This particular reinforcement was held constant because I considered it more important to continually reinforce the idea that here was someone who <u>always</u> did as she said she would do, someone upon whom he could <u>always</u> rely. His mother could do all the partial reinforcing required.

His reactions, therefore, on the one day on which I actually forgot

them, were of interest. I explained the main reason for my forgetting them; he actually smiled and said, reassuringly, "It doesn't matter. You can't have them all the time."

He did begin to work from then on, and his standard of work was sometimes very high, particularly in comprehension or general knowledge and vocabulary. I found particular reinforcement in an apparently hitherto unrecognised fear, viz. of being kept back in the primers for yet a third year. Being placed in the Special Class was evidently regarded as of no damage to self-esteem; in fact at times I thought it could almost be regarded as an aim - "You can do as you like there!" which sounded a delightful prospect. But when I became annoyed one day with the apparent apathy, stubborn, shoulder-shrugging behaviour I was being shown, and demanded, "Do you want to stay in the primers then?" and received an emphatic, "No!" I pointed out that that was a possible consequence of his not working. From then on I worked continually on verbally reinforcing the notion that he was a big boy now, he did not want to stay in the primers, he <u>was</u> really an intelligent chap and wanted to work hard and get through school so he could do the work he wanted to do and liked doing, when he was grown up.

At the end of the term (i.e. after some two months' work with him) the headmaster promised that Jack would not be put in Special Class even if a vacancy occurred; his reading was much improved and so was his behaviour. At the beginning of the next term, however, he "played up" again (a natural corollary to indoor life, discipline and disliked work after the freedom of the holidays), the schoolroll, particularly his class, increased, and a vacancy in the Special Class occurred. On several occasions he was considered for placement therein. His official I.Q. score (he was tested when

originally considered for Special Class,)was in the 76 range which made him eligible for placement there; my testing showed him as having considerably higher intelligence, (118) but I was not the official authority. Finally I was driven to call in the person responsible for the original testing, who advised that the original test could be wrong, mine was much more likely to be correct, and that, under all the circumstances, he should not be placed in Special Class. Nonetheless this remained a very real threat whenever progress was interrupted or not constant; it also remained a "let-out" for the teachers.

It should be noted that Jack's teacher was pregnant for the entire period I was there; but I do not know if this affected his relationship with her in anyway. I am inclined to doubt that it did.

As his behaviour and work output had increased, by the end of the year it was decided to promote Jack to Standard I "meantime" and provided that I continued "to keep an eye on him". Any suggestion that I might not do so was followed, regrettably, by manifest anxiety on the part of the staff.

The entire therapeutic programme may be summarized as follows:

1. Testing (see above)
2. Reading first "Peter Pan", followed by "Kidnapped" (both books chosen by Jack) to, and with him, and from which I drew every possible appropriate behavioural - or moral - conclusion, and thereby carried on "suggestion", i.e. indirect and direct verbal conditioning.
3. Miming - based on the I.T.P.A. results.
4. Playing educational games (see p. 384)
5. Verbal conditioning and reinforcement.
6. "Reward" and "punishment" regime.

7. Massage or stroking when he seemed particularly tense; casual physical contact, e.g. hair tousling (when I teased him, always gently,) putting my arm around him if he sat or stood very close to my side, or a reassuring or "goodbye" pat.
8. Attempts at modifying the environment pressures - in terms of changing the mother's attitude and family behaviour, and the teachers' expectancies and behaviour.
9. Some drawing or modelling - but this he disliked and would do only on request.
10. Attempts to get him to verbalise his fears, hates, likings. As an aid to this I used the Pickford Cards.

At first Jack was seen twice weekly, but after the initial testing programme and satisfactory rapport had been established and maintained, this was changed to a weekly interview, usually of an hour's duration, but modified as occasion demanded to meet the needs of the teacher and school educational programme. He was permitted to quite a degree, to choose the order of activity, the length of time expended and, to some degree, the material utilised. If he had had his own way he would have spent each entire period being read to; if I left the procedure entirely to his discretion sometimes he would lie on the medical couch listening, sometimes he would sit close beside me, sometimes he would attempt to read with or to me. But never once did he fail to know exactly where we were up to in the story, the events which had gone before, nor some conclusion which could be drawn from it.

He was always required to do some reading with or to me (the amount

depended on the degree of co-operation or resistance); some miming (which he didn't like - it was "sissy" - but which I required as essential conditioning procedures until I had established to my satisfaction his level of intelligence and knowledge; this was dropped almost entirely in the final term in which he was seen, though utilised as a "change" or "fill-in" procedure if he seemed bored or indecisive); and play some educational game. In the last term approximately half the period was spent with reading, the other half with the games.

I always commenced the interview with enquiries as to what had happened in the past week; what had he liked/disliked most. Only rarely did he verbalise spontaneously to any degree. More often than not my enquiry was met with a shrug of the shoulders. Only when I displayed affection overtly by putting my arm around him or perhaps changed the tone in my voice, did he respond more easily. This I think is a defensive habit gained from interaction with his sisters (whom he hates) and his mother. The latter is very raucous and demanding in tone of voice, and, so far as I could see, inclined to display little overt affection toward Jack and the two older children. Her affection was displayed rather in the tone of her voice when she spoke <u>about</u> them, not to them; and in a very genuine concern to give them all of what limited goods she has to offer. It was noticeable that Jack would respond more readily if his attention were elsewhere - he would talk far more if he were playing one of the card games. (This could be a conditioned response based on observation and imitation of adults or deriving from experience at homes with his sibs, who did play "Snap" with him.) Furthermore, his verbalisation increased after he had begun to watch t.v., first at a neighbour's home, and then later in his own home.

The boy's preferred activity remains "playing", or sport where there is gross motor activity; he likes to swim, play soccer, do gymnastics. He is very good at all three. It helps to account for his restlessness in school and his dislike of "sissy" activities.

Two important factors remain unclear. Firstly I am quite convinced that the mother's friendship with "Harry" was good for her morale and modified her behaviour and attitudes generally, while his presence in the house gave Jack a vitally necessary and liked father-figure. But I am unaware of Harry's attitude to the child himself. Secondly, I understand the entire family (including Harry) responded to some degree to my request for them to foster and reinforce Jack's interest in reading and schoolwork; but I do not know the degree to which this was done, nor the actual result it had. Jack hates the oldest sister, who, according to him, was his own father's favourite (confirmed by the mother), is allowed by Harry to do as she likes, and who hit, punched and kicked Jack and his other sister, 10-year old Mary, whenever they annoyed her or she thought they had been generally cheeky or naughty (confirmed by the mother, who said she had tried to stop this, and promised she would "have another talk with Maggy"). He is also jealous of Mary.

Punishment is both physical and verbal, apparently meted out somewhat indiscriminately, and is a general family pattern. The children are sent to Sunday School; the mother, conservative in her religious beliefs, does not always practice what she preaches, but is nonetheless inclined to be moralistic in principle and verbalisation. (When Jack was asked for his association with the word "gambling" in one test, he replied, in a derogatory voice, "drinking"). When I asked the mother to give

Jack more love and attention on the first occasion, she looked blank, and insisted he had everything he needed, she had just bought him a new sweater. The second occasion I asked for this I modified the term "love" to "affection" which was immediately understood and appreciated as I required. She promised that Jack would not be hit "unless nothing else would do", which was some modification, and was indeed carried out. He was simply "put outside the door" on the only occasion when he rose in open rebellion and tipped his disliked and unwanted cabbage on the floor. Following this he is said to have apologised spontaneously.

She claimed she had no time to do tests so these were not procured.

The last three months during which I worked with him, held few surprises. Early in the second month after our initial meeting, he had said he wished he had a painting book like the cowboy one I used initially as the stimulus for naming objects, exercise in verbal expression ("tell me a story") and miming. On his birthday I gave him another copy of this painting book and a box of coloured pencils. He sat and stroked the book as though it were an animal or toy, and rushed back to class as soon as permitted to show the other children. His mother did give him a birthday party of some sort, but apparently his birthday present was a necessary article of clothing.

Early in the last term antipathy had seemed to develop between Jack and his teacher again. I finally tried direct interpretation: "Jack, you know I think you dislike females; in fact I think you might even hate them." His response was immediate, and explosive, "I do!" I tried again. "I think you just take that out on all the females you know, don't you?" The result was a further outburst: "That Maggy she's awful.

She kicks 'n hits me, us all. You should see Mary's legs, they're black and blue, where Maggy kicked her." I expostulated, "But surely she doesn't do that on purpose." "She does - all the time. I hate her!" "Well, we'll have to see if we can stop that; but I'm sure your mother doesn't know." "She does so!" "Well Mrs. Jones (the teacher) doesn't do things like that." "She hits you if you're naughty". (I understand the strap was administered very occasionally; the usual punishment seemed to be sent from the class.) "Well you must be very naughty, surely, for Maggy to hit you like that; what do you do to her, tease her?" "We tease her sometimes. But she's AWFUL." "She gets everything. Me farver (N.B. - this is Harry) gives into her all the time. She's allowed to do as she likes." I commented that she was much older than he, Jack, so it might seem like that; but we are allowed to do more as we get bigger and older; he would too. "Well, when I'm a big joker nobody'll hit me!

The following is indicative of his verbalisations:

Me: "Well, what have you been doing all week?"

Jack: "Aw, I was up at a boy's place. His father's got a van." Long silence.

Me: "Did you have a ride in it?"

Jack: "Nope!" (Pause) "Ooh and I saw a cartoon last night; good too. Last week he hit a bear right in here (holding his stomach) and made him eat golf balls" (laughter).

Me: "I'll bet that gave him indigestion!" (Jack laughs). "Will you come and tell me stories about some of these cards please?"

Jack: "Aw, orright." (As on similar occasions when he has finished with a card he puts it down, and refuses to either add more, or elaborate. Questions

simply bring a shrug of the shoulders.)

Pickford No. 85 (A man is holding a woman in his arms on a couch; while a child stands at the end of the couch watching).

"It looks like a big elephant mother is sitting on a chair. (Pause) Who draws these pictures? (crossly) Not very good; can't see it properly".

Me: "They are just meant to remind you of something, so you can tell me about it, or make up a story of your own."

Jack: "A father is holding sister. A little girl or little boy down there (pointing). The little girl was watching them."

Pickford No. 87

"Mother is getting off a train and the boy is helping her to carry her baskets home."

(This is quite an accurate assessment of the picture.)

Pickford Picture No. 84 (This picture obviously invites a sexual interpretation, even though, according to the authors, it is meant to test "Relationship of older to younger child or children" and/or "More play and conflict between children"; (Notes and Instructions, pp. 2, 3.) A female figure is lying on her stomach, one arm twisted in peculiar fashion, and with both legs wide apart, also in odd position. One child is seated on her, somewhere between waist and buttocks; a taller child stands with legs astride both hers, while a third middle-sized child, although standing, is holding her ankle).

Jack: "The children are playing acrobatics and the girl is swimming"; which is perhaps the most realistic interpretation one could place on it.

Pickford Picture No. 88 (A woman holding a child is in a double bed. The

door of the room is closed; but outside there is a man apparently hitting the door with an axe, and carrying another weapon or stick in his other hand).

Jack: "Looks like an Indian and ..... a good tomahawk. The lady is in bed and the Indian came in." Silence.

Me: "What happened then?"

Jack: "I think the Indian went and killed her."

Me: "Why?"

Jack: "It was a bad lady, trying to poison his ...Oh, someone ....poisoned her husband, was an Indian man. She went and poisoned him, so this Indian chief dressed up like a white man and went and shot her. Like on t.v."

Jack, by this time, was on the floor, with his voice fairly muffled.

I sat on the floor too.

Me: "Do you like t.v.?"

Jack: "Yeah. But Bobby (his younger brother), he likes the horses and that, but half the time he doesn't like the news and that and the weather and he goes out and gets a drink of milk for himself or has some cocoa".

Me: "What about you?"

Jack: "I sit and Mum takes it in. Mum says she thinks she will take us to Scotland when she has the money. Harry, he was going up there to see his little children up there, but he never. He was married to this lady called Jane or something and then this lady kicked him out and then he came over for a month and stayed, and his mother is going to come in this weekend and stay with us. Syd (Harry's uncle) isn't going to come in."

Me: "Do you still like Harry?"

Jack: "Yes, he's all right; but he says that we're not going to stay up

and see t.v. and he gets mad about that when Mum says we can. He says we can't."

Me: "What happens then?"

Jack: "Oh, usually we can, but not always. But Maggy can. Sometimes Mum says to Maggy to ask him if she can go out. She asks Harry and she's allowed to go out every Saturday. It's not fair. Mary can and she's nearly eleven, and Syd, he's allowed to go out on his own; he's only thirteen. Syd comes in at the weekends on Fridays and goes home."

A natural opportunity seemed to have presented itself; Jack was talking freely, sitting on the floor, close beside me. I asked, "Jack, when your Daddy went away you were very upset, weren't you?"

He replied, almost angrily, and yet as though he really meant it, "No I wasn't! I've got two brothers (these are his half-brothers). They look after us. My brothers have got lots of brother and sisters (children?) About six children at Bob's, there are. They're not all our family; only Dad's, not my mother's; Laura, she got married to some other bloke. They are only my step-brothers."

Unfortunately the bell rang at this point and the session terminated.

In the following session, arising from a conversation about Mr. Darling of "Peter Pan and Wendy" - Jack thought he was "mean, a mean old joker" but "supposed he loved his children" - I suggested tentatively that children and their parents didn't always understand each other, and asked why he thought his father had gone away.

Jack, immediately, "Because we were noisy. And naughty. Too much noise."

Me: "Do you think you were to blame Jack? Did you play up too much?"

Jack: "Yes! I did too. It was my fault. And all of us. He didn't like

us, any of us, either. Only 'cept Maggy. She was his favourite. He liked her." (The mother agreed with this later.)

Me: "Jack, I am quite sure it was not your fault. You know, when we're children we often think things are our faults, just because they happen at the same time as we've done something we shouldn't. But it's not our fault, not really. It wasn't your fault, Jack. It's difficult for children to understand, I know. But I'm sure he went away because he needed something for himself. We are all different and we all need different things - don't we?"

Jack: "Mmm. Yes. I s'pose he did want sumpfing."

Me: "Yes, and no matter what you did, or how good or naughty you were, it would still have been the same. It wasn't your fault, Jack. Don't think that it was. You know, we make ourselves sick, or very unhappy, or mad with everything, when we feel guilty and think something's our fault; and often it's not at all. We should always try to find out for sure, and try to do something about it."

When I later went to see the mother again partly to check on the situation, partly to tell her Jack was going into Standard I, I repeated this conversation to her, telling her how Jack had blamed himself, and thought he and the children were to blame. For the first and only time her face really softened, and she said, quite softly, "And to think he was the one who felt it most. He was the one who was most upset."

Fortunately I had left this until towards the end of the interview. Earlier she had become very upset when I told her that Jack thought the girls always got everything and he didn't. She replied indignantly, and with reason, "Mary did get a new pair of slippers. And a new pair of shoes, but she needed a new

good pair, and I saw them marked down in a sale. Bargain price, they were, and if they hadn't been, she wouldn't have got them either. Jack gets what he wants when I can get the money. He wanted a new pair of boots for Christmas. Well I got them, and gave them to him. He said he wanted them now, because football had started."

Following this interview, however, and without any prompting on my part, she took time off work and went down to see his year's work and attend the class Christmas Party.

The following week I was unable to visit the school; but a fortnight later I saw him for the last time. I tried to explain to him about his mother's need to shepherd her money, and how she needed to buy things when she saw them at a cheap price; but he still insisted the girl's got everything, indeed "Mary gives her clothes away to another family down the street, so she's got to get something new". He showed more anger than I had ever seen him express.

I reiterated that his mother loved them all, "pretty nearly equally." (I could not say "equally" because I don't believe she does). I merely reminded him that Mrs. Darling had loved all her children and they were all different.

As it was Christmas and I was leaving, I presented him with the remainder of the bag of marbles. He put them in his pocket, grinned delightedly and patted his pocket several times. Finally he said, "Thank you very much." But his "reward" for working so hard that he was actually going into Standard I (a book) and his Christmas present (a game) were too much. He grabbed them and was out of the door and into the classroom to publicly unwrap them and show the other children. I had followed him,

and the teacher and I both agreed loudly for the benefit of the class, that he did deserve a special prize for behaving so well and working so hard, because he really had tried hard and we were very pleased with him, and were sure he would do even better next term.

The children in this class - as those in the class of Caroline (see Case 5) were most helpful. Jack was larger than most of them, yet they all seemed to look after him. Although one or two of them always sought my attention, or came to tell me a story or show me something, no-one seemed to mind that Jack was getting special attention.

The "reward" seems, on the surface, at least, to have been the primary motivating factor; on the other hand the whole therapeutic regime was designed to give Jack a certain, warm, accepting environment from which he could once more begin to expand his curiosity drive. I tried to desensitize his feelings regarding his father's departure; to give him reason for a more positive approach to mother and sisters. Environmental manipulation, both at home and school, should mean greater acceptance and security for him.

.....

Case 5:

Caroline Quirke was a nine-years' old "brain-damaged" child who was seen over a period of six months. When first interviewed she was in a Centre for very retarded children; but within three months, with the help of educational officers and staff, I had managed to place her in Standard I of a local school. At the end of the ensuing term (when I last saw her) it was decided to place her in Standard III at the beginning of the next term. She does, however, still have difficulties with her speech and English grammar, though both are much improved. Arithmetic is particularly good.

There is some evidence of rejection by both parents, to whom she was undoubtedly a social problem for many years. Both parents are defensive and their scores on the tests reported below (the only ones they completed) are of interest in this respect:

Willoughby:

Mrs. Quirke rates a score of only 15 on the Willoughby, while her husband rates still less with 13.

16 P.F.:

Mrs. Quirke appears to have very high emotionality, but is below average on nervous tension; has extremely high sensitivity (top sten); is a little above average in regard to surgency and optimism and also sociability; shows a slight extrovert tendency; is trustful and non paranoid. Mr. Quirke is below average in sensitivity and apparently an ambivert; ergic tension slightly above average. His scores show him as being "trustful" and not paranoid, which I do not fully accept (see the record below).

Child's Tests:

Caroline was tested on the I.T.P.A. For first test and re-test profiles and discussion see the following page. She was also given the full W.I.S.C., gaining a total I.Q. of 123: the C.A.T., Rosenzweig, and Goldstein-Scheerer.* The latter she finished correctly in three minutes performance time. (*Cube and stick tests.)

Her stories about the C.A.T. pictures were, in the main, down to earth and matter-of-fact, but the responses to (5) and (7) demonstrate her fearfulness, and hints at some dominance of her family. E.g. "This a little rabbit sleeping in the own, own bed and they left a door open so they come in. He doesn't want a door shut to go to sleep. They have just a door open, and they just have to go to sleep. With door open instead of shut."

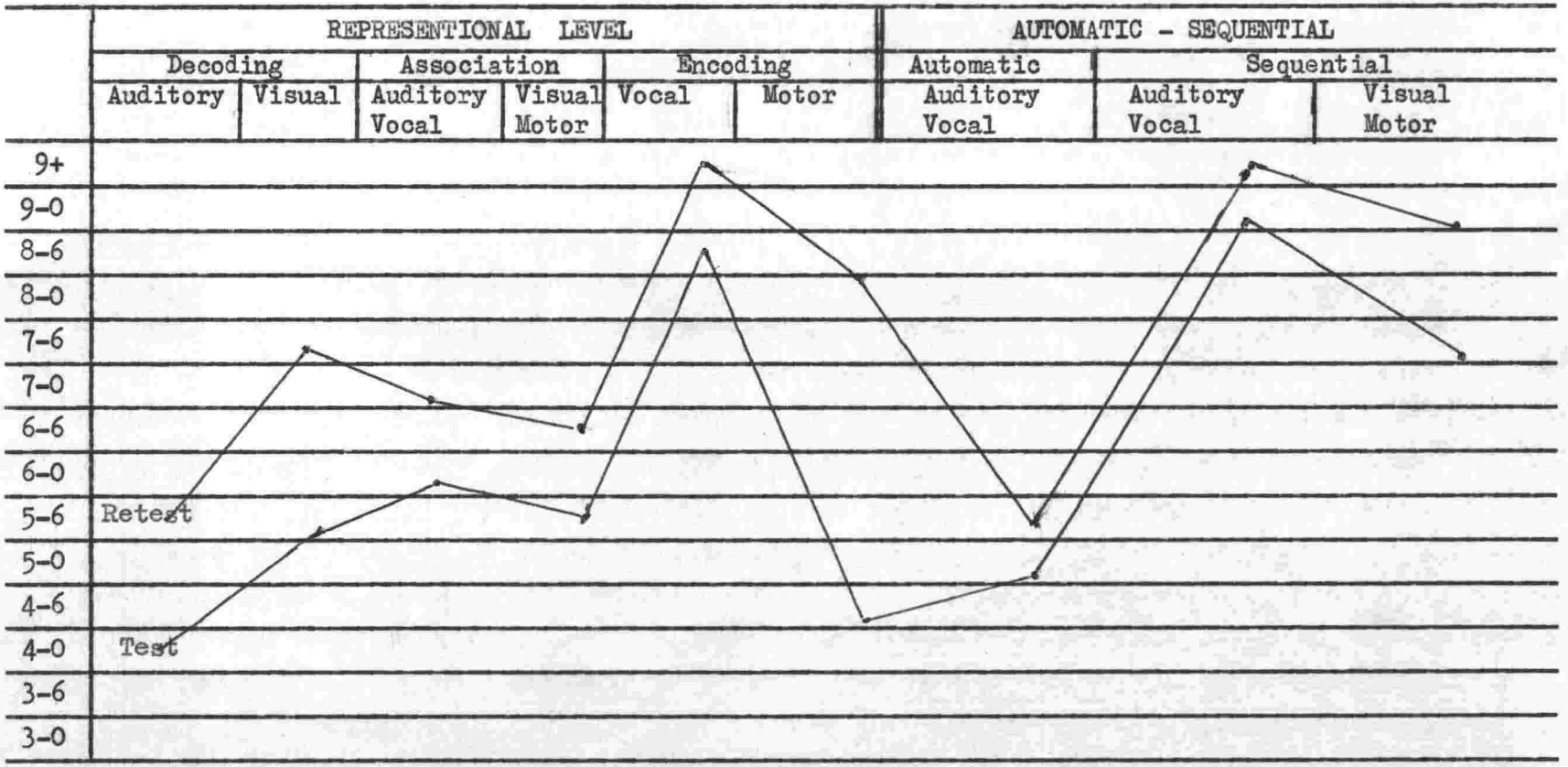
The response to Picture 7 denotes a security need.

Although she was said to be "highly aggressive" (a favourite complaint

THE ILLINOIS TEST OF PSYCHOLINGUISTIC ABILITIES

Language Age Scores

Name: Caroline Quirke **Age:** 9 yrs. 3 mths. **Retest:** 9 yrs. 9 mths.



For discussion of the profile, see p.458a following.

I.T.P.A. Profile:

In the original test only one function, auditory vocal sequential, reaches average level, and three are depressed by at least 4 years of language age.

Any attempt to assess these results must take into account the high degree of stimulus deprivation which this child had experienced, as well as the peculiarities of her environment.

The remarkable jump of over $3\frac{1}{2}$ years in motor encoding development during the six months before re-test may hopefully be taken as an indication of her potential development. One is inclined to speculate that an appreciable proportion of this is due to emotional release - note similar results in the case of Jack King, Case 4. I did, however, spent quite a lot of time with her in miming activity.

There has also been a rise of approximately 2 years for the visual decoding score. This is probably consequent upon the great increase in visual stimuli available to her. For example I frequently used a Children's picture encyclopaedia as well as the card games when working with her, and, of course, there is much more for her in a normal class environment.

The degree of progress generally is very encouraging and it can be hoped that the richer environment in which Caroline now finds herself may enable her to quickly catch up on her arrears in language development.

of her parents), the Rosenzweig Picture-Frustration test scores show her intra-punitive score to be 3.5 percent above the American norm average. Her impunitive score is low; the extra-punitive score is 15.1 percent above the American average (but considerably below Jack's score - see Case 4). She is above average on ego-defense and below average on obstacle-dominance and need-persistence scores. As will be seen from the case history, in view of all the circumstances prevailing, she cannot be said to be unduly aggressive, and a high ego-defensive score is to be expected.

Her disorders may be described as (a) retarded or impaired learning due to physiological deficiency and environmental deprivation; (b) a lack of "positive" conditioning of the affection drive, and abnormal conditioning of affection within the family and peer groups; (c) abnormal conditioning of drive-traits.

The therapy record reads as follows:

Caroline Quirke was nine years three months old when I first saw her in mid-June. She was attending the local Occupational Centre for retarded children aged 5-17 who are not capable of Special Class work or any formal education. She had been transferred from a kindergarten three years previously the staff of which had, after much patience, finally found themselves incapable of coping with her tantrums, obsessional high-pitched screaming and generally aggressive behaviour. At that time the Education psychologist had only been able to test her with very considerable difficulty and had found her I.Q. to be within the range 46-56 on the Revised Stanford-Binet Test, Form L. The school paedetrician had found her to be "brain-damaged." Whenever she had been officially observed at the Occupational Centre her behaviour had shown no improvement, though the Supervisor at the Centre, Miss O'Mally, had been lately asking for a further test to be made. It was suggested by the senior officer of the local Educational Psychology Service that I should test Caroline with the I.T.P.A. in the hope of finding some way of helping her, and should carry out any remedial or therapeutic work I deemed necessary. I was warned, however, that she would probably prove

difficult and uncooperative.

When arrangements were made for me to visit the Centre in order to carry out the test, Miss O'Mally advised that Caroline's tantrums were much less than they had been. When she had first arrived at the Centre she had been very difficult indeed and was inclined to become hysterical and develop a tantrum at the slightest provocation. Her expression was always entirely blank. The staff had nursed her as much as she would permit them (which was not at all for a start), and she was always nursed or cuddled whenever she became particularly upset. Her hands were never still; she was constantly moving her fingers or rubbing them. When she had arrived she had practically no speech, but this had been developing although the sound was frequently "odd" and her verbalisations frequently incomprehensible. Nonetheless during the three years she had been at the Centre she had learned to read quite a number of words, print and do some simple arithmetic, although her parents insisted that she was entirely self-taught (and this they still contend). She was particularly adept at drawing or working with the constructional toys provided by the Centre. Activities there consist mainly of play, singing, dancing, watching films and some work with constructional toys, jigsaws, colouring-in books. Miss O'Mally, who was a retired primary school-teacher, said that sometimes watching Caroline she "wondered if she had a genius on her hands"; though she usually "looked like a zombie". She was most concerned for the child and her future. The parents were always complaining bitterly about the child's behaviour, though it seemed clear from what the father had to say, that the brother evidently teased her maliciously, while he also teased her to see how she would react, At the time of my visit

great pressure was being put on Miss O'Mally to say Caroline should be placed permanently in the Brighton Home for Handicapped and Defective Children. This she refused to do; though she was convinced it was the parent's intention to place her there as soon as they could, probably at the end of the present school term.

When I entered the Centre Miss O'Mally told me Caroline had been told I was there, but she would not come as she was washing the morning-tea dishes. I then went with Miss O'Mally to the kitchenette, where I found Caroline busy as indicated. She looked round at me and then back to the dishes. One of the older pupils parrotted Miss O'Malley's remark that Caroline was washing the dishes and wouldn't come; I accordingly commented "That is all right. She's a good girl to finish the job she has to do. I don't mind." Miss O'Mally then introduced me to Caroline, who responded politely, "Good morning" to my "Hullo Caroline." "Mrs. Adcock," prompted Miss O'Mally, "Good morning, Mrs. Adcock," She then finished the dishes promptly, wiped her hands very thoroughly, and came with me quietly to the office.

Caroline appeared tall and rather big-boned. She is clumsy in her movements, as though there is some slight lack of coordination. She was dressed in slacks and jumper, was very neat and tidy, and appeared well-mannered. She did, however, sit with her eyes apparently unfocussed on external stimuli, until spoken to. She did not move unless asked, but did everything requested co-operatively, and at times with some interest. I gave her the I.T.P.A. During the test the telephone rang and I went to call Miss O'Mally. Caroline remained quite still with a strange "dead" expression in her eyes. This is what the staff referred to as her "zombie

expression", and had been frequently observed. When I finished the test she got up of her own accord and went out quietly, answering "Goodbye" when spoken to. Her speaking voice seemed unusually deep, but this lightened during the period we were together. At no time was there any hostility; in the main she seemed more like an automaton or a puppet.

It was then arranged that I should call at the Centre whenever I wished to see Caroline, Miss O'Mally making her office free to me. Accordingly I saw her twice a week for six weeks and once a week thereafter, with the exception of two occasions; the Education Board doctor and nurse were checking the children on one day, I was sick myself on the other.

Because so many complaints had been made of her "tantrums" and "aggressive behaviour" I determined to give her the Rosenzweig Frustration Test, as well as the C.A.T. (also in the hope of gaining some insight into her mode of thought and level of verbalisation). It also seemed most advisable to re-test her I.Q., so the W.I.S.C. (complete) was added to the battery.

At the beginning of the second session I put out my hand when I approached Caroline; she took it and walked hand-in-hand with me to the office. She still did not smile in response to mine, nor did she look at me directly unless spoken to, when she appeared to respond more readily than on the previous occasion. Again she simply seated herself and sat motionless and expressionless until I administered the test (Rosenzweig). I was mistaken in thinking she could not print; she could but somewhat slowly. As I was concerned with finishing the test before her set lunch-time, and also with the rapport I could build up, I administered the test verbally,

writing the answers given in shorthand, which appeared to intrigue her. Her voice was at a more normal pitch, though she stumbled over some words. When the test was finished I tried to question her about her activities at home. She replied in one word, "Homework". "What sort of homework?" "French, Algebra, Mathematics." She offered no comments of her own accord, and again went back quietly to the activities the other children were occupied with.

The following Tuesday lunch was late at the Centre. Caroline looked at me but did not speak when I entered until I said, "Hullo Caroline," whereupon she replied, "Good morning." She went on quietly getting her own lunch and helping another child at the same table. Later I heard her telling another child, "That's Mrs. Adcock!" After having a cup of tea myself I went to the office, desiring to look at the W.I.S.C. which I intended administering, before calling Caroline. However, another child brought her to me. I told her I was not yet ready, and I would come and get her when I was. She went quietly, but equally quietly showed her annoyance or disappointment later, when she would not take my hand but walked some distance from me to the office. However, she immediately got her chair, sat down and looked eagerly to see what she was to do. This time she was much more relaxed and behaved naturally. She seemed to enjoy doing the entire test very much. She again got up immediately and went off quietly when the test was finished. I told her I would come and see her again on the Thursday - she nodded but did not smile. However, while I was talking outside to the Supervisor later she did evince some curiosity, standing still and watching. In obedience to Miss O'Mally's request she showed me how she could play chasing, and finally said "Goodbye" to me through the gate.

During all this period she kept me at a considerable distance. She chose to sit opposite me with a large desk in between, only looked me in the face when doing a test or when she was spoken to directly, never smiled, and rarely permitted me to take her hand. Judging it wiser to permit her to take her own time in the development of any warmth or close relationship, I endeavoured to give her simply a feeling of friendly acceptance so that she would not, at least initially, feel called upon to respond beyond any point where she felt safe.

The results of the Psycholinguistic test showed major differences in the development of the various abilities tested (see profile above). I now wished to learn more of her history and family background and it was therefore arranged that her mother should come to the Centre the following Thursday (20th June), at 12.45 to see me. I arrived shortly after 12.30. Because the Maze and Coding Test sheets had been missing from the W.I.S.C. the previous Tuesday, I had Caroline complete these tests. This was all I had intended doing so far as she personally was concerned, but she showed such evident disappointment in her facial expression and unmovingness that I took out the C.A.T. which I had with me and she happily started work on that. She was more tense than on the Tuesday, and her speech at times became very quick and slurred. We had not finished when her mother arrived by taxi. Caroline straightened, looked in the direction of the sound (the window was too high for her to see), listened intently, made no comment, and then went on with her task. I thanked her when she had finished and opened the door for her. Mrs. Quirke and Miss O'Mally were standing just outside. Caroline made no attempt to speak to her mother until

Miss O'Mally told her to say "Good afternoon", which she did. Caroline gave no manifest sign of observing us when her mother accompanied us back to the office, but I felt she was watching nonetheless. Her mother was with me until nearly 2.30 when she decided she had to go in order to be home either with or before Caroline. Caroline refused to go with her, saying she "had to wait for the taxi" (provided by the Board each day) which she did. Miss O'Mally told me that Caroline had recently told her mother she did not need to be home any more when she got home, "she was a big girl now and could let herself in." When I went out into the main room Caroline sat apparently gazing frontwards at nothing. I patted her on the knee and told her I would see her "next week". She just repied, "Yes", and answered, "Goodbye" in response to my own farewell.

Mrs. Quirke is a pleasant-looking woman of about 35, well and smartly, dressed. She smoked one cigarette, on my invitation, during the interview. There was no hesitation or shyness about her. One had the impression of either little depth of feeling, or else of considerable masking. Her eyes in particular gave no impression of depth.

I asked her to tell me the whole story in her own words. She told me that "we first had Peter; then when he was two I was pregnant again, which I lost at eight months. It was a boy. The doctor did his best; however the baby was lost. No reason why I should not have another one; but doctor suggested waiting for a few months. Peter was four and wanting company. There was a normal birth with Caroline. But even when she was tiny, she would never look directly at you, never a direct look.

"She sat up at the usual age, fed herself at the usual age; may have been slow at toilet training - I used to hold them out, but not force them.

She walked at about 13 months, and then I found her very slow at starting to talk. By about two we sometimes wondered if she was deaf - she would take no notice whatsoever. If she was ever taken into strange room she was immediately interested in what was in the room, she would never give attention to whoever spoke to her. The Doctor called her - no answer; he clapped hands - Caroline didn't look back but clapped hands back.

"Caroline was a very poor sleeper; when she was put in her cot she would be extremely active but didn't want to come out.

"I took her to the Eye specialist who said the only thing to do would be to put her into hospital and test her under local anaesthetic, and said there was nothing wrong with her eyes or her ears. Most times she was still not focussing on you, most of the time she would look past me. Then we took her back to the doctor who attended her birth - he said she wasn't normal, so sent her to a psychiatrist. By this time she was about three; he said she was really too young for him to test, come back when she's five. She would say an odd word, but used to whistle a lot, which seemed to impress the doctor. At five years of age we took her back to him. He gave her tests; but said he could not get any co-operation from her. She wouldn't call them pence - she would call them money, for example. However, while he was talking she did all the tests up to the age of twenty-one.

"The psychiatrist said she might progress to the age of eight, maybe to twelve; but in any case she would always need a sheltered environment.

"We tried her at kindergarten. At home I would read to her. She amuses herself very well. She was at kindy for over a year; by that time among four or five year olds she looked huge. If they annoyed her she would hit out and take something off them. As long as she gets everything her own

way she's as good as gold.

"She'll fight with Peter; but he teases her. She must be first in everything; first when she says her prayers; says she's 'No. 1'." (I asked what religion: Presyterian. I asked if Caroline went to Sunday School - "Oh, no! she wouldn't behave.")

"When she is asked what she did today, she says "Don't ask me'.

"The family runs around Caroline. I am really quite placid. Her father is too. We are finding it difficult now Peter is at Grammar school. Whether he is embarrassed or not, I don't know. He never brings his friends home."

When asked why Peter should be embarrassed. Mrs. Quirke replied, "Because of the way Caroline behaves. Both her hands are going all the time. She always has to have something in both hands."

When asked if there were any incidents in babyhood which could have frightened Caroline very much, Mrs. Quirke replied that "about the time she was two or three years' old she pulled the chest of drawers (it wasn't very heavy) over on herself. She didn't hurt herself, but she cried and cried."

Mrs. Quirke gave the impression here that she thought very little of the incident. She went on to say, "Caroline always had had to have a light. Until she was nearly eight she would come in with her pillow; until my husband would automatically go into her room when she came in. But in the holidays she went to stay in a special home in the country. I told the matron she always had a light, but she said Caroline would have to go without like the other children. Apparently she slept right through. When she came home my husband told her she was a big girl now, she didn't need the light.

She said, "All right' but wanted the blinds up. Now she sleeps through but still takes a long time to go to sleep."

Mrs. Quirke went on to say that her major anxiety or worry was what is going to happen to Caroline, what she should do. She had thought and was thinking, about putting Caroline into the Brighton Home for handicapped and mentally defective children. The first time she went to have a look, she thought, "Oh no. It's too big. I couldn't do it." But she has been out on a guided tour, and itewas all explained thoroughly, and now she thought it might be best. After all, what if anything happened to her or Arnold - what would happen when Caroline gets older? And she had to think of Peter.

I said I thought it might be better to keep Caroline at home at present; but it was evident that this particular question loomed large in Mrs. Quirke's mind, and the above comments were indicative of her thinking.

Mrs. Quirke happily co-operated with me in filling in the Willoughby Scale, and started to do the 16 P.F. Unfortunately she could not complete it before she felt she had to go to be home in time for Caroline's home-coming; but took her uncompleted form, plus forms for her husband, and promised to send them to me.

These had not come to hand in a week (26th I could not see Caroline because doctor and nurse at Centre); so when I rang to tell Miss O'Mally I could not come because of a bad cold, I asked if she had heard anything about the questionnaires. Miss O'Mally said she would ring Mrs. Quirke and remind her.

Mr. Quirke informed Miss O'Mally that he did not intend to co-operate in filling in the questionnaires, unless he saw me first. I wanted to see him in any case, and accordingly arrangements were made for us to meet

at the Centre. He was extremely high-handed in his dealings, and on this occasion kept me waiting for an hour; twenty minutes on the second occasion, and without apology. As Miss O'Mally had predicted he had hardly introduced himself before he was telling me that his family went back some 600 years and he spent much of the next hour-and-half seeking to impress me as regards his family, and his handling of personnel (he is a factory manager). As regards the tests (16 P.F. and Willoughby) he thought the questions were "very shrewd; very shrewd indeed; very carefully worded; a real trap." He gave the impression of being paranoid or very lacking in self-esteem. He told me that, though his brother was more successful than he, it was he who could always argue with his father about things. He considered heredity to have a great deal to do with "it" - if Carol hadn't been brain-damaged she would have been a great leader. From his ambiguous statement I was not sure whether he thought the tests should or did relate to inheritance; I suspected the latter, and this was possibly borne out by the fact that much later he told Miss O'Mally one of his close relatives was mentally retarded "like Carol".

He reported and repeated that Caroline had never been taught anything - what she knew she had learned herself; that she got into terrible tantrums and that he would sometimes try to see just how much she could take, how far he could, and she would go; that she and her brother used to fight a lot, and he "had to admit that the table was really a little small. He supposed they could get a bigger one and there would be less trouble." I suggested that indeed they should but so far as I know this was never done. He stated finally that he "knew one thing, and that was that his wife would go off if something weren't done about Caroline soon," the "Something" appeared to

relate to placing Caroline in a Home. I suggested, in fact I suspect I begged (which would have been wrong tactics with such a man), that Caroline should be given as much affection as possible, not punished, not pushed into or permitted to get into situations where there was a conflict of wills; and stated flatly that I thought she was much more intelligent than anyone realised.

(My own wish was to call in the Family Protection Society and have the child removed from what appeared to me to be a highly detrimental environment, and I am forced to admit that my own dislike for this man and fear of making an uncontrolled remark which might create undue difficulties was so intense that I did not actually visit the home until nearly six months' later although it had been my intention to do so earlier. My antipathy is shared with all those I worked with in this case. However, it could not be gainsaid that Caroline was improving; and it also appeared as though the mother were possibly more rejecting than the father.)

He insisted that there was much friction between the mother and child, and, as Mrs. Quirke had done, said that everything had to revolve around Caroline's wishes, and that she always wanted everything done exactly the same way. I gathered the general impression that the parents were actually intimidated by the child, while their behaviour reinforced her unfortunate and unhealthy responses. From Mr. Quirke's account, his wife's health was also breaking down under the strain and she seemed "headed for a nervous breakdown."

As I was told later by the doctor concerned, Mrs. Quirke was actually put onto tranquillisers about this time.

Although I was impressed by Caroline's handling of the test material, I

was agreeably surprised when I scored the various tests, particularly the W.I.S.C. The score (checked by another psychologist) gave her an I.Q. of 104, on the Verbal Scale, and an I.Q. of 132 on the Performance Scale, giving a total I.Q. of 123.

Bearing in mind that, at least within the Centre, her behaviour was, on the whole, "good", though her personality could at best only be described as "restricted", I decided that the development of her psycholinguistic abilities, at least to the point where she could take her place in a normal school class, must be the primary aim. Accordingly the following regime was instituted:

> 15 minutes' naming, describing, discussing the use of, and appropriate miming of, pictorial, verbal or model stimuli; 15 minutes' playing "Statues" (this consisted of my twirling her around and her miming or freezing into a "statue" of whatever word I called out (it was during this that she first spontaneously smiled and finally laughed - a response which sometimes came more easily when she called the word and I mimed it suitably); 15 minutes' of telling me stories (using first a colouring-book and then the Pickford Pictures as stimuli) or reading to me (we finally worked through Books 7, 9, 10, 11 and 12 of the Mike and Mandy Readers).

From the 18th July onwards she also usually drew me a picture. Her pictures were most interesting. Although a full box of coloured pencils or crayons was always given her sometimes she used no colour at all. Outlines are always very clearly drawn, and she is always very painstaking and neat (she has reprimanded me on occasion for my untidy writing or casual squiggles). Colours are used harmoniously but are generally

muted in tone - except for two pictures she did for me in August. One labelled, "This is a Mrs. Addock's car", gave me a bright red Humber (labelled so); the other she told me was "Mrs. Adcock's house", and shows a two-storied many-coloured house, encircled by smoke curling from the chimney. Beside the house is a fir tree pointing directly at a very large sun immediately overhead. Her very last picture was labelled, "This is Mrs. Adcocts Xams tree" which was lit with candles and topped by a very large yellow star. Her very first picture, drawn in response to my request to draw me herself, shows a very wooden figure, dressed exactly as she was; all the features on the face are placed correctly, including the lines curving from the sides of the nostrils. The expression is one of staring sadness. When she finished it she told me "That's your sister, Jane." The same day she drew me a picture of the family at home; here she is shown as smiling somewhat, standing beside the mother more or less normally represented, the brother (several years older than she) is shown as slightly smaller than she is, with an extraordinary expression on his face, while the father is depicted with a curiously twisted expression, one eye staring ahead and protruding and placed higher than the other which has the pupil in the corner.

Miss O'Mally came in frequent contact with Mr. Quirke and she became of the opinion that the end of the school term might see an attempt to place Caroline in the Brighton Home for retarded children. By the end of July she and I were both firmly convinced that Caroline could stand up to normal school life and that she would probably fit into Standard I. The matter was taken up with the eudcational authorities, who apparently questioned its wisdom and discussed placing her in Special Class. Miss O'Mally and I were both equally firmly convinced that such a step would be

detrimental.

I sent for Mr. Quirke (who, as stated before, kept me waiting only twenty minutes this time), who once more proposed the Home for Caroline. I laughed at the suggestion, stating that it would be preposterous to put such a clever girl as his daughter undoubtedly was, into such a place; in fact I was sure they would refuse her admittance. Instead, having regard to the home situation, I suggested a boarding-school and asked if this would be possible, or failing this, were there any relations to whom she responded amicably where she might stay while settling into a normal school routine. He spurned the latter suggestion and was non-commital about the former, saying he would have to think about it. I gathered - as was confirmed - that nothing would be done.

Meantime I had fortunately been able to develop extremely cordial relations with the headmaster and staff of the Bermondsey school where another of my cases (See Case 4) was situated, and sympathy for, and interest in, Caroline. It was accordingly agreed that I should take Caroline to the school one day for a "try-out" and she was tentatively assigned to a Standard I class presided over by an extremely capable and sympathetic young woman.

Part of my record for Thursday, 8th August, reads as follows: "Took Caroline to Bermondsey School. She did not want to go at first but was finally persuaded to by being reminded that she had been for a walk past the school with one of the Centre's Staff. We agreed she could be back by morning tea time, which, Miss Smith suggested, would be late that morning. We arrived at the school at 10.15. Mr. Younger (the headmaster) took Caroline and me to see Standard I classrooms, the children being at a

film. Caroline was nervous, as shown by the deepening of her voice and blurted replies. She showed Mr. Younger that she could read well, and was even able to answer all the questions on the board. Mr. Younger introduced her to some children, but she clung to my hand and refused to leave me. At morning-tea in the staff-room she drank milk and ate a piece of bun, saying very loudly and deeply, "No thanks, I've had one", when Mr. Younger asked if she would like more. She sat straight and quiet, with her arms folded and stared unblinkingly ahead. Some of the staff tended to wonder what had come amongst them; but fortunately Miss Jackson (the Standard I teacher) seemed to win her confidence immediately when they were introduced. I held Caroline's hand or put an arm on her shoulder from time to time, particularly when the noise from the schoolgrounds was very loud. She was decidedly afraid, but seemed absolutely determined not to show it. After morning-tea we went with Miss Jackson to the classroom, and then I left her. She appeared quite happy about it; but Miss Jackson reported later that she seemed very nervous of the other children. Miss Jackson tried her in the lowest reading-group, found she had to be put in the top reading-group. I fetched her away at 11.45 and Mr. Younger drove us back to the Centre, Caroline clutching a school journal Miss Jackson had given her to take home."

The general consensus of opinion was that the experiment had been a great success and I should take her back again on the following Tuesday. This I did. Miss Jackson meanwhile had "had a long talk with the children telling them that Caroline had been ill and not been strong enough to go to school and would just be coming in now and again, for the present." The children were wonderful. When Miss Jackson took Caroline back into the school-room at 9.30 on the Tuesday, they clapped and welcomed her back.

She "looked happy". She stayed there very contentedly until 12 noon when I took her back to the Centre, Miss Jackson having reported that she had joined in the reading, answered some of the questions in the back of the book and everything was going well.

For the first time since I had seen her Caroline skipped happily and excitedly along the road with me, then quietened down and walked sedately. She proffered no conversation of her own; but answered questions, named articles in shop windows, etc.

At the Centre the other children were outside. Caroline went outside and immediately the girl (quite retarded) who had been her special "friend", and enemy, began fighting with her and gave every evidence of being jealous.

Caroline, in response to a query from me, said she wanted to go back to the "big school" the next day.

It is a matter of note that she had not told her parents very much about going to the school the previous week, nor of her proposed visit this day. As it happened I had tried to contact her parents several times to tell them and ask if Caroline could wear a dress or skirt this day instead of the usual slacks, but had not reached her mother until 8 a.m. that morning. Mrs. Quirke told me that Caroline had told her last week that she "wanted to wear a skirt on Tuesday". When asked why she had responded "Because the other girls at Bermondsey school do." When asked how she knew, she replied, "Because I've been there", and nothing else could be learned from her.

Her mother then went on to complain of Caroline's behaviour at home, saying she was a "real problem." When told to pick up her pyjamas, she had said, "No! This girl is tired." When told that she

did as she was told at the Centre, she replied, "That's different. This is home." Dr. Mayhew had just recently visited the home and seen Caroline working with both hands. She had asked if Caroline were always so over-active and had given them a month's supply of tablets for her. When I expressed concern lest the tablets affect Caroline detrimentally at such a very critical phase of events such as the present, she gave me permission to take the matter up with the doctor, which I did. Caroline was promptly taken off the medication (and as equally promptly showed she did not need it, at least under the new circumstances); while I learned that the doctor had in fact been asked to examine Caroline with the apparent aim of a direction being issued for her admission to the Home if not to a mental hospital. The doctor had expressed the opinion that this was quite unwarranted.

At ten to nine the following morning a crucial point was reached in the carefully graduated introduction of Caroline to school. How, everyone wondered, would she stand up to being in a crush of children? I took her in the school gates as the children waited en masse outside the Assembly Hall. Two girls, much smaller than she, called her by name and carefully showed her where to stand. The crowd jostled her slightly but, apart from a glance toward me where I was standing at one side, there was no apparent reaction from Caroline. She duly went into Assembly and then, escorted by her small friends, went back to the Standard I classroom. She was left at the school for the entire day - the other children looking after her at the lunch-hour. It was also arranged that this day her mother should come in and take her home on the bus, showing her how and where to get on and get off. (Caroline had apparently not been on a bus since she was very small, because she made so much fuss her mother had been too ashamed

to take her out). I impressed carefully on Caroline the manner in which she should behave, and Miss Jackson reinforced this by a general talk in the class-room. Meantime I arranged to meet Mrs. Quirke, take her to the school, introduce her to the headmaster, and see mother and child back onto the bus.

For several days Mrs. Quirke was most anxious about taking Caroline on the bus, and, despite my plea, insisted she would have to take her into the school in the car if she were going.

Miss O'Mally, Mr. Younger, Miss Jackson and I were agreed that Caroline should not go back to the Centre again, once having settled into a normal school successfully. The following week was the end of the school-term and I should also be away at a Conference, so it had become imperative that the parents should now take over the task of seeing Caroline safely to and from school. Mrs. Quirke expressed herself several times as being "still shocked" as a result of Caroline "going into a normal class"; in fact she sounded almost resentful, and there was a long tirade about Caroline's misdoings. I pointed out to her Caroline's belated need to accept herself as an individual and to assert her independence. For several months longer both parents were to continue to express to the teacher or myself suggestions that Caroline could or should not take part in the general and social activities of the class. On each occasion they were reassured every attempt was made to develop and reinforce their esteem of her.

Within the school situation Caroline did have her difficulties. It is still not always easy to understand what she is saying because of her slurred speech and odd voice production (she is to be seen by a Speech

Therapist when the new school term commences). At times her syntax disintegrates. In the beginning of the next term Miss Jackson sometimes found that Caroline would become decidedly negativistic, if not antagonistic, when she was forced to learn something new and could not grasp immediately what was wanted. Her attention would wander; she would show annoyance; each time Miss Jackson had to give her highly individual attention. Meantime I continued to see Caroline weekly, carrying on the regime started at the Centre. But now she always smiled when she saw me and was much more spontaneous in movement, expression and verbalisation. There are still times when her facial movements seem more like contortions, and she still tends to walk past adults without apparently noticing them. I have also seen her cast anxious glances at some of the bigger children, a few of whom are known to think her "queer".

The father told Miss Jackson and myself that he had "kept a watch on Caroline"; he frequently used to drive past the school and watch her in the playground. Unfortunately we both gained the impression that it was more in the hope, than in either the expectation or fear, that he would find her in a tantrum or something else wrong. If she were tense, or her hands in constant motion, we found this usually occurred on a Monday, and, rightly or wrongly, placed the blame on some unknown event which had occurred during the weekend. She did, however, become increasingly relaxed and the hand-movements were to be seen only occasionally - at no time did I see them in my own sessions with her. She still rejected (and rejects) any attempt to probe her own attitudes or important experiences; but she would now come and sit close beside me and permit me to occasionally put my arm around her.

For some time, and perhaps even now, she feared/s that she might be returned to the Occupational Centre. Her father told me on the telephone on one occasion that "it would be possible - but, of course, they wouldn't - to frighten and control her by threatening to send her back there." One wonders if she has indeed been threatened, either explicitly or implicitly, with such punishment. He was naturally told never, under any circumstances, to do such a thing. On the first occasion I went to get her from the classroom (with Miss Jackson's and the headmaster's full approval and partly at their wish), she spontaneously took my hand and came smilingly with me; nonetheless she rejected Miss Jackson's offer of reading-books because she "was coming back to read with the other children". At the end of approximately twenty minutes she began to get restless and anxious, and demanded "Go back to other children. I must work with other children." In order to reassure her she was permitted to return to the classroom immediately, and on all such occasions I would put my arms around her and say "Of course. I like you. I understand. Off you go" or some such statement.

It became my practice to take her from the classroom to the Medical or appropriate room immediately at the end of the morning break (10.45), the period 10.45 to noon being a reading period in her class which, as she was in the top stream and in advance of the others, she could easily afford to miss in terms of actual work to be done. If, however, the children were being read a serial I would wait for this to finish. She was always permitted to return to class as soon as she became unduly bored or restless, or expressed an anxious wish to do so. She usually stayed between half to three-quarters of an hour; sometimes the entire period until noon.

On the second occasion on which I told her that I liked her, she looked directly at me and responded, "I like Miss Jackson". We agreed that Miss Jackson was a wonderful person and should be liked. I ventured to query if she had liked Miss O'Mally (at the Centre) - she replied "Oooh, yes. But I not go back to Centre. I a big girl now." When I had first taken her to the school and she seemed anxious, I had kept repeating that she was "a big girl now", she therefore, had no cause for fear, now she was big enough to go to the big school, thereby hoping to offset a fear of returning to the Centre, to condition her to an acceptance of what, in these terms, could perhaps be regarded as an orderly progression in her life, and to provide a suggestion (reinforced on appropriate occasions) that now she was a "big girl" and did not need to, should not, respond to unexpected stimuli or teasing in infantile, "little girl" fashion.

Part of a conversation recorded on 17th September will demonstrate that this did have some effect. She was at the time drawing me a picture of the school. I had just coughed.

Caroline (anxiously) "Oh! Are you sick?" (this was the first occasion on which she had shown any real concern for my welfare).

Me: No, it was just a cough.

Silence.

Me: How are Mummy and Daddy, Caroline.

Caroline: Pretty well. Very well, thank you.

Me: And Peter (the brother)?

Caroline: Yes he's well.

Me: Have you quarrelled with him lately?

Caroline: No.

(Father had recently commented that she was teasing Peter and making a nuisance of herself, interrupting his study.)

Me: Do you still tease him?

Caroline: No.

Me: Not even sometimes?

Caroline: I do anything. I do skipping and play with ball! Your brother play with ball?

Me: Yes.

Caroline: And skip?

Me: Yes, he used to skip. Tell me, Caroline, what are little girls frightened of?

Caroline: If they little toddler, when little toddler burst a balloon he gets frightened of it.

Me: Do you get frightened too?

Caroline: No, I don't get frightened of balloon.

Me: What do you get frightened of?

Caroline: Nothing! Big girl I am.

Me: Does Peter get frightened of anything?

Caroline: No, he's a big boy. He's big as me.

Me: Is he a good boy?

Caroline: Yes.

Me: Does he do what Mummy tells him? (There had been a complaint that she would not stay out of the way when her mother was hurriedly dishing up the dinner).

Caroline: Yes.

Me: (As indirect suggestion and reinforcement) Then he's a good boy, isn't he?

Caroline: (finishing the drawing and changing the subject) Here's your school, Mrs. Adcock. Your brother's school. Do your brother at home for a holiday?

Me: Sometimes he goes back to New Zealand for a holiday.

The conversation then centred around my brother, where he lived, what he did. Despite this knowledge she sometimes spoke of "your brother" or "your sister" (non-existent) either as though they were projections of her own attitudes, or were an indirect query about mine, e.g. when I reprimanded her one day I was informed, "your sister Jane did it," and, again, "Your sister Jane like playing?" (we were playing a game). I was unable to trace the origins of "sister Jane" but assume it was an echo of a conversation or story she had heard. I have no record of this behaviour occurring after mid-October.

At the beginning of November she suddenly demanded, "Mrs. Adcock, why don't you get another girl? Plenty of other girls." This was said somewhat aggressively. Putting my arms around her I told her, "Caroline, we are quite sure you are getting along very well here. You don't need to be afraid. We just want to make quite sure that you can do everything just as well as you possibly can. We think you are a clever little girl, and want to help you be happy and do all your schoolwork properly." She made no verbal response, but immediately initiated a card game. From this time on, however, she would leave her desk as soon as she saw me and come straight to the door. She also seemed more friendly. It was always the practice, of course, to continually reinforce her self-esteem; I praised

her good work, good behaviour and admired her pretty dresses.

In the next session I finally introduced the term "love", deeming that the time had come to instil greater warmth into the therapeutic situation, and to pay more attention to her interpersonal relations. Miss Jackson had informed me that there had been a small outbreak of teasing about her speech; the girl responsible actually liked Caroline very much, but Caroline had hit out quite violently. I now told Caroline that maybe it seemed "funny" to her, but we often tease those people we love; and I began to tease her very gently myself, reminding her that I "loved" her. She finally responded by laughing. She was also told that she must not hit other people unless someone else hit her very badly first, and an attempt was made to condition (or reinforce any such previous conditioning) anxiety to aggressive behaviour on her part, by telling her that if she behaved in such a way she made it very difficult for people to love her, just as she found it difficult to like people who hit her.

During all this period her schoolwork was constantly improving - Miss Jackson began to give her Standard II arithmetic, at which she excelled. Her behaviour now changed in the stressful learning-situation. Miss Jackson reported that another child had told her Caroline was crying (the first and only time such behaviour was observed in class). When Miss Jackson went to ask what was wrong, Caroline whispered "broken-heartedly," "I can't do it. I can't do my English". Miss Jackson explained the particular grammatical point, and Caroline, after determined efforts, finally grasped it. She was then told, and I later reinforced the suggestion, that, in future, if she could not understand anything she was

to immediately ask Miss Jackson for help. I repeated on several occasions that it did not matter if she could not do something immediately, we still all loved her, she did not require to be first all the time, she should just do the very best she could.

On December 3rd I administered the Goldstein-Scheerer Test. It sounds incredible but she finished all correctly in three minutes.
The same day Miss Jackson told me she was considering recommending to the headmaster that Caroline should actually "skip" Standard II and be placed in Standard III at the beginning of the next term; she was still behind in English grammar, but far in advance of the remainder in the class in arithmetic. Placing her in Standard III would bring her into contact with children of her own age and size. The head provisionally agreed and I arranged to visit the child's home to check on the conditions prevailing there, being concerned with the amount of stress she will be called upon to face. I arrived at the time set, and found what appeared to be a situation carefully contrived for my benefit: father was at the front gate gardening, mother was in the middle of doing her housework - here was what I was supposed to be looking at, "Family at Home." Caroline rushed out to meet me and took me to the back garden to demonstrate her newly acquired ability to do handstands; I took the opportunity to suggest a gymnasium or ballet to help with her still-clumsy movements. The mother agreed enthusiastically. Contrived originally or not, the family were indeed relaxed and appeared happy together. Both parents were enthusiastic about the "news" or "changed Caroline" - her behaviour at home was said to be much better, she was better controlled, and her hands "did not go" nearly as much as formerly. They were very pleased both with the school and

the work she was doing. It was pointed out again that they did indeed have reason to feel proud of their daughter - she was highly intelligent and was "doing well". The mother corrected Caroline's English on several occasions, but in a pleasant way. She commented that she "would not have dared to do that" only a short time previously. I could not help recalling a remark Dr. Sam Kirk once made,* "Give the parents a chance to be proud of their child, and you won't need to worry about the emotional problems". The Quirke's do now have factual grounds for pride in their former "problem child", which they had experienced, I am quite convinced, as a social disgrace, and I decided that the home environment was probably now sufficiently nurturing to permit Caroline to stand up to any stress associated with the proposed jump in her schooling.

At that point, however, a highly illuminating incident occurred. Caroline, who had been sitting at a nearby table busy writing in a book, stood up and came toward me, where I was sitting almost opposite her father. His former pleasant expression vanished, and his face became utterly blank. He absolutely pounced at her, making some noise as he did so. I was so startled myself I have no recollection of what he said or what noise he made, only that he did make some sound. The child jumped, then stood completely still, her own face expressionless, with her eyes downcast. When I looked back at him his face had resumed its former expression and he picked up the thread of conversation as though nothing untoward had happened. I imagined this sort of thing had occurred many, many times during Caroline's childhood; but she had finally managed to inhibit, the innate temperamental, or conditioned "tantrum", response.

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* Personal communication, seminar, U. of Illinois, October, 1962.

Accordingly I too pretended nothing was wrong, hoping she might find some reinforcement from my attitude for her own inhibitory behaviour. My own reactions at this point are, I do not doubt, open to considerable question. Perhaps I should have expostulated with him, expressed my own anger; but I deemed it better to leave the home situation as it was, at least until I could find it possible to discuss the matter without the presence of the child herself. As it happened, a few minutes later she actually went to her father and climbed onto his lap and hugged and caressed him; while two days later Miss O'Mally (in whom Mr. Quirke had confided) told me that he had been extremely surprised and pleased a week or so before when, for the first time in her life, Caroline had told him, "I love you Daddy". (It will be recalled that she had recently been conditioned to the use of the word "love").

It seems quite possible that she has been conditioned to complex sado-masochistic sexual behaviour or attitudes, but that must remain a problem for the future. Meantime she would appear to have become habituated to "teasing" and her temper tantrum responses seem to be practically extinguished.

When I rose to leave the father disappeared, but the mother accompanied me to the car, Caroline running off to practise more hand-stands. Mrs. Quirke looked at her and then commented, "What a different girl she is! You can't imagine! When she was a baby, just a tiny baby, her face was completely blank. She looked right through us, all the time. But look at her. You don't know what you've done. This is a different family now, a different family, a different family altogether." I pointed out that the two people she really has to thank are Miss O'Mally at the Occupational Centre,

where I believe the therapeutic process (apart from the child's innately determined intellectual development) really began, and Caroline's teacher, Miss Jackson, upon whom the responsibility fell for actually initiating Caroline into adaptive, disciplined, learning habits, and helping her through the day-to-day stressful situations which she had to learn to overcome.

Therapy in this particular case was carried out, or supported and reinforced, by many people as well as arising from the intellectual and affectional stimuli which the child so badly needed. The psycho-linguistic conditioning and interpersonal and situational learning for which I was responsible, have undoubtedly had considerable therapeutic effects, but the case has many elements of what is frequently called "spontaneous remission" but perhaps better described as natural development and "environmentally induced conditioning or extinction". There are still, however, many problems ahead.

For instance, it would appear that Caroline has had very few toys. She told me she had three dolls, "Eeny, "Meeny" and "Miny" - "Mo is a dog's name; you call the dog that!" and proudly brought them to school to show me, three diminutive, thumb-sized dolls, which she had dressed in scraps of cloth. At Christmas I gave her, beside the book "prize" for doing so well with her school-work (she contends, I am told, that she "is going into Standard III because now she can do headstands"), a doll's swing and equally small sleeping-doll. She tipped it back and forward, holding it as though she expected it to break at any moment, and announced: "Her name's Jennifer." Then turned unexpectedly to me, and put her hand in mine. "See you after the holidays?" I promised she would and she gathered up her parcels and ran out of the room and up the stairs into the

classroom, interrupting their work with the cry, "Look what I've got! Look what I've got!"

It may, I think, be assumed that in the more distant past Caroline has broken, or been disinterested in, whatever toys were given her. This is a point yet to be cleared up. But it would seem inevitable that the child has experienced almost complete deprivation as regards such stimuli- possibly this reinforced her intellectual development. Conditioned to respond aggressively or with fear to her parents and brother, she would appear to have had little opportunity for learning or imitating warm, relating behaviour or even acted-out aggressive such as that usually demonstrated by a small girl playing with her dolls.

It should also be noted that, although she usually writes or draws with her right hand, Caroline tends to be ambidexterous. When I took this up with the parents at the interview just reported, her father told me he considered himself "75 percent ambidexterous" though he claimed that much of this had been learned intentionally in the handling of tools in his work. The parents do not consider a neurological examination warranted but have promised to bring her for an E.E.G. "sometime next year".

Whether it will ever be possible to be completely sure of the diagnosis of Caroline's predisposing condition is a moot point; the fact remains, however, that there was a belated and distorted development of speech function. The "blank face" of babyhood could well be the result of brain damage affecting the areas concerned with deciphering verbal stimuli (with the "decoding" and "encoding" of all such stimuli) which, under such conditions, doubtless acted as arousers but never, or rarely, as tension or drive-reducing agents. It is my considered opinion that

while there was possibly an inherited predisposition to some disorder of an uncertain type "brain-damage" was the correct diagnosis; that, through fortunate circumstances, the correct therapeutic procedure was begun in the form of the nurturing environment and "controlled freedom" associated with much motor activity and some intellectual activity, of the Occupation Centre. Only from such a situation could Caroline really begin to explore and manipulate her world. It seems quite probable that the mother, suffering from fears of social embarrassment as well as her own reactions to Caroline's aggressive outbursts, was actively, but not necessarily deliberately, rejecting; while the father, despite or even as the result of his sadistic-type behaviour patterns, gave the child some measure of acceptance.

They have promised to give her every help in her school-work. Any therapeutic aim should now be concerned with consolidation of her verbal fluency and expression, as well as the conditioning of more positive interpersonal relations. It was essential previously, at least in my opinion, to provide her with support and a nurturing, gently disciplining situation, and to develop her powers of communication. This has, to a considerable extent, been done.

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Case 6:

James Barrett is another "brain-damaged child" of some nine years. He has one older sib, a girl, who does not live at home, but in the city where she attends university. The father is a school-teacher, the mother is running a grocery and dairy in a seaside resort, mainly to obtain money for James's future and, to some degree, to enable the family to travel eventually.

James was a large baby at birth, which involved delivery by instruments. He suffered considerable feeding-traumata, being actually starved into submitting to taking the bottle, after the nurse insisted the mother's milk was insufficient and not good for him. He is an anxious child, with artistic ability, and I should imagine high autonomic lability, although he has been well "socialised", possibly too much so. Physical-punishment is said to be very rare indeed; mother controls verbally, using a quiet but very firm tone of voice. He has masturbated considerably in the past, and this was permitted provided he did it only in his bedroom; the habit appears to have almost disappeared.

His parents' scores on the Willoughby, P.F. 16, and Myers-Briggs tests are as follows:

Willoughby: Mrs. Barrett has the extremely high score of 63.
Mr. Barrett, also scores quite high, with 49.

16 P.F.: Mrs. Barrett appears to have higher intelligence than her husband (which I would suspect after talking with them); has very low surgency, i.e. is inclined to be depressed and silent; is very shy; has extremely high nervous tension (top sten). Her scores for trust/paranoia, super-ego rigity and sensitivity are all average. She appears to be decidedly introverted.

Mr. Barrett is apparently much more trustful than the average person; sensitive, almost effeminate, on Factor I (premsia); with very high nervous tension (sten 9, slightly lower than his wife's); and does not appear to have an unduly rigid super-ego.

Myers-Briggs: Mrs. Barrett is an Introverted-Sensing-Thinking-Judgmental type; her highest score is for thinking, but she is also very decidedly introverted and judgmental.
Mr. Barrett, on the other hand, is an Extraverted-Intuitive-Thinking-Judgmental type. Thinking and judgmental scores are equal, extraversion score slightly less, and intuition score least; but scores are particularly high.

Like his son, Mr. Barrett, has very considerable artistic ability. Indeed, as Pavlov would have said, both father and son could probably be described as possessing "artistic temperaments."

It will be seen that the mother is in an occupation which can hardly be described as well suited to her temperament or needs, and this must create considerable stress. There is also likely to be some clash between her introversion and her husband's extraverted needs. Fortunately for themselves they are both "Thinking-judgmental" types, but I would suggest this could be a drawback where James, and any question of fantasy, is concerned.

One can certainly see the interplay of the parents' characteristics in the conditioning which has occurred in the child.

James himself is more intelligent than was generally realised. While therapy was primarily built upon his communication needs and the I.T.P.A. scores (see next sheet), he was also given the shortened W.I.S.C., (cube & stick tests) the Goldstein-Scheerey, and the C.A.T. His prorated scored on the W.I.S.C. give him a verbal I.Q. of 90, a Performance I.Q. of 100, and a total I.Q. of 94.

It took him three attempts to do the Goldstein-Scheerer (he would do so much and refuse to continue); but he finally completed it, all correctly

So far as the C.A.T. responses are concerned, the only response of interest is the number and perseveration, of food-linked responses. E.g. his response to Card 4, was:

> "Kangaroos. Riding the bike and playing jumping. Baby in the pocket. Got a balloon. (Q. Where from?) Christmas. They are going shopping, to buy bread, ice-cream, milk, jam, figs, butter, pie. (Q. And then?) Get money. (Q. What for?) Buy things from the shop."

It must be remembered, however, that while feeding-trauma did occur, he has also been conditioned to attend to the foods his mother sells in her shop.

He agonised over each response, and being tested was exceedingly disliked, mainly, I think, because he was ego-defensive.

James suffers from the learning disorders of (a) retarded or impaired learning due to both physiological and environmental deficiencies (he has inadequate speech models), resulting in (b) maladaptive habits of speech (leaving out conjunctions and other "joining" words; (c) classical conditioning and perhaps dissociated affect due to feeding-traumata and possibly birth-trauma; (d) somewhat abnormal conditioning of affection; and (e) abnormal conditioning of drive-traits, primarily of anxiety.

Therapy was primarily designed to assist the child in his communication difficulties, to condition him to approving acceptance on the part of others and desensitize his anxiety and to reinforce his motivation to learn and self-esteem or ego-ideal. Some modification of the parent's attitudes was also required, but there was no apparent suggestion that the child was unwanted or unloved, although there could perhaps be some sign of reaction-formation on the mother's part in her over-protective and pessimistic attitude, (the latter a characteristic of her own) and the child may have experienced her controlled behaviour as rejecting. Controlled warm behaviour towards the child was shown her, partly in the hope she would learn to inject some more warmth into her own.

James was seen once a week over a six months' period, 23 sessions in all.

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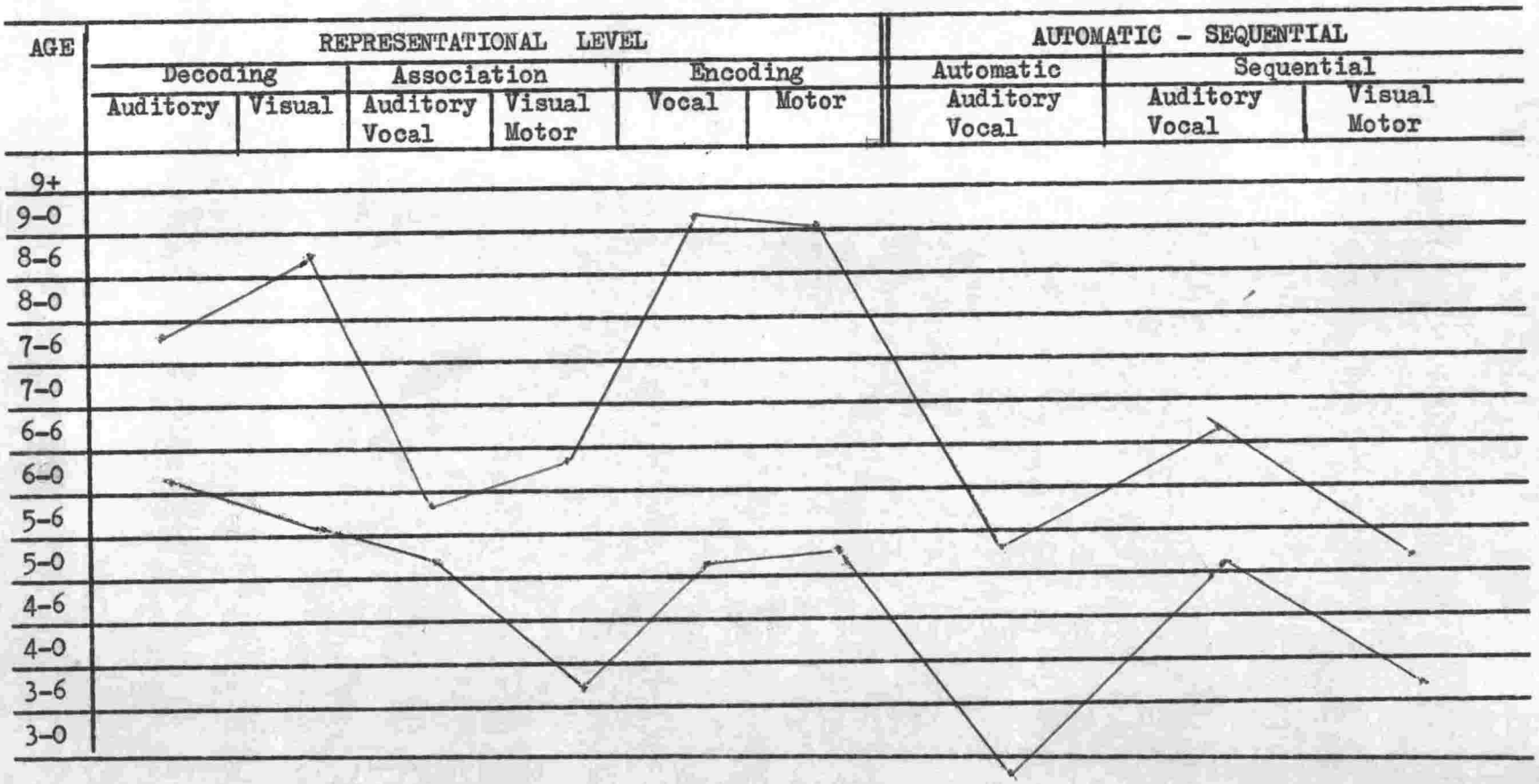
THE ILLINOIS TEST OF PSYCHOLINGUISTIC ABILITIES

Language Age Scores

Name: James Barrett **Age:** 9yr. 4mth. **Retest:** 9yr. 10mth.



For discussion of the profile see p.492a following.

I.T.P.A. Profile:

The original test shows major retardation in all functions with auditory vocal automatic ability below that of a three-year old child. The retest shows striking improvement and seems to indicate that James's defects were yielding well to treatment.

The auditory vocal automatic test is concerned with the structural relationships of language rather than word meanings and his failure to speak in properly constructed sentences was one of this boy's outstanding characteristics. The fact that it was possible to raise his score here by a minimum of $2\frac{1}{2}$ years during a 6 months' period seems to indicate either that his defect was not due to brain damage, or that vicarious functioning is now proving satisfactory.

As with the other two cases retested (Jack, Case 4 and Caroline, Case 5), there is highly noticeable development in motor encoding abilities.

It should perhaps be noted that, when allowance is made for the fact that this test is far from culture-free, the level of scoring for all the children concerned is probably greater than would appear from the profiles.

The patient, James Barrett was nine years four months when first seen. He is the younger of two children, his sister being some ten years older than he.

This child came to me as the result of his father, a teacher, hearing of my investigations through a Speech Therapist whom I had met when endeavouring to test another child. The boy, is in the Special Class of his father's school and was labelled as "brain-damaged" by the paedetrician. The parents were seeking all avenues of help; and his mother actually drove some fifty miles each week to and from my home in order that the child should see me.

At the first interview to which his mother brought him, she was neatly dressed, rather "school-marmish" in appearance, and apparently of sober disposition. James did not appear very happy, did not look directly at anything, though he later gave me one apparently appraising glance. He also was neatly dressed with clean, shining face.

They were late in arriving, Mrs. Barrett claiming difficulty in parking. Although it was raining, she was carrying their raincoats and James was a little wet. She immediately pointed out the ships on the river to the boy, and they both admired the view.

Mrs. Barrett was very composed, only the fairly short sentences and breaks in continuity of thought demonstrating any nervousness; but I was unable to gain a full history on this occasion. She told me James was a ten pound baby at birth. He was breast-fed. But they "could not get him onto the bottle. Refused the bottle. Had to starve him onto it because he wasn't getting enough feed." "James was always very good. (They) can't make him do much against his will, but he's very good."

He "learned to manipulate things very early." He "would pull himself up and things along." He "had never talked very much."

On being questioned, Mrs. Barrett claimed she could not remember whether instruments were used at the child's birth or not. She became even more incommunicative at this point, appeared anxious to get away, so, after testing James with the I.T.P.A., I let them go, making an appointment for them to come the following week. Mrs. Barrett appeared very distressed when I took James into my study, leaving her in the lounge, so the intervening door open, was left open. (It is possible to argue that this is wrong practice; there were times, indeed, when I was sorry for having established the precedent, but the child had been represented to me as badly "damaged" with very poor speech. It did appear to allay her anxiety as well as that of the child; and, although, as will appear from the record, it possibly created problems, these were offset by the greater knowledge the mother came to have of her child and his difficulties; her co-operative attempts to help him, based on this knowledge; and some change in her own attitudes; as well as her ability to translate for me some of his more jumbled efforts at speech, and the invaluable additional information she gave me from time to time.)

The details of James's history which I was able to fill in later, both from her husband and Mrs. Barrett's spontaneous or associative comments during the therapy sessions, are as follows:

The baby was actually two weeks late in arriving, and forceps were used at birth, the baby being marked about the head. The mother was well during pregnancy.

The child was submitted to a shocking feeding trauma at approximately

two-three months. Against the mother's wish the nurse had insisted that he be taken off the breast and put onto the bottle, which James flatly refused to accept. He had been deliberately starved for two days until he had finally given in, but he had still sought the breast. He was, however, usually picked up at feeding-time and nursed as he took the bottle. (It may be noted that the additional information here was not given until the very final session. Mrs. Barrett told me, with her face unusually alight with fury, when some relevant association brought it to her mind.)

He is said to have sat up and crawled early, and was walking at ten months. There was no bother with teething; but he had ear trouble during his second and fourth years, and twice had abscesses caused by colds. He had had various childhood complaints, but in general his health was very good.

He has been ambidexterous in the past, but uses his right hand now. He has always been exceptionally independent; when he was three years of age he would help himself to whatever he wanted and was very frustrated when he could not manage anything on his own.

However, he did not speak until he was four years old. His parents had not been worried until this time as they had just thought he was a "late talker". The parents, came down to London some eight years ago, and the father was originally teaching in the Lake district. On the advice of their medical attendant who was concerned with the child's lack of speech, the family shifted to a larger centre, where James was taken to a Children's Clinic. During his period at the Clinic he began to be monosyllabic. He was placed in an ordinary class at his father's school, but was recommended

for a Special Class. His father therefore transferred to his present appointment so the child could enter such a class. When he first went to this school (which is a much larger one than he was used to) he was terrified of the other children, and for quite a period walked in his sleep and developed enuresis, which cleared up again.

On the occasion when I first saw him he was extremely restless, ringing or twisting his hands, jiggling, and moving his feet. His parents said he was always like this. He also yawned a few minutes after starting any activity.

By the end of the fourth session the yawning disappeared; only coming back very sporadically when he was bored. I did not see him yawn again after the session, when I told both him and his mother that I was quite sure he was really quite an intelligent little boy. The hand-twisting and wriggling was also much improved by this time, but likewise took a downward turn and had entirely disappeared (at least for the period during which he was in my presence and was said to have diminished elsewhere) by December.

James had always masturbated to quite a degree. This was permitted by the parents, who insisted, however, that it be confined entirely to the bedroom. He was masturbating quite frequently when he first came to me; but this habit is also said to now be practised only infrequently.

Since being at his present school James has also had the advantage of being seen weekly by the Speech Therapist, who, however, was then unable to see him individually or give him very much time to himself. An I.Q. test given by an Educational Psychologist using the W.I.S.C. placed him in the range 66-76 (Special Class level). He was extremely hyperactive

while being tested - which in my opinion brought his score down very considerably. He scored at the mean for his age-group on the information sub-scale and achieved poorly on the comprehension scale. The psychologist considered him to be "brain-damaged"; the Speech Therapist considered he could be suffering from "developmental dysphasia" (incomplete language function).

On his first visit I administered the I.T.P.A., although he was then one month outside the age limits for which the test was designed, i.e. two years three months to nine years three months. It also has the disadvantage of not being standardised for use outside America; but I deemed it likely to be helpful in pointing to those areas of disability which seemed most in need of remediation, and in giving some insight into his levels of psycholinguistic development.

In looking at this child and his test results it must always be born in mind that his disabilities have meant very little communication with other children or adults. For the first four-five years of his life he lived in a comparatively isolated country district (and, incidentally, does not like animals). Apart from the children in his school-class (and the school is a considerable distance from his home) he has only occasionally had children (always younger) to play with. His peers usually tease and frighten him, or shun him. He has, therefore, been almost entirely dependent upon his mother for most of his company and communication. The very close ties existing between mother and child have been reinforced by circumstance. But as regards the tests - no child can produce adequate responses without adequate stimuli; it is quite possible that this child was deprived of such stimuli to quite a degree. Indeed the mother was shocked to learn

(as the result of overhearing this first testing session) just how little the child knew of the names for household and other equipment which he used intelligently every day. It is the tremendous hiatus between conditioning of nomenclature and the child's actual knowledge and use of materials which throw the tests out, and illustrate so little of his potential intelligence.

There were many times when I wondered if I were listening to schizophrenic-type verbalisations. Four particular incidents, however, threw some light upon causation. It will be recalled that in the initial interview the mother spoke in short, frequently unfinished, sentences. Sometimes her sentences would consist of one word. This was habitual whenever she was under stress, though usually she spoke well. During the holiday-period the father instead of the mother brought James to see me. He left an extraordinary number of connecting links out of his sentences "and", "ifs", "buts", "the", "so", did not seem to exist for him. When I mentioned this to Mrs. Barrett she commented that she "supposed they really did speak badly; this speech was typical of the city district from whence they come." One sees, therefore, the type of verbal conditioning to which James has been used.

The two other incidents to which I refer, however, relate to the disintegration of his speech patterns. Once I tried to tape-record the interview - James was so excited he could not speak properly. He was quite incoherent. Early in December my husband also was in the house, and James wished to tell him something. He was already quite excited, but still intelligible; with the additional excitement his speech - by then very considerably improved - deteriorated completely. Not even his mother could understand what he was trying to say until we had stopped him and made him repeat everything very slowly. Even then his speech was comparatively dis-

integrated. This child's speech functions are quite disrupted, then, when he is either under stress or over-excited.

As stated earlier in addition to the I.T.P.A., I tested him with the "short" W.I.S.C. and the Coldstein-Scheerer Test, as well as the C.A.T. He intensely disliked being tested; and performance tests were met with extreme hostility. The first time I tried to obtain a score with the Goldstein-Scheerer he did three of the tests and refused to continue; a second attempt brought little more success. Only on the last day did he consent to complete it - and only if I started from the point where he had left off. He put it down in anger at one point, but came back to it and concluded it - correctly. (Perhaps I should state that I disliked giving the test, as I find the stick test inclined to dazzle, depending on the intensity of light prevailing and possibly my own tension level.)

The parents were also most co-operative and both completed the Willoughy Personality Schedule; Myers-Briggs Type Indicator; and 16 P.F. (See above).

Psychotherapy:

After consideration of the I.T.P.A. results and the C.A.T. results and his general history it seemed best to concentrate upon de-sensitisation of his anxiety and arousal responses and development of his language abilities. His need to communicate with both adults, and even more particularly, his peers, was obvious, and pressing. No real assessment of his intelligence will be possible until he can communicate adequately and freely.

To shield him from undue anxiety a set routine was maintained unless or until he chose to break it. At first he would rock on his feet, then he tried this on the chair he chose to sit in. Fortunately I own a rocking-

chair. He was permitted to rock only in this - he used it twice, then didn't bother again.

At the second interview I asked him to draw a picture for me. He drew a picture of himself in his bedroom. It was noticeable for the fact that it showed him with no mouth; and he also included a reading-lamp he wanted but his mother had refused to buy - six weeks later his own pictured outline became a very definite one. He likes drawing and to my unsophisticated (as regards child art) eyes shows promise. Unlike Jack (Case 4) who usually drew restricted pictures usually in purple, James's pictures are colourful, vibrant ones. He dislikes plasticene modelling, and after one attempt (when he made me a post with traffic lights) refused to touch it.

From the second interview onwards pencils and/or crayons and paper were always waiting for him, and he usually drew me a picture as soon as he arrived.

A set of plastic tools and kitchen utensils were obtained and he was required to name these as I pointed to them, and to describe and mime their use. Although his I.T.P.A. score would not suggest it he could tell me the use of the tools on the first occasion they were shown to him, though it took three sessions for him to remember the name "pliers", and he was at first unable to name the axe and screwdriver. He had much more difficulty with the kitchen utensils, and it took three sessions before he seemed sure of them. One incident should be noted here: on the first occasion when he saw the model tools, he took them out to show his mother and in displaying their use, went to hit his mother's head with the axe. Fortunately she just laughed and he then apologised in a normal voice.

Following his learned familiarity with these, a Picture Encyclopedia was obtained and shown him. Again he was required to name the picture, describe and mime their use. Later Educational games were introduced and he played alone or with me.

When he became tired of any activity he would cry "And that's all" and it was frequently only with considerable cajoling that he would continue. When he decided he had had enough altogether, he would announce "Time to go", get up and walk out of the room. At first he would also rush out of the house, demanding that his mother come "quickly" but he soon came to wait patiently for her or go out to explore the garden.

At each session I also gave him a number of the Pickford cards about which he had to tell me a story. My primary objectives here were to obtain any unconscious or normally unverbalised material that I could; condition him to thinking and talking around a point, i.e. conditioning of attentional focussing; to correct and condition correct grammatical construction and verbalisation; to develop verbal fluency.

As will be seen below, by the time the sessions terminated he was speaking much more fluently, more correctly, at greater length and with greater depth or breadth.

He usually chose to tell me six stories; and frequently I could not get him to continue beyond very brief verbalisation.

Although he terminated the therapeutic programme each day himself the time he spent in the study with me (apart from a very occasional foray into the garden) was never less than three-quarters of an hour (which is perhaps the usual length of time any activity was carried on in his class), usually between that and an hour in length, and sometimes, especially toward the

end, longer.

The major highlights of the programme are given below, as well as incidents and factors which throw some light on both the child's and mother's (and the therapist's) problems and on the therapeutic process as it developed in this particular case. I have included only a selection of the stories given me, but to produce them all would only be unnecessarily repetitious.

At the mother's request the time of the weekly appointment was 11.15 a.m. She is running a small grocery shop and dairy in a seaside resort (which shows up in his stories) and the shop is closed for one day a week. It was on this day that she brought James to see me. She was almost invariably late; though this lessened as time wore on.

Second Interview:

This day was cold and wet and they were ten minutes late. The lounge was well-heated and Mrs. Barrett relaxed somewhat by the fire. James had a cold. I immediately took him into the study. He yawned immediately he sat down, but I only laughed and made him take a number of deep breaths; and this I adopted as standard practice whenever he yawned a number of times in succession or I suspected he was doing it deliberately. Except when he was doing a test he yawned only rarely after the fifth session.

He then drew the picture of himself in his bedroom; but I could obtain no verbalisation from him. I then gave him the C.A.T. pictures. His responses were as follows:

C.A.T.:

1. "Birds, they are having parties. Butterfly cakes. Cream. Eating

jellies. Rooster. Cock. Cockadoodledoo. Mother, father, baby."

2. "The bears pulling rope. Want to break it." Silence.

Q. Why?

"In half. Baby bear, mother bear, father bear.

Q. What are they going to do with it when they break it?

"To tie the boat with. Catch fish. A big, big fish. Eat it."

3. "The lion is looking. He's sit in chair. Is looking at hole."

Silence. Puts card down.

Q. What does he see?

"Mouse in there. The lion is going play."

Q. Who is he going to play with?

"Nobody." (Card is down again)

Q. What will he play?

"Games." (Yawns terribly).

4. "No!"

Me, laughing, "Yes!" He did not smile but did pick card up immediately, and verbalised very rapidly.

"Kangaroos. Riding bike and playing jumping. Baby in the pocket. Got a balloon." Silence.

Q. Where did he get it from?

"Christmas." Again he puts card down.

Q. What else do you know about it?

"Is going shopping - to buy bread, ice-cream, milk, jam, figs, butter, pie."

Q. And when they have bought that?

"Get money. Buy things from shop."

(At this point he looked up and announced, "I am sitting. You are working" and laughed. I agreed with him.)

5. "Bed. The bear's bed. Mother Bear, Father Bear sleep at big bed. He are making porridge. Little bears sleeping. They are going wake up in morning. It's a big house." Stops.

Q. Where?

"Don't know where house is."

6. "Are polar bears. In a cave. Baby is in the cave too. They are sleeping." (Puts card down).

Q. Are they dreaming?

"Not dreaming. Going wake up late!"

7. "The tiger is growling at monkey."

"Father tiger. Monkey is not hitting tiger. Monkey saying, Get away! Get away! Monkey going to get away up tree."

8. "Monkeys singing. Having a cup of tea. The monkey's pointing. He is talking." (Puts card face down)

Q. What is he saying?

"Don't know."

9. "Bunny Rabbit is asleep in the cot. The door is open. Because it's morning. He's going to get up. Going out to play."

10. "Dog has jumped; the other one is holding it. He's going over to toilet. There's a towel. Clean towel. Wipes his hands a ..... he makes it dirty."

It will be seen that he actually was capable of making complete sentences, although he only did so occasionally. He always spoke with great expression in his voice, and there was never any question as to how

his verbalisations should be punctuated.

It was, and is, my opinion that part of the problem lay, and to some degree still lies, in slovenly speech habits developed as he learned to speak and reinforced by his mother's comprehension of his meaning. There seemed little pressure on him at that time to speak any better; He was just "Special Class" level, i.e. comparatively stupid, and one could not, or dared not, expect more. Both parents stated and reiterated that they thought it better to be pessimistic or conservative in their outlook than to hope for too much.

Third Interview:

This was a particularly fine, sunny day. James came in, looked out of the window, really grinned with delight, and, of his own volition, sat down and drew me a picture which he labelled "Summer" and which really reflected the day. It shows a train travelling at speed through a vividly green countryside, in which one tree stands out. A ship is sailing on the canal in one corner of the page (which is entirely covered by the picture). Somebody is standing watching. As I was wearing a green frock and the figure has a green skirt this figure might be me, but he would not elaborate on his drawing. I praised it highly and he took it out to show his mother.

We then practised miming for approximately seven minutes but he then refused to continue, so a switch was made to the Pickford Test cards. The first nine stories are as follows:

1. The man is wanting, telling (him) to get something in the shop.
Q. Who? The boy. They have my ..... Nothing.
(Whispered to himself) .... Saying my name. Roger. Goes to the shop. He buys bread. Token. Buys a pint of milk with a token.

2. Stops. Says nothing. When asked why, says, "You haven't told me

to start. That boy pushed that boy down on the road. He pushed it down. He's naughty. They want to go and tell the policeman, and they put him in prison. Locked in. Then stay until the days get hot. That man has to go to hospital.

That man has to go to hospital. He go off the road quickly before a car comes. And the policeman saw him. He said, "I am going to take you." He said "You are very, very naughty".

3. The man is holding the boy. He is held up. He is carrying the boy. The man is carrying the boy and his name is Peter. Someone fell off the road. The policeman DID NOT come. He did not come. He says, "What's the matter?" "Someone push me". And the man said he can tell who pushes that boy on the road. He is asking another boy, "Did you push poor Peter?"

4. The man is running. He is going to catch this girl off the road. The man is going to give that girl something. He is going to give ..... His name is Carol. It's not Carol, it is Susan. The name of the man is Mr. Peters. I would like another name. No! Mr. Pavement, Mr. Pave. Q. What does he look like? A. I don't know.

5. The policeman is coming along to the road. He is carrying Jan (girl). "What happened?" "I am lost. Do help me. I can't find Daddy and Mum. Stay in the sun with Daddy and Mum."

6. Susan is going to have a gingerbread boy. She is go to eat the gingerbread that is on the table. It is on the table. Susan is going to eat it. SUSAN. She can't eat it for a long time, but she wants to eat it.

He stopped here, yawned. Then decided he would go on.

7. Susan sat on a stool looking inside to see if there are any toys to play with. She is a little girl. A tiny girl. She's not five, she's four. She lives in this house.

8. Ha!Ha! That boy is slip, laughing. That boys sat in the water. Got all wet. Slipping. The two boys are at the seaside. She sat in the water. She got very watery. He's happy.

9. The girls and them going shopping in town. Susan is going out with Daddy and Mummy is go with her. They are going to go with us. She's going out with us. And the door is open. Should be back at 2 o'clock In town to do shopping. They have lunch at quarter past twelve, and she'll be going to the library and she'll get some ham and celery and apples. They are going in the car to get some petrol. Going to go to the fair in the morning.

It will be seen that he promptly gave names to the characters in the pictures, but so far as his mother is aware they do not relate to people

he actually knows. Where he gets the name Brendan from remains a mystery.

He yawned after the sixth card, but completed nine, and seemed pleased with his own output. "I worked hard, didn't I?"

He usually insisted on holding all the cards at once or having the box where he could see it, and he would go from one card to the next without stopping.

On these first two occasions I did not correct him; but from thenceforth I insisted he put in the words he left out, or repeat correctly those things which were stated incorrectly or ungrammatically. He frequently mixed his pronouns while, as noted previously the more interested or excited he was, the more connecting words were omitted.

4th Interview:

He was extremely tense and restless. I experimented to see if I could get him to relax his muscles (Jacobson's method); but this appeared impossible. Accordingly I turned to massage, particularly across the shoulders, back of his neck and, when he twisted his hands very much, his arms.

I continued this particular practice whenever he was unduly tense and restless. At first he eschewed all personal contact usually sitting in a chair opposite me, but gradually he came to accept and show he liked the massage and the casual gestures of affection or support I gave him, until finally he spontaneously came to stand beside me and even sit on my lap. His mother did call him "dear" or sometimes "darling" but on no occasion in the beginning did I see her touch him; nothing was specifically

said to her but I tried to show her how to give him the mixture of casualness and warmth he seemed to need and respond best to.

5th Interview:

An E.E.G. was carried out at the University. He was very nervous, but responded well, and the record itself showed no abnormality present.

6th Interview:

He had become very co-operative, and on this particular day seemed very verbal, voluntarily giving me 14 Pickford protocols. The four most interesting were:

10. "That boy is looking. Mother is sitting, holding the baby. The boy is looking. The baby is looking at his mother sitting in the chair. There was a stool. No-one is sitting on it."

20. "The boy's father, Mr. Pave, is looking at something dirty."

21. "That Peter and Brendan. Father is holding. They are crying. Somebody hit him - a naughty boy called Ray. He putting something for healing germs. He want to get home. They go to bed early, at half-past five."

22. "That baby is going to sleep in the pram. Mother is pushing to see- is taking the two children, Peter and Brendan, to the swings and (the) baby is called David. There are no swing for David because baby sleeps. Here are some swans and a duck in the long pond. The swans are trying to get (the) fish. They have only a little while. They took a slide, see-saw, rocking chair, tractors, trains, roundabouts and water-slides, high slides. When they get home it will be ten o'clock. But when the lady gets home it will be 11 o'clock. They have lunch early - at half-past eleven."

Arising from his response to No. 20 I asked Mrs. Barrett what the family attitude to sex was. She replied that it was taken extremely naturally, they walked nude in the house if appropriate and there was no false modesty. Lately, however, James had begun to object to anyone going in the bathroom when he was there.

It was also quite obvious that everything, including the child himself, was discussed in front of him. No matter how hard I tried to

see that James was out of earshot his mother, who now verbalised spontaneously herself, said whatever she thought or had to say, in front of him. This particular day she told me within his hearing, that "of course, they were concerned about his future. Of course he could never marry - at least she hoped he never would." When I asked why not, she responded simply that "Of course he would never be able to; he would never be able to live like that. She had thought perhaps of getting a small flower or vegetable garden, which he and she could do together." (Later she had begun to wonder about making use of his undoubted artistic ability and having him earn his living doing cake-decorating.) I expostulated that I was quite sure that eventually he would be quite capable of standing on his own feet and earning his own living, and there was probably no reason why he should not marry. James, who had been playing with a toy bus in one corner of the room, turned and looked at me and then looked away again. It was quite clear that he was at least trying to understand what was being said. In considering the mother's attitude here, however, it must be pointed out that her attitude was always one of complete realism; there was no pretence of any sort, one faced facts - for example, James had never been taught to believe in Santa Claus. Fantasy was unacceptable.

After the following session, notable mainly for the fact that James had spontaneously read a small book The Minicar for me, and then insisted on putting "the" in his sentences in both inappropriate and appropriate places, Mrs. Barrett talked for another 25 minutes (despite the fact that they had been 20 minutes late in arriving). Deriving from some remark she made I suggested she was over-concerned about other

people's feelings and judgments. With this she agreed. On my killing a fly which was upsetting James by its presence (he is said to be "very pernickety even scared" by flies), she suddenly demanded if I had ever psychoanalysed my desire to kill things. In response to a query she replied that she had no desire to kill things, but "she'd often wondered."

She then burst out with the comment that she "had had an inhibited, over-protected upbringing." She "felt that she had never blossomed," and she had "brought up her daughter deliberately to be independent; at eighteen she might even be a little hard. The neighbours thought she was terrible letting her daughter live in London - the city of vice."

When asked what she would like to do or have done, she said that "her daughter told them all sorts of interesting things about movement of populations, etc. She'd like to study herself. Get more culture." I told her of my own educational background and suggested a University course - she thought she might consider enrolling as an extra-mural student.

She then went on to say that she "supposed James was her life," and again commented that she thought he should never marry, following this up with an outburst about the helplessness of men compared with women - "men pay so little attention to various things happening around them." I suggested that women were trained to pay more attention to stimuli within any home or social situation; that they generally require to be more on the qui vive as regards their children's activities. She agreed emphatically and departed with a warm smile.

The only drawback was that, from this time on, mother and child sometimes seemed to be in competition for my attention and possibly

affection. In my opinion both needed it, but I had to give prior consideration to the child. I always, however, spent some time talking with the mother.

It was only after this that I learned how much James hated his sister - he did not even want to come in on the following occasion because she would be with them in the car. Later I was told that she teases James very much (though not so much as she used to) and he can't stand it.

Seventh Interview:

On 11th September they were on time - five minutes early in fact (11.10). It was a sunny day. James came in smiling - immediately took his coat off and put it down on the settee and went straight into the study and began drawing a picture for me. The first thing he drew was the sun followed by the word "summer".

On my asking him what he liked about trucks he said, "Watching", "Passing", and "just looking."

I then gave him four of the W.I.S.C. tests. After the three verbal tests he noticed the toys - correctly named and showed me the use of the tools; then asked if he could open the cellophane pack containing the kitchen equipment. He did not know a mincer (his mother confirmed that she did not have one and he would not recognise its use); nor the name of "ladle", though he named "soup spoon", nor "colander", "strainer," or "fish or egg slice". (When I had him show them to his mother afterwards, again naming and using them, she was surprised at the amount of kitchen equipment he did not know, and said she would show him the things in the house.)

He co-operated well, though he continued to play with the mincer while doing the block test, and afterwards.

I then gave him the Pickford cards specified for "Aggression against parent figures, and retaliation: - his responses were interesting - in only one was there any "retaliation" and that referred to the natural possibility of a boy being run over when he "got in the way" of the truck, just behind the tram. No other sign of aggression was to be seen.

After this I asked him to tell me what he did at school: "Listening to the radio; morning talks, toys, music, readings; lunch and have Mr. Gower for printing and numbers." He took a breath and then, "We go out to games and listen to stories." I praised him for the long sentence he had just made, and told him he should continue to make long sentences, because he was getting bigger, and so that other people would understand him better. This was repeated three times in slightly different ways.

I then asked him to tell me what little boys didn't like.

"They don't like Church. (Q. Why not?) Too long ("It takes too long") It takes too long."

"Pantomime. (Why?) It is too long."

As he just sat silent, I asked "what <u>do</u> you like doing?"

"Moving!"

"They like playing."

"The children don't like play ("to" - "to") play football; little boys don't."

(Tell me about big boys.)

"The boys don't like fighting."

(Why?) "Don't know."

(Then what are little boys afraid of?)

"Afraid of getting knocked over and getting hurt on the nose and make it bleed."

(They are afraid of being hit in the face.)

(ditto ditto)

Do children like grownups? "Yes, they like grownups."

What do you want to do when you grow up?

"Work as a sailor or pilot (or be a pilot) - or be a pilot - or be a fire-engine."

He then picked up the "First Picture Encyclopaedia."

"Look at the vegables!"

I made him repeat "vegetables" three times - he had some difficulty, but later pronounced it correctly again. I told him to remember that we put the cooked vegetables on the table - vege'table. (slowly). He read, or remembered, the names of them all accurately. I asked him if he were reading the word or looking at the pictures, he said "looking at the pictures"; I then had him read to me from the book, having him sound out the words he did not know.

He had been yawning through all this - so I asked him if he were tired - massaged his back. On doing the latter he told me "I had an itchy back yesterday...."it was a spot", and wriggled around until I had scratched it for him.

He then told me it was time to go (12.15) and went out into the lounge.

Mrs. Barrett and I then talked for some time. She had forgotten to bring back the tests I had given her - left on the table, remembering only when half-way into the city. I asked if she and her husband would do the Myers-Briggs for me (they will) - explaining the test to her.

She commented that she thought home environment was very important to the way we thought and acted - repeated to me again the story of teaching her daughter to be independent, how she was very dependent herself until she came to the city, how coming here had helped her to be a "more complete personality". I told her I would discuss the results with her husband and herself. "Good - that'll give us something to nag each other about." (!)

She told me that James "has several books at home which he loves and reads nearly every day - but he just gabbles through them missing out the words he knew." She "couldn't stop him - he was somewhat self-willed." I suggested rewarding him. She replied "Oh I hadn't thought of bribing him," in tones of relief. I commented that we were inclined to think of this in moralistic terms, but when it came to learning anything we were all involved in reward or punishment, with which she agreed. I said it was a question of finding some means of motivating him.

We discussed the possibility of having him taught Elocution - and I pointed out again that both she and her husband, particularly the latter, left out the connecting words when they were speaking rapidly. She agreed that they spoke slovenly - "most people do where we come from". We also discussed the possibility of their buying a tape-recorder and having him listen to himself and to good speech. She said that they would at least probably buy an old gramophone and records for him, as they were considering this now.

The Eighth Session was most important. I told Mrs. Barrett the results of the I.Q. test I had given James, explaining the nature of the test itself and the sub-tests, as well as the problems involved in accurate testing of children such as James. I told her that I was sure that eventually

James would be found to have at least average intelligence - a view which was shared by another psychologist who was, later, usually at home when they came and to whom James usually went to show his drawing or to "say Hullo" while his mother and I talked. And I pointed out that I considered him to be more than averagely gifted with artistic ability. Following this conversation she bought him some oil paints and told me that he was "proving very good with them". She also seemed to think that some of her burden of concern had been lifted though she and her husband "didn't believe in being too optimistic".

On the next occasion James arrived calling he had a present for me. At first I was touched, later embarrassed. The gift-giving became a deluge, mother and child both arriving with at least one each. Mrs. Barrett finally stopped - possibly because I refused to respond over-much for, while at first I am sure it was gratitude, later it sometimes seemed to be an attempt to buy affection - but resumed again just prior to Christmas. James always insisted on bringing me a present - usually chocolate wafers - always carefully wrapped and labelled by himself. Certainly no fees were being paid, but the gift-giving was both extremely touching and pitiable. And as a result I myself found it extremely difficult to maintain any controlled distance. It did, however, bring about one change in my routine. The time of their approval was always most inappropriate for the serving of coffee, but I had felt very inhospitable in not always serving it, though I did if the day were particularly cold or wet. For the remainder of the sessions we always had coffee when they first arrived - James always enjoyed this very much, but he sometimes became annoyed if his mother kept me too long.

On the Tenth Session I gave Mrs. Barrett the results of the 16 P.F. tests and also the Myers-Briggs Manual to read. She did not appear very pleased with the results. She said that she "considered a good example of her husband's behaviour was the time he was speaking at a meeting (he likes to speak, usually speaks well) and teachers are often called on to do this." He was "going quite well when all of a sudden he tailed off and stopped. When she later asked him why he said it was because his attention was suddenly distracted by someone's bald head. He kept looking at it and forgot what he was saying, or supposed to say, so he just stopped."

During the Eleventh interview James was sitting on the floor making words from the "Teachatot" Game and his mother came to the study to admire his efforts. At the doorway she said that her daughter had told her our brain cells are dying (her emphasis) continuously, but we had so many billion cells it didn't matter. She thought "it sounded awful." James had apparently made the word "Liza" and seemed lost. I asked him if he knew it were a girl's name and had he made it because of that. He replied emphatically, "No, I didn't know." Guessing, I asked "Were you trying to make lizard?" to which he replied softly, "Yes, but I couldn't make it go." He seemed withdrawn, so he was told "Of course! You were listening to what we were saying - all intelligent little boys listen to adults when they are talking, even if they don't understand what they mean, don't they?" He smiled and looked both pleased and relieved. He immediately became more active and made another word quickly. Almost coincidently he claimed his back was itchy, so I rubbed it for him, massaging his shoulders as well. He responded by getting the Pickford cards and telling me

the longest stories to date; they were also the most disturbed:

Card 59:

" Brendan is trying to get Stephen to keep out of the sea because the water is very deep, because he might get drowned, because he doesn't know. He has to keep out the water. Got to let the man go first to see how deep it is, if the man goes to be up there (touches his head), the fish would be right up there and the man is trying to catch the fish,, eight fish and is going to take it to the shop to sell and so he got a big long stick and if it pushes it could be deep. And he is going to catch a grey fish and send it to the shop. He's got twelve grey fish to send to the shop. The man has only two, none left, no fish at shops, no drink. Got to catch fish, 30 fish to send to the shop for people to buy because they haven't any meat. If people have no meat they have to buy fish and chips. The lady can't cook it, because the man got very busy."

Card 56:

"And so Brendan tried to take the rice bubble cakes. He loves. He didn't taste it for a long, long time. He want to taste. He wanted just a little bit in case he hate them. He hates them now, he doesn't like it, because he tasted it and he hates them; doesn't taste nice to him. Mrs. Pave had three children, three boys and two girls, got five children and one's name is Stephen, one's name Brendan, one's name is Peter and there was this girl named Kathleen and Janet and the man called Mr. Pave and Mrs. Pave. Lots of family. They makes five and two makes seven. Seven peoples in the house. He had a very big house and he got a red house, and she got a car called Austin."

Between his telling me these two stories I had knelt beside him and put my arms around him and asked him if he were afraid of dying. He made no comment, displaying what I can only describe as a "closed-off" expression. I told him that he did not need to be afraid; it was usually only very old people or people who were very sick who died, not children. This suggestion was reinforced by my telling him that I thought he was a big, strong boy, and I was quite sure he was going to live until he was an old, old man. At the time he made no response, staying still until I moved away, when he went on with the story-telling. Afterwards, however, he was running up and down a path in the garden (which sloped down steeply to a vertical drop) and called to me that he was "playing at monkeys and

he had to be careful on the path otherwise he would fall down and get killed". This was said cheerfully and with no apparent undertones. A few sessions later when mention was made of the death of an animal, he told me he wasn't afraid of dying, only old men and sick people died.

On this occasion, however, his mother told me he had indeed had a fear of dying, which they tried to allay; when his dog had been killed they had tried to treat it casually and show no emotion in front of him. They had tried to make him take it for granted, and he hadn't shown any emotion about it.

Although his behaviour was now much more spontaneous, and the rocking or leg twisting movements had stopped, it was not until a month later that he came and sat close beside me while I was talking (or listening) to his mother in the lounge. The following week he appeared somewhat disturbed when he arrived, though I did not find out the reason. This was doubtless compounded by his mother looking at some of my books and asking what could cause such conditions as James's. I told her there were a number of different theories and possibilities: virus infection, instrumental damage at birth, birth trauma, feeding trauma, lack of dominance of one of the cerebral hemispheres; but repeated what I had told her several times previously, viz. that, if there were damage, it was possible by appropriate conditioning to create new cortical pathways. She became somewhat upset at the mention of feeding trauma, declaring vehemently that she "had told that nurse she was wrong." She then referred to birth and its possible effects on a human being and the belief of some people that we all want to return to the womb, "a nice, warm, safe place

anyway." When I entered the study where James was drawing me a picture he launched into a somewhat incoherent story about a cave, which I simply did not understand. Influenced no doubt by the conversation just concluded I was sufficiently stupid to think in terms of related symbolism, and I asked him if he were trying to tell me about a nice warm place where he would be safe. His response was a blank stare; when I asked him another question I received no reply. By now we were both sitting on the floor with James playing albeit mechanically with some of the toys. I patted him and told him it didn't matter if he didn't want to tell me anything, or if he were angry with me. I understood. But learning to talk properly was probably the most important thing, wasn't it? He looked at me, nodded and went on playing. I returned to my chair, and he then got one of the card games, said, "I want to sit by you" and proceeded to share (to my considerable discomfort) the dining chair on which I was seated, while he turned out all the cards onto my lap. When I later raised the matter with his mother she told me that he was undoubtedly talking about a cave in the hillside which they had seen on their way into the city that morning.

Actually there is no proof that symbolism was not involved in James' attempted verbalisation. It would be possible to argue that as James was upset this could stem from fear associated with the cave, which in turn just possibly could be associated with a reactivation of the memory-trace of the original birth trauma (real and not hypothetical in his case). On the other hand usually his stories related almost entirely to his own experiences and to stimuli available to him in the recent past, (this I always tried to gain some confirmation of).

However, a fortnight later he produced an unusual and associated drawing - "Goblin" (in a bright red pointed hat) is standing outside his cave (which contains a heater and a mat (labelled)) apparently looking backwards at a tree. The sky is completely blue and the sun is shining. Apart from telling me somewhat impatiently that it was "Goblin" no explanation was obtainable. But any fear was apparently dissipated.

Likewise I am still uncertain as to whether one (and if so which one,) or all of the statements I made to him on this occasion, was/were responsible, but at some point in each of the following sessions he either sat beside me or half on my lap while we played the card games, though he always returned to his chair to draw or tell me his stories.

His stories were now usually fairly lengthy and his grammar much improved. He would correct himself if he left words out and certainly made conscious endeavours to improve them. I cannot claim that he always spoke well; he didn't. Under stress his speech patterns still tended to disintegrate. But in my company and within this environment his speech was very much improved; his nervous mannerisms were completely gone (though he still used to swing for long periods on one of the posts at home; but considering his lack of company I'm not sure that this was as abnormal as it might otherwise appear); he related to me quite spontaneously, though probably at a somewhat lower level than his chronological age. Mother-child relations also seemed warmer; she was more optimistic about his, and her future; very concerned to see he had whatever might aid him to develop. When she left she thanked me profusely for what I had done, not just for James, but for all I had done for her. But just what that amounted to and what the future holds I would not be sure.

The last session (December 18th) was an extraordinary one. In the first place during coffee, Mrs. Barrett upbraided James for not telling me what had happened. He said he didn't know what had happened. In strongly accusing tones, she replied that he did know - about the guinea-pig. Finally he did say that the guinea-pig was dead; whereupon she took up the story with considerable excitement and gory detail. His pet guinea-pig had been pregnant; the previous evening it had obviously been in great pain. Finally Mr. Barrett had killed it and opened its belly in order to try and save the young; but the litter had also died. In answer to my query, she added that she didn't think James had minded - he had "just looked at it and laughed and walked away." Perhaps the laughter was defensive, perhaps it was symbolic of aggression, perhaps the thing did appear grotesque - I do not know. He walked away into the study while his mother told me the story. Later when he and I were alone I told him that I was sorry about the guinea-pig, but drew no response. He maintained an outer blankness, though he did appear to listen. He has been, as we have already seen, conditioned to display no overt emotion, possibly even to feel no emotion when confronted with the death of an animal, particularly his pets. His mother certainly demonstrated far more emotionality.

James himself was much quieter than I had ever seen him. At times he gave me the impression that he was not so much "withdrawn" as "standing a little aside, listening" but showing no immediate evidence of response. When I told him later, as he stood very quietly by the bookcase, apparently looking at nothing, doing nothing, that he must not be afraid of anything, if he were he was to tell his parents or me what it was all

about, he did, however, suddenly ask me, "Are you shifting?" I assured him I was not; that, if he wanted me, mother could either telephone me or bring him to see me; in any case when the holidays were over he could probably come and see me again like he did now. It was, however, decided by his mother that, unless there were any crises, he would only come up occasionally.

During the course of this session, as I reported earlier, James did consent to try and finish the Goldstein-Scheerer tests for me. Although it took him some time, while twisting the blocks this way and that, to complete the designs, he did manage to complete the test with each design reproduced correctly. I praised his patience and persistence as well as the correctness of his responses.

He also told me the longest stories to date; indeed I think he only ceased verbalising (he spoke at very great speed) with respect to the last one because I became so tired I could not continue to record it properly.

During the early sessions I had tried to tape-record his responses, but he became too excited, difficult to understand, while the rate of his grammatical mistakes shot up. Now I tried to take another recording, only to be told to take it away because it made him make mistakes.

His final story is as follows:

"Peter is trying to stop those trucks. It gets dangerous. He doesn't like it to be broked. The other driver doesn't like it so he stopped. Stephen said the tram can go now. The policeman put the red light to stop. The boy catches the tram. Because he was too far (away); because at night he went to bed at half past five. He went to sleep at 6 o'clock. He went (got) up early at 6 o'clock. All the children was (were) happy. All right then. All right then. We go to the seaside. The sea is too rough; the sun is not coming up. We have breakfast. He asked for the police. He went to the shop and they tried to catch the airways bus.

Then we went on the top deck. They want to go quickly. Three can go. Mother and Brendan and Stephen; Peter doesn't like going on the aeroplane. He wants to go with his Daddy. The aeroplane is called - "Vode". Which colour is the aeroplane? It is red. He sees the landing and he tells the pilot, "Stop quickly". The other aeroplane pilot says, "Hurry. You go first." "What happened?" The little aeroplane stopped; it broke down; it hit the church. The other aeroplane was a new one with writing on it. The other was like a jet, and they went on and bashed a church because he didn't know, he couldn't turn around, and the aeroplane went bang. But Brendan goes on the aeroplane with the mother; it didn't go down. The broke(n) one - the pilot got dead, go down; he hadn't landed but he went down. The pilot (musingly) .... he likes it on the top dresser aeroplane very much. He likes little aeroplanes not big ones. He got off and they tried to buy some lemons. They tried to buy something in the shop: nails, raspberry drinks, fizzy drinks and orange and lime. Lots of things in the shop and then the Ice cream van came (so) they get some ice cream. And they have no money. They have to get money-box to buy. And they stop and the man came here. "What do you want?" 'We've got things." "We got to get some ice-cream, and she wants orange and hokeypokey and lime." I like orange. All right! He gave me one. But Brendan wanted to plant some corn and he poured some corn out and he put it into the bag and Brendan left. And he got to go somewhere else. And that's all!"

The disturbance reflected in this story and the symbolism involved is much greater than it had been (the previous week e.g. he had told me a long story about Xmas presents for all the Pave children) partly I am sure due to the guinea-pig incident partly to some form of separation anxiety. He was reassured of my continued concern and later came of his own accord and sat himself on my knee while mother and child were shown some travel slides. When he got bored he jumped down and went off to visit the greenhouse apparently much more relaxed.

As it was Christmas there were, of course, presents for both mother and child. The mother was emotional, verbalised excitedly, and completely overshadowed, if she did not overwhelm, James who sat down quietly and unwrapped his gifts, one as a reward because he had worked so hard, the other (a jigsaw) for fun and to help amuse him on wet days during the holidays. Bearing in mind his need for increasing span of attention and

some motor activity I suggested that the parents might obtain a meccano set for him, and this they promised to do. He had had little experience of building or construction toys evidently. Mrs. Barrett was again reminded that her son was intelligent, that she should expect more not less from him, and that she should continue to reinforce the suggestion I frequently made to him that he was doing well but he should try even harder to continue to talk in long, full sentences, and to build up many paragraphs around a central theme.

It will be seen that the therapeutic process here involved both mother and child. James has indeed, by force of the circumstances pertaining, been practically her "whole life". The sooner he can be taught or learn, to consistently speak properly, the better for all conderned. The bond is a strangling, rather than a healthy one. The boy gives fair evidence of being over-socialised; he is usually very polite and well-behaved, and is promptly reprimanded if he ever falters. Both parents, incidentally, claim that it is in their opinion absolutely essential that such a child should be thoroughly taught good behaviour; he can't explain anything adequately so he must behave so well no explanation is ever required. One suspects, therefore, that on top of possible brain damage and early decidedly traumatic events we have a boy of high arousal, and probably high autonomic lability, conditioned to rigid "good" behaviour. The ensuing stress could well be expected to reinforce any underlying deficit in language function. At the same time the undemonstrative, over-rigid, dominating mother could well have been experienced as rejecting.

Therapy, while primarily designed to give the boy practice in all the activities associated with linguistic development was also carried

on in such a way as to give the boy maximum warmth and support so that he in turn gave responses which reciprocally inhibited anxiety and tended to desensitize his habitual maladaptive responses. At the same time wherever possible (and to a degree not actually reported here) constant verbal conditioning relating to his ability to learn and understand was carried on, both with the intention of helping to increase his own, and his parents', self-esteem and of motivating him to additional effort.

I should like to take both mother and child into therapy quite separately, with the mother not present when James is or else deal with both as one unit; but this would not appear feasible.

.....

Case 7:

The patient, a boy of 14½, was referred because of anxiety, examination-panic and associated sleep-walking. He was treated by reciprocal inhibition therapy over 18 sessions with excellent results.

As will be seen from the case-study, in learning terms he was suffering from (a) some environmental deprivation particularly in regard to music and art - sport is the approved extra-curricular activity, though preferably this is related to status: (b) abnormal conditioning of anxiety; (c) incidental psychosomatic symptoms (Headache); (d) some distortion of the ego-ideal and the development of maladaptive defense habits; he was inclined to devalue intellectual achievement through jealousy of his sib and anxiety-provoked fear of failure.

Unfortunately no tests were scored by the parents.

Willoughby: On the initial test Matthew scored a high 56 points. This dropped by eight points in the first re-test, and two months after therapy concluded a furtherre-test showed a drop of seventeen points.

The 16P.F. (Junior HSRQ form): On this test he scored very highly on fastidious individualism (J) and individual resourcefulness (Q2); very low on A (cyclothymia) and F (surgency), thereby appearing to be cold, aloof and depressive. He approaches average on shyness (H), but is rather sober and serious and introverted. On Q4 (nervousness) he scored somewhat above average, is just on average in emotionality, with super-ego rigidity slightly below average, but ego-control above average.

I.Q.: He was given the Differential Aptitude Tests (Verbal and Abstract) both of which he completed several minutes under time. His scores (69th percentile for the former and 67th percentile for the latter) are probably no fair indication of his real capacity. This is confirmed by an inspection of his actual errors, many of which occurred in the earlier parts of the test.

E.E.G.: Normal, within limits, but with some occasional spike activity.

... ...

This is an excellent example of the highly satisfactory results achieved with the use of reciprocal inhibition therapy; although there are points indicating the possibility of other problems which one could well expect to become of importance later.

The patient, Matthew McKelvie, was 14 years 7 months when first seen. His mother knew of my work and asked if I could help her son. The presenting symptoms were high-anxiety; sleep-walking at examination times, and a chronic record of never doing school-work at what was deemed, by both teachers and parents, to be his capacity level (born out by the innumerable school reports presented).

As he also has a record of illness and accidents, and occasionally complained of headaches, he was immediately referred to a general medical practitioner for a general physical examination with a request that he be further referred for neurological examination. He was found to be somewhat tall and underweight (but slightly built) with some immaturity of development, but with no abnormality. An E.E.G. carried out at the University gave a record "normal within limits" but showing some occasional spike activity.

His medical history, which records many traumatic events, is as follows: Pregnancy and delivery were normal; however at four months he only weighed the same as at birth. He was breast-fed, but a "difficult feeder", and at six months he was sent to the children's hospital and weaned; he was apparently in the hospital only for a few days. At five, six and six and a half months he suffered from ear abscesses; at fourteen months he fell and broke his teeth requiring X-rays; at seventeen months he had a bowel obstruction and operation, was in hospital for four weeks, very sick when he returned home, and returned to hospital for a further week; at nineteen months he fell in a creek; at 22 months he burnt his foot badly, requiring hospital treatment; at two years one month, he trod on a nail and developed a "bad foot"; at three years two months he burned his hands; at three years four months he cut his head badly; at three years eight months he was involved in a car accident and received twelve stitches in his head; at four years he burnt his hands badly; at four years two months he cut his chin; at four years six months he fractured his nose; in between all this he had measles, mumps, scarlet fever.

Matthew is the younger of two sons, the older sib being sixteen months when Matthew was born. The mother badly wanted more children, particularly

a daughter, but underwent a hysterectomy when Matthew was about three or four. She herself is the younger of two daughters, her mother, who brought up her daughters to "always act as ladies" and hoped for marriage into "society" for them, died about twelve years ago, since when her step-father has lived much of the time with the McKelvie family (in preference to living with his own children). Both the boys loved their grandfather, but Matthew was particularly close to him, calling him "Pal". Matthew's father is one of dizygotic twins, both of whom served in the air force during the war, and have worked their way up to become managers of the respective firms for whom they work. Mr. McKelvie is the slightest, and more delicate twin; he was apparently only reared with difficulty, and, as the result of his ill-health, the brother (now living overseas) was ahead at school and "qualified" just prior to entering war service; while Mr. McKelvie only obtained his qualifications after his children were born.

Both Matthew and his sib may well be described as "over-socialised" extremely well-mannered and well-behaved. The sib, Barrie, is somewhat taller and heavier in build, is described as "more persistent" than Matthew, finds school work easy though he works hard, and is usually in the top three of his class. Matthew would seem to be the more introverted of the two, and more "artistic" in temperament; he also excels in certain sports, particularly tennis and gymnastics. Unlike the sib, who plays no musical instrument, since being "in treatment" Matthew has commenced to learn and play the trumpet, which he "loves very much", "driving the rest of the household mad" while he practises. An interest in music is acceptable (though perhaps only barely) in this family; but the emphasis is on intellectual achievement, preferably in the academic field, but otherwide

in the commercial area. Both boys want to be doctors; the mother, however, frequently wonders if Matthew only wants to be one because Barrie<u>d is</u> going to be one.

Both parents, but particularly the mother, claimed that they didn't or wouldn't, mind if Matthew "didn't get very high marks" but they did demand that he should work at his full capacity. The father would "rather like Matthew to enter the firm to which he is attached and work his way up there" - this would involve "a period" in being "a traveller" concerned with marketing the firm's products, a job for which I would judge Matthew to be extremely ill-suited. The parents are, however, prepared to give Matthew all financial assistance required to become a doctor if that remains his wish and he demonstrates the necessary academic ability.

The parents appear to be "sensible, down-to-earth, realistic" types, who are sensitive to their children's needs. Until the begining of this year both boys had attended the same school and the parents considered this might have had some detrimental effect on Matthew who was, therefore, forced into competition with his brother's public image. However, due to change of domicile, sometime earlier, it became possible to send the boys to different schools. Whether due to the different school-environment or teachers, or to the absence of his brother, or to other factors, shortly after beginning work with me, Matthew managed to obtain ninth place in the school examinations, which was better than his previous record.

It became apparent during the interview that Matthew is by no means verbally fluent. Any communication is short in length and not easily constructed. English was by no means his best subject (he gains highest marks in Maths and Science); but when I made further enquiries into this

he finally commented that he didn't think he knew his grammar properly because of "poor teaching and standards" at a school he had attended earlier. A complete practical English grammar manual was accordingly obtained and given him, and he worked through this in his "spare time".

Matthew attended the University Psychology Department for his weekly interview. In order to come to the interviews it was sometimes necessary for Matthew to miss all or part of his last class (regarded as an "unimportant" subject, and not affecting his progress toward matriculation), travel twenty miles by train and subway and walk to the University. (He usually made it a practice of running from the subway station, however, which meant he was usually "out of breath" when he arrived). He was sometimes late in arriving; but he was still required to meet his father, again some distance from the university, not more than one hour after the set time for the session, in order to be transported home. With the exception of the school holiday periods and days on which special school or sports events prevented his coming, he came from July to December, eighteen sessions in all.

It should also be stated that the parents occasionally displayed some fear or suspicion of psychology and what Matthew might "find out". Sex is not entirely a taboo subject - the boys would be answered factually if they asked questions - but is apparently not discussed. The parents do not go to church, "don't know the answer", but are inclined to be moralistic. Matthew is supposed not to have masturbated as a child; does not do so now. (Freudians will probably be inclined to take one look at the medical history, and contend that the hand-burning episodes were doubtless linked with masturbation and punishment. They may have been - but the mother is the type who would be constantly forbidding the child to touch practically

everything it saw, anyway, and Matthew sufficiently self-willed (and so impatient) to promptly do so.) The mother admits that she actually prefers the older son, ("Matthew is too much like me, perhaps - we are always clashing somewhere") who always behaves as she would like him to, but she tries not to show it. She is also working part-time in order to help pay off the house-mortgage and gain sufficient money to "put the boys through whatever education they require, University, etc. etc.")

Mrs. McKelvie accompanied Matthew at the first interview, which is when the history was obtained. When she left she cautioned him to be on his best behaviour. Matthew was somewhat shy and nervous, would smile in response, but not spontaneously otherwise. He spent much of the time looking out the window of the study used, which has a very wide view over the nearest square. He seemed to be absorbing and reacting to much of the detail observed. When circumstances later caused the use of another smaller, very shut-in, study on one occasion he became somewhat restless, then extremely subdued, admitting he did not like the room, and breathing a very audible sigh of relief at the following interview when he found the original room could be used. One could suspect a tendency to claustrophobia, though it was not mentioned. He has a very great love of the outdoors, and says that, if the choice were his, he would spend every fine day outside. He also likes to be alone a lot. When asked what he did on such occasions he replied that he "just looked, and thought, was quiet and enjoyed himself." On being pressed he could add nothing further, except to say that he "thought about the world and what it was."

At the conclusion of the interview he was asked to bring back with him next time a list - as long as he could make it - of the situations or events

which made him anxious. He evidently did not understand what was required, because at the second interview he produced the following list:

1. Being inside working on a fine day.
2. Don't like to be told to do something when I am already doing something interesting.
3. Being pushed around when I am trying to do something, e.g. getting books in locker room.
4. I don't like people who are sitting beside me stopping all the time.
5. Having dirty hands when writing or doing homework.
6. I don't like people being noisy in class while I am trying to work.
7. I don't like having to wait long for a train or bus.
8. I don't like sitting for long periods.
9. I don't like heights very much.

It will be seen that there is undoubtedly an element of anxiety invoked in all these situations, as well as an element of aggression. Conceivably he is afraid of expressing his aggression; but whether this is due to "socialisation", conditioning or fear of actually being hurt physically as the result of counter-aggression is a moot point. He admits to a fear of being hurt and of violence, and approved my suggestion that he should learn Judo or some such protective device (but this was not carried out as his parents thought he could ill-afford the time or money; it was better that he should play tennis at which he shows considerable promise.) On being questioned about the statements, however, he said these "were things he didn't like or resented, not things that worried him or made him afraid." He was then asked to prepare a second list.

He was asked what happened when he was "told to do something when he

was already doing something interesting," and he replied that he tried not to listen; that this was "something Mum was always doing" and that "eventually he had to do what was wanted."

His association to Statement three was that "the boys all rush in and push against you and your books tumble on the floor, and then there's trouble. There's such a crush you can't help it."

With regard to (1), he "just wanted to be outside walking ... enjoying himself."

(4) bothered him, "particularly in exams".

(5) meant he "got marks on the paper and probably got into trouble."

(6) again referred particularly to exam or test time.

(7) he considered was mainly because he "was impatient - just didn't like waiting."

(8) is self-explanatory; while (9) referred to a fear of falling when actually on a steep hillside rather than a neurotic fear of heights. The fact that he was peering out of a window from a room several hundred feet from the ground would not (and did not) bother him in the least.

There was no explanation as to why he should not have washed his hands before doing his homework apart from a comment that sometimes he got ink on his hands. It was pointed out that to go and wash them would take very little time and reduce the anxiety, but he evidently disliked the necessity.

During the second interview Matthew was also given the Willoughby Personality Schedule to fill in, for which he received a score of 56

It is interesting to note that he rates himself as never day-dreaming (he "thinks about things, how they are made and why, and so on" or he reads, a favoured activity) and as being lonely only sometimes. His anxieties would appear to relate very considerably to his ego-ideal or self-esteem and the esteem of others.

On this occasion the rationale and technique of reciprocal inhibition therapy was explained to him; he was instructed in the practice of relaxation. He was also advised to start practicing assertive responses in real-life situations.

At the third session Matthew presented the following list of anxiety-provoking stimuli, or situations, which we then proceeded to put into hierarchical order:

(1) "Seaweed in water when swimming under water

(2) Five minutes before a test

(3) In an exam room

(4) When I'm walking to catch a train - scared I'll miss it

(5) Angry voices away from home

(6) Dark - walking to put milk bottles out - as though someone I can't see is watching me

(7) Heights

(8) Scared when people blow up - raise their voice."

Discussion elicited the fact that (8) referred particularly to the school-situation, where he was always very anxious when the teacher became annoyed, one teacher in particular bothering him very much.

As with all his problems which were discussed, he was offered all possible rational explanations of the behaviour (his own or others') or

situations which bothered him. He thus came directly and indirectly to learn something about causes and effects of various behavioural patterns as well as some areas of general knowledge. In particular regard to (8) we had some general discussion of the causes of people "blowing up". He was then instructed to choose whichever seat he preferred or to lie on a couch which happened to be part of the furniture of the room, and to relax as completely as possible. After two attempts at using the couch he gave it up and always sat in one particular chair. Once relaxation was obtained he was instructed to imagine himself in his classroom with his best liked teacher "blowing up"; as soon as he felt the slightest tension he was to stop immediately. On the first occasion relaxation was maintained for less than two seconds; but progress was rapid, until he could finally retain relaxation in conjunction with the suggested imagined picture of himself being confronted by his most disliked teacher "blowing his top".

In part Matthew's rate of progress and the results obtained were undoubtedly due to his pleasure in, and assiduous practice, of the relaxation techniques. He reported that, of his own accord, he practised relaxation several times a day and de-sensitization every night in bed.

Unlike Jennifer (see Case 8) on no occasion did Matthew proffer any associations connected with the stimulus-situation nor could I obtain any from him. Whether this was due to his paucity of verbalisation or to inhibition (probably to an interaction of both) it was not possible to tell. But as Wolpe infers this certainly did not detrimentally affect the results.

The speed of his progress will be apparent when it is realised that we worked through Nos. (8), (6), (5), (4) and (3) in fifteen sessions.

No. (7) (Heights) was excluded because it was decided to concentrate on the more common situations. No. (1) (Seaweed in water when swimming under water) would seem to present a very real hazard at any time; but we had not reached this point when the sessions were terminated.

Mrs. McKelvie, who claimed to see some rudimentary change in Matthew from the second session (beginning of relaxation and de-sensitization therapy) onwards, considered this partly due to the very fact of Matthew coming up to the University and being seen by a psychologist. She thought it gave him an added sense of importance and helped his self-esteem. In August she informed me that her step-father (Matthew's beloved "Pal") was seriously ill and possibly dying. She asked me to say nothing about it to Matthew because he "was so terribly upset." It seemed to me that this comment offered some hint of the amount of conditioning of inhibition of expression of feeling and/or emotion which had been imposed on the children in this family. I did not mention the matter to Matthew until later - he neither mentioned it nor gave direct indication of anything being seriously wrong. What did happen, however, was that in the first session after the school holidays he informed me that he had thought of something else to add to his anxiety hierarchy, "Space.....just space.....space going on for ever." He told me this just as he was heading for the door at the end of the session - presumably the de-sensitization process aided him to verbalise his fear. I promised that we should discuss this next time he came.

This problem, however, was not considered for some weeks. The day before the next scheduled session (i.e. in the following week) his father rang to say that Matthew was taking part in a P.T. display in a fortnight's time and had to practise late each night. Unless I insisted he

would be unable to come for the next two sessions. Being aware of how much Matthew enjoyed P.T., and of how scared he normally was of appearing in public (according to his mother, later, he usually disappeared just before he was scheduled to take part in such a performance and could not be found until the performance was over), I immediately acquiesced. Matthew and his parents were particularly pleased with the result - he was actually the star performer and won considerable praise.

When I did see Matthew next it was a session in which we were pushed for time. When I did ask what it was about space that bothered him, he replied "Just the endlessness of space and what happens when you die and that, and where do you go. Space going on and on and never stopping."

I asked, "What do you think about dying? What do you think happens?"

He responded: "Well, you die and you just don't know after that; whether you go to heaven, where's heaven where you go, and all that. Well, is God and Jesus true?" The mention of God brought up another interesting question - "the Bible states that Adam and Eve were the first persons in this world, and the scientists say the cavemen; and the Bible says nothing about cavemen. What <u>is</u> true? Who <u>is</u> right?"

"What do your parents think about it?"

"Aw! They don't know." (The tone of voice implied that they didn't care, either).

"Are you asking me to tell you the answer? Maybe I don't know much more than they do."

"Yes. What do you think? What <u>is</u> true?"

He was very intense and the matter obviously disturbed him. At the same time I was unsure of his parent's teachings or beliefs, no matter how

rational they might think themselves. It was apparent that he had at least met with Biblical teaching (in the schools perhaps). But it is my considered opinion that mental health demands a healthy relationship with reality and factual or rational knowledge all important.

I told him what the "scientific" or "rational" view of the Bible was; that the Old Testament is essentially a history of the Jewish people; suggested that one of their poets or philosophers or some factually ignorant person trying to explain life, had formulated the myth of the creation (and I here explained "creation" and evolution, as well as the notion of the expanding universe). I pointed out that we know from the work of the historian Josephus that a man, Jesus, had actually lived around the time of Pontius Pilate and suggested that he might have been a very good and wise man, probably something of a poet and philosopher, about whom stories grew up and with whom pre-existent myths were associated. He was told that the real story of life, of how the brain works, how people behave, is much more of a "miracle", much more exciting than any creation by a super-human-being; that apart from genetic inheritance there was, so far as it is known, no "life after death" - but that "eternity" was really the effects of our behaviour, good and bad, on all the lives of all the people we know and all the people they know, going on in ever-widening circles, like a stone being thrown into a pond of water.

Knowing that Matthew had been fearing the death of his grandfather (who, however, is still living) and wondering if he wanted an after-life accordingly, I was a little apprehensive of his attitude and response. He went out of the room smiling broadly and almost gave one the impression of his walking on air. I assume that I had removed his fears of judgment and

hell-fire and damnation, but of this I received no proof. During the final session, however, I asked him about his fear of space - he replied airily, "Oh, you know I just can't imagine space like that anymore. There's always a line - like looking across the park, past the lake, and seeing the trees on the other side."

During the lecturette, as on other appropriate occasions, I repeated several times that he must learn to question statements and ask for facts and must always make his own judgments on all the facts available. I also used the analogy of the Maori myths and told him how they had passed their history on by word of mouth; I told him, too, that it was many centuries before the Phoenicians had evolved a written language, and that it was easy for things to get confused.

Another major point of distress to him which was discussed generally, was the question of his mother "going out to work". He "thought she should stay at home", although he could, or would, never tell me why. He "just thought mothers should stay at home", and appeared to feel considerable resentment (judged by both facial, and intensity of verbal, expression) that she should do so. It was pointed out that she had never been employed outside the home until such time as he was more than able to look after himself for the short period during which she might not be at home, and that, in fact, she was usually there when he left, and returned home from school. Further the reason for her working, as he well knew, was to provide the best home and education possible. He admitted that he had not considered or even really been aware of these facts. I endeavoured to use this particular example as reinforcement for the precept that he should always pay attention to all the facts and aspects of a situation before making a judgment. But,

perhaps even more importantly, I pointed out that his anxiety was probably the result of the conditioning of fear when, as an infant, either he or his mother was in hospital and he experienced a sense of deprivation. Later he advised that he "didn't much mind about his mother going to work anymore."

It will be seen that straight verbal conditioning was carried out in these two instances, apparently with reasonably successful results. It does not follow, however, that such conditioning would have been successful in, and of, itself.

Answers to questions, direct and indirect, put during the various sessions showed an unvarying loyalty to his family. Matthew said he and Barrie argued sometimes, but he thought Barrie was a wonderful brother as well as being "terrifically brainy"; while his mother and father were "the best". They "all went everywhere together".

The mother reported that, during the course of therapy, Matthew became much more considerate and thoughtful for others. This even generalised to the neighbours who apparently benefitted by having their lawn mowed and gardening done on occasion. She was "very proud and touched" one evening when she attended the School Parents' Evening. She stayed behind "to have a cup of tea" while Matthew had gone home, thinking she had gone ahead. He then returned in order to escort her home despite the dark and ill-lit streets. I noted the fact that he had previously been afraid even to go to the gate with the milk-bottles; she noted that he had never shown such concern for her previously.

Considering that he undoubtedly required some form of emotional expression, I had asked Matthew in the third interview if he were interested in painting or drawing or music. He admitted that he would "rather like to learn a musical instrument". I pointed out that a relative was a

professional musician, so he had a model to hand if he needed one. It was also explained to him that intelligence takes many forms and a discussion ensued around this point. Two interviews later he informed me that he was learning to play the trumpet for the school band. He was very pleased with himself about it, and "loves" it very much. His mother received a secondary gain, even if the practice annoys her, for she said she was very proud to see him playing "up there" (apparently on the stage) and that "they had performed quite creditably". There were two important points here: Matthew was actually performing in public and doing something where any mistake he made could readily be noticed; and (b) he has an accomplishment where his apparently intellectually-superior brother has not.

In Spring he told me that he was now second on the tennis list; which also meant considerable improvement.

Then came the feared end-of-year examinations. Everyone was on the qui vive to see what was going to happen which, of course, tended to reinforce his own anxiety. Two weeks before the examinations he found that the length of ti time which he could remain relaxed while imagining himself in the examination situation remained constant, though he could not retain relaxation for more than one minute in conjunction with the imagination of "five minutes before the examination." I suggested, therefore, that if he felt really worried he should rather relax and imagine coming out of the examination room feeling pleased with the work he had done recalling times when he had done well. I was concerned here to reinforce the confidence-value of the relaxation, being associated as it was with the desensitization of his anxiety, but it must be admitted that such a suggestion in this context might also well

prove excitatory in nature. He said, however, he "really wasn't worried about these exams, matriculation next year might be different." At the same time he asked me why he "sleep-walked." In order to reinforce his confidence, I gave him the rational explanation that possibly it correlated with his brain's activity in searching for and filing away all related data which he might want in the context of his examination answers. I told him that he "really had a jolly good brain which was quite wonderful in its operation." The response was unexpected but important; he said "So long as it's all right and not damaged." On being asked if he were still afraid that his accidents might have caused some damage he said, "Yes". Strong reassurance was given in terms of the E.E.G. results and medical and related examinations and he appeared satisfied.

His parents reported that he did not sleep-walk. Their delight in his scholastic achievement was expressed in an excitement which far outweighed Matthew's vivacity. He managed to achieve second place in the class for the year's work (covering tests and term exams.)

A Willoughby Re-test showed a decrease of eight points which, while demonstrating some improvement, bore out the contention made in the last paragraph. It is possible, however, that, in the short period the new responses had been operating, there had not yet been sufficient reinforcement or habituation to overcome long-learned expectancies of behaviour, and the Re-test does not in fact show the actual amount of improvement it could, and possibly should, measure. A more likely explanation is that he sought to provide the same answers as previously, as the excellence of his memory and probity is important to him.

As reported earlier, two months, after therapy concluded a Willoughby Re-test showed a drop of seventeen points.

Although in my opinion the functioning of this boy's personality is still unduly restricted and should be benefited by working through other anxiety hierarchies, his parents consider he no longer requires psychological help. His symptoms were ameliorated, and he, himself, seems a much happier person, with considerably enhanced self-esteem. He smiled more readily and far more frequently at the end of the series of interviews than he did in the beginning. And he knows that if he feels the need to return he is free to do so - which may prove supportive in itself.

.....

Case 8:

The patient, a girl of 18, referred herself primarily because of the psychosomatic complaint of "blotching" or "blushing". Initially therapy was intended to be based purely on reciprocal inhibition and the learning of assertive responses in an attempt to desensitize her anxieties and condition new behaviour patterns, as well as observe the effects on her psychosomatic complaint. It soon became quite clear, however, that Jennifer required some immediate assistance in her efforts to achieve adulthood as well as in her constant conflict with her mother and the stressful situation in which they lived. What is perhaps best described as a counselling or neo-Rogerian type of therapy was accordingly carried on simultaneously with the desensitization of specific anxieties.

Taking into account the various factors which were operating in this girl's personality and behaviour, as shown by the 16 P.F. and her scores on the Willoughby (see below), I think it is correct to say that the success of therapy with regard to her psychosomatic complaint and some of her general behaviour was due to the reciprocal inhibition programme and abreaction and knowledge (or "insight") gained therefrom.

Jennifer was seen 16 times only, but this covered approximately 28 hours.

The following are the results of the tests administered, all of which were given initially within the first three weeks of therapy;
Willoughby: Initial score - 63. Re-test at conclusion of therapy - 33, a drop of 30 points.

M.M.P.I.: All scores within normal limits.

16 P.F.: On Factor H, Jennifer scored on Sten I (extremely shy), which is in interesting contrast with her score of Sten 7 on factor A, cyclothymia, (warm sociability). This suggests a conflict between a natural desire for social interaction and something which is producing a high degree of shyness, probably her original physical and psychosomatic complaints (reduced under the reciprocal inhibition regime). Anxiety was unduly high (Sten 8) with ergic tension at Sten 7, which would seem to indicate high emotional reactivity. Added to this is a very high Sten 8 on sensitivity. Surgency was at Sten 3, but, like the H score, this was probably influenced by her psychosomatic worries. Her dominance score stood at Sten 4, which is just below average.

Allport-Vernon Scale: Her ratings on this test are as follows: Theoretical - low; Economic - very low; Aesthetic - less than average; Social - very high; Political and Religious - high.

Ego-Structure Scale: This test was completed at the beginning and finish of therapy. No norms are yet available for this test; but the re-testing shows a fall from 2.0 to 1.5 on the Religious Super-ego factor and a rise from 1.0 to 1.5 on the Super-ego (Secular) Factor. There is also a rise from 1.0 to 1.5 on the Aspiration Factor.

The Myers-Briggs test: shows her as being an Introverted-Sensing-Thinking-Perceiving Type, with scores for sensing, perceiving, thinking and introversion in that order.

In addition to her incidental psychosomatic symptom, the learning

disorders from which Jennifer suffered included: distortion in all ego-structure components; abnormal conditioning of drive-traits, viz. anxiety and dependency; operant conditioning relating to her evasion of study and responsibility; abnormal conditioning of affection in regard to family relationships.

As will be seen from the account, in addition to the particular results of the reciprocal inhibition programme, modification in the environment, abreaction, learning by imitation or through the provision of models, modification of her self-ideal and reference systems, and the establishment of new behaviour patterns as the result of advice and self-decision, occurred.

....

This case should perhaps be considered almost as much a study of the growing-pains of, or "becoming" a personality, as a report of therapeutic procedures and results. As the patient's mother was reported to be about my own age, and considered to be "extremely dominating" and always in conflict with her daughter, I adopted as permissive and non-directive a role as possible. The wisdom of such a procedure is arguable, for I suspect(ed) that much time was wasted while the patient sought to indirectly manipulate the therapist, and get out of the required "work" and obtain the maximum pleasure possible in the given situation - a pattern which would appear to be, or have been, habitual with mother and daughter and which, at least, partially stemmed from very considerable frustration. On the other hand it did give the patient opportunity to express all her emotions, (which, from the speed and length of verbalisation - one session lasted three hours, others two - would appear to have been suppressed only with great difficulty) and to permit of immediate abreaction, both of which were experienced as a great need. She frequently spoke at speeds well over 200 w.p.m. disjointedly, but without stammering, and it was impossible to obtain a full verbatim record. However, as a very considerable amount of what she did say was exceedingly repetitious, this was of little account. She also had a habit

of waiting until my pen or pencil was put aside before saying anything really important; on other occasions she gave evidence, by tone or stance, of needing - and sometimes of demanding - my full attention, so that I would put my pencil aside of my own accord.

This constant verbal expression, in conjunction with the warm, accepting, consistent, but gently disciplining "nurturing" situation and relationship I judged her to need, and tried to maintain, in order to first stabilise herself so as to permit of her desensitization therapy and then develop further towards "self-actualisation" or "self-identification", actually brought about the therapeutic situations referred to above where two types of therapy were proceeding side by side. This case shows, I suggest, some of the difficulties and experiences inhering in therapeutic situations where very free verbalisation is sought or used. If I had insisted that she should add to or build a second anxiety-hierarchy it would, I believe, have considerably shortened the length of time required to be spent to overcome the particular anxieties. On the other hand, the very-important question of ability to work to a required schedule could well have been completely buried under the avalanche of anxieties deriving from the mother-daughter relationship. It would have arisen for consideration eventually, but possibly much later rather than sooner.

If I had been a male and not so intimately concerned with the female-image which this girl was learning to disintangle herself from and newly create for herself, I should conceivably have been more concerned only with the anxieties involved and their inhibition or extinction. But in my opinion it was essential that this girl learn about and possibly imitate other patterns as well as those she had already been conditioned to imitate

or respond to. Jennifer was concerned also in learning about mother-daughter and female relationships and problems; not just with her "blotches."

... .

Jennifer J. (aged 18 years 5 months when first seen) came to the London University to see me as the result of hearing through academic sources that I was seeking Subjects in order to investigate the successful use of Behavioural psychotherapeutic techniques. She was under the impression that such an investigation would require only the holiday period, so she was immediately informed that she would be required to come at least once, preferably twice (she signified she could not arrange this) a week for desensitization sessions; the theory and application of Behaviour Therapy then being explained to her. She appeared to have an immediate grasp of both the requirements and possible results, and told me eagerly that she would be only too willing to try, and that she had come principally because of her tendency to "come out in great red blotches." She had been to her own doctor, and he had simply told her she "should control herself."

(On being told that I would first require a medical examination and report, she chose to return to her own doctor, who laconically wrote, "This is to certify that 'Miss Jennifer J.' is in good health and is physically fit.")

Jennifer was a dyed blonde, though with natural blonde colouring and blue eyes; had a good figure and was well dressed. She wore a scarlet overcoat trimmed with white fur, and carried a brief-case. There were patchy red welts on her neck and what I could see of her chest from the v-neckline of her frock - these gradually diminished during the interview. She talked freely and very rapidly when I invited her to tell me her life history in her own words. The verbatim report is as follows:

"I was brought up as an only child with three adults in the house, including my grandmother. I was brought up harder than my sister. At school I found it difficult to mix with other children; I get very sensitive to other people's criticisms.

"In Standard IV I had a girl friend, really my rival all my life. Anything I used to do she did. I was a very bossy class captain, more for teacher's praise than for class mates. I used to be keen on organising group activities; have a club; used to go to them on a Saturday morning.

"In class I worked fairly hard. In secondary school I didn't like having to do the work. In the Fifth Form I had to fall back. In the Sixth Form I was absolutely hopeless. I was a prefect; liked to organise activities.

"Last year I had a marvellous job at Arthur & Martha, dealing with people, meeting people, going down to the ships, generally having to use my own initiative; but found it hard to do things I didn't like doing.

"My problems - still dealing with other people. If I meet somebody on the second occasion, worse. On the third occasion, feel extremely ill at ease, and instead of being quite natural, feel awkward with them for no reason at all.

"My mother calls me completely inarticulate because I never carry on with what I am saying.

"From early times there has always been these nervous rashes. When I'm in a hurry, or a flutter, or something big coming up and don't know what I am going to do; sometimes when I'm tired. I'm often tired - can't be bothered doing anything.

"I went to Dr. Blank. He said there was nothing wrong. I should control

myself.

"Then I took a course of four Yoga lessons. Found them marvellous. But I still get the blotches."

(There followed a pause, so I queried if her grandmother still lived with the family.)

"No, she only lived with us for five years. She lives about a mile up the valley. At one stage I hated her and rejected her. But now I worry about her. She's old, though she's still active. She's about 73 now. I went crook at mother about her being on her own.

"In childhood I was very homesick. I used to go away for a weekend with the Life Brigade and whenever the family turned off, there'd be floods of wet tears from me. I was only away for two days too. I used to go out at nights and baby-sit; or they might be going to a ball, when they were driving off in the car, I'd suddenly start to cry.

"My sister, when she gets frustrated she does things which I recognised in my own behaviour, early.

"I accept mother's disipline; get in bed-room, never express myself, read or do something for a while and then come out. My mother and I get on too well. We talk too much and never get things done. We get on each other's nerves; it always affects me till I do agree. It annoys me that I rely on her so much. I work myself, and do the best, when I have had an argument with mother.

"Father. I get on very well with him. He's the ruling hand. I notice that if there is any major issue that has to be decided about me, the two are inclined to disagree, which is a pity; but my father generally has the last hand. I agree with him; my mother's reasoning is just

generally because it annoys me. I don't agree with the way my mother thinks. When my mother went into the hospital for a week and we weren't sure when she was coming home because of my sister, it never worried me, about if she came home or never came home. When I was eleven. My father was very hurt.

"I think mother and father are happily married. I realise how lucky I am about it.

"I've got interested in Bible Class lately. My mother helps quite a bit. She's interested in art work. We both like organising and yet we are both hopeless at it. Mum did practically everything for me. My bed - was still making it when I was ten. I never had to.

"As for work it's a case of drilling things into me and writing a programme that I have to follow strictly. Not sufficiently self-displinary. I'm more worried about the kids given jobs to do not doing their part - if we talk I get sick of it; I'd sooner do it myself.

Q. Which Church?

"Protestant. They're both religious. (Parents I assume?) I gave up tramping which I loved for it; being too enthusiastic over it. I'm all eager then I am fedup because I can tell them what to do better than they know. I think I'm enthusiastic; but I'm sure I can do the work.

Q. Do you feel good when you've actually achieved something?

"Oh yes."

Q. Tell me more about your sister. "My feelings towards her are rather negative. I wonder what would I feel if she were hurt or killed, I don't know. As far as I can tell I don't feel very much for her at all. We fight, which is ridiculous. I was never allowed to touch her, hit her in any way. I feel sorry for her sometimes because of her discipline, because

I can feel what she feels - in odd moments she gets frustrated. People say she is spoiled, no reason if she got what she wanted, far from it, but she's made centre of attention quite often. I think I may have been too.

"One nightmare I had when my sister was about 18 months old, I had crawled underneath my sister's cot, then tried to stand up. I cringed back and wouldn't come out. I had to get the cot up and come out from under; I was white and shaking, but I couldn't. But I always wanted a baby sister - I think I was annoyed because I wasn't doing what I liked for her. I wasn't allowed to pick her up - I went rushing through when she cried. When she got to two and about that annoying stage I used to take her for walks; I found her more annoying at that stage than now. She was born two days before my eleventh birthday. It was one of the best parties I had, I was very pleased and loved it."

Q. Don't you think your mother is bringing her up properly?

"No, for one thing her discipline is inconsistent."

Q. What about illness? "Oh, just the usual childhood complaints; I only had chickenpox two years ago.

"I fear to cry. I had a boy-friend. He annoyed me - I willed myself to cry, but when he came back I was giggling. But later in the evening when he made a comment about the colour of my dress, a flood of tears came out.

"I have cried more this year, for no reason at all - mostly through my mother when she used to have me on a bit. Something I was going to; she just kept on; usually I would just throw it back. Finally I went out of the room into the bedroom. I got annoyed, and went to break down completely, which is unusual.

Q. What about boyfriends?

"I've had them from about the Fifth or Sixth Form - always been a terrible crisis in myself. Usually I don't want to go out more than two months and the boys always like to be tied I think, and after two months you want to break it off. The next two months you get annoyed; two months later you break it. It always goes about that. Haven't been going seriously with a boy for about two months now. I have a boy about 23 who I thought wasn't ready to be settled, but he was, which annoyed me, because he could understand my point of view much more than chaps of my own age. He comes out to my own place; went to a ball and I pretended to be very airy-fairy. I liked it very much and in three years' time I might be prepared to settle down. I'm still pretty sure of what he feels. I enjoy his company very much; it annoys me that he got serious and spoilt the relationship."

Q. Any sex relations?

"I've never been particularly interested, and in fact rejected any suggestion of it. Felt, Oh I don't know. Sometimes wanted to and afterwards I've been disgusted. I would never go very far; but these last few months it's been quite - it has the most horrible effect. Since I've broken off with him, no prolonged petting. We never had intercourse. Sometimes I'm inclined to challenge him to see how far he will go. He said he never could with me now, he knows my attitude .....

"My first love. Always when I'm at a loose end he crops up. If I know I am going to be on a train I try to arrange an accidental meeting. I went out with him for about three months and then lost interest in him; the next three months were complete agony. Strangely, about six months later

I began to be interested in him again; then later he rang up. The following night was the last I heard of him. I was annoyed at him at the time, probably because he took this girl home. Same feeling cropping up again. Same age as I am; Mother advised me that if I did go out with him .... he's in an office doing book work.

"Most of the boys I know are rather drippy, too full of their own opinion. They are around 18 - 25, no 18 - 20.

"Mother did tell me about sex but I'd placed it aside until one night a kiss made me want to sink. One boy I thought wouldn't want to kiss a lot - I used to dread parking for some reason, and then we'd get fairly tooled up. Got this habit, but I got tired of him. My attitude towards boys - wish they wouldn't get serious.

"I've always said I would never have children of my own; I would adopt them all. I'm afraid of childbirth. With Richard I would have long discussions about it. He was quite upset about it.

"I'm happiest when I'm in a pair of jeans or out playing sport. I quite like getting dressed up for a ball - but I feel more self-conscious when I'm dressed up.

"I've never been actually proposed to. I don't call myself intellectually-minded.

"I was born with webbed feet and fingers - my fingers were operated on - fairly successfully. I suppose I should exercise this one (showed me bent finger which she was trying to hide) but I don't. My girl friend can remember me crying (which is unusual) because the teacher had asked me to take my shoes off and I refused. Now I bury my toes in the sand if possible; if possible I always cover them. I don't think it would affect me in

relation to going to bed. I used to like the first boy because he never mentioned it. He saw, but he never mentioned it.

"I'm frightened of animals a bit; any sort of dog growling up behind my ankles.

"I'd like a career best."

The interview was terminated with my asking her to prepare a list of anxiety-provoking situations.

It will be seen from the foregoing that Jennifer had already touched upon a number of her immediate problems: boy-friends, sex; self-consciousness about her appearance. She showed considerable insight at all times - but insight without control or adequate motivation and goals for change or development is more likely to be a burden than an asset. She was constantly judging her own behaviour as well as that of others, but she was able to do nothing about it.

2nd Interview:

On the second occasion I saw Jennifer she verbalised over a considerable period about a "money-making" dance she was busy arranging for the Bible Class. The arranging of this dance created much turmoil and conflict - between Jennifer and the rest of the committee; between Jennifer and her mother, and in Jennifer herself. Some part of each session until the dance was actually held was given over to verbalisation about her fears that the others wouldn't do the work, or anger because they didn't; fear that she might be trying to be dominating, concern that it might be a failure and she might have failed to persuade or manage the others; and conflict with her mother who "was always changing her mind" and "trying to get Jennifer to change hers, and becoming annoyed when she did." According

to Jennifer's constant report, one moment the mother would be upbraiding her about the work she was doing in connection with the dance; the next she was being growled at because she wasn't doing it. Also spread over the interviews was Jennifer's constant reiteration that her mother would show her annoyance by "banging things around" and not speaking to her. At its worst, the mother did not seem to speak to her for several days on end; which caused Jennifer to become even more highly anxious and disturbed.

But one of the most crucial points of conflict was Jennifer's hair. On the second occasion she appeared with it a much darker shade. She mentioned it somewhat hesitantly; I told her I thought it looked very pretty and said I preferred it that shade to being "brassy" (which it had not been but I had the impression this was how she felt about it). This comment broke her verbal control. She absolutely poured out a spate of words. She herself wanted to wear her hair its natural shade of brown; mother always wanted it blonde. Twice more Jennifer was to darken it and twice more her mother was to respond by buying her the necessary blonde rinse or colouring fluid; whereupon Jennifer, apparently protesting, would "give in" and then be extremely annoyed with herself for "permitting herself to be dominated so."

She was quite sure that her mother was doing it because she honestly believed it best for her, and, no matter how hard she tried, her mother could neither agree with her nor let her have her own way. Just before the final interview Jennifer in desperation had her hair professionally reduced to its original colour and charged it to her mother's account because she had insufficient money herself.

During this second interview the blotches came and went on her

neck, though they did not appear as severe as during the first session. She discussed various specific occasions on which this "blushing" (as it was called throughout the sessions) occurred. She also stated that it used to arise every time before she went out to a dance or a party, or with a different boy. She thought it had begun to get bad about two years previously but could never pinpoint a particular occasion. Now it was at its worst when she got wherever she was going and was talking. Probing brought to light the fact that she thought it happened usually when she was with people she didn't know though this did not appear to be borne out by other reports she gave me. It also seemed to occur on occasions where there seemed no reason for any anxiety and particularly when she was hot.

The anxiety hierarchy she produced is as follows:

"Afraid of:

1. Seeing an accident
2. People who are in pain.
3. The dark in general - known or unknown places.
4. People who have a disability.
5. Being alone with men I don't know in a deserted area."

Later she added:

6. "Afraid of getting up on stage or speaking in public."

She was then given instructions in the technique of relaxation, before the session terminated.

Third Session:

Jennifer's entrance was heralded with the announcement that Richard was "out". They were "finished." She then turned to a discussion

of pre-marital intercourse. Where I deemed it suitable and/or helpful I fed her back her own statements in the manner of the Rogerian school; on other occasions I gave her whatever other information or argument seemed cogent. For example, the mechanics of selective perception were explained to her. Essentially she was trying to argue with herself the pros and cons of the argument in favour of pre-marital intercourse, about which she heard much talk among students. After much verbalisation on her part, Jennifer finally decided that pre-marital intercourse would probably be a good thing if it weren't for the risk of having a child.

Associating from this apparently, she went on to state that her mother hadn't spoken to her for four days recently over her hair, the dance and her boyfriends. Sometimes she "felt like telling her to grow up." She herself had finally got "so worked up" she had started to cry.

From this she swung back to the fact that she "couldn't get married for years yet anyway"- she intended to teach for some years. She was promptly warned of the dangers of flying into marriage simply to escape an unpleasant family situation - that this would create more, not lessen, her problems.

She was then asked for associations to her "list of things of which she was afraid" as she called it. The only association she could offer was with regard to the fear of seeing people with a disability. A cousin who is palsied had come towards her on one occasion "swaying as he walked, and looking as though he were drunk." On several occasions she had had a nightmare in which she would be coming down a street and a man with one leg would follow her; or "a man with a wooden leg comes tapping, tapping towards me on railway stations." No link between these two events, or the

experience underlying the nightmare was ever recovered during the interviews; but desensitization of this fear was apparently achieved by reciprocal inhibition. She was asked what she thought the man and his wooden leg symbolized and replied, "It's very vague, nothing but that there is something wrong with somebody and I am very sensitive to something being wrong with somebody." This would appear to point to some event connected with her webbed feet or fingers or the operation she underwent in that connection.

She concluded the interview with a comment about her social activities, saying that she could never tell a boy when she didn't want to go out with him. "I can't tell the truth; instead of telling the truth I lie about that; say I am going visiting or something." She was told that here was an excellent opportunity to practise her assertive responses, she should be courteous and friendly, but firm in stating that she wished to carry on whatever activity she planned. No blotching was observed, and unless stated otherwise this was the case from thenceforth.

Fourth session:

Jennifer usually started the sessions with a preamble about the boys with whom she had been out with or met in the previous week. On this occasion she gave me a warm report of one of the boys mixed up with her Bible Class activities, concluding that, "After Richard, who was so self-conscious it's nice to have someone at ease." It became clear over the ensuing sessions that Jennifer realised she, too, was more at ease when no-one was pressing her for intimacies she didn't want to give ("I just don't know how to say 'No'. I worry about how they must feel too. I don't want to hurt their feelings.") or about which she had mixed feelings

herself. Richard was several years older than the majority of the other boys she met, and apparently the one to "put most pressure on."

She reported that she had been practising her assertive responses, but she was all right only until someone replied assertively. As was her wont she immediately began to introspect and blame herself. "Maybe I really want to show them something; maybe I'm trying to show them where I stand in relation to them." She was told that no harm lay in that; she should try to state clearly how she felt and why. She did not need to become aggressive and hurt others' feelings, merely assert herself. It was possible that she might overdo things now and then for a start, but this would tend to correct itself.

There had been further conflict at home. Her mother "was on a diet and scratchy, and she thinks I should be too." (Mother went on and off her diet for the next few months; frequently insisting that Jennifer should diet too, and hiding the cake tins so she could not "get at them"). Jennifer thought she should be on a diet herself (which did not look necessary) but resented her mother trying to force her to. The hair question was still a vexed one; Jennifer maintaining that she felt more comfortable with less blonded hair - she did not "have to live up to something I'm not."

Jennifer had endeavoured to "assert herself" with her mother on two occasions during the week, once when her mother had criticised a girl for marrying an Indian, and once over the proposed Bible Class dance.
I gained the impression, which remained constant, that the mother was highly emotional, irrational and vacillating, while Jennifer, though more rational and possibly more intelligent, was equally emotional and vacillating, and constantly being overwhelmed by the welter of confusion and argument deriving from her need for adulthood and independence in conflict both

with her mother's needs or wishes, and her own maladaptive childish habits of response and action as well as her ambivalent attitude towards her mother. On the night in question the mother's recriminations became so violent Jennifer had retreated to her bedroom and was still there crying half-an-hour later when her father had actually gone in to try to calm her, and finally her mother had apologised to her.

I suggested that perhaps her mother had problems too. Jennifer admitted that perhaps she had - "she had always wanted to paint and things but Dad pooh-poohed it." "Now she's 42, and let herself go. But she's always been interested in higher development. She's marvellous with my girl friends - they talk to her. Possibly she does them a lot of good."

She went on to compare her mother with herself - they were both rather alike, both completely disorganized. This was followed by a further flood of complaints about her mother's demands on her - "bleach my hair," "find a nice boy," "drop my organisation of Bible Class work - and I only started in the first place because of her, and she wanted it," "go on a diet", "get good marks in school work and a good place in class; and then straight afterwards she wants me to go and use up the pieces of dress material I haven't sewn", "finish jobs I haven't finished at home; do something else."

In response to my query as to whether her mother wanted her to get married, she replied that her mother would "like me to have my future settled." And added that sometimes she thought it would be "nice to get things settled, not get married for a few years, but find a boy and get that settled and over and done with." It was pointed out to her that she might really find it preferable to "play the field" and in the meantime concentrate

more upon making sure of the career she said she wanted; that, if she did meet someone she wanted to marry, well and good, but that, once she had her qualifications, she was sure of a career now, or compatible work when any children were grown up. She agreed with this and then bewailed the fact that she was very much behind with her work - she was hopelessly behind with her assignments. She would set herself timetables, but she was always last in the class with her assignments.

It was pointed out to her that she would be responsible for keeping her work-books up to date when she was teaching, and I asked if she really wanted to teach. She "wasn't sure; had originally hoped to be a physical culturist, but had changed her mind; thought she'd like to try work with backward or problem children." It was again pointed out to her that she would have an even heavier responsibility then for keeping everything up to date. Her reply was that she "liked responsibility, liked to be responsible." I pointed out that being so far behind in her work could lead to her teachers thinking her irresponsible, and that even now she had a responsibility to the tax-payer. The following week she informed me that she had gone to bed early and got up at 10 o'clock and worked until three or four and got all her work in. This was said with a peculiar grimace; the impression I received was that mentally she was "cocking a snook" at me.

We finally reached a point where she was able to try to practice relaxation and desensitization of the least fearful of her anxieties. Not surprisingly, she was unable to hold the relaxation for more than three seconds the first time; but after four attempts she held it for ten seconds. We found that the best procedure was for me to suggest a scene -

"there is an accident at the corner of the street, you are some distance away, but you can see the broken glass and hear the sirens. Now you are coming closer, and can see the blood." I would stop and she would then build up her own image, altering the details, such as the distance she was away from the hurt person, the loudness of people screaming, and so on, until she could imagine standing up close to the hurt person and helping them, or whatever was appropriate to the particular fear we were working on.

We spoke again of her fingers, and I pointed out that if she didn't exercise her finger, she should at least not try to hide it; in fact in general she should just accept herself as she was, a very pretty girl who, like 99 percent of all human beings, had some unimportant imperfection.

She promised to continue practising her assertive responses.

Fifth Session:

On this occasion Jennifer was very pleased with herself because she had spoken up in class where previously she would have feared to do so. The question of religious instruction in schools had been under discussion and she had felt that those who claimed to be Christians should have something to say. She had had her say, and finally 24 out of more than 50 had said something.

She said she had also done more organising of the dance and also more school work. She was enjoying life more in general; but the previous night she had tried to talk quietly to her mother about her problems. Her mother had failed to understand and she had given up. Frequently if she tries to talk to her mother she makes Jennifer feel ridiculous - or makes her laugh at something which is really nothing; after which Jennifer feels

annoyed again. Jennifer felt that her mother always influenced her in this way so that she could never stand up for herself properly. It often made her self-conscious. When asked what effect she thought this had, Jennifer replied that her mother had never made her feel ashamed in front of anyone, just self-conscious. She "did it with effect and gets upset when I get upset." "When she upsets me she is upset; I think it's almost crawling. That's when I get mad with her; she's not doing it to comfort me but to ease her own conscience." Recently her mother had actually caused her to cry in front of her cousin, and later her mother had told her the cousin had said, "If you ever make Jennifer cry again you'll hear all about it."..... "But when we are on the best of terms we are more like sisters until we go from one extreme to the other and we don't talk to each other." Jennifer had tried to be accepted by Croydon Teachers' College but there had been no vacancies. "If I were away I wouldn't have to ask her opinion all the time and do what she says; I could stand on my own feet and be independent."

As she sometimes stayed the night with some friends at their flat (she herself lives in a very distant suburb) I asked if she had considered trying to share it with them. She admitted that she had, but she couldn't until the Bible Class dance was over at least, even if her parents would let her. I gave the opinion that it would be best for both her mother and herself if she could find a suitable place to live elsewhere than at home.

She then gave me some additional historical material:

She had not menstruated until she was about 16½-17; but she "did not think this could have upset her because her mother kept on worrying about it." She had started and then nothing happened for three months; but everything

was normal now. It is possible that the dating of the blotches "getting worse about two years ago" may coincide with this; but Jennifer thinks she had them when she went to Third Form dances six years ago when she was 12.

Her earliest memory she thought "had to do with barley sugar; something related to the operations to her hands when she was about 18 months or two years of age; associated with things unpleasant; big white houses like the private home where I had the operation." Another very early memory was of an instance when she had been locked in her room. "And I used the potty - couldn't have been very old - and yelled out to my mother to let me out. She wouldn't come and so I chucked it out the window and then realized what I had done and was thoroughly fearful. I can't remember mother's reaction afterwards." She laughed at this memory, particularly at her mother's surprise. (These memories are most enlightening. In the first, we see a conditioning of anxiety and pain at a very early age, associated with some inhibition of, or at least an attempt to inhibit, this response with sweet food (which she uses now to offset anxiety). The second memory would point to high emotionality, low frustration tolerance and lack of socialisation or ego control; and very likely to counter-aggression from mother thereby leading to conditioning of further anxiety and hostility; there is also an element of pleasure at revenge against mother; all patterns which can be seen operating in the current situations.)

When asked if she ever fantasied killing someone who had greatly offended her, when she was a child, she replied: "I don't think I ever wanted to kill them, just wanted something to happen to them that they would be sorry about; something that would make them sorry for what they had done. Somehow get my own back, revenge more in terms of running away and making them feel guilty."

"them" evidently referred to her parents. I asked about the sister. "No, not my sister. I wished a girl friend would be dead (think I would be too scared to actively want to do that), which lasted over a long period of time. We were great rivals, now we only speak to each other when we have to. We are very much the same type. She has an extremely forceful type of personality which I enjoy; she can get anyone to do anything for her, even I do. But I dislike her because she's so ruthless with it and hard, but people don't realise that. She's the one I wanted out of the way." (Later Jennifer gave evidence that she considered herself as wanting to be too dominant and didn't think it a "good" trait.)

In reply to a query regarding masturbation, she replied that she "remembered mother talking about a little girl friend of mine bouncing on a rubber ball with her stomach and my mother was horrified and disgusted. I understood what mother meant at the time and what the little girl was doing and getting satisfaction from". (The inference is that she herself had probably masturbated; but she did not answer the question.)

She had first indulged in sex play when she was about 9, in Standard III or IV, about ten. "There was a bad boy I used to play with. Then he took me into this little shed, and made me feel his and did likewise to mine. That time, about that age, I had some childhood complaint, and was feeling most terribly worried in case he caught it, and told him to wash his hands afterwards, and I remember thinking 'this is funny', and I didn't like it. Another time about the same age, ten, I went to get a ball and a boy told me to lie down and I lay down - in fact I think he was lying still in the grass, and I felt something pressing into me and he started whispering and he asked if it hurt. I hadn't a clue what he was doing. I should say he

might have been a bit ignorant - often wondered what happened to him. The last boy came from very respectable parents. I did tell mother but much later on when something came up, and she said she could remember it and I came in looking very upset. She couldn't have questioned me though. Think I confided it to a girl friend, so when I learned it was common I had enough courage to tell mother."

I asked how terrified she had been. "I think it wasn't terrifying, I just couldn't understand it. When I was 14 or over I used to get picked up by pick-ups and thought it was marvellous; but anything of that nature, the rubbing of the skin had to stop. I wouldn't like it with a strange boy now, or even with someone not strange, such as Mark and Luke - I don't like any delayed petting."

"We do go straight home, but it's when we get there. I just can't ask them to leave the house. I feel mean. It's so many miles out to our place. You can't stop them from doing it. Well, I generally do.

"With Richard it would be queer. I would feel guilty, and I'd think it might hurt his ego; I wouldn't like it to be me, and after all he's been good to me. I suppose, unless I really detest a boy and he doesn't deserve anything at all, I would kiss him goodnight as a matter of courtesy. But if I'm keen on him and don't want to show it, I won't kiss him goodnight."

Then followed a long monologue about petting and just how girls should handle the situation, with a further reiteration that she felt obliged to let her escorts do some petting "out of courtesy" for coming so far. I asked if she would consider she had the right to handle the boy's penis if by some chance she should drive him home out of helpfulness or courtesy. She replied indignantly, "Certainly not." It was therefore pointed out that none of her escorts had any rights either; than in our society it was

expected that a boy should escort the girl home, and that she was the only person who had any rights over her body. It was suggested that she might be making excuses for her own desires and the urgency of her own sex drive; and she was told that it was imperative that she should reach some decision about her own attitudes in the matter, and stick to it. She was also told to practice her assertive responses on the boys who wanted more than she was prepared to give.

She then informed me that she was practising reciprocal inhibition at home, particularly in connection with getting up on the stage and facing a crowd. She was very concerned about the forthcoming dance which was almost here (and about which I heard practically every large and small detail as preparations continued). It was suggested that if she were so scared she felt her new responses were not yet sufficiently habitual, she should preferably imagine the people in the hall as being simply kind, well-disposed people, but failing this to think of them as loved teddy-bears or even gollywogs, about whom there was absolutely nothing to be scared.

She complained once more about her study being behind. I asked how important this Bible Class business really was. She replied, "My views on Christianity are very outlandish - I don't believe in life hereafter and pleasing God; to me it's just a way of life to follow and be sure you are doing some good around the place. What I am worried about is becoming apathetic about the things that concern me. I know I'm using more time than I should be; I suppose it's because I am trying to show my mother what I can do - she didn't want me to go to College in the first place." It was suggested she should seek to clarify her own wishes as regards the actual career she wanted and to make that a deliberate goal.

After this we again practised desensitization, this time working on her fear of "people who are in pain." Although it is listed as being second lowest in the hierarchy, the anxiety which was generated in connection with the imagined situation was so great that she first tried to manipulate the situation so that she did not have to practice desensitization during the session, and then played tricks on herself, and me.

She had wanted me to suggest the picture she was to imagine, so I suggested that she was in a hospital, approaching the ward, entering it and walking down the ward to a bed where there was someone in pain. She had, of course, to stop her imagining the moment there was the slightest fall in her relaxation level. On the first occasion we tried the very thought of beginning to imagine the series of events described was sufficient to interfere with her relaxation. Two sessions later she was completely relaxed, I suggested that she was just at the door. An instant later she burst out laughing, and, opening her eyes, told me that she "was hiding around the door." Following this she discovered posts in the ward and hid behind the post just inside the door. It was quite an extraordinary experience. Sometimes she would manage to get "two posts down the ward" and then she would report she was headed back for the door, and we had to start afresh. She now began to associate to the feared or disliked stimulus; and indeed her associations reflected a considerable measure of resentment as well as (and the whole story was only gained over several sessions) anxiety. It appears that her grandmother used to visit a hospital for the aged and take Jennifer with her to entertain the sick people. Jennifer was learning ballet at the time. Her grandmother tripped going down the ward and broke her arm, and both grandmother and little girl were very upset. She had a

big black bruise on her arm, and the dislocation gave her great pain. Jennifer thought that in the hospital she had constantly had the feeling she was going to trip and she realised that people were watching her. "When I used to walk up that Ward, I used to be conscious of the old ladies watching me. I would be concentrating on something that, not tripping over, in order to get up there."

"On another occasion someone had been crying with pain. She had felt horribly confused and didn't want to stay there any more. She always used to be afraid of going back in case she saw them crying. It wasn't long after that that her uncle was killed and she saw her mother cry for the first time; then her grandmother had a faint and had her house burned down, so she was very upset altogether. She used to be taken back to the hospital to dance - had "felt she ought to go back but used to hate it." She finally used to go about once every four months until she was about eleven."

(Considerably more was to be added to the list of stimuli which had conditioned her to fear hospitals. See pp.577-8).

Jennifer said she used to feel she should do something, then would do something for somebody; and after a while she would find she was being taken advantage of, and didn't like that.

During the course of the interviews Jennifer had been completing a number of tests (see above). She had also suggested to her parents that they might care to complete the 16 P.F. and the Myers-Briggs Tests, too, but they declined.

At the Sixth interview we took an E.E.G. record of Jennifer's cerebral activity, (normal). I suggested it might be easy to obtain contact

as she was blonde, but she instantly denied this, saying she was really a brownette, her hair was still not its natural colour though she had had it darkened somewhat.

She did not "blush" once during the entire two-hour interview, even when others were present during the E.E.G. recording, and told me that that day she had walked from the Underground with a boy who had previously always made her "blush" whenever she spoke to him. Nor had she gone "blotchy" at the dance.

The Bible Class dance had fortunately "gone off with a bang." It had been a success, possibly the most successful held in the district and Jennifer had even managed to get up on the stage and speak without any nervousness. Life, temporarily at least, was wonderful.

Jennifer was still interested in the eventual possibility of teaching in a problem children class and spent some time telling me about some of the children she had seen and who had badly needed help. There was some discrepancy between her expressed views about these children and her usual demand for discipline of children, particularly of her sister, who annoyed her more than somewhat, and this was pointed out to her. There was a general discussion about reward and punishment in the learning situation.

Once more we returned to the fact that Jennifer "just could not get her work done in time"; she was "hopelessly disorganized", etc. Some 45 minutes was spent exploring the possible causes for, and plans she could adopt to help her overcome, her decidedly maladaptive work habits. It is quite obvious that in this respect Jennifer's mother presents a hopelessly inadequate model; Jennifer herself has undoubtedly learned to imitate the parent's haphazard methods and vacillation. At the same time the conditioning

of this habit from this source would appear insufficient to account for the ambivalent avoidance-approach behaviour Jennifer seemed to adopt. She thought "she had just worked in the past to please her teacher" - this was said in a very derogatory manner. I pointed out that we all work to please somebody; in pleasing ourselves we are frequently pleasing the models of the parents which we have introjected. She should, therefore, not feel ashamed because she sought to please her teacher. She thereupon informed me that her mother and the mother of her girl-friend had been in competition with each other and pushed the children on to compete with each other. Again it was pointed out that in our society to compete effectively (and, in some cases, to lose gracefully) is regarded as of moral value - did she consider it wrong? She thought she did, but without competition work was sometimes difficult. "It was the principle of the thing that bothered her." It was suggested that, if this were so, perhaps she should consider the moral worth of working at her full capacity or not doing so. She still appeared to be searching for excuses, so she was told that there is a theory which suggests that sometimes we punish ourselves and accordingly deliberately or incidentally prevent ourselves from succeeding in some particular field. She promptly recalled that when she was about seven her mother used to stand over her in order to try and make her do her homework. "I can remember sitting through football time resisting my mother's suggestion. I couldn't take instructions; I couldn't take advice. I think it was the case of being an only child and not getting disciplined always. It meant Mum's letting me do something meantime and then the rest later."

After further desensitization practice she left.

The following week (Seventh Session) she told me she had gone home and brought her work up to date. At this time the underlying tension, which had however been barely mentioned previously, between herself and her sister erupted. She had actually given Constance a "hiding". According to Jennifer Connie would continually wear her clothes to play in; Jennifer had set certain things aside which Connie could use, other things she was forbidden to touch. But not only did she touch, she sometimes wore, and sometimes broke Jennifer's good things, including her good shoes. The parents were said to let Connie have her own way whereas Jennifer was always supposed to be responsible and always to blame. I suggested she lock her door, but this evidently could not be done. The problem of discipline was discussed, Jennifer being highly punitive in her general outlook. It was suggested that she should do some reading about, and give considerable thought, to the function of reward and punishment, particularly in relation to her work as teacher.

She turned again to the "approach-avoidance" behaviour of her mother, who when asked if she (Jennifer) could do something "would start off saying, "Yes", then become indecisive, hesitate and then she would say "No", and then finally I could." "But when she did things for me I always used to feel guilty and think I wasn't showing my appreciation."

Her obsessional thinking with regard to her mother having returned I now broke the sequence of thought (a form of negative conditioning which was always used when no new material seemed to be adduced and I judged that she was merely becoming over-repetitious - or trying to get out of "work" in connection with the inhibition or extinction of her fears) and consideration was given to her fear of the dark.

She said that she "was just afraid of the dark in general, of the unknown, dark shapes, wondering what was in a car, men." On the other hand she had "always thought myself of going along the bedroom floor and not being afraid, or there being a thief and I was always going to throw him out. I have often imagined myself and knowing something going to happen and I can't do anything about it; the scream of tyres." (This would appear to have some relation to her fear of seeing an accident or people who are in pain, but was not seen as such; indeed all her specific fears are related and the generalisation of fear from one to the other situation must have provided constant feedback and reinforcement. And all have undoubtedly some sexual component but an even earlier basis. Indeed she continued here:)

"Even before knowing of such things as men raping, I couldn't walk from a lighted room into a dark room. I've always had a natural fear of seeing live shadows. If the wind drops during the night - and to this day I'll swear I was asleep when I saw a tiny materialised ghost and a whole lot of little people walking along my windowsill early in the morning, I can see the windowsill with uprights. It was before Connie was born, when I was about eight. And I used to feel someone was watching me from the door, always somebody watching me from the doorway. Just lately I've had the same feeling and my tongue gets too big for my mouth and everything seems to get blocked and everything echoes before I am going to sleep. As a child I used to get the same result with my ear on the pillow and it would magnify itself into something coming down the road and suddenly I would be in a big room and the tapping, tapping of a wooden leg. It came up before I had to give a speech to the church and the ... it was quite regular."

Questioning revealed that "just lately" actually referred to a time before she had commenced working with me. This was the first occasion on which she had referred to much of the material given here; but once again she could give no association to the "tapping of the wooden leg", nor was this ever recovered during the sessions. It might be logical to hypothesise that this probably relates to her experiences in the orthopaedic hospital, both as in- and out-patient, but this was at first my own assumption because her expression and verbalisations here always brought to mind my own experience of "going under" chloroform. So does our own conditioning affect our judgments! She did realise later, that she consistently muddled the house where the operation occurred with another one, but why, or what the link was, again unfortunately was not recovered.

She was then asked, "These little people - tell me about them."

"Oh, they were humans, no wings, leprechauns. My grandmother is firmly convinced that there are leprechauns and fairies, same sort of difference as between religion and science, between fairies and fact."

I asked "Do you believe in them?"

She hesitated obviously before replying, "Nooo! I don't suppose I do really, I just wish."

She could, or would, add nothing further to this, so she was asked if she were afraid of death. To this she replied, "No death doesn't frighten me in the slightest. It's more the form of killing insects and what of dead people. Myself dying doesn't bother me."

The following session (Eighth) she reversed her stand, and insisted she did believe in fairies. This lass is undoubtedly imaginative, an only

child in her own dream-world for many years, with considerable conditioning to (and reinforcement of) superstitious beliefs, whether in the form of fairies or more orthodox religious teachings. She later told me she "had tossed out the idea of hell" but was still concerned with what happened to dead people. Bearing in mind her religious-minded family, she was told to read biology, genetics and evolutionary theory and come to her own conclusion. It seemed much wiser to let her reach her own philosophical formulations in her own good time rather than help at this point to create yet another serious point of conflict with her family. As was born out by the Myers-Briggs Test, she also likes to make judgments - a few more facts she herself found could only reinforce her final conclusion. When, however, she wondered about my beliefs, I told her to go and look at a tree; there were many trees in its own background; it would live many years, giving shade and pleasure to people, and die down, and probably one of its own seeds would take its place. The analogy was a rough one, but we could see the tree from the window.

And so we finally reached the point of relaxation and the gradual desensitization of her fear of the dark, which, along with her other fears, she claimed to have been extinguished - at least to the point where she could freely imagine such situations at will - during the following sessions.

At the Ninth session she beamingly announced that her relationship with her mother was much improved, and everything at home was "good." She "had been thinking about her mother's problems and realised she had many." The relationship with her sister, however, had again deteriorated. If Jennifer remonstrated, or in desperation tried to push Connie out of her room, Connie would "go squalling, louder and louder the closer she gets to Mum,"

who promptly sided with Connie. It was "always Connie's word against mine - so that it looks as though they gang up on me."

However, she "had made a programme of home work and got some of it up to date". There followed a report of all her social activities. She had even refused to go out except to the pictures one night because she wanted to do her homework. She was praised (as always on such reports) for her use of her assertive responses and for her more responsible behaviour in regard to her study.

The only thing to mar the picture was that, for the first time for about six weeks, she had "coloured up" badly on the Saturday night before she "went out". So far as she could tell this was, however, due to the effects of heat and cold. "Sometimes when it's hot and I eat; it comes up as it did on Saturday night". She claimed there were no anxiety-producing causes (this was a denial of the facts - later she admitted she had gone to a party given by the ex-girl-friend of the boy who escorted her and she had been concerned about what the girl might think of her.) and added that "I didn't mind about it so much, though, as I used to do; in fact I forgot all about it."

She then turned the conversation to tell me about some activity she proposed to undertake in connection with raising funds for charitable work with children; such work appeals to her very much. This led to a discussion of marriage and family life and finally to the statement, "Now I'd be afraid not to get married. I'm afraid of being an old maid; all the school-teachers who are old maids seem to be somewhat cynical and sarcastic. I think the ideal situation would be to get married and hope that your husband would be killed somewhere or other to say that you had been married,

experienced sexual life and have no more ties." A query about this statement brought the information that "this is what we used to say at school." She added, "I always remember my mother's comment, 'fancy having to go through it all your life for no reason at all and not being able to have children'." Whether this comment referred to menstruation or sexual relations remained unclear, for Jennifer immediately expanded some earlier communication, saying "Mum wants to be an artist really, but she wants everybody's approval. Dad calls it "bloody nonsense" so she wouldn't have anything more to do with it. She draws or paints and Dad pulls them to pieces and she just doesn't get any satisfaction. On another occasion she was determined she was going to illustrate some Bible Class leaflets; first she had a set-back and said she wouldn't use her own design; when she did do them she was furious and disappointed because there weren't enough people to see them." Jennifer agreed that her mother is, in many ways, a disappointed and frustrated woman, but that she brings much of this upon herself.

Before practising her desensitization exercises, Jennifer advised that she had been told at home that when she was very small she had been very upset because a kitten had disappeared into the room, while on one occasion when she was in Middlesex Hospital she had had to get out of her bed for someone who had had an accident.

After the desensitization practice she poured out at great speed and somewhat incoherently that she "remembered someone calling the doctor to get to the hospital, a man was very ill. Friends and relatives pouring into the waiting room, some crying, some shaking; some child. This went on for about three hours, and there were these red dripping towels.

Happened years ago, still the same now. Went down at 6 o'clock still waiting to be attended to at ten, had to wait for X-ray man until he went down. I was always frightened of the unknown, and going into dark rooms and having things pushed at me. X-rays, things on their sides. Being pushed off and having revolting tasting mouth washes. Coming back and being put to sleep and stitched up. And your eye twiggles. And in Standard I, I was absolutely terrified because they put a gas mask over me to take my teeth out."

There appears to have been quite a massive abreaction here of what appears to be a coalescence of several experiences which had occurred in the Hospital. Following this she claimed to be desensitized, at least to the images, developed in relation to Anxieties 1-4.

The following session (Tenth), Jennifer's hair was more blonde again. Her mother had bought her some hair-blonding preparation, and finally she had "given in again" but didn't like, and was definitely not going to use, it again. I told her mildly that "I was afraid my taste didn't coincide with her mother's." She said, with what sounded like relief, "Thank goodness for that."

The next 35 minutes was taken up with a monologue about the various boys who were taking her out. She wondered if she were making use of them and considered the immorality of such behaviour. Finally decided, "I am just going out with Thomas because I haven't the strength to say, 'No thank you.' I used to be afraid to say 'No' to Richard. Because I think I was a bit afraid of him - I knew he could twist me arouhd his finger with his talking - that's where I thought he was a good salesman."

She was asked about her religious beliefs and how these would

affect her if she had pre-marital intercourse. She wasn't sure but thought perhaps she might not be able to go back to church. Discussion was centred around the dangers inherent in believing one thing and acting in a way which would contravene the belief.

Her ensuing verbalisation returned to sex and Richard so often I finally told her that, if she ever did go to bed with someone, she should at least have sufficient sense of responsibility to take the possibility of pregnancy into account, and demanded what she knew of birth-control. She replied, "Nothing", so, without ado, I told her of the various methods in practice. Her reaction was interesting; her body became quite stiff and remained so for most of the time I was talking, at the same time the "blush" began to rise, centred mainly in patches around her neck, and the final smudges of it did not die away for approximately 50 minutes. When the discussion faltered I asked her if she had been embarrassed - she admitted that she had been, "but there were other questions she would like to ask me when she didn't blush any more."

A somewhat general conversation then ensued with regard to the need for self-esteem, love, attention and approval, and motivation for learning.

She then practiced desensitization - this time she was to imagine herself in a dark street with an unknown man. At first she was unable to relax at all. She tried twice, managing to hold the relaxation approximately five-seven seconds. She had no associated memories, with the exception of the dream she had mentioned in the beginning, about which she had no ideas and could suggest no symbolism. She relaxed again, the suggestion this time being that she should imagine herself with an unknown man beside her in a crowd. But she immediately broke off the relaxation, sat up and started

discussing her mother and her problems. Her father had gone away for a business trip and so far there had been no letters from him. She thought her mother was worried about him; in any case her behaviour had been highly temperamental and she and Jennifer had clashed once more, the mother appearing to take her own fears and ill-temper out on Jennifer.

I reiterated that I thought she would be better in the city-flat with her friends, but otherwise it might help if she thought of her mother rather more as a child with problems. Jennifer replied, "That's the trouble. I often feel as though I <u>am</u> the mother, and mother my daughter."

She then asked if she were staying too long and taking up too much of my time. I suggested that perhaps we might begin tapering the sessions off now, and that I thought she would not need me very much longer. She looked rather taken aback and she was assured that she could, of course, come until after her examinations if she thought it helped.

As she left I apologised for embarrassing her so much, saying that it was clumsy of me, I had handled the situation badly. She said sotto voce, "That's nice," then smiled very fully at me and assured me that "That's quite all right." I hoped that she might learn to apologise to her mother in similar fashion, but said nothing.

The following session (Eleventh), Jennifer was immediately noticeable for her peculiarly blank expression. She waited for me to ask what had happened during the ensuing period before she told me "There was the most perfectly ghastly flap, and now I'm living in a flat." The previous Wednesday when she had reached home her grandmother was there, and there had been a discussion about her behaviour towards her mother. Jennifer "cried. I seem to have done nothing but cry this week." Jennifer was said to "have been perfect up until the last few months," and it was supposed

"that her psychologist thought her parents didn't treat and look after her properly." Jennifer had retorted, "My psychologist is concerned about mother too. She says she's got problems, and that what's wrong is probably just a clash of personalities." The grandmother, hearing that I thought her daughter had problems of her own, had become very sympathetic, and promptly taken up the cudgels on Jennifer's behalf. In the end, Jennifer's mother had "even put a hot water bottle in the bed for her."

On the Friday her mother had suddenly asked Jennifer how much money she got a week from her scholarship. Jennifer noticed immediately that "she was actually looking at the "Board Available" notices so I said I was going to have a look for a flat on Monday. On Sunday mother actually started to pack me up, she got out the suitcases, took all the things off my walls. I didn't know what she was doing. She just went ahead and did it."

As it happened there was a vacancy in a flat shared by some senior students, and the next day Jennifer went along to have a look at it. When she told her mother there was immediate turmoil. Jennifer had been asked if she disliked her home, "why was I going; what was wrong; there was no need to go." Jennifer herself hadn't known what to do. The next morning mother had asked her what she wanted for lunch (an unusual request) and kissed her goodbye; which had produced more tears. That night Jennifer had decided she would actually go and live in the flat, "at least meantime," and on the morning of our session her father had moved her in. She had told her parents that "she was going flatting because I think it's time I was independent and stood on my own feet."

She was given considerable reassurance and support and was told to come to my home if she felt she needed any additional help. She did not come.

She arrived for the Twelfth interview more relaxed that I had ever seen her, and full of smiles. She was "loving the flat; had been a little homesick, but didn't really want to go back home." She had rung her mother the previous day. "She's good. Everything seems all right out there. But something's worrying Dad. He's got his worries too."

This was the first, and only, occasion on which much of her verbalisation centred on her father. He had however had a long talk with her, during which, in response to a query from Jennifer, he had admitted that he did not know whether she should apologise to her mother or not. She had thought about it a lot, and decided she wouldn't do so. She felt that she really wasn't to blame for anything, and therefore would not apologise.

This was not said at all defensively. It was evidence of her determination to "assert herself" - to say and do only those things which she really wanted to and which she believed herself correct in so doing. Previously such a statement would have produced considerable guilt and much obsessional soul-searching.

From this session on the time of the interviews was considerably lessened. She frankly wanted to "go home". She even found, to her great surprise, that she no longer wanted to "go out" every night; sometimes staying at home completely of her own accord (which must have meant that she had also said "No thank you" without thinking or worrying about it.)

Now she herself offered to "start relaxing", presumably so that she could get the session over with, instead of dragging it out as long as she could. Once complete relaxation was gained (which in any case by now

was habitual) her closed eyes gave no evidence of tremor. (This was the usual sign which I had come to know meant interference in relaxation. Sometimes such tremors are so fine as to be quite imperceptible unless one is watching carefully, as one must do, for some patients will be more concerned with (mistakenly) "pleasing the psychologist", and endeavour to go beyond the point where they should stop their efforts). When she finally opened her eyes three minutes later she told me that she had imagined a man and herself alone, on a station, and she had even gone up and talked to him.

At the following session (13th) Jennifer told me that there had been one or two small disputes in the flat but they didn't worry her as anything similar at home would have done.

She had "blushed" once during the week - at a barbecue, where she had got hot, but where she had also been "slightly worrying.... about what we were going to do next. Most of them were total strangers and I was thinking about what they were going to do next."

Exploration of this statement brought the communication that she "always worried when people didn't seem to know what to do." She "felt she ought to be able to organise something or do something for them." On this occasion she had finally "got up and handed things around and stacked up the dishes" because she "had decided they should be left to decide for themselves." Her "blushing" had died down. It "had not worried her at all."

She was asked what, if anything, she considered to be the results of the work she had been doing with me.

"It has caused me to reorganise my opinions of myself quite a lot.

They have turned from being 'good opinions to bad opinions in that I always thought I was sensitive to other people's thoughts or wishes, while quite often I ignored the other person unconsciously. I am more self-centred than I thought I was - more faith in my own powers than I should have. I've learned a lot about other people too. Now I am taking things more in my stride, than worrying me, except for the times when I am tired or for some other such reason I can't get on top of them.

"I've altered considerably in my opinions of sex." (How?) "Well, before I wouldn't have considered that going to bed with a boy was a healthy thing to do. Now I think I could even do it and want to do it and like doing it except for the risk of a baby being born. I wouldn't want to do it with the use of contraceptives - I would compare that with pre-planned murder, premeditated I mean. (This was later elaborated so that it was seen she felt some concern for aesthetics &antipathy to the activities involved as well as a wish for her "first sexual experiences at least" to be "natural".)

"The major thing was that I woke up to the relationship between my mother and I and how much I really relied on her, how much I didn't make up my own mind. It was fortunate about going to the flat. When I went home she had bought some more bleach."

I suggested that she hadn't told me about her relations with her father. She actually thought for a moment before speaking. (It must be borne in mind that she is aware of Freudian theory.)

"I don't think I'd have been jealous of my mother. I remember telling her one time that she was the only lady I knew who went to the door to greet her husband, and it worried me when she stopped using make-up. Recently it seemed to me that she was taking too much from him, not standing up for her own ideas against him. I can remember feeling that quite

strongly - when I was working out my own attitude to any girls that clung too much to the boys and were having a bad time. I compared that to Mum who clung to Dad and Dad in taking it. Dad never changes his attitudes. It's only recently that he's been different from his usual self. When he greets me he'll be his usual self, then after talking with her he's different. What she could have said to him I can't imagine. On the Sunday when she started hauling out the suitcases I thought he must know what was going on, what she was doing, but he didn't.

"I still feel slightly guilty when I go home when they ask me when I'm coming to see them next time. I think they worry about me and I should be grateful. But I don't want to go much, not really."

She was unable to suggest why she should still be afraid of making public speeches, or of standing on a public platform. She endeavoured to practice desensitization in this regard and failed. I asked if she could imagine how she appeared to other people when she was standing on a platform. She had no idea, but she wanted to be able to without being afraid.

She was then given two lessons at once. I am considerably shorter than Jennifer, somewhat overweight, and was wearing a tight skirt. Nonetheless I promptly clambered on a chair, and deliberately smiling, demanded how she thought I looked. Personally I thought I must look either comic or ridiculous. She opened her mouth in amazement, shouted with laughter, and finally told me, "You look very dominant." It was suggested that this was either what she wanted - i.e. to dominate - or feared, i.e. to dominate or be considered dominant. She was then asked if she thought she perhaps might dislike people. She responded, "Oh no! I like people."

Then, very shyly, "I love people."

It was then suggested that she should again try imagining the hitherto feared railway scene, with herself alone with a strange man, tapping along. She relaxed, and this time registered what was tantamount to a so-called dissociative response - where previously she had imagined herself as one of the actors, this time she had "found she was observing herself and the man - like two shadows." No fear was experienced, at all.

The ensuing (14th) session was very short, and found Jennifer once more furious with her mother. She had taken her girl-friend home for the weekend, and while there found her mother had written a report for the local paper asking for donations and help for some charitable organisation, all interested being invited to ring Jennifer J. Jennifer herself had by now dropped all social activities in her home area, and she was "angry with Mum because she knew I didn't want to have anything to do with it. She's interested in it herself and I think she feels I'm something to help her along the way."

After this airing of her resentment, she began to discuss the study which she was going to take part in "out in the field", and would cause her to be away for the next two weeks.

She told me that she was practising relaxation at home, but now she imagined herself standing on the stage or talking in public and actually making a real success of it, "as she wanted it to be".

She left without practicing desensitization. She had by now completed her presenting hierarchy, and she made no effort to check either on the completeness of the inhibition of her other fears or to produce a new hierarchy. She thought everything was "fine, wonderful."

Life and the world were even more wonderful according to her report on the interview following her return. She "had had an absolutely marvellous time ..... never been so relaxed, had so much fun, been so happy." She had recalled my standing on the chair, and she had "acted as she felt like doing." One of the lecturers had sat beside her and told her he just could not believe that "this warm, laughing girl was the same as the self-conscious remote student he had seen all year."

The following week she excused herself from coming to see me. She "was giving a pre-wedding party for one of her girl-friends the following day and wanted to do some baking, and would I mind." It was obvious that she no longer needed me for support either.

Session 15 produced a considerable problem. Jennifer was behind with her work again - the girl in the flat with whom she was most friendly and who was closest to her own age, was unfortunately even worse in this respect than Jennifer, so she found no help there. Instead of examinations it had just been announced that a series of projects were to be handed in by a given date in the following week. Jennifer had seen some relevant material in my study and this was loaned to her. As she was about to leave, she reiterated that she had never been able to get anything in in time, she didn't know how she could manage now.

It was an appeal, and at the following session I suggested that perhaps what she was doing all the time was crying for someone to help her or do it for her, like the spoiled child she had apparently been, but that when help was given her she resented it because she really wanted to be independent and do it herself; that she must choose to be either the child or the mature adult she was striving so hard to become.

On this occasion, however, I felt that, if indeed she did fail to get her work finished in time, the responsibility would be mine for not having insisted that she attempt to properly desensitize a maladaptive habit which caused so much trouble in her life, as indeed I should have done if she had been a full patient and not a subject being treated for the symptom for which she sought help. Accordingly she was placed in what appeared and purported to be a slight hypnotic trance (she was instructed to relax as usual, told she was relaxing more and more deeply, and that when I told her to move her arm she would find it so heavy she could not do so - she did not do so), and it was suggested that "at some appropriate time after reaching home she would open her books and become increasingly interested in the subject matter of her projects, that within the next few days she would do the necessary work, becoming happier and more and more pleased with herself for getting it done on time as she did so." The reports were evidently handed in only just in time to be marked but they were there. Jennifer herself felt that the suggestion had had no effect - she really would have done it anyway and was sorry she had not been able to show she could. Because this procedure had only been adopted to give her maximum support at an unexpected high point of need no attempt was made to make her amnesic to the suggestion. I was somewhat afraid that there might be some counter-force exerted within herself from whatever habit of action (or inaction) or fear was the main motivator of her dilatory behaviour, or from her dislike of any attempt to tell her what she should do with regard to anything about which she already knew herself to be hesitating, or judged herself to be in the wrong. On the other hand it was hoped to more sharply focus her attention on this problem, while giving

maximum support and reinforcement (she was to "become happier and more pleased with herself" for her positive attempt to complete her work). Subsequently, as partly noted above, she admitted to some ambivalence on her part - she "wished she had been left to show she could do it, she was interested in seeing what happened, but she was grateful for the support and glad to know that I accepted some of the responsibility for her apparently continuing vacillation, myself." It was agreed that should this continue to be a problem in the ensuing year she should come back for further reciprocal inhibition therapy in this connection.

The question of responsibility is one that Jennifer raised herself on a number of occasions. Adler (1932) has suggested that first-born children are often more responsible, and this may possibly have resulted in the conditioning which has caused her to place so much value upon the concept. In any case this aim did not need to be inculcated, but she still has to learn to accept the responsibility for her own actions. As it was a value of her own, the concept of responsibility was consistently reinforced and suggested as a motivator at all appropriate points throughout the sessions.

At the last interview, (16th) she happily told me that she had managed to get an average of "C" for her work throughout the year (she had feared she might have got less because of her lateness in handing in her work; which she now explained as "being due to a habit she had developed in secondary school when she had wanted to be accepted by her peers and hadn't done her work so they would like her - those who did their work were sneered at"); she was going off to work in a factory for the vacation in order to save some money for the coming year, and when she has completed

her training she is planning to do voluntary work in undeveloped countries. Not quite so happily she added that "My mother has lost a stone in weight since I've been in town - she's been on an awfully strict diet (Jennifer herself had put on weight since flatting) and she's taking up some painting portraits, and Connie's got a kitten - they'd never let me have one; so everything's all right out there too."

She had also had her own hair redyed to its natural colour. She hadn't had any money to pay for it so she'd put it on her mother's account, but she'd "got a shock" when she found out the cost, and gave some evidence of feeling guilty about it. It seemed to me I could not offer support as she should have asked permission of her mother first, though I thought it poetic justice and no more than mother deserved in this particular case; but both her hair and appearance were admired. She does indeed give an impression of glowing health and vitality totally different from the cool inhibited persona she first showed. I had noted during the sessions that, although she did not mention it, she had stopped trying to hide her hands and her crooked finger. It seemed appropriate to reward her with a ring for her Christmas gift, which resulted in the statement that she would have to remember to try practising movement of her finger in the hope of straightening it somewhat. (This is a similar motivation to that given small girls who bite their finger-nails, i.e. special nail-manicures.)

Finally, she "had not blushed" since the last occasion reported and it wouldn't bother her any more if she did."

Case 9:

Mrs. Wong, was a young Chinese woman from Hong Kong, who was referred because of examination panic, including vomitting. As she was seen twice only within two or three weeks of her first major examination, therapy had to be brief and very much to the point. She promptly rejected any suggestion of satiation or reactive inhibition therapy. Therapy, therefore, mainly consisted of support, and verbal conditioning relating to her self-esteem and ability to carry out her examinations successfully; an acceptable rational explanation of her vomitting was also offered. But further to this she was directed to take practical steps to ensure her ability to perform adequately within the examination situation; as her English is poor and her thinking and writing in this language slow she was told to practice writing essays on topics related to her subject within the time-limit of the examination period. The therapy given may be regarded as successful with regard to its purpose. The case history establishes quite clearly the underlying stresses to which this young lady was subjected.

She suffered and suffers from abnormal conditioning to anxiety, as well as from frustration due to environmental pressures. Related to her early conditioning, there would also appear to be some distortion of the ego-structure components. Further therapy would be most advisdable, but I doubt if it will be sought.

....

Mrs. May Wong was a young Chinese woman who was referred to me by another university lecturer. In some special examinations she had actually vomitted a number of times throughout the examination period.

When I first saw her shortly before her final examinations she was extremely tense, twisting and untwisting her hands and smoking throughout the entire interview. She was "unable to stay very long because her baby-sitter could not stay long"; but she "was scared stiff about the exams", and she "just had to get through." She told me freely that her mother had sent her the money which paid for the baby-sitter, and, if she didn't get through the exams, she would probably be unable to return next year.

I asked her what other anxieties, outside of the examinations, concerned her, or which ones she could name. There "weren't any."

I explained the principles of reciprocal inhibition therapy and the utilisation of relaxation responses. She "did ballet exercises every day." She was told this was not the same thing at all. With considerable persuasion she finally consented to try them, but the level of her anxiety was really too great.

When she was relaxed she was asked if she would imagine herself in the feared situation. She closed her eyes and then said indignantly that she could not possibly do so, it was a <u>past</u> situation and no longer applied. She then proceeded to speak of Chinese education, and I gained the impression that she thought Chinese were taught to think only in terms of the past in connection with their ancestors, and only in terms of the future when it came to achievement, or vice versa.

It may well be that social conditioning was here reinforcing high anxiety related to her own experiences and fear of loss of self-esteem. It would be an interesting possible cultural difference to investigate. No matter whence the fear derived from, she insisted she could not possibly imagine herself afraid in the examination; nor could she try "satiation" or reactive inhibition therapy - it was indeed not possible for her to imagine herself as frightened at all.

Accordingly I sought more practical (at least to her) ways of coping with her fear. Questioning elicited the fact that her English was far from good (she speaks with a considerable accent), she could neither express herself fluently nor well in written English; when she had done an I.Q. test she had concentrated on the problems because she couldn't always understand the English easily (although she told me

later she read Shakespeare for pleasure); she was "terrified" of the subjects requiring essay answers. I told her she must understand the principles of her subject in any case. As for essay writing, she was instructed to pick out various topics on which she thought she might be examined, and to practise writing an essay around each topic within a given period. She accepted this advice with considerable excitement and manifest pleasure, and "was going home to immediately start practising."

At the second interview, a week later, she was considerably more relaxed. She smoked only one cigarette during the interview, although she frequently rubbed her fingers or moved her hands nervously.

On this occasion she told me her family history. Her mother was upper middle-class, very wealthy, but badly crippled. Her father had married her to a poor man in the hope that her wealth would give her power and hold over the man. Mrs. Wong's father had used the money very cleverly, gained even greater wealth, but her mother unluckily had no son, only daughters, of whom she was the youngest. Her father took concubines, and when the family fled from the enemy to Hong Kong he took his sons by one of his concubines for his wife to bring up. Then one day the concubine had arrived and demanded her sons, and Mrs. Wong's father had brought her to live in the household, while her mother retired more and more into her own rooms. Mrs. Wong's eldest sister had become a doctor; the second daughter was submissive and had married the man chosen by her father. Mrs. Wong had married her own husband, from a much poorer social class, mainly because her father had forbidden her to do so. The father thereupon "cut her off," and her mother had also had

to fight for her share of his wealth. From this she had sent Mrs. Wong the money which enabled her to go to University this year (and all of which had been given to the baby-sitter), and Mrs. Wong felt she must get through for her mother's sake.

She told me too, that she had worked for a considerable period as a journalist on a newspaper in Hong Kong. This had been a great strain because there was considerable competition and also much criticism of a woman doing such a job. Finally, when she had a little money, she had come to England, because she had wanted to study, but had had to get a job in order to live. Eventually she had become reunited with her husband who had also come to England. He thought she was "mad" and did not approve of her going to University; he was from a lower-class and did not approve of her activities nor share her interest. She "thought kids need both parents, but she would indeed go mad if she were tied to the house and domestic chores."

Mrs. Wong advised that she had been practising the relaxation techniques, "but they didn't seem to help much." She had not, however, been attempting any desensitization in conjunction with them. She still couldn't do that, but she might be able to imagine herself being successful. She was told to do this if she thought it would help, but so far as I know this was not carried out.

She had, however, "been practising essay-writing within the period stipulated and found that the words were flowing much easier." I told her to cut the time down she was at present allowing herself for each question, and also gave the standard advice given students to divide the number of questions into the time of the examination less half-an-hour,

thereby leaving herself that period in which to read the exam paper and add things afterwards if necessary.

She was concerned lest she should vomit again, so I offered as a possible explanation the hypothesis that her vomitting could well be a physiological mirroring of her attempt to spew out information; she had been under stress for many years and the effort had become temporarily too much. Now, however, she knew she could write an essay-type answer within the time limit and the stress should accordingly be so diminished she would not vomit again. If however, she felt "sick" in the examination room she was simply to communicate this information emotionlessly to herself, so that the mediating central mechanism could deal with the situation.

Mrs. Wong then told me of her difficulties with the tutor in her second subject which she had studied previously "at home".

I gave her general reassurance, telling her that I was quite sure she would pass. She replied suddenly, "That's it. That's what I wanted. To be told I would be all right." I repeated several times my belief that she would be all right and would pass.

At the same time I also again pointed out that she had had a constant battle for most of her life, been under much continual stress, and that I was sure her mother would not want her to pass at the expense of too much strain. I reiterated that she had indeed already had much success to her credit, and she was instructed to try to feel again in imagination those situations where she had succeeded and to keep these in mind, rather than to think of fear of failure.

Mrs. Wong has very decided opinions on a number of subjects, and

she tended to clash with authority. Accordingly she was fearful of "negative halo rating". She explained at considerable length and in great detail a clash with the tutor in her second subject. On the evidence as she presented it, he had been most unfair and irrational. I advised her to take the precaution of repeating any statement given in an examination question, and to adopt a "Yes (this is, e.g. legally, so because).....but....." attitude in her answer. She said, in scandalised tones, "You mean I should go along with them a little way first?" I pointed out that, if she had indeed been a journalist, she should know well enough by now that there were some people who just could not tolerate others to be in complete, or even comparative, disagreement with them. If the person she expected to set and mark her examination questions were like this, it was indeed regrettable, but the only intelligent thing for her to do was to take heed of it. With this she acquiesced, but one could see some evidence of a rigid moralistic attitude which had not only produced many difficulties for her, but also a not inconsiderable measure of intolerance for other people and their problems. From an ethical viewpoint I was in agreement with her and said so; one should be free to completely disagree, provided one presents facts and rational reasons for one's disagreement, and one should, indeed, be free to state honestly what one believes; but one also needs to take reality into account and then decide on action after weighing up reality, needs and values. She found the argument congenial and said so; but her highly emotional reactions continue to cripple her.

I did not see her again before the examinations. Afterwards she called on me, once more in an extremely nervous condition. She had

passed her major examinations, though in one question at least she had insisted on saying what she really thought. It was quite evident from her remarks that she had known the facts the examiner was probably looking for, but she had "thrown all that guff out the window" and written about what she herself believe to be crucial.

She had also actually passed one paper in her second subject (the one she feared most) and had adopted the suggestions given her; but had failed a second paper. She admitted, however, that she had done practically no work on this paper at all having depende d on study she had already done in Hong Kong. Now she wanted to know what she should do - should she give up all idea of University work? If she sold all her jewellery she might manage to pay her University expenses for a few years, but she would have to complete her studies and obtain her degree by the time the money ran out. Could she do it?
Every possible argument for and against was adduced; it was suggested that she should just do some study each year as a hobby, for she has need of intellectual interests and activity, but her domestic difficulties would not permit of this, it was a question of so much achieved per year and a degree or nothing. Finally the appropriate syllabus for the ensuing year was obtained and she was told to study it carefully, to read some of the textbooks concerned, and to decide whether or not she thought she was sufficiently interested to do the amount of work she would require to do in order to pass.

Her husband and his friends had said, and thought, she should give up now she had failed, which, of course, made her more determined to go on if she could. Whatever Mrs. Wong does she is going to be faced with considerable psychological difficulties.

.....

Case 10:

A woman of 40-odd years was referred because of her high anxiety and a work-performance which her firm's Personnel Officer thought far inferior to that posited by her intelligence, which appears at least above average.

She is caught in a highly stressful and uncongenial marital situation, about which, however, she will take no action to ameliorate the conditions or resolve the conflict. The children, for whom she has much concern, are undoubtedly suffering badly under the present regime, and would conceivably be in happier and certainly less stressful circumstances if the parents actually separated. It is my opinion, however, that she had previously made up her mind to leave her husband as soon as all three children are working - if a more acceptable man capable of dealing with her husband does not come along meanwhile.

Willoughby: Mrs. Thompson has a very high score of 64.

16 P.F.: Her scores on this test show her to be very submissive, very desurgent and depressive, very shy, a little below average on cyclothymia (warmth and sociability), and decidedly introverted. She has very high ergic tension (Sten 9) and extremely high insecurity and anxiety (top sten).

Myers-Briggs Test: This test shows her to be an Introverted-Sensing-Thinking-Perceptual type, with considerable emphasis on introversion and thinking.

Ego-Structure Scale: Her scores here show her to have a slightly above average ego-ideal; low ego-control; slightly above average emotional reactivity; a desire to be thought well of and a concern with social approval.

It is obvious from the above, as will also be seen from the case history itself, that this woman suffered from distortion of the ego-structure components; abnormal conditioning to anxiety, dependency and submissiveness, and possibly to withdrawal; maladjustive habits (e.g. hand-twiddling); environmental frustration; and, to an earlier-environmental frustration of learning in terms of formal education.

Therapy was primarily aimed at desensitizing specific anxieties through reciprocal inhibition therapy, reducing the overall anxiety level, conditioning her to less concern with feared social approval, and to more assertive behaviour generally, thereby freeing her to apply herself, work and live at a generally higher level.

Some semantic conditioning and support was also given. Therapy was concluded on Mrs. Thompson's initiative before being finalized. The Personnel Officer who referred her, considers her work and social interaction "much improved".

....

As stated above, Mrs. Sylvia Thompson, aged 42, is married with three children, a daughter (16) and two boys (12 and 7). When first asked about her children she said she had two, but it became clear later that she had

not taken the younger one into account. Her attention was focussed almost exclusively upon her problems with her husband, and the two older children, more particularly Joan, the daughter, are concerned in these far more than the younger boy.

Mrs. Thompson was seen for a total of six sessions over a period of nine weeks. The Personnel Officer of a local firm where she was employed intermittently on various surveys, had recommended her to come to see me as it was considered Mrs. Thompson had many problems which were impeding her work-performance. The Personnel Officer considered Mrs. Thompson of good intelligence and capable of far better output.

With me at least, Mrs. Thompson proved to be a highly verbal type. She was always very neatly dressed, but gave the appearance of being quick and nervous in temperament. There was not one moment while she was talking to me when she was not moving her fingers in some way, rolling and unrolling paper, twisting a rubber-band or a pin, twiddling with her hair. When I suggested a medical examination she flatly refused to have one. She said she was undoubtedly wasting my time and no-one else could help her anyway, but the Personnel Officer had been kind to her and she (Mrs. Thompson) would do what she could.

In response to my request to tell me her history (met with a blank stare), all about herself, she said:

"I'm an only child, in a wonderfully good position - my father was a book-binder. What I remember most is the depression. The very, very first thing I remember is being in a house with two entrances - with a push-chair at one door. I don't know whether I played there coming in and out one door and then another.

"I remember living in Edgeway Road. Had a brick backyard instead of

concrete. Even to this day I am conscious of what I am walking on. My husband was building for a while and we had concrete, concrete, concrete.

"Father was very,very quiet; mother rather dominating, always wanted to do everything for me. Even now when she is elderly and we would do things she will hop up to do things until I push her back.

"I was very fond of sports. Had happy school-days. I feel if you can't cope, sport's a good thing. I go to Scottish Country Dancing; go to Badminton. But I don't feel I have much energy."

Q. What about your sex relations?

"Oh they're no good. Her father doesn't help my 16-year old daughter. He is very hostile to her. Nothing she does is right, he picks on her. I wonder if it isn't taking out what he would like to take out on me. She's a red-head - I believe red-heads are temperamental and difficult. She's very stubborn and won't take advice, wants her own way. She doesn't have an easy nature to cope with. Difficult sort of person really. To my mind very much like her father. She and he don't hit if off. I think he sees his faults in her and he just can't bear the girl.

Q. Is she really like him?

"She is difficult but I do try to ignore it a bit. Our marriage relations have been bad ever since a couple of years after we were married. He's dominating and gradually got worse and worse until I wouldn't be pushed around more and more. It's always been the same ever since she was small. The first incident I remember of him was when I was trying to wean her, eight months, and he took it and tried to force her. 'She's not going to beat me. She's not going to beat me.' He smacked her legs until red. She always had a little paddy and plenty of determination and he doesn't like

that; so all her life she's been at him.

"Different with the two boys; he is very different with them. The second boy is very pleasant, easy boys to manage; this naturally makes him feel differently towards them. He shows his unfairness - picks at the girl all the way through the meal whereas the boy can get away. Doesn't say much about the boy - he's smaller. He has a sunny nature and will stand up to father in a different way - just laughs at him.

"We were married about a year before the daughter was born. At the moment he's made her leave college because she doesn't do her home-work. He just up and said she had to leave. She's not very bright academically, so I didn't fight about it. Just collected her books at end of term.

"He was at a psychiatrist and had some treatment a year or so ago. He's very much quieter now; prior to that he was at the girl far worse than ever. Used to have her in tears all evening. Went to Dr. Jones. Prior to that he never stopped talking. He's quite a bright person, very brainy. At the moment he's in a factory fiddling with radios; prior to that he took a job in Mansfield and then he became rather strange and had a nervous breakdown - in hospital. He was a bomber during the war. Quite clever really."

Q. What about your own education?

"Had two years at grammar school. Was a Burroughs operator. Didn't get married until 27 - had dozens of boy-friends. War-time remember! I was quite interested and keen on learning things.

"When I came to get married my mother wasn't very pleased about it. All right for a little while and then .... my father had died just a couple of years previously. Gradually thought about it and decided she wasn't so

pleased about it after all. After a little while she started to have words with my future husband; but I think she was right. In after years I found him doing those things which have gradually annoyed me and made him worse. They don't get on now at all. She's a bit difficult and often not keen to help with her family - better with strangers. Terribly difficult to get far with them."

Q. What of your sex relations?

"Sex relations weren't bad for a little while. He gradually pushed me around more and more until I got so I couldn't stand him. Just got worse and worse until I can't bear him in the room even. When I am home I get very distressed."

Q. Is there anyone else in whom you are interested?

"Oh, met up with old boy-friends and I would throw my husband in any day for one or two of them. Got one hanging on the door-step now who's very friendly. I'm having a job to push him off."

Q. Would you feel guilty about having extra-marital intercourse?

"Guilty!! (Laughs) You'd only feel guilty if you got caught wouldn't you? Guilty! No."

(I felt here that perhaps she may have had some extra-marital affairs - there was a gleam in her eye and her expression altered; but she would not admit to any if she had).

Q. Do you want to leave your husband?

"It would probably mean taking children to Mansfield. Main reason why I don't do anything - you don't know what he would do. Think he could be quite dangerous if I tried that."

.....

Mrs. Thompson returned to the question of her daughter, commenting that she had to come into the city to look for a job. I queried if it would not be possible for the daughter to stay with her grandmother ("But that would mean she would have to go to Mansfield. No.") or in a hostel, or, as she is not apparently well qualified for anything, get a live-in position. Mrs. Thompson said she had considered it, but didn't think it would work. "The girl is very fond of her home. She does gardening - likes it. She loves her home." One felt also that Mrs. Thompson loved having her at home, but further querying only brought a re-statement of her concern about the girl. It was finally agreed that perhaps the daughter having a job and some measure of independence might make her easier to live with.

I gave Mrs. Thompson the Willoughby Personality Schedule and the 16 P.F. to fill out at home, and told her to practice Assertive Responses, as well as Progressive relaxation; she was also to prepare an Anxiety hierarchy.

The interview terminated after approximately 1½ hours.

Second Interview, 2 p.m. 5th September:

Mrs. Thompson dressed much as before. She began to tell me about her recent trip to Mansfield (to see her mother) before she was inside the door. She had been to Mansfield with the two boys, leaving the girl with a friend. There had been a big row when she originally suggested going - so she evidently "paid him out" by not leaving one of the boys behind, as she usually did "to keep him company and put his meals on; though he can really manage all right on his own, he certainly did when I was in the hospital." On such occasions she always leaves the main meals prepared, all ready to be warmed up. She had gone up and back the next day - returning

to find the door locked and no key left. One of the boys had climbed in the window and opened the door. When her husband came home there was not such a big "row" as she had expected.

While she was away also her daughter had actually got a job - as office girl. Her husband had demanded to know what Joan was doing away from school: she reminded him of his orders and told him of Joan's job. He made no other comment and, as Joan was very tired when she got home and went straight to bed after tea, there had been no rows; father, too, did not pick on her at meal-time.

I asked her again about her own relations with her husband. They "haven't slept together for a couple of years. He's quietened down since the shock treatment, doesn't seem to mind. Before that he was always after it." I pressed her about her own sex-drive. She considered she "had low-drive." She "certainly didn't want it, particularly with him." She "couldn't even stand his smell any more."

I asked about the boy-friend. "Oh, the religious one! I believe he rang up while I was away. Oh, I don't think much of him."

Again I pressed her on the alternatives of separation and trying to impreve and "make a go" of her marriage. She didn't think he would agree to a separation anyway, he "could be dangerous." We discussed this and finally she agreed he might be stopped from doing anything. She was certainly afraid of him to quite a degree. She went on to tell me, however, that she had "stood up to him more during the past week" and things did indeed seem a little better. I impressed on her not to argue with him unless she could produce good arguments or felt implicitly she was in the right.

On glancing through the 16 P.F. she had completed I noticed a comment

written on her answer sheet. She thought the word "moral" idealism should be left out of Q. 21; it was "religious idealism" that was important. From the ensuing discussion it became clear that she considers "moral" behaviour to be "socially conforming behaviour" with which she does not necessarily agree. She does not go to Church, is not sure of her religious beliefs altogether though she tends to reject Christian dogma and believe just in some creative force, "God"; ethical behaviour, however, is important. (16 P.F. sten scores of six on Ego Strength; five on Super Ego Strength; five on Conservatism).

As she had not written out her Anxiety Hierarchy for me we discussed the question of the things she was anxious about. She had two immediate suggestions; driving down Piccadilly and stalling, and going home after being in Mansfield and meeting her husband.

I then had her practice Progressive Relaxation exercises until she claimed she felt completely relaxed. I then had her imagine driving the car down Piccadilly and stalling. She tried but was soon tense. I had her relax again completely, chatting idly about the comfort of chairs as she did so; then had her imagine the scene again. This time she asked if it should be "the good car or the other one." She again became tense after a slightly longer period. We repeated the whole series again. This time she suddenly burst out, "Oh, I don't really care about these silly buggars." I commended her for this feeling and suggested this was how she should always feel, for we all make mistakes at times. She then told me that she now recalled the first such incident when she had really been terrified, and described it to me. (I found some difficulty in restraining myself from telling her I should have been in a panic myself). She went on to tell me

that she had saved up the money to buy herself "the other car", "he only goes wherever he wants, when he wants". Her husband had been furious when she bought it, telling her that she should have put the money into the house. What she earned in the future she would put into the house; but meantime she had to help Joan get a wardrobe together, and later there was the boys' education.

We then discussed the matter of "having a goal or aim in life." She agreed that having the goal of buying the car had "helped to get and keep her going at the research work (which she likes very much", and that having a goal "did make her feel better".

She then went on to say that she was afraid when she did the interviewing - afraid she would not do it properly. I told her to put this down on the anxiety hierarchy.

She added that she had even shouted at her husband, "Shut up and leave me alone, I've got a dozen things on my mind," when he wanted something while she was preparing her report. To her surprise he had "shut up". I suggested that perhaps this was because he respected the fact that she was working and had a real, obvious reason for her impatience.

Mrs. Thompson left at 3.15, still talking as I escorted her to the door. She arranged an appointment for the following week.

On the day for which the next appointment had been arranged Mrs. Thompson rang to say she still had some interviews to complete for her work, could she come the next day? This was arranged. She commented that she had plenty of work to do at the moment, "which is a good thing - keeps me from

getting depressed, doesn't it?"

Third Interview:

As was to be the pattern for all the interviews, Mrs. Thompson immediately told me a long story about an argument her husband had had with her daughter, and another one he and she had had. The picture never varied, though, as she worked through the anxiety hierarchy and continued to practice her assertive responses, she seemed to lose quite a lot of her fear of him.

On this occasion she gave me her hierarchy. The situations which caused her anxiety, starting with the least important, were:

1. Stalling the car in the middle of Piccadilly Circus.
2. When she had completed her interviews and report, waiting for the supervisor's comments.
3. Stagefright (including doing an interview with the supervisor watching to see how it goes).
4. Any suggestion that requires an argument at home.
5. Returning home from a visit to her mother in Mansfield if everything has not been threshed out properly beforehand.

Mrs. Thompson reported that her car had actually stalled again; but this time she "just said the bloke in the car behind could wait." As no further desensitization seemed indicated, once relaxation had been properly established, Mrs. Thompson practiced imagining situation No. 2. It would seem from her associations that a large part of the problem lay in the fact that her husband "was around a lot", or seemed to be, during the periods in which she was waiting to hear from the supervisor.

She reiterated again and again that she "simply could not bear him,"

"the look of him, the smell of him, or anything else." She dated the worst of her antipathy from the breakdown he had, during which he "had changed completely in appearance," "had grown a moustache and was all unctuous, ugh!!" She shivered with revulsion. She had tried to have sympathy, tried to help him over it, but she just couldn't bear him.

I tried, first indirectly by speaking of other people, then directly, to make her face the situation squarely. She again rejected the suggestion of separation, saying first that he would kill her, and second, when I pointed out she should be able to get police protection if necessary, that the boys needed a father. The stresses of the situation both as they affected herself and the children were again pointed out to her, and I endeavoured to have her consider (a) her husband's problems and (b) her own attitudes to him and the sexual deprivation she was inflicting on both of them by reason of her refusing to sleep with him, as well as the apparent results of their frustration, and (c) the possibility of both discussing the situation with a marriage guidance counsellor or her husband's psychiatrist or someone of their own choosing, (d) simply trying to "start afresh" of her own accord. Again she rejected any real solution to the problem, and interestingly, when she first arrived at the next interview she presented me with a bag of lemons. From thenceforth no attempt was made to resolve the situation in terms of either better marital relations or separation. Instead I set her to the task of a more rapid desensitization of her fears, a building-up of her self-esteem and preparation for a return to full-time employment when she feels she can manage, as well as looking after the children and her husband adequately. It was pointed out to her that her self-esteem would be greatly diminished if

she continued to live in his house without at least caring for his wants - it was far better for him to be in her debt, even if she were discommoded at times, than vice versa. With this she concurred. Two sessions later she reported that she had found sufficient self-confidence to start lessons at a Commercial College so that she might perhaps be able to find a permanent part-time office job near to her home.

At the fourth session she reported that she "had stood up to him better and he got a shock." After relaxing, which she was now able to do much more easily and rapidly, Mrs. Thompson again practised imagining the second situation. This time, however, she imagined actually being in the office, waiting for the supervisor to make some comments. Three separate practice periods were used, the period of relaxation - imagined picture rising from seven seconds to fifteen seconds to 32 seconds.

An attempt was made on No. 3, but immediately she imagined the supervisor watching her, relaxation was interrupted immediately. Indeed she gave indication of near-panic. She was accordingly relaxed once more and a more pleasant topic of conversation (clothes) introduced in order to ensure the continued association of the practice of relaxation techniques with a minimal degree of anxiety.

Session 5 began with Mrs. Thompson in more cheerful mood. She claimed she was "feeling a lot better", though she apologised profusely for wasting my time. She was chided for apologising in this manner. She agreed that she was over-apologetic to everybody. She was "afraid she couldn't manage a job and keep her house properly too" - with this she moved a curtain and found I had pushed some things out of sight in my own hurry to tidy the room. She watched my reaction very carefully, but I

evidently managed a convincing enough laugh, for she smiled and relaxed, and said "maybe you should just take things as they come."

Desensitization of Item 2 was again practised, but she felt very much less concerned about this, and accordingly another trial was made to imagine the supervisor watching her. There was a second failure, and Mrs. Thompson giggled, talked rapidly, and tried her best to distract me from trying again.

The success of the inculcation of relaxation and imaginary pictures relating to feared stimuli, in the cases of particularly anxious people would seem to me to partly relate to the personality of the therapist. I felt that if I had been older or more dominant (she told me I reminded her of the best friend she had), or a male I should have had more success at this point. Without the benefit of such adjuncts as hypnosis, of which she was too afraid to permit its use, it seems to me the best alternative is to utilise positive suggestion provided positive rapport is maintained. Accordingly I suggested that she should practice relaxation at home (as she claimed to have been doing) but ally it with an imaginary picture of herself interviewing some (increasingly) difficult interviewer and "not giving a damn" for the supervisor. "Who the hell is a supervisor, anyway - just another woman just as capable of making mistakes as you; in fact if you didn't act so scared probably you would make less mistakes." This she did, with the result that at the following interview she was able, albeit with difficulty, to imagine the picture in neutral as it were, without relaxation being interfered with.

She asked if she could bring a friend with her next session, "someone who is very badly in need of help, but won't try to get it." Permission was

given and the Sixth session was given over largely to the "friend", who proved to be highly depressed and, at least verbally, suicidal (both states appearing to have been of long, intermittent duration). She was given as much verbal support as possible but immediately referred back to her own medical practitioner with the suggestion that she should also consult a psychiatrist. To the best of my knowledge she refused to seek such help. (As support and discussion of Mrs. Rowe's problems was the only therapy given and I saw her only on one occasion, details of her case are not reported here.)

Mrs. Thompson proved somewhat inconsolable. She had evidently identified with the woman concerned, and spent the seventh interview entirely discussing her problems, as well as begging me to persuade her to come back to see me again. She was assured that if Mrs. Rowe wished to see me again I would, of course, do everything in my power to help, but was told again that I thought her friend required at least a medical examination. The opportunity was taken to again suggest that she herself should also have at least "a routine check". Mrs. Thompson, however, does not like the medical profession though no reason could be obtained for this.

At the eighth session, Mrs. Thompson advised that she would be going out on a research job and would not be able to come in the following week. Mrs. Rowe did not feel well enough to come and would not come without her. The week after that she rang to apologise once more, telling me, however, that she was much better and had actually got up and spoken in a meeting and was told she had done well.

Based on only my intuition and an unidentifiable expression in her voice, I decided Mrs. Thompson would not come again. She did not. Nor did she report further. The Personnel Officer however, reports that Mrs.

Thompson is "definitely much more assertive than she was, in fact sometimes she argues with her boss now even when she's wrong, which in turn annoys him, until he realises that this is indeed improvement of a sort." The Personnel Officer also had received second-hand information that Mrs. Thompson was much more assertive with her husband, particularly where the daughter was concerned. While the marital situation remains unchanged this would appear to be the best that may be expected.

... .

PART NINE

DISCUSSION AND SUMMARY.

I. DISCUSSION.

The aim of this thesis has been to explore the relationship between mental disorder, psychotherapy and the principles of learning. I have argued that most mental disorders are related to some kind of learning defect, and that the many forms of treatment in one way or another involve unlearning or re-learning. This conclusion gives great unity and meaning to the principles but it leaves wide open the question as to what forms of therapy are preferable.

Three considerations are of outstanding importance: the nature of the learning deficit involved; the accepted aims of therapy; the resources available to the therapist. When these are known it remains only to choose the most efficient of the methods.

The first and third considerations referred to are really matters of fact. The second one is a question of principle about which there has been much discussion. It will, therefore, be desirable to consider it before proceeding with the subsequent discussion.

.. ..

1. Aims of Therapy:

The aims of psychotherapy are sometimes confused with definitions of mental health, or with the aims of individual psychotherapists. In Behaviouristic terms, psychotherapy means the inhibition, extinction or desensitization of maladaptive behavioural patterns or specific habits, and,

where required, the substitution of reciprocally inhibiting habits. Quite obviously this is not always enough to promote completely adaptive behaviour in all spheres of activity.

Presumably because of the ethical question of cost in terms of time, money and energy or "trouble" involved, and the so-called moral question of behavioural change instigated by others, Bandura (in an address at the University of Illinois, November, 1962) has insisted that the therapist must be bound by the wishes of the patient. This, of course, raises the question as to whether the patient always knows, or is capable of knowing, what he needs and/or wants.

A further point which has concerned those who are bound by the ethics of their profession, and who do not suffer themselves from a pathological desire to be needed, or a liking for omnipotence and authority, is the long conditioned fear of symptom substitution. This stems from a simple acceptance of so-called authoritative statements and a misconception of symptom formation based largely on the hypothesis that symptoms are "chosen", either to gain sympathy or some other end, or as defence reactions against anxiety. In effect we have a symptom of "symptom substitution". But, if a "substitute symptom" did appear, it could mean only that either (a) such symptom was next on the hierarchy of learned habits of response to a given stimulus or attached to a given drive - in other words the first symptom was masking the second; or (b) the patient

had not yet learned sufficiently well required adaptive behaviour patterns.

I would state the aims of psychotherapy as being:

(a) primarily the "cure" or "disappearance" of the mental overt behavioural disorders from which the patient suffers and desires cured (or, in extreme pathological states, of which he requires to be cured for his own safety and that of others); and

(b) secondarily, to the degree the patient desires, the inculcation of adaptive patterns which will lead to other desired changes and/or goals and/or a permanent state of mental health.

It would then become encumbent on the therapist to lay, so far as is in his power, the basis for future adaptive learning, change and performance; to adequately inform the patient regarding his potentialities and present situation; and to alleviate current symptomatology.

2. Learning Deficit and Resources.

When there is agreement about aims it remains to be decided in any particular case what is the nature of the deficit and what resources are available to deal with it. Obviously the method of diagnosis itself involves some commitment to method.

The mere statement of the patient is not enough to establish the real nature of his trouble any more than in the comparable physical case the medical practitioner can accept the stated symptom of his patient as adequate basis for

diagnosis. There must, therefore, always be more or less time devoted to interview, testing or other diagnostic procedures. At a fairly early stage, however, there should emerge some indication as to whether the patient's disorder stems on the one hand from a simple conditioning effect such as a phobia or an abnormal drive-trait, or on the other hand fromsome distortion within the cognitive or ego system.

In the former case the appropriate antidotal learning process can be selected at once, a suitable instigator chosen if operant conditioning is involved, and available reinforcers considered according to their convenience and effectiveness. The therapy will be of the appropriate "Behavioural" type. If, on the successful completion of this procedure, a new symptom should appear, the possibility that a higher system is involved should be given serious consideration. A further use of diagnostic techniques may be called for. The nature of the findings and the insight of the therapist must then decide whether further direct conditioning is desirable or a change of tactics called for.

In the case of distortion the approach of the therapist may need to be on more analytic lines, designed in the first place to increase the insight of both patient and therapist as to the nature of the disorder. The choice of analytic procedure should be made according to the nature of the situation. To make the most effective use of the therapist's

knowledge and skill there must be appropriate direction by him; direct commonsense discussion will be more rapid than "depth" methods. Jargon of the psychoanalytic type should be used only when it is required as a subtle instigator for new behaviour. Free association and study of dreams may be resorted to sometimes when a new lead is required, but the therapist should be duly alive to the peril he risks from the ease with which such material can be twisted to fit diverse hypotheses. Such an approach should be used only to provide new hypotheses, and these should never be accepted without adequate confirmation by more objective means.

Tests of various kinds may greatly shorten the time for diagnosis. As we gain more insight into the nature of mental disorder the provision of such aids will doubtless be greatly improved. The various interview techniques should likewise improve. The value of these must be decided by careful research studies using objective methods of assessment. Much work has already been done, Eysenck and others have exposed the startling weakness of some widely used projective tests; but until much more is done the therapist needs to keep an open mind and be ready to experiment with the tests and procedures of other than his favourite school when the better-established tests or procedures seem inapplicable.

Various claims have been made for the effectiveness of different types of therapy. Wolpe (1958) for example, claims nearly 90% success for reciprocal inhibition as compared with 62% for the Berlin Psychoanalytic Institute and 53% for the

New York Hospital using convential therapy other than psychoanalysis, but it is difficult to assess the significance of such figures since they may refer to very different populations. The hospital sample may be an unfair comparison in that much less time may have been devoted to each patient than in the case of the reciprocal inhibition series, but the psychoanalytic series almost certainly was given more time. Nevertheless the poorer average success with the latter does not necessarily indicate that the psychoanalytic method has no merit. The cumbrous and indirect approach of psychoanalysis may be decidedly inferior for the simpler type of case; but it is still possible that it has merit for certain other types. This hypothesis still requires investigation.

3. Prophylaxis.

There are - as I have endeavoured to show throughout this thesis - several major general prerequisites for the development and continuance of a state of mental health or well-being. These may be listed as:

(1) Open communication at all times within ourselves and with others - this obviously requires "honesty" or correct factual information, and "rational" concepts or conclusions based on the known facts but left open to change as and when new facts become known.
It is quite obvious that we cannot possibly "live", "behave", "work" or "express ourselves" at our optimal

level if our nervous systems are choked up with a never-ending stream of messages based largely on fear or anger, undue hope or despair, in situations which should either stimulate none of these reactions, or only to a degree leading to positive adaptive behaviour, in the form of changed reference systems or externalised behaviour.

(2) A positive affective drive towards all human beings, modified only within given situations by harmful experience, and leading then only to "healthy" adaptive behaviour either by the individual, society or its agents, aimed at self-protection and modification of the aggressor's behaviour.

(3) The provision of adequate learning situations, the teaching of all known techniques, and the reasonable provision of equipment or other stimuli (or of avenues whereby appropriate stimuli can be obtained), for the full expression of each individual's capacities and drives. (This, of course, includes the sex drive).

(4) The constant development of goals just sufficiently difficult of achievement to motivate effort, but not so difficult of achievement as to create over-exertion and undue anxiety or depressed effort and psychological depression.

(5) The minimum of controls concomitant with one's own welfare (which requires constant goal - or maturational -

directed effort and the ability to resist extraneous or harmful stimuli) and that of other human beings.

(6) The maximum of material goods (shelter, clothing, food,) which is necessary to maintain healthy life.

One can speak of these in terms of "honesty", "responsibility", "self-actualisation", "adequate heterosexual relations", "self-discipline", "self-expression", "security" as one may prefer.

The major fact remains, however, that mental disorder, and mental health, are matters for both the individual and society. The degree of disorder and health is based almost exclusively upon the learning processes, and the teaching and learning of both individual and society. Although arguing for a somewhat different concept, Mowrer (1960) still quotes approvingly Rollo May's (1953) comment that "whenever there is widespread need for individual psychotherapy in a society, there is an institutional and structural crisis in that society." (Mowrer, ibid, p.138).

There have presumably been institutional and structural crises in all societies from the very beginnings of time. We are only now beginning to solve many of these crises. It will only be when all men are committed to the welfare or to the maximum "actualisation" of each and all men, that the constant socially-produced stresses on mental health will disappear. In the meantime prophylaxis consists of the adequate implementation of the 6 goals I have enunciated

above; while psychotherapy consists of the appropriate learning of adaptive behaviour and unlearning of unadaptive habitual responses.

II. SUMMARY:

This thesis has sought to demonstrate:

I. That the individual is born with genetically inherited drives and abilities which provide a basis on which learning takes place according to the laws of conditioning. We may distinguish several aspects of this learning process:

1. The development of an understanding of the nature of the environment, an integrated cognitive reference system in which all the stimuli of our experience typically find their place and which provides us with a multi-dimensional, cross reference map of the universe to guide our activities.

2. The development of a complex yet largely integrated motivational structure which is based primarily on genetic drives but also involves the control of these same drives in their own interest by means of the inhibitory mechanism which is a basic part of our structure.

3. The development within our motivational system of a set of social values which, while satisfying basic drive-needs in the individual, should lead to the preservation and optimal development of the social organisation.

II. That concepts of mental disorder have historically been

related to the knowledge system of the time and the socially supported values. These have shown systematic development and broad trends can be distinguished in the evolution of the concepts of disorder. There has been increasing recognition of the role of learning in both producing and treating these disorders and there has been a difference in emphasis on the area or type of learning involved: in recent times the Freudians have stressed insight (cognitive learning), the Behaviourists have stressed direct drive and response conditioning, while Existentialists and related schools have stressed social values and the ego-system. Many neo-Freudians have moved in this latter direction. All schools other than the Behaviourist seem to have neglected simple conditioning.

III. Any aspect of the personality system may be the source of maladaptive behaviour. If we are to consider treatment as essentially a process of relearning it is useful to classify disorders according to the forms of original learning involved. Diagnosis in these terms will give the maximum information as to the therapeutic techniques most likely to be useful.

1. Retarded or impaired learning due to:
   - (a) Physiological deficiency
   - (b) Enviromental deficit
2. Maladjustive habits
3. Abnormal conditioning of drives
   - (a) Classical
     - (i) simple
     - (ii) with dissociated affect
   - (b) Operant

4. Abnormal conditioning of affection (special form of 2), relating to:
   (a) marital relations
   (b) family relations
   (c) social relations
5. Abnormal "drive-traits" or conditioned affect.
6. Faulty ego-structure components:
   (a) Ego control
   (b) Self sentiment
   (c) Ego-ideal
   (d) Super-ego
7. Distorted cognitive reference frame
8. Abnormal physical symptoms:
   (a) Incidental (psychosomatic)
   (b) Instrumental ("conversion symptoms")
9. Maladjustive defence habits ("ego-defence mechanisms)
10. Psychotic reaction
   (a) schizophrenia
   (b) paranoia
   (c) manic depression
11. Environmental frustration
12. Anomie.

IV. All forms of therapy are ultimately directed towards re-learning or unlearning. Psychoanalytic and associated therapies are not to be criticised because they are not concerned with learning but rather because they do not properly realise learning is the aim and do not make use

of the most efficient forms of learning for the purpose concerned. It is more efficient for a teacher to drill a pupil on the fact that 11 x 12 = 132 than to strap him for low marks in arithmetic. In therapy we may sometimes have a similar contrast between clumsy and efficient ways of dealing with a deficit. It is useful, therefore, to classify the different ways in which learning is involved.

A. Type of learning process
   1. Cue conditioning and counter-conditioning
   2. Operant conditioning
      (a) incentive learning
      (b) probability assessment
   3. Satiation
   4. Extinction
   5. Reciprocal inhibition and conditioned inhibition
   6. Cognitive learning

B. Current behaviour instigator
   1. Role-playing
   2. Imitation
   3. Counselling
   4. Revised cognitive reference

C. Reinforcers
   1. Natural consequences
   2. Approval and disapproval of therapist
   3. Environmental change
   4. Artificial
   5. Hypnotic suggestion or fantasy

D. Area of learning involved

1. Conditioned drives, etc.

2. Ego-structure components

3. Cognitive reference system

E. Facilitating techniques

1. Relaxation

2. Abreaction

3. Catharsis

4. Scheduling reinforcement

V. The application of these principles to ten adult and child patients produced notable improvement during treatment periods of a few weeks to six months.

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APPENDIX A

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QUESTIONNAIRE E.S.

Blacken in, on the answer sheet provided, the circles which correspond to the answer you prefer.

1. I go to church (a) always (b) often (c) seldom.
2. (a) I would not willingly do anything to lose the respect of my fellows.
   (b) There might be circumstances under which I might risk loss of respect.
   (c) I don't think one should be overconcerned about the respect of others.
3. (a) I want to be a leader in my profession.
   (b) I would like to achieve some distinction in my profession.
   (c) I shall be satisfied to do a good professional job and live a worthwhile life.
4. I easily lose my temper. (a) true (b) doubtful (c) untrue.
5. I find difficulty in deciding what I ought to do (as opposed to difficulty in doing what I have decided!)
   (a) often (b) occasionally (c) seldom.
6. I do things for which I am sorry afterwards.
   (a) frequently (b) occasionally (c) seldom.
7. I refrain from doing something because I do not wish to hurt someone's feelings.
   (a) often (b) sometimes (c) seldom.
8. I would commit a mildly dishonest act for the sake of a friend
   (a) if it meant very much to him
   (b) only to avoid an extreme threat to him
   (c) under no circumstances whatsoever.
9. (a) I frequently deny myself things because I know it will be better for me in the long run.
   (b) I take reasonable care to avoid over-self-indulgence.
   (c) I believe in enjoying the present as well as one reasonably can.
10. I want to make some creative contribution to the world
    (a) strongly (b) sometimes (c) not important.
11. I get panicky with little provocation. (a) true (b) doubtful (c) untrue.

12. After I have decided on some course of action I find that my attitude has changed so that I wish to change my decision.

(a) often (b) occasionally (c) seldom.

13. I do not keep careful control over my behavior and so I suffer shame because of failure to live up to my ideals.

(a) frequently (b) not often (c) seldom or never.

14. When I see a fluffy kitten I feel a desire to stroke and fondle it.

(a) often (b) sometimes (c) seldom or never.

15. When Oedipus committed incest with his mother

(a) he was not really guilty because he did it in ignorance

(b) he was technically guilty but justifiably excused

(c) he had gravely infringed the moral law despite any excuse pleaded.

16. (a) I hope always to be able to fully control my behavior.

(b) I shall be satisfied if my lapses from self-control are seldom and unimportant.

(c) The person who aims at rigid self-control lacks the elasticity necessary for living.

17. I aim to get at least

(a) a bachelor's degree (b) a master's degree (c) a doctorate.

18. A sad story or picture brings tears to my eyes

(a) often (b) occasionally (c) seldom or never.

19. It is not easy to have clear-cut priorities which will guide one's behavior under all kinds of circumstances.

(a) strongly agree (b) inclined to agree (c) consider this overstated.

20. I am impulsive and often act without sufficient thought for the consequences.

(a) true (b) doubtful (c) untrue.

21. The keeping of animals as pets should be discouraged.

(a) strongly agree (b) doubtful (c) disagree.

22. The spy who seduced the admiral's wife in order to gain important information for his country

(a) committed a grave sin

(b) was probably justified if no alternative was open to him

(c) did his duty commendably.

23. (a) There is at least one person (living or dead) of whom I know whose moral behavior I should like to equal.

    (b) I am often impressed by the accounts of highly moral behavior which I cannot hope to attain.

    (c) As an ordinary human being I am content to live according to the standards of people like myself.

24. (a) I shall be happy to achieve my degree.

    (b) I shall be disappointed if I do not pass with high grades.

    (c) I am keen to get top marks in my class.

25. I feel embarrassed in social situations

    (a) often (b) occasionally (c) seldom or never.

26. If I have done something wrong my conscience continually nags me even when I can find good justification for my action.

    (a) frequently (b) sometimes (c) seldom.

27. The end justifies the means

    (a) occasionally (b) very seldom if at all (c) definitely never.

28. There are occasions when I feel ashamed because I have failed to live up to my own ideals in some way.

    (a) often (b) sometimes (c) seldom.

29. (a) I often daydream of future success.

    (b) I spend quite a lot of time planning and thinking of the future.

    (c) I make plans but do not waste time dreaming.

30. I am inclined to worry

    (a) very much (b) not more than average (c) very little.

31. I am perhaps too "straightlaced" about my behavior.

    (a) true (b) doubtful (c) untrue.

32. An action is right or wrong in the eyes of God and no human reasoning can alter the fact.

    (a) strongly agree (b) doubt this (c) disagree.

33. I want to satisfy my sense of duty to my community and my country.

    (a) feel very strongly

    (b) occasionally feel rather strongly

    (c) seldom if ever consciously consider it.

34. (a) If I got low grades I would be ashamed.

    (b) If I failed an exam I would be ashamed.

    (c) If I failed an exam I would be sorry but not necessarily ashamed.

35. I wish that my emotions were not so intense.

    (a) often (b) sometimes (c) seldom if ever.

36. To betray a friend is far more reprehensible than to break some abstract ethical law.

    (a) strongly agree (b) doubt this (c) disagree.

37. I want to become prosperous and have a large income.

    (a) very much (b) average (c) this is not very important to me.

38. I feel an intense thrill of delight in contemplating some scenes

    (a) often (b) occasionally (c) seldom.

39. I swing from being very happy to being very sad or vice versa.

    (a) often (b) occasionally (c) seldom.

APPENDIX B

QUESTIONNAIRE E.S.

Blacken in, on the answer sheet provided, the circles which correspond to the answer you prefer.

*E.C. 1. I am impulsive and often act without sufficient thought for the consequences.

(a) true (b) doubtful (c) untrue

*Em. 2. I am inclined to worry

(a) very much (b) not more than average (c) very little

*S.S. 3. (a) I want to be a leader in my work.

(b) I should like to achieve some distinction in my work.

(c) I shall be satisfied just to do my work competently and live a worthwhile life.

*Comp. 4. When I see a fluffy kitten I feel a desire to stroke and fondle it.

(a) often (b) sometimes (c) seldom or never

*R.S.E. 5. An action is right or wrong in the eyes of God and no human reasoning can alter the fact.

(a) strongly agree (b) doubt this (c) disagree

*E.I. 6. (a) I hope always to be able to fully control my behaviour.

(b) I shall be satisfied if my lapses from self-control are seldom and unimportant.

(c) The person who aims at rigid self-control lacks the elasticity necessary for living.

*Exp. 7. The spy who seduced the admiral's wife in order to gain important information for his country

(a) committed a grave sin

(b) was probably justified if no alternative were open to him

(c) did his duty commendably.

*N.S.E. 8. I would commit a mildly dishonest act for the sake of a friend

(a) if it meant very much to him

(b) only to avoid an extreme threat to him

(c) under no circumstances whatsoever.

*In original test.

*E.C. 9. I do things for which I am sorry afterwards
(a) frequently (b) occasionally (c) seldom

*Em. 10. I easily lose my temper.
(a) true (b) doubtful (c) untrue

*S.S. 11. I want to make some worthwhile contribution to the world
(a) very much (b) slightly (c) not at all

*Comp. 12. A sad story or picture brings tears to my eyes
(a) often (b) occasionally (c) seldom or never

*R.S.E. 13. I go to church (a) always (b) often (c) seldom or never

*E.I. 14. It is not easy to have clear-cut priorities which will guide one's behaviour under all kinds of circumstances.
(a) strongly agree (b) inclined to agree (c) consider this overstated

* Exp. 15. The end justifies the means
(a) occasionally (b) very seldom if at all
(b) definitely never

*SE. 16. When Oedipus had sexual intercourse with his mother, whom he had not seen since his birth
(a) he was not really guilty because he did not know she was his mother
(b) he was technically guilty but justifiably excused
(c) he had gravely infringed the moral law despite any excuse pleaded

*E.C. 17. I do not keep careful control over my behaviour and so I suffer shame because of failure to live up to my ideals.
(a) frequently (b) not often (c) seldom or never

*Em. 18. I wish that my emotions were not so intense.
(a) often (b) sometimes (c) seldom if ever

*SS. 19. People who are too ambitious miss the most important things in life
(a) true (b) doubtful (c) untrue

*Comp. 20. I refrain from doing something because I do not wish to hurt someone's feelings.
(a) often (b) sometimes (c) seldom

R.S.E. 21. If we do right we need not fear the consequences

(a) true (b) doubtful (c) untrue

*E.I. 22. (a) There is at least one person (living or dead) of whom I know whose moral behaviour I should like to equal

(b) I am often impressed by the accounts of highly moral behaviour which I cannot hope to attain.

(c) As an ordinary human being I am content to live according to the standards of people like myself

*Exp. 23. I want to become prosperous and have a large income

(a) very much (b) average (c) this is not very important to me

S.E. 24. Should a girl consent to sexual intercourse if it would save the life of a friend?

(a) Yes (b) doubtful (c) No

*E.C. 25. There are occasions when I feel ashamed because I have failed to live up to my own ideals in some way.

(a) often (b) sometimes (c) seldom

*Em. 26. I get panicky with little provocation

(a) true (b) doubtful (c) untrue

S.S. 27. I want to have an important job where other people have to take notice of my ideas

(a) very much (b) would like this (c) not important

*Comp. 28. To betray a friend is far more reprehensible than to break some abstract ethical law.

(a) strongly agree (b) doubt this (c) disagree

R.S.E. 29. God would not punish us for a sin committed for a good purpose.

(a) agree (b) doubtful (c) disagree

*E.I. 30. (a) I frequently deny myself things because I know it will be better for me in the long run

(b) I take reasonable care to avoid over-self-indulgence

(c) I believe in enjoying the present as well as one reasonably can.

Exp. 31. It is not what one <u>does</u> that is right or wrong but what one achieves

(a) Agree (b) doubtful (c) disagree

S.E. 32. Theft can never be justified no matter what the purpose

(a) agree (b) doubtful (c) disagree

*E.C. 33. After I have decided on some course of action I find that my attitude has changed so that I wish to change my decision

(a) often (b) occasionally (c) seldom

*Em. 34. I am perhaps too "straightlaced" about my behaviour

(a) true (b) doubtful (c) untrue

S.S. 35. I should like to distinguish myself in some way and not be just an unknown individual all my life

(a) very much (b) would like this (c) not important to me

Comp. 36. Parents who are cruel to their children are unfit to be accepted as decent citizens

(a) strongly agree (b) doubtful (c) disagree

R.S.E.37. A good man is one who obeys the laws of God in every detail

(a) agree (b) doubtful (c) disagree

E.I. 38. (a) I hope I shall always behave in a morally approvable way

(b) I hope that there will be very few occasions in my life when I shall feel I have failed to do right

(c) I think one should take a commonsense view of the ability of a human being to behave perfectly

Exp. 39. It is sometimes justifiable to tell a lie

(a) agree (b) doubtful (c) disagree

S.E. 40. A person may commit a crime without being found out but he can never get away from his own conscience

(a) definitely true (b) usually true (c) doubtful

Em. 41. I get so worried that I find it difficult to sleep

(a) often (b) sometimes (c) never

E.C. 42. I think one should enjoy life, not spend it preparing for the future

(a) Yes (b) doubtful (c) no

R.S.E43. I always try to behave in accord with the teachings of the Bible

(a) yes (b) doubtful (c) no

E.I. 44. It is more important to maintain one's own self-respect than to secure the approval of others

(a) strongly agree (b) doubtful (c) disagree

Exp. 45. Acting according to moral values when important issues are at stake is either intellectual laziness or fear of responsibility.

(a) agree (b) doubtful (c) disagree

S.S. 46. In my work I:-

(a) Always try to do a perfect job

(b) Strive for a reasonably high standard

(c) Do not waste energy in trying to do something better than is needed

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