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FOR THE PHYSICIAN IN GENERAL PRACTICE

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THE MEANING OF PAIN - PAGE 7

the psychiatric bulletin

for the physician in general practice

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The Cover

● **Although pain is a universal experience, its meaning is completely personal. Whatever the cause, the reaction of the sufferer is the essential guide to care. A discussion of the evaluation of pain begins on page 7.**

● **A concept of pain is depicted in the cover drawing by Joseph F. Schwarting.**

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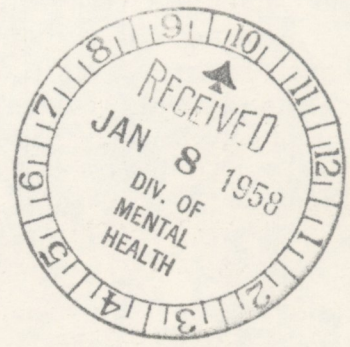

CONTENTS

The Schizoid Personality

The self-imposed barriers to total adjustment

ESSENTIAL CHARACTERISTICS of the schizoid personality include the avoidance of close personal relationships, inadequate expression of aggressive feelings, and autistic thought processes. The schizoid child is usually reticent, shy, obedient, and sensitive. Such children have few playmates and ordinarily are considered unusually well-behaved. During adolescence, social withdrawal becomes more pronounced, and the adult of this type is introverted, aloof, and sometimes eccentric. Competition is distasteful to the schizoid, although he may admire or envy the accomplishments of others, and may experience vicarious triumphs in daydreams. At times the schizoid may seem to wish for companionship but because he is unable to respond to friendliness, associates soon discontinue attempts at social exchange. Even when a presumably close relationship does exist, communication may be limited. For example, the wife of a schizoid patient stated that although she had lived with her husband for 20 years, she felt that she did not really know him.

Except for seclusiveness and inability to relate well to other persons, there is no absolute personality profile of the schizoid individual. Menninger described several types, which include the seclusive, the artistic, the insensitive, the disagreeable, the rebellious, and the apparently stupid.

The seclusive type of schizoid may be observed in the studious, reserved, pedantic individual who obviously prefers to be alone. His selection of activity is limited to solitary pursuits such as long walks, listening to music alone, and extensive reading. Frequently, he is a learned person with much to offer as a companion but so self-conscious that he is distressed by the intrusion of other persons.

Despite lack of social contact, the artistic schizoids often achieve success and acclaim. Their talents provide methods of expression and communication which can be recognized and appreciated. Many writers, artists, poets, and musicians have demonstrated this type of personality.

The schizoid who lacks sensitivity may be most representative of the original meaning of the prefix *schiz-* or split, because the insensitivity is often observed in an otherwise seemingly normal individual. Furthermore, the emotional detachment is manifest in specifically directed behavior. For example, callous, ruthless cruelty may be demonstrated in criminal acts. In contrast, the specific behavior may be constructive; the individual's detachment may be used in objective scientific work.

Perhaps the most unpopular schizoid is the consistently disagreeable individual. In any occupation which involves association with other persons, his disagreeable manner may seem both deliberate and inherent. Actually, such an attitude is a defensive measure to insure protection.

The rebellious or visionary schizoid is concerned with radical reform. Although such persons are not obviously shy and withdrawn, they seldom permit close individual relationships. The successful ones may be known as great religious or political leaders; otherwise, these individuals are regarded as troublemakers.

Menninger explained the category of apparently stupid schizoids as that of "pseudo-stupidity." Obviously, there are schizoid individuals with diminished intellectual ability, but it is not characteristic. Therefore, the indifference or the lack of interest, initiative, or progressiveness is simply another form of evasion. Frequently, such persons take pride in conservatism and dislike for innovation. They may choose to live in remote areas with only the most rudimentary facilities, or may isolate themselves in large cities and protest the progress around them.

Whatever the type, all schizoids experience some anxiety. This anxiety is sufficiently pervasive to influence every endeavor and the individual is seldom free from it. The many schizoids who achieve and maintain adequate adjustment throughout life do so as a result of much more effort than is required of most persons. Undoubtedly, the schizoid individual is subject to many frustrations that engender feelings of hostility, although they are not usually interpreted as such. Fisher, as cited by Nannarello, stated that the accumulated inner tensions sometimes become displaced and discharged in an uncontrolled manner. Hoch has described as characteristic the sudden, apparently unprovoked rage of the schizoid, with outspoken hatred, particularly toward a member of the patient's own family.

Less dramatic but equally unusual behavior may occur in inappropriate responses. The schizoid's behavior is conditioned primarily by inner motivation rather than external stimuli. Examples of such behavior are flight from a friendly approach, or an abrupt reply to a courteous comment.

The term *schizoid personality* does not, of itself, connote a degree of disturbance. Mildly schizoid persons usually maintain satisfactory adjustment. Occasionally, however, such an individual may seek assistance because of difficulty in making friends, feelings of inadequacy in work situations, or general social discomfort. The physician may help the patient to adjust within the margins of his limitations. Specifically, such

patients should be encouraged to engage in activities which cause the least discomfort, and those which will provide emotional fulfillment.

The physician's further responsibility is that of observation for demobilization of the patient's defenses. This might be demonstrated by such manifestations as heightened anxiety, complaints of sleeplessness, increased autistic thinking, and beginning denial of reality.

Hoch and Polatin reported features which distinguish the schizoid from the neurotic individual. In addition to diffuse anxiety, the schizoid experiences many different neurotic symptoms, sometimes simultaneously. In contrast, the neurotic patient usually suffers from one emotional disorder, with otherwise normal adjustment. Another difference may be noted in presentation of complaints. The neurotic usually describes problems in detail and tries logically to find a causative factor. The schizoid's recital is more likely to be vaguely contradictory, with few details, and with considerable repetition of the initial comments and complaints.

Studies of schizophrenic patients have shown that more than half were of the schizoid personality type before the development of psychosis. Although many schizoid persons do not become schizophrenic, it is apparent that individuals with such traits have some predisposition toward the disorder. This predisposition is probably the result of a combination of genetic, constitutional, and environmental factors.

The schizoid personality is not uncommon, and includes several different structures. The most obvious characteristic in all types of schizoid personality is the avoidance of any close personal relationships. Schizoids, however, often do maintain family and social adjustment and make significant contributions to society.

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BOOK REVIEWS

● PSYCHOTHERAPY OF THE ADOLESCENT. *Edited by Benjamin H. Balser, M.D. Pp. 270. Price $5. New York, International Universities Press, Inc., 1957.*

A symposium on the subject of psychotherapy with adolescent patients was held in May, 1955, before the Child Psychiatry Section of the American Psychiatric Association. The ten papers in this collection are an outgrowth of that symposium, expanded from the authors' presentations, and with two added supplemental papers. The discussions concern psychotherapeutic procedures with adolescents at the levels of private practice, school, clinic, and hospital. There is a bibliography of 61 items, and a subject and author index. The physicians represented are I. M. Josselyn, W. L. Peltz, J. F. Robinson, S. Berman, H. I. Harris, F. P. Heald, D. C. Greaves, P. F. Regan, III, E. E. Welsch, E. A. Steele, B. H. Balser, and R. R. Pottash. Mr. C. I. Chase adds the viewpoint of the schoolteacher to this collection of opinions as to emotional problems of adolescents.

● CLINICAL APPLICATIONS OF SUGGESTION AND HYPNOSIS, *3rd ed. By William T. Heron, Ph.D. Pp. 165. Price $3.75. Springfield, Charles C Thomas, 1957.*

It has been four years since the last edition of this book, and during that time therapeutic hypnosis has had another renascent period. Because of the increasing and changing usage, professional literature on the subject is needed and important. This particular monograph is, according to the preface, a statement of practical principles and not a compendium of the accumulated knowledge of the subject, a handbook instead of a summary. Although the volume is only slightly longer than the second edition there are added chapters, and for the first time specific induction routines are included. Three production methods are described, and there is a chapter on utilization of tape-recordings. The author cites case histories, itemizes suggestions for the practitioner, and there is an annotated bibliography. The volume is indexed by subject and by author.

● ART AND PSYCHOANALYSIS. *Edited by William Phillips. Pp. 552. Price $8.50. New York, Criterion Books, 1957.*

The essays in this interesting and surprising collection pertain to psychoanalytic examination of artistic creativity. The debated kinship of genius and neurosis or the relationship of artistic productivity to mental imbalance has been the subject of much speculation and of many literary studies. William Phillips explains briefly his criteria for choosing these particular papers and, in his introduction, the changing ideas both of the artist's function and of analysis of the creative process. Twenty-six papers are included, some by analysts, others by professional writers. The volume opens with Freud's paper on Dostoevsky, and concludes with Edmund Wilson's "Philoctetes: The Wound and the Bow." The editor's selection has been fortunate and the reader is afforded variety and contrast, whether in essays on theory, or in others on individual artists and individual works of art.

William Alanson White

TWENTY YEARS AGO American psychiatry lost an important influence with the death of William Alanson White (1870-1937). The impact of his dynamic character upon many aspects of psychiatric endeavor is still discernible. Famed as the long term administrator of St. Elizabeth's Hospital, throughout the 34 years from 1903 until his death, his talents were never confined to a single scientific discipline. White was a man of enormous intellectual curiosity, with an open mind for new theories. He wrote voluminously and made innumerable addresses upon an amazing variety of psychiatric topics. These included expression of his forthright, definite opinions on such subjects as psychiatry and criminal law, mental hygiene in all its ramifications, the need of sound psychiatric instruction in general medical schools, the importance of military psychiatry, and, above all, the sturdiest early support in America of the theories of Freud.

Possibly White will be best remembered as Freud's staunch defender at the very time, in 1914, when psychoanalysis was being assailed by withering condemnation from many distinguished psychiatrists. White made what he called his first public defense of psychoanalysis in that year's meeting of the American Medico-Psychological Association, at Baltimore. The President of the Association was openly and violently opposed to the psychoanalytic movement, and two papers had just been read by confreres of White's, each calculated to tear to shreds all Freudian concepts. In a brief impromptu rebuttal, spiced with tolerant humor, White frankly proclaimed his own position: "I am a psychoanalyst; I want the truth and I am willing to welcome any light that may be thrown on the situation. . . . If our interpretation is wrong, there is a right interpretation, and I ask the people who criticize the movement to come forward and tell us what these things mean."

When only 22 years old, White was appointed to the medical staff of the State Hospital at Binghamton, New York. By 1903, he had become Assistant Superintendent. While here he first met Jelliffe, and soon was making abstracts of foreign medical publications for Jelliffe's "Journal of Nervous and Mental Disease." Also at this time, White became interested in Kraepelin's categories of mental disorders. Thus, even before his preoccupation with Freudian ideas, he was making detailed notes upon the disjointed conversations of his own patients.

To the pathological laboratory, hitherto the only scientific adjunct of the usual American mental hospital, White added the psychological laboratory. Thereby he instituted intensive diagnostic screening of new admissions, to segregate the potentially curable. He was likewise an early advocate of follow-up procedures and assistance in social adjustment for discharged patients.

A few months after his appointment to St. Elizabeth's, White made his first trip abroad. Whatever practice White noted as valuable in Europe, he characteristically adopted for use in this country. For example, he noted that at Berlin and Heidelberg German Army medical officers were regularly receiving psychiatric instruction. On his return, he promptly suggested to the U.S. Surgeon-General liaison between St. Elizabeth's and the Army Medical Corps, if only to avoid wastage incurred by the then frequent enlistment of defectives. His suggestion was accepted, and the plan was soon expanded to include the Navy and the Public Health Service. When the United States entered World War I, White introduced to Surgeon-General Gorgas the organizers of the first psychiatric unit to be attached to an American military hospital.

Under White's administration, St. Elizabeth's became also the first American mental hospital to establish a ward for criminal offenders. And it was White's appointee as head of this department, Dr. Bernard Glueck, who was invited by the American Mental Hygiene Association, in 1916-17, to make a survey of 608 Sing Sing Prison admissions. It has since been agreed that the results of this survey were to establish psychiatry as a basic adjunct to effective penal administration.

These are, however, only a few highlights of an extraordinarily productive career. In 1924-25, White served as President of the American Psychiatric Association. In 1930, twenty-two years after his first eager participation in the inception of the mental hygiene movement in this country, he delivered, as President of the American Association, an address to more than 3000 delegates who attended the first International Congress on Mental Hygiene. The William Alanson White Foundation was begun during White's lifetime, and has afforded valuable service in both education and publication.

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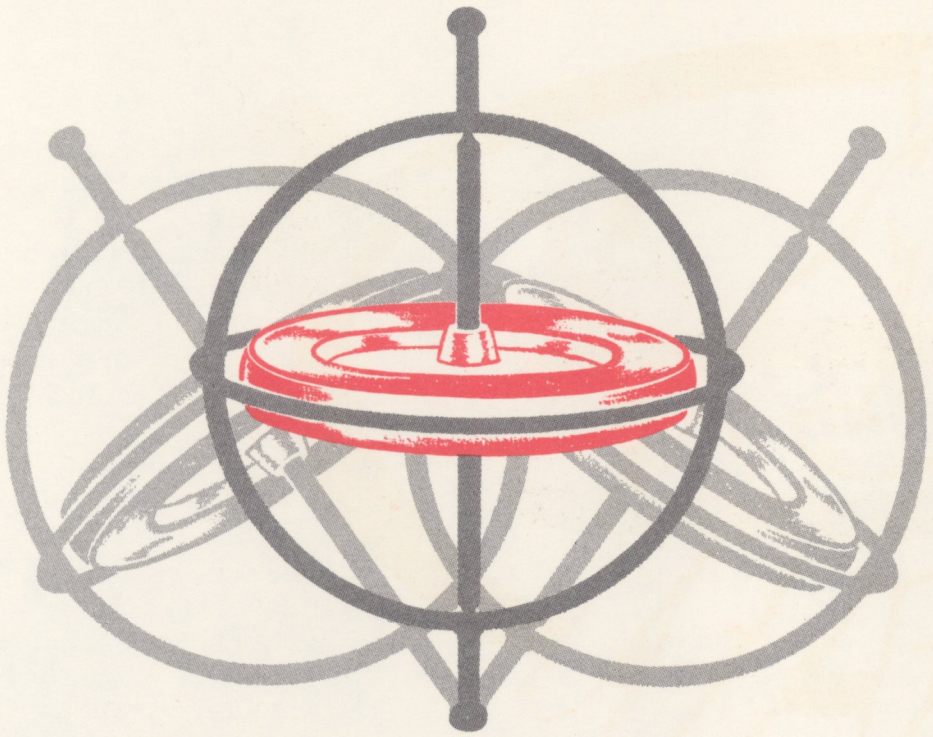

TRANSFERENCE AND COUNTERTRANSFERENCE

Emotional balance necessary in the successful therapeutic relationship

● During the process of personality development, each individual attempts to find a behavior pattern which will be well received by the persons in his environment that are significant to him. Conflict results when the behavior necessary for approval is in opposition to the individual's emotional reaction. In order to maintain a serene relationship, however, conflict is repressed, and, later, the emotion may be unwittingly expressed by inappropriate behavior toward another individual. This later demonstration is termed *transference*, and is frequently evident in a patient's attitude toward his physician. The patient is unaware of the reason for his behavior, or of the effect of the previous conflict. In psychoanalysis, the therapist interprets both aspects, and helps the patient toward self-understanding. Two types of transference are recognized: an unwarranted display of affection is called positive transference; unprovoked hostility is designated as negative transference. The attitudes described may be evidenced by expensive gifts, unnecessary calls, and other devices to get attention; or, conversely, by refusal to cooperate, questioning of the physician's competence, or withdrawal from treatment. Either situation requires objective evaluation, and, if no causative factor can be determined, either may be considered a transference reaction. Transference is actually a form of resistance, because emotion is discharged without painful recognition of the initial conflict. However, since the release is displaced, it does not afford adequate relief from distress. Transference is also considered a valuable indication of the patient's specific need. Exploration of the origin of a transference reaction is best performed by a therapist who has himself been psychoanalyzed, so that he can avoid projection.

Similarly, when the physician's behavior to a patient is determined by emotions experienced in an earlier relationship, the reaction is termed *countertransference*. This emotional reaction has also been described as the physician's response to the patient's transference reaction. Intense feelings toward a patient are generally regarded as unprofessional, but they are sometimes unavoidable. Several recommendations have been made for the management of countertransference. According to Fenichel, the physician who reacts as the patient's parents had done simply repeats the circumstance that caused conflict. If he demonstrates the emotions that the patient wishes from him, the possibility of interpretation may be lost, because the patient will have responded to a present stimulus instead of a previous one. Fenichel believed that the physician should react in neither of these ways, but should concentrate upon interpretation. In contrast, Brody cited an instance in which neutrality from the therapist resulted in the patient's increased agitation. The patient was hostile, sarcastic, and vexatious toward the physician, who, with considerable effort, maintained an increasingly solicitous attitude. Since the patient's depression did not improve, the physician asked advice, and was told that his unrealistic response of extreme kindness simply increased the patient's feelings of guilt. When the physician reacted more normally, the patient's guilt and depression lessened. Flescher remarked that complete emotional separation from the patient precludes the empathy necessary to successful treatment. Hora has described transference and countertransference as "growth-promoting" for both patient and physician. Furthermore, the physician who reviews and examines the psychic interaction implicit in any such professional relationship may benefit in greater understanding of human interdependency.

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The Meaning of Pain

The reality of pain to the patient

● INVESTIGATION OF HUMAN PAIN is a difficult problem because pain is not simply a sensation or a reflex reaction to a particular stimulus. Instead, pain is a complex experience and consists of the perception of pain and the reaction to it. The simple perception of pain is, presumably, the same for all persons. The biological meaning of pain, as Szasz phrases it, is the same for all individuals, and experiments by Wolff and others support this opinion. Biologically, then, pain is a signal by which the organism registers the message that there is something wrong. Since pain is also a cognitive process, it is widely variable as far as the individual reaction is concerned. According to Beecher, this is explained by the fact that there is a cortical mediation. This is a processing of the simple perception, which is affected by many factors of the patient's total experience. Despite the uniformity of pain perception, variations in tolerance of pain occur at different times within the same individual. Also, among different individuals, reactions to the same stimulus vary from mild protest to complete vasomotor collapse. Actually, little is known about the amount of variance of the threshold of pain among different individuals.

If the simple sensation is a constant, variations in the pain threshold must arise from the second or reaction component. Evidence that the two components of pain can be separated actually as well as analytically is provided in clinical observations. For example, Kolb found that a patient after prefrontal lobotomy for intractable pain no longer complained of pain; yet, if asked, the patient would state that he still had the pain. In other words, the emotions of anguish and dread become separated from the perception of the pain stimulus.

Hardy and Wolff noted other instances of dissociation of the two aspects of pain. They cited the disinterest in injury during games or combat; the failure to react to tissue damage during hypnosis or catalepsy; indifference to tissue injury during auto-suggestion and during religious and mystical experiences; failure to perceive injury in sexual excitement; and the obliteration of pain sometimes witnessed during parturition.

Understanding of the second component of pain involves recognition by the physician that the expression of pain is a primitive method of asking for help, and that pain can be a symbol whose referent is not distress of the body. The second component is a kind of communication related to the well-being of the whole organism. All of the factors involved in the experience of pain should be understood, because the nervous system must be thought of by the physician as a functional unit.

The experience of pain, no matter what the origin of the actual sensation, is closely bound with the ego which has been conditioned by previous experiences. The communication of pain has been construed by Szasz as a cry for help, and when the plea is unanswered, "the persistence of the pain becomes a symbol of rejection . . . The repeated complaint of pain is also a disguised aggression (retribution) against the frustrating, rejecting authority," whether that authority is the physician, family, or institution. Since there is a kind of symbolic transformation in such a case, the pain means far more to the patient than a simple reaction to an immediate physical stimulus.

According to Kolb, pain may be said to have undergone some such transformation, and to have become a psychiatric problem in such instances as these: when there are no indications of organic disorder or the symptom persists beyond the usual known period for an acute illness or injury; when analgesia neither relieves nor aggravates the symptom;

when the pain is alleviated by the use of sedatives and hypnotics; when the patient affects indifference to the symptoms; when pain is initiated or exacerbated by discussion of particular topics; when pain is relieved by medical and nursing care that answers dependency needs; when character traits or individual symptoms suggest neurotic or psychotic disturbance; and when the life experiences are of a sort known to produce psychogenic illness.

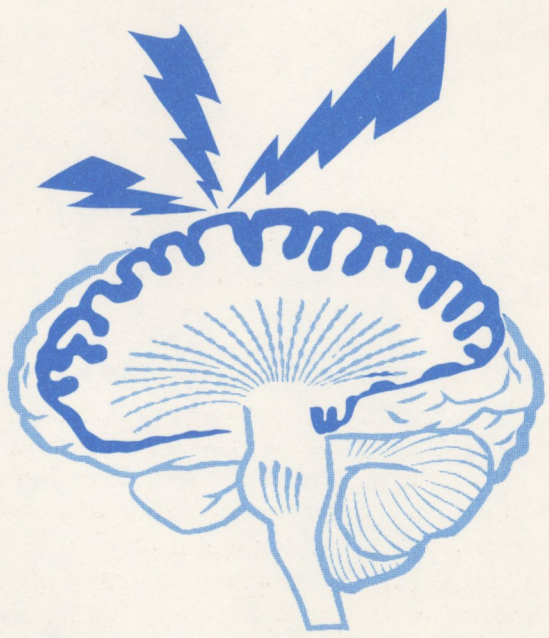
The word "pain" is derived from the Latin word meaning penalty. According to Gianakon, the experience of pain always has some element of the concept of punishment, guilt, penalty, or despair. Szasz observes that if the expression of pain consists of asking for and getting help, then pain that is silently endured may be interpreted as punishment.

An individual patient's reaction to a procedure known to cause slight pain may provide an indication of that patient's tolerance. The attitude toward pain, or pain threshold, may differ in a single individual at different times or between individuals, depending on attention to it. In addition, tolerance is affected by the state of mind, previous experience of other kinds of pain, or the duration of the present pain. Farnsworth points out that a patient bears pain more easily when he is hopeful, when he can anticipate a cessation of pain, and when he has absolute confidence in the capability of his physician.

A low pain threshold may indicate that the complaint symbolizes to the patient an emotional state associated with a previous experience of pain. The pain may express anxiety, or be a form of masochistic self punishment. What the simple perception of the pain sensation connotes to the patient depends upon the body image that he visualizes, upon his personality structure, and upon his emotional history. Schilder describes pain as a kind of focal point at which the individual's complexes, fears, and attitudes converge. This primitive means of communication is used by some patients to test the affections of others and may become an unconsciously employed mechanism by which friends or other members of the family are manipulated.

Often to unstable personalities and sometimes even to stable ones, "It is distressing but only too true," says Erasmus, "that trauma inflicted by certain therapeutic procedures . . . may itself be the starting point of a disabling painful state. The knife of the surgeon, the forceps of the dentist are as potent sources of such a state as the bullet of an enemy."

Where the pain threshold is low, relief of pain without relief of the underlying conflicts or tensions may cause depression or another manifestation of severe internal stress. In fact, in such cases the patient may



cling to his symptoms almost with desperation, especially if he senses that the physician doubts the existence or the intensity of the pain.

In such instances, even when the pain is of undoubted organic origin, its loss may bring unhappiness. Several such examples were observed by Penman after the relief of painful symptoms of tic douloureux. Pain, according to this investigator, often becomes an old friend after about six months and may be the patient's chief occupation. Pain may afford a means of avoidance of unwelcome activity, a stimulus to bravery, a sense of achievement, a refuge, a means of participation in drama, or a habit.

Penman suggests that in instances of chronic pain, the patient's personality and social circumstances should be assessed before initiation of treatment. Thus, those who will "miss" their pain can be discovered and prepared for this possibility. In his opinion it is preferable to have a smaller number of cured patients, who know that they are cured, than to report a larger group of the technically cured who are dissatisfied.

The attitude of the physician toward the patient whose pain threshold is low is especially important. The physician, says Gianakon, must "fully accept the reality of the pain which the patient feels." If he is to be of help, he must recognize the patients' rights to feel as they do about their situations and must accept the reality of their complaints.

A physician who feels that pain is not "real" because it is greater than the stimulus ordinarily excites, fails to understand the etiology of pain. He must recognize that the individual's experience of pain is actual and may be more severe than that of another patient with the same disorder. Otherwise, the physician is subject to the all-too-common tendency to reduce all pain to nothing more than a signal or referent of bodily disorder. If a child of school age, for example, complains of pain to his mother in the morning, it could be said that he complains because he does not want to go to school, implying that the child's pain is not "real." Szasz maintains that this is a meaningless assertion, because the claim of pain is a cry for help. The meaning (to the child), then, is "my situation in school is so painful to me that I need help in dealing with it." This is what Szasz calls the communication level of pain, a level always implied when a low threshold is indicated. Under such circumstances, the physician should ask himself why the patient feels pain in the absence of demonstrable disease, or feels it disproportionately.

It is helpful to the physician to remember that pain is subjective and can be evaluated meaningfully only by the ego involved. Pain is "real" to the sufferer, and "really" experienced whether it is organic or psychogenic. It is interpreted as severe or mild depending upon, not the perception threshold, but the reaction threshold of the ego. In fact, as Szasz points out, the terms *organic* and *psychogenic* do not refer to the pain at all, but to the judgment of the observer and what he considers to be the source or location of the pain. If the physician can determine a physical source for the pain, and can find it in a degree that he judges to

be "normal," the source is called organic; if he cannot determine the source as physical, he may call it psychogenic. Nevertheless, to the sufferer, the pain is as real in the one case as in the other and, in fact, may be greater and more ominous in the latter circumstance.

The close relationship between pain and anxiety is noted by many writers. Pain represents a dislocation of the ego-body relationship in the same way that anxiety represents a disruption of relation of the ego to the external world. Since physical pain is sometimes more tolerable to the ego than anxiety, a transformation takes place by which insupportable anxiety is symbolized by psychosomatic disorders, or by intensification of pain of organic origin. Even when such disturbances do not find outlet in diseases they do tend to lower the pain threshold considerably. Laughlin points out that pain can produce or increase anxiety. Conversely, when the level of anxiety is already high, the threshold of pain may be lowered. The anxious individual has less tolerance to pain, and its effects are more devastating to him than to others. Because pain and anxiety have a reciprocal influence, Beecher points out that experimental or laboratory pain is hardly comparable with the pain of the suffering patient. The difference here is one of "significance" and it is this difference which may effectively alter the pain threshold of the individual.

Experiments to determine the effectiveness of drugs in raising the pain threshold indicate that efficacy of analgesics is in proportion to the production of euphoria. Therefore, the reaction threshold is affected and not the sensation threshold. Actually, the reaction threshold can be raised without any change in the pain perception threshold.

The difficulty of analysis is increased by the fact, noted by Beecher, that human pain is unlike that of animals and, consequently, little information can be acquired from animal experimentation. Furthermore, he stated, there is little reliable correlation in comparative studies of the experimental pain threshold level and the suffering of patients.

Cooper and Braceland, among others, suggest several basic factors to be considered by the physician who evaluates the problem of pain. First, the discovery of emotions which precipitate or exaggerate a specific pain reaction is essential. Second, the individual's life situation and manner of reacting to stress should be investigated. Finally, the patient should receive a full explanation of the physical and mental interaction in disease. Mechanical efforts to relieve "psychically perpetuated pain" may, of course, perpetuate neurosis and lessen chances for successful therapy. The physician must realize that his own hostility will have adverse effect, so that patience is necessary to engender confidence. Reassurance is not always curative and may actually be harmful, while re-education of the patient is almost always the more efficacious procedure. In the evaluation of pain, the first indication to the physician is the pain threshold, for the measure of the pain threshold of an individual is the measure of the meaning of his pain to him.

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Glossary . . . . .

The terms *neuroses* and *psychoneuroses* are used synonymously. They connote reactions by which patients express anxiety directly, or unconsciously control it. For example, such defense mechanisms as conversion, phobia, or depression are employed by patients to manage the characteristic anxiety. Awareness of external reality is retained, and, except for the specific neurotic disorder, personality organization is also maintained. These two factors distinguish the neurotic reactions from the psychotic. Most neurotic individuals have had some degree of maladjustment from childhood.

Diagnostic and Statistical Manual Mental Disorders, Washington, D. C., American Psychiatric Association Mental Hospital Services, 1952, p. 31.

SEXUAL PROBLEMS OF

ADOLESCENCE

The conflicts inherent in physical and emotional maturation

DURING THE SECOND DECADE of life interest and curiosity about sex are renewed and sexual drives are reinforced. In the Freudian concept of normal psychosexual development, three stages of pre-adult sexuality are described: the period of infantile sexuality, the latency period, and the period of adolescence.

In normal development, the latency period is one of comparative emotional comfort and minimal conflict. With the onset of puberty, rapid changes occur in both physiologic and emotional structure, and the frame of reference that was formed in early childhood is suddenly inadequate. Early sexual fantasies which had been recognized as undesirable were repressed; pleasurable activities which did not receive parental approval were sublimated; and relative equanimity was achieved. This process, however, was not precisely one of selectivity. Instead, the need for acceptance by parents and by other adults, and the wish to eliminate constant instruction and control, necessitated conformity. Finally, in order to maintain self-esteem as an individual, the child rationalized the superimposed criteria as his own. These modes of behavior, with periodic modification, persist for the remainder of life unless they are displaced by other mechanisms of maladaptation.

The period of greatest modification of standards is adolescence. Sexual instincts and fantasies return with increased force and cannot easily be repressed. Further, according to Anna Freud, the sexual instinct is not the only one to be reactivated: other basic instincts and aggressive impulses are intensified. Therefore, the adolescent must determine which of the multiple drives should be preserved and which suppressed.

The selection is seldom accomplished without anxiety, although the degree of anxiety varies individually. In some instances, signs of puberty are welcomed as fulfillment of a wish to be adult. According to Bernfeld, the anxieties that occur in the adolescent who eagerly anticipates adulthood result from "external" conflicts. The adolescent is thwarted by apparent lack of adult recognition and may rebel against restriction. Actually, adolescents who claim dislike of restrictions are often dependent upon restraint, and really wish for stable parental direction. For example, Aldrich cited the instance of a young girl's calling her mother late in the evening for permission to go on to a later party. Permission was denied, whereupon the girl berated her mother in a loud but greatly relieved tone of voice.

In contrast, the other extreme in reaction to onset of puberty is the rejection and denial of even the most obvious somatic changes. The barriers against sexuality are so strong that the new manifestations may

represent considerable threat. As protection, the adolescent may eschew heterosexual contact, deplore the artifices used to attract the opposite sex, and try to maintain the serenity of the latency period. Although it is true that the adolescent should be allowed to progress toward mature relationships at his own rate, parental approbation of disinterest in sexuality may simply delay an adjustment which must be made. For example, a mother proudly spoke of her 14-year-old daughter as "good and wholesome with no interest in lipstick or boys." By the time the girl was 18 the mother consulted a physician because this lack of interest in the opposite sex persisted.

There are, of course, variations as well as combinations of the reactions. One of the principal characteristics of normal adolescence is vacillation between the wish to be adult and the wish to remain a child.

Effects of pubertal physical changes

The most significant pubertal change to the adolescent boy is the initial emission, which usually occurs at approximately the same time that the secondary sex characteristics develop. According to Kinsey, after the first emission 99 per cent of males adopt a pattern of release for sexual tension which continues until senescence. Problems may develop with respect to involuntary erection and emission, and nocturnal emissions may reactivate anxiety about enuresis. According to Spiegel, loss of control is a "severe blow to the narcissism of the male adolescent."

The most significant change to the adolescent girl is the onset of the menarche. The first menstruation usually occurs at about the age of 13, although earlier and later beginnings are normal. Usually, secondary sex characteristics appear at about the same time. In contrast to the first emission, onset of menarche does not necessarily initiate a pattern of sexual activity. Indeed, according to Kinsey, males at the age of 15 achieve a level of sexual response which is not reached by females until the age of 29. There are, however, emotional problems that may be precipitated by the menarche. The manifestation may be regarded as punishment for masturbation, or as genital injury or mutilation. A further reaction may be rejection of femininity and the associated concept of childbirth.

Masturbation

Auto-eroticism is almost universally practiced during adolescence. The belief is generally accepted that no physical or mental injury results. Emotional trauma, however, may result from the associated feelings of guilt. Even informed parents find it difficult to refrain from implied disapproval, which, in turn, impels the child to feel guilty. Adolescents themselves may believe that acne, dark circles under the eyes, and other physical disorders result from masturbation. Usually these misconceptions can be resolved by the reassurance of the family physician. According to Aldrich, however, such reassurances are negated by concurrent advice to limit frequency or suggestions of sublimation. The assurance that physical injury does not result from masturbation should suffice without added comment. Equally important, in some instances, is the knowledge that abstinence is not physically injurious, and that nocturnal emission does not result in debilitation. Baruch cites masturbation in adolescence as only a substitute until mature contact can be established. Since some adolescents do rechannel sexual activities, while others are unable to do so, parents may help most by actual understanding, whether tacit or expressed. It is apparent that most adolescents are as sensitive to implied disapproval as they are to verbal criticism.

Sexual intercourse

In the process of masculine or feminine self-identification, the adolescent will seek as an object of love someone of the opposite sex. The attachments are often short-lived but the search is a normal and necessary component in the resolution of intrafamily emotional involvement. With the new associations, and particularly in those relationships which continue over a period of months, the extent of intimacy to be permitted may be a troublesome problem. Mild demonstrations of affection are socially acceptable; sexual intercourse is not. The moral contraindications are

well-known; and Baruch has stated that the initial experience may not be particularly satisfactory, that haste and furtiveness are not conducive to relaxation, and that the security of marriage is usually requisite for adequate adjustment. Baruch further states that parents will provide meaningful help only by understanding the adolescent's strong sexual inclination and, with the acknowledgment, by affording a realistic discussion of the problem. Federn, as cited by Spiegel, mentions adolescent sexual relationships as "coarsening" and Deutsch confirms this idea with respect to adolescent girls. Parents are often particularly concerned and, as a result, establish restrictions which are too stringent. Fischer states that the parents have had 15 to 18 years in which to inculcate their concepts of good behavior, and can exert only a limited amount of influence by the time their children reach adolescence. Fischer also states that most adolescents conduct themselves adequately in this respect; promiscuity is an exception; and, indeed, adolescents are usually more inclined to be inhibited.

The adolescent who does become involved in sexual escapades may do so for one of several reasons. Such activity may be a demonstration of defiance of restriction, or a release of general hostility. The wish for a close relationship which will provide acceptance of sexual impulses that parents have not countenanced may be another reason. Baruch cited, as an example, a 16-year-old girl who reported being "tired" of her parents' lack of understanding and constant blame, and mentioned a wish to hurt them. The adolescent may be attempting to gain a sense of achievement or prowess, and subsequent recognition. Usually, these results are not accomplished; instead, the adolescent suffers anxiety and strong feelings of guilt. Any of these manifestations would be indicative of the need for psychiatric referral in order to resolve the underlying problems and achieve behavioral adjustment.

Sex education

Ideally, a child should be prepared for adolescence well before puberty. Sex education begins, as do sexual instincts, in early infancy and continues throughout childhood. By the time of puberty, attitudes toward affection, demonstrativeness, and love have been absorbed from family interaction. In addition, factual information about procreation has been provided. According to Baruch, the adolescent's particular need is for clarification of details, reassurance about unpleasant imaginings, and honest discussion of physical and emotional feelings. For example, a 16-year-old girl who became pregnant stated that although she had been told of the mechanics of impregnation, no one had explained that emotions might be uncontrollable. Many parents who can describe anatomical and physiological processes are reluctant to discuss bodily sensations. The latter subject, however, is the aspect about which adolescents are most curious. Properly, these sensations should be discussed in an atmosphere of love, understanding, and acceptance. If, however, the parents' constraint is such that embarrassment and tension dominate discussion, it is advisable to seek assistance from a suitable counselor. Often the family physician is asked for help in this matter. The physician may offer guidance to the parents, or he may talk directly to the child. If the latter method is decided upon, the child should be told why he is being sent to the physician. Several interviews may be required in order to effect an exchange of ideas. The physician may discover that the child has considerable information and that the problems are minimal, or, that a serious disturbance exists and psychiatric referral is necessary.

Conclusion

Sexual problems in adolescence may be reactivations of previous anxieties or may develop as a result of physiological changes and emotional stress. At best, adolescence is a period of confusion and conflict. It seems worthy of emphasis, however, that, despite the many hazards, most young persons achieve a sense of decorum, responsibility, and respect for themselves as well as others by the time they reach maturity.

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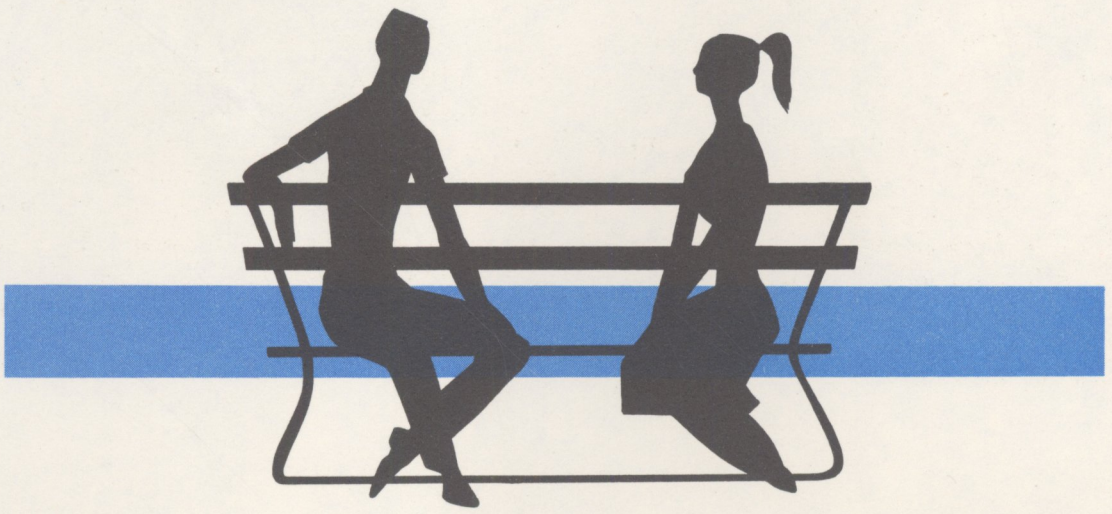

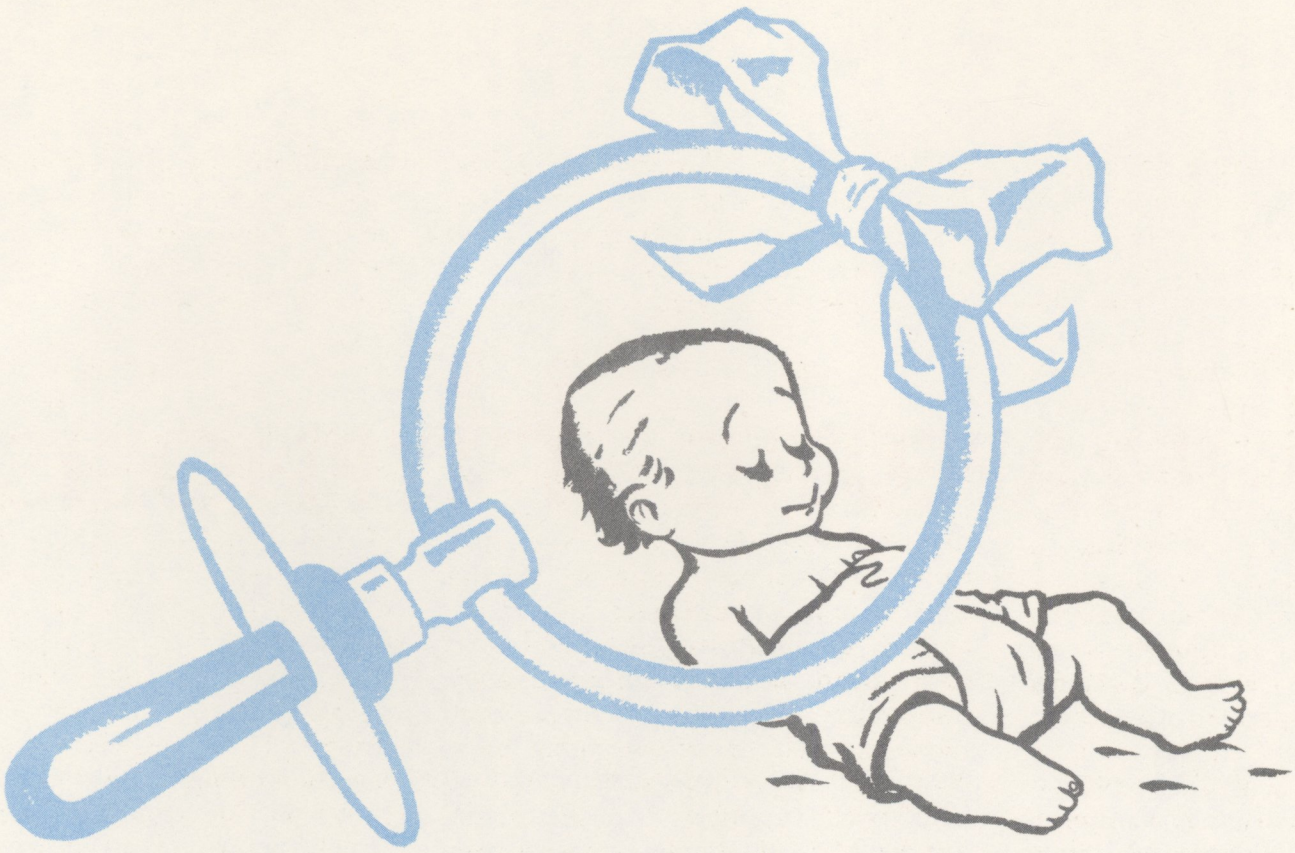

Psychogenic Aspects of Colic in Infants

● ALTHOUGH THE TERM *colic* connotes only the symptom of paroxysmal abdominal pain, it is often used to designate a common clinical entity. Colic, or "three month colic," usually begins suddenly when the infant is about three weeks of age, although earlier onset has been observed, and continues until the child is about three months of age. The infant apparently experiences severe intermittent abdominal pain. During the pain, the abdomen is rigid and distended, the legs tightly flexed, and the infant screams, seemingly in great distress. Usually the attack persists for several hours although there may be momentary alleviation of the discomfort by passage of flatus.

According to Kanner, colic occurs with greater frequency and violence in breast-fed babies, occurs more often in infants at home than in those in institutions, and recurs at the same time each day, usually in the afternoon or evening. Breslow stated that the greater frequency in breast-fed babies is attributable to inadequate food supply. Greeley and other investigators have cited the mother's apprehension or reluctance in breast-feeding as causative. Levin, in a study of 645 institutionalized infants, reported eight cases (1.3 per cent) of severe infantile colic. Brennemann has ascribed the periodicity of colic to fatigue and tension of mother and infant at the end of a day.

Breslow, in a study of 90 cases of infantile colic, classified the patients according to cause of disorders, into eight different categories. Almost half of the cases were grouped in two of the categories, with 22 per cent in the carbohydrate intolerance group and 22 per cent in the psychosomatic disorder group. The percentages of cases in the remaining groups were: eleven per cent in the fat intolerance group; eleven per cent in the hunger or underfed group; ten per cent in the allergy group; nine per cent in the group with carbohydrate intolerance plus a second factor; two per cent in the poor feeding technique group; and 13 per cent unclassified. The last category consisted of twelve babies, eight of whom were relieved of symptoms by administration of milk-free mixtures, one by elimination of orange juice, one by withdrawal of an aqueous multiple vitamin preparation, one by relief of a tight anal sphincter, and one by correction of constipation. Although several of the infants improved after dietary change, the author stated that they did not fulfill the requirements for classification as allergic.

The emotional cause of colic in infants has been defined by Ribble as inadequate gratification of the basic need to suck. Ribble observed that the initial evidence of satisfaction and release from tension in the newborn occurred after vigorous sucking. In infants weighed before and after feeding, it was demonstrated that the amount of intake was incidental to the apparent relief. Ribble studied 600 infants in the first few months of life, and concluded that the process of sucking provides both satisfaction and orientation to environment, while restriction results in anxiety. The infant may evidence distress by development of colic, and may become so tense and hyperactive that even sporadic opportunities to suck are refused. A baby may become lethargic to such a degree that stimulation of the sucking reflex is impossible. In contrast, infants who were permitted unrestricted sucking were described by Ribble as free from abdominal distress, generally relaxed, and more alert and responsive.

Levine and Bell reported the study of 28 infants, with classical colic

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Therapeutic Hypnosis

Therapeutic procedures for which hypnosis is valuable

In December, 1956, the Medical Society of the District of Columbia adopted the following resolution: "Resolved, that the clinical teaching of hypnosis and hypnotic therapeutic technics to students of medicine and dentistry as well as to practicing members of these professions be conducted under recognized medical or dental auspices, as is the practice in other branches of therapeutics." At present, the American Medical Association Council on Mental Health is preparing a report which will include delineation of the place of hypnosis in medical practice.

Measures such as these have resulted from recent heightened interest in hypnosis. Many physicians have received inquiries about hypnotic procedures, and, according to Lebensohn, non-medically sponsored courses are being taught by persons whose experience is limited. The potential usefulness and the hazards of hypnosis are recognized in plans of official societies to provide instruction for physicians and dentists.

The manifest reaction in hypnosis

The outstanding clinical feature of the hypnotic state is the subject's increased suggestibility. Suggestion, when used in a psychological sense, is defined as the process by which an idea is accepted and acted upon without criticism, analysis, or resistance. The reaction of the recipient rather than any quality of the idea is the determinant. There is general agreement among investigators about what happens in the hypnotic state, but little agreement as to the reason. In hypnosis, the individual, with the help of the hypnotist, assumes an attitude of acceptance. Many explanations of this phenomenon have been suggested but no physiological or psychological theory has been proved.

Uses of hypnosis

Despite lack of knowledge of the precise nature of hypnosis, excellent results have been reported. For example, Crasilneck and others studied eight patients who had been severely burned. The detrimental events that occurred after thermal injury included intense pain, which disposed toward dependence upon narcotics; anorexia, which resulted in poor nutrition when good nutrition was needed to aid in tissue repair; resistance to exercise, with subsequent contracture formation; and personality changes, evidenced by withdrawal and negativism. In an effort to interrupt this cycle, the authors employed hypnosis and posthypnotic suggestion. Two of the patients were not amenable, but six were excellent subjects. Hypnosis was substituted for anesthesia in the debridement procedures, skin grafts, and dressing changes. Posthypnotic suggestion sufficed to alleviate pain, and to encourage ambulation. The most remarkable result, however, was the extraordinary increase in food ingestion with concurrently hastened healing. In addition, freedom from pain and from confinement to bed contributed to improved emotional status. The authors recommended further investigation of the possible value for chronically ill patients.

In obstetrical practice, hypnosis has been effective for patients with special problems. For example, a patient who developed poliomyelitis six weeks before term required a tracheotomy and continual respiratory assistance. In order to facilitate respiratory exchange, labor was induced, and hypnosis employed instead of anesthesia. During low forceps delivery the mother showed no evidence of pain, muscular tension, or apprehension. For patients with uncomplicated pregnancies, Maclurkin devised a method to teach autohypnosis in which the patients learn to relax and to maintain a hypnotic state.

In the practice of surgery, several instances have been reported of hypnotic induction used in lieu of anesthesia. For example, a 14-year-old girl developed severe epileptic seizures after head injury, and electroencephalographic studies showed a temporal lobe focal discharge. Craniotomy and excision of the epileptogenic focus were sustained by the patient with hypnosis and local infiltration of procaine for the initial incision. Once during the procedure the patient evidenced awareness and complained of pain, but she responded promptly to the hypnotist's direction. Use of hypnosis in this instance was particularly advantageous because electroencephalographic monitoring was possible during the operation.

Another example cited was that of a patient with congenital heart disease who required gynecological surgery. No preoperative medication was administered; hypnosis was induced; and the patient evidenced no perception of pain during the procedure. The posthypnotic suggestion that there would not be subsequent discomfort was also effective.

According to Lebensohn, hypnosis is used more frequently in dentistry than in other therapeutic practices. Atterbury has described a light hypnotic state as most satisfactory for dental procedures. In dental case histories cited by Heron, the patients' apprehension had caused them to delay in seeking dental care, and, because of this, many required extensive repair. With hypnosis, the patient's apprehensions can be allayed, relaxation achieved, and response to directions assured. Usually, the dentist talks throughout the procedure, explains unexpected sounds, and suggests that the session is of short duration with minimal aftereffects. One dentist reported an instance in which resection of bone and tissue was necessary. Upon completion of this lengthy process, the patient expressed relief that the operation had been simple and brief.

Busse has cited other examples of effective hypnosis. Suggestion may induce voiding in cases of urinary retention, or decrease hyperemesis.

The most obvious contraindication to hypnosis is lack of receptivity. The patient must wish to be helped for effective results to be achieved. Occasionally, even a willing patient will be unable to achieve a hypnotic state, or will assume a state too light for therapeutic purposes. Children under six years of age, feeble-minded persons, and psychotic patients are considered ineligible for hypnosis. Hypnosis in neurotic patients may be dangerous, according to Busse, because repressed conflicts may be aroused; hostile impulses may be reactivated; and fantasies of having been attacked sexually may occur.

In addition, difficulty in terminating the trance sometimes occurs. This may be caused by hostility toward the hypnotist or may result from reluctance to return to a responsible state. This is a minor danger, since the patient can be allowed to sleep until he wakes naturally, or can usually be aroused by another hypnotist. Consideration should, however, be given to the reason for refusal to wake.

Extreme caution should be exercised in posthypnotic suggestion to remove a symptom which serves as a protective device. For example, a patient with hysterical paralysis may be induced to relinquish that symptom; and then adopt another. The second symptom, in such instances, is more difficult to resolve because of the patient's reluctance to risk loss of another protective mechanism.

According to Lebensohn, hypnosis is employed least frequently in psychiatric practice. Psychiatrists who utilize hypnosis have stated that the procedure is applicable infrequently, and then only under particularly favorable circumstances.

Hypnosis may be used to induce relaxation, relieve pain, provide analgesia for operative procedures, and ensure postoperative comfort. Any suggestion which is not consistent with the patient's motivation and understanding must be avoided. Before the hypnotic state is induced, the patient should understand that neither ability nor inability to comply is indicative of inadequacy; and that he will not be persuaded to act in a manner foreign to his best interests.

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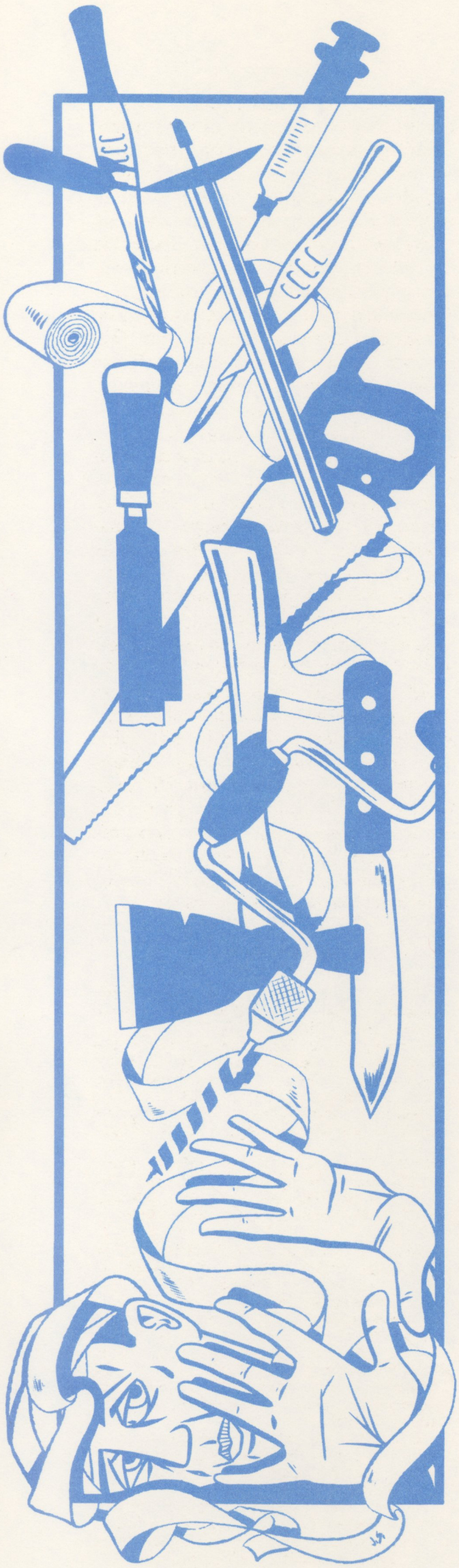

Stress Reactions to Routine Medical Procedures

What physical examination may connote to the patient

● It is a truism that many common diagnostic procedures induce patient-reactions disproportionate to the discomfort of the experience. All physicians are familiar, for example, with inordinate fear of injections. There is, however, some degree of pain with some kinds of hypodermic injections. In many examination procedures, though, in which no pain is induced and which require no forbidding array of implements, there are still conspicuous emotional reactions, wholly incommensurate with the activity. For instance, three routine procedures which frequently produce anxiety are rectal and vaginal examinations and catheterization. Some of the more pronounced of the patient's disturbances may be considered in relation to the reasons for the examination, the possible connotation of the examination to the patient, and the patient's relationship with the physician. Kaplan has said, "The physician's awareness that his patients are frequently uninformed and frightened is a first step toward reducing their discomfort and recognizing their defensive maneuvers."

The reason for the examination

Malev comments that although the routine check-up is certainly a sensible precautionary measure and a rational function it can be misused. Some patients request examinations repeatedly and others will never come, not only not periodically but even when there is manifest dysfunction. If the patient is neither agitated nor peremptory, neither dramatic nor patently stoic, there is a possibility that he may require precisely what he says he does. If the patient has a deep and denied fear of illness —usually of a particular illness—he may only be wanting an affirmation of its absence or general reassurance of well-being. He may hope for physical attention and personal interest, or he may only want a positive statement that he is well. He may require some sort of medication, a form of immediate relief of a particular ailment. These facts or the means by which to ascertain them should be available, at least in part, through the history-taking. A soundproof office, absence of interruption, and complete attention can do much to allay reticence and to prevent difficulties or panic at the time of examination. The medical history can be informative and preventive of subsequent awkwardnesses as well.

What the examination may connote

Among the more obvious reactions to examination procedures are shame, fear, and anger. The patient's history may, again, be significant in determination of the meaning to the individual of the particular body system that is involved. The patient's age is another decisive factor. In children, of course, examination of the anogenital areas may be traumatic. In adolescent patients this is also true. The heightened body-consciousness of the period, the necessity to seem knowledgeable, and the doubts,

fears, and ignorance that accrue during adolescence may combine to make examination not only difficult to perform but a seriously frightening experience to the patient.

Fears of illness or of mutilation are not uncommon and may constitute a residuum of childhood emotions, or may have developed from ideas of punishment or adult hostility. The wish to be pronounced well by an authoritative person may well equate with the desire to be punished and be rid of guilt or to be forgiven and restored to health. Threat to the body image or self-image is known to produce disturbances and anxiety or depression. The patient's reaction to examination may be correlated to either of these wishes.

The anal and genital areas ordinarily may be examined without notable discomfort to the patient. Because of the emotional significance attached to these body sites, however, particular gentleness is desirable. The initial examination of any body area is of especial significance to a patient, and these particular areas and their functions are mentally related to early childhood training, to forbidden aspects of sexuality, to fear of mutilation, and with masturbation. On an unconscious basis, these procedures may be construed as sexual intercourse or rape. Glib or offhand statements that "this won't hurt" are about as useless as peremptory commands to relax.

Haas has said that at whatever age it occurs the first gynecologic examination is more significant to the patient than any other. She stated also that this experience is a highly disturbing one to children and to adolescents, and, again, the reason for the examination is important. The parents and the child may believe that abnormality exists and this factor is in itself productive of dread. Associated ideas of punishment, exposure of fantasy activity or of autoerotic activities may disturb the patient and bring about hostility or anxiety. Aldrich says that pelvic examinations in adolescent girls "should be limited to the minimum consistent with good medicine."

Rectal or genitourinary examinations of men can connote to a frightened patient activities that are reminiscent of early experimental sexuality. In addition, the passive attitude necessarily adopted by the patient during manipulation may seem to him to be similar to homosexual activity. Extreme distress may result from activation of latent homosexual inclination. Alarm or embarrassment with resultant tension can defeat the purpose of examination. One physician remarked that much could be discerned about a patient's personality during digital examination of the rectum.

Also, Silagy has stated that genitourinary examinations in men produce all of the reactions of rectal and pelvic ones and, in addition, the patient's fears or even his symptoms may relate to sexual inadequacy. Many patients, according to this investigator, presume that catheterization is extremely painful. Besides the dread of hurt, the idea of instrumentation, of penetration, is contributory to fright and anxiety.

Procedure

According to Malev, patients expect from the physician the knowledge, power, and authority attributed to the parent figures, and the protection, decision, and personal attention which, in childhood, came from those figures. Malev has commented that ". . . the doctor's ministrations are the same as they have been throughout the ages—the supplying of the same unchanging, unrecognized, imperative childhood needs."

Explanation of the procedure or reason for the examination is necessary to eliminate fear of the unknown or to correct misinformation. Patients refrain from asking many simple questions because of mistaken notions of indelicacy or because of embarrassment at their own ignorance. Sometimes they fear that they will betray their apprehensions, be ridiculous, and, consequently, be rebuffed. In other words, they hesitate to jeopardize what they imagine to be their relationship to the physician. Reassurance, if it can be afforded honestly, is the first part of the explanation. Over-explanation is unwise, as it can also be productive of anxiety. The possible findings, for example, need not be discussed at this time. Even educated and highly articulate patients, though, require some brief statement if cooperation and trust are to result. Impassive, apathetic, or elaborately casual individuals may conceal the same dread or sense of outrage as the overtly emotional and visibly frightened. Besides explanation, the physician should manage to bring into the conversation or interview the usualness or routine necessity for examination. The stress of the actual procedure is minimized as a source of embarrassment by the connotation that this service is performed many times daily for many patients. Although most individuals know academically that these are not unusual procedures, there is yet an individual idea of personal damage and physical shame. Aldrich mentions that any necessary departure from routine that will be obvious to the patient should also be explained. For instance, if the physician reacts to some phase of the procedure or makes a side remark to the nurse the patient may be unduly frightened.

With proper interpretation of the history and interview the physician should be able to initiate and maintain a relationship with the patient that prevents development of anxiety. On this subject one physician recently remarked, "Five minutes more spent in conversation with the patient in the front office will save thirty in the examining room."

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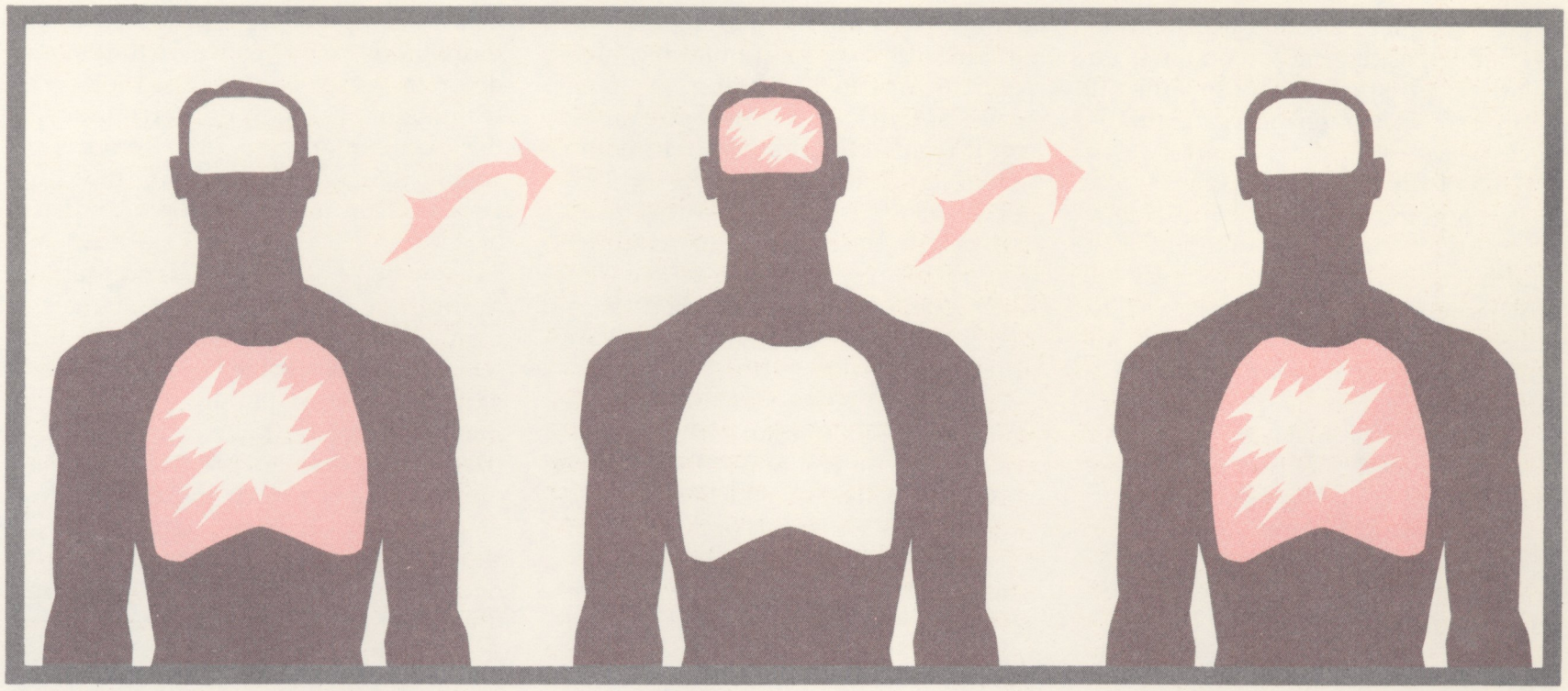

Psychosomatic Disorders in Psychotic Patients

The infrequency of psychosomatic illnesses in patients with mental disease

● CERTAIN COMMON PSYCHOSOMATIC illnesses occur infrequently among psychotic patients. For example, in mental hospital populations, researchers have found a strikingly low incidence of headaches, hypertension, dermatitis, mucous colitis, and asthma. It is generally accepted that allergic reactions occur in from ten to twenty per cent of the general population. In surveys from mental institutions, however, the incidence is between one and five per cent.

The exact relationship between psychosomatic disorders and active psychoses is still the subject of a great deal of research and theorizing. However, it has been found that many patients with severe psychosomatic diseases, particularly those of the respiratory system, have also incipient psychoses. Physical disease alternates with the psychologic disturbance in a reciprocal, either-or relationship. In a few patients studied, the psychosomatic disorder was aggravated during psychosis.

Funkenstein noted that in some instances of schizophrenia recovery was rare unless psychosomatic illness developed in place of psychotic disturbance. Although there was increased parasympathetic reactivity in the patient while asthmatic, and alteration in the nervous system functions while psychotic, Funkenstein could find no feasible theory of causality. His conclusion, shared by other investigators, is that psychologic and physiologic changes are both aspects of the patient's reaction to stress. In their theory, a psychosomatic disorder may serve as a defense against a psychotic break. Expression of tension in terms of physical disease is actually a less primitive manifestation than regression to the mechanism of psychosis. Under stress, the ego disintegrates to such a degree that the body is no longer adequate for expression of unconscious conflict, and psychosis develops.

Kubie suggests that the expression of tension is a symbolic process, mediated through the "visceral brain." The process begins internally and extends to include external points of reference. Other investigators explain the rarity of hay fever, asthma, and other such illnesses by the as yet unknown function of the adrenal glands in development of mental illness. Many investigators believe early life experiences are significant in establishing the pattern of development of psychosomatic illness.

In the few patients who do not conform to the general pattern of alternation of physical and mental manifestations there is an intensification of psychosomatic disorder during the course of psychosis. Sabbath and Luce offer an interesting theory to account for these exceptions. They divided their thirty-two cases of psychotic patients with asthma into levels or depths of psychosis, and noted that a relationship existed between the individual patient's asthmatic attacks and the extent of his break with reality. In general, symptoms of asthma co-existed in patients who demonstrated only a partial break with reality, abated in those with deeper levels of psychosis, and disappeared in patients with disorganized behavior or symptoms of withdrawal. These investigators conclude that whether the patient retains or loses his asthma appears to be

directly related to the level of his psychotic disturbance.

The inclusion of peptic ulcer among the illnesses infrequently found in psychotic patients has been challenged by several investigators. West and Hecker find the incidence of peptic ulcer to be about the same in psychotic and prepsychotic patients. The generally accepted belief that the incidence is low may, they feel, be based on the greater difficulties in diagnosis of ulcers in psychotics. Some patients offer no subjective complaints while others give unrelated and confusing accounts.

A typical case is that of a schizophrenic patient, described as being dull, introverted, and emotionally deteriorated. On admission to a hospital he offered no complaints referable to the gastrointestinal tract and appeared to be in good health. Some years later he was observed to vomit a thin, watery fluid, and although he seemed to be in acute pain, he denied it. When surgery was performed this patient was found to have a perforated duodenal ulcer.

The type of patient who compounds the difficulties of diagnosis with illusionary material is illustrated by the case of another schizophrenic patient who upon suffering an acute ulcerative attack which culminated in death persistently denied his obvious abdominal pain, and repeated that he merely had a chest cold. It is obvious, therefore, that the physician cannot rely upon the usual presentation of symptoms among psychotic patients, and must look for more common suggestive signs and symptoms such as vomiting, anemia, loss of weight, melena, hematemesis, and epigastric tenderness.

In psychosomatic illnesses, the physician should also keep in mind the possibility that the physical disturbance may manifest itself in some form of psychosis. Care should be exercised in administration of drug therapies as the manifestation of physical disturbance may be replaced by severe psychologic upheaval.

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PSYCHOGENIC ASPECTS OF COLIC IN INFANTS

Continued from page 13

symptoms. The purpose of this study was determination of the effect of a pacifier for relief of colic. In all but three infants the symptoms of distress ceased. Two of the three infants refused to accept a pacifier, and, in the third instance, the family would not permit its use. Follow-up studies of the 25 infants who were relieved of colic by use of pacifiers showed that the practice was not habit forming, and that the children discarded the pacifier spontaneously at an average age of 13.8 months. The authors concluded that infantile colic and crying result from inadequate oral gratification, and from pain associated with intestinal spasm caused by emotional and physical tension.

Other investigators have observed that infants seem to perceive maternal apprehension, and that this may be a cause of infantile anxiety, tension, and colic. According to Holt and McIntosh, an infant's status is often improved when a calm nurse acts as substitute for an agitated mother. Bonar, as cited by Kanner, stated that it was possible to predict the occurrence of infantile colic by observation of the family. The frequency of colic is greatest in "nervous" families, and the infant is usually the first-born of unduly apprehensive, insecure parents.

Stewart and others, in a study of mothers of colicky infants, pointed out that anxiety resulted from "conflicts about their acceptance of the feminine role, their dependency needs, and rivalry with the child or husband." The anxiety may be evidenced in such extremes of behavior as overattentiveness, neglect, or inconsistency in care of the infant. For example, an overattentive mother fed her infant as often as eleven times a day; a neglectful mother put cotton in her ears in order not to hear the infant cry; and another mother demonstrated inconsistency in care by holding the infant for as long as ten hours on one day, and not at all the next. Stewart also remarked that the infants would continue to cry when approached by the mothers, and did not cease until their needs were actually met. In contrast, most infants after the age of six months will usually stop crying at the mother's approach, apparently in expectation of fulfillment of their needs.

In summary, infantile colic may result from inadequate oral gratification, or from varied types of mismanagement by insecure or hostile parents. In evaluation of the infant with colic, the physician will wish to consider the psychogenic factors as well as the strictly medical causes in formulating a plan of therapy.

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Quickies

DYSMENORRHEA: A recent study of 2,706 students in four different schools (two controls) was made to determine the effectiveness of group suggestion in management of dysmenorrhea. In the experimental schools, teachers stated repeatedly throughout the school year that exercise was most beneficial in relief of dysmenorrhea, and in the control schools, the subject was not mentioned. Health questionnaires were answered by the students at the beginning and end of the experiment. The results showed no significant difference in incidence of dysmenorrhea in any of the four groups of students. In the entire group, 23.1 per cent stated that they no longer suffered from dysmenorrhea, but this percentage consisted of an almost equal number of experimental and control students, and the authors believed the figure to be compatible with expected spontaneous resolution of disorder in that age group.

Golub, L. J., et al.: Teen-Age Dysmenorrhea, Am. J. Obst. & Gynec. **74**:591 1957.

SERUM COPPER LEVEL IN SCHIZOPHRENIA: Horwitt and others have reported a study of blood copper levels in 76 male and female schizophrenic patients, with 24 controls. The Gubler method was employed for the determinations, and the findings were correlated with erythrocyte sedimentation rate, C-reactive protein, ascorbic acid, basal metabolism rate, and sulfobromophthalein retention tests. The authors concluded that the results were not sufficiently definitive for diagnostic purposes or for evaluation of mental illness. Minor infections, however, were shown to increase serum copper, which may account for the high levels reported by other investigators.

Horwitt, M. K., et al.: Serum Copper and Oxidase Activity in Schizophrenic Patients, Arch. Neurol. & Psychiat. **78**:275 1957.

READINESS FOR NURSERY SCHOOL: In order to estimate a child's readiness for nursery school, the parents may need help in recognition of the stages of physical and emotional maturation. In most instances, a child develops a sense of individuality at about the age of two, limited primarily to self distinction and with little recognition of the needs of others. A child of two is reluctant to share his possessions, has some difficulty in expressing his wishes, and, usually, needs more help at meals and toilet than can be provided in nursery school. At the age of two and one half, the child reacts impulsively, expects his wishes to be granted promptly, and has poor tolerance of denial or postponement. Usually, it is not until he is three that a child has sufficient social maturity to cooperate in group activities and conform to school regulations. Obviously, children differ in rate of development, but as the child becomes less dependent upon his mother, he will usually welcome the opportunity to share activities with other children in a school atmosphere.

Buckman, W., et al.: Nursery School, J. Dis. Child. **94**:258 1957.

EMOTIONAL FACTORS IN DERMATITIS: Many skin disorders are believed to be associated with emotional disturbance, although it is not always apparent whether emotional disturbance causes the dermatitis or is a result of it. Psychiatric referral of a patient with a skin disorder depends upon the degree of emotional distress. Patients in whom dermatitis can be established as self-induced should certainly receive psychiatric help. Factitial dermatitis, in which the patient deliberately damages his skin, is indicative of emotional disturbance. Neurotic excoriation as a result of a patient's compulsion to damage a particular skin area is a similar example. Other skin disorders in which the patient may be helped by referral to a psychiatrist include pruritus, urticaria, rosacea, lichen planus, and neurodermatitis.

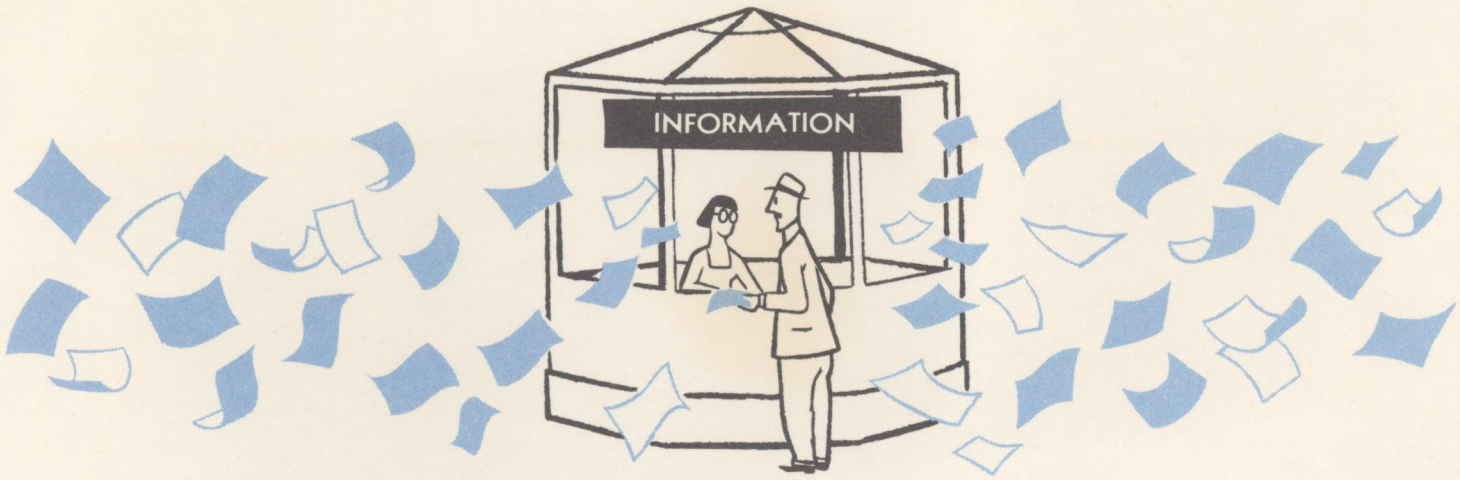
Patterson, J. F.: Emotional Factors in Skin Disorders, Southwestern Med. **38**:489 1957.

REACTIONS TO RADICAL SURGERY: Every individual has a fundamental need to be personally acceptable. Unconsciously, adaptive techniques are developed to assure acceptability and prevent such misfortunes as illness or injury. Any particular method of preservation is assumed to be effective because the adaptive method is not challenged, except in critical situations. In radical surgery a patient sustains threat to body integrity and adaptation. His adaptive methods must either be reaffirmed or renounced, and he may alter the significance of the event or deny its reality. Such a test of personal conviction provokes reactions of depression, rage, or, sometimes, the patient may, paradoxically, be elated. If the patient blames himself for the event, he may be depressed, but his original adaptive technique will be preserved, since it was he who failed and not his method. When blame is assigned to others, anger usually results; and, in the less frequent reaction of elation, the patient concludes that he was especially chosen to suffer.

Orbach, C. E., and Bieber, I.: Depressive and Paranoid Reactions, Arch. Neurol. & Psychiat. **78**:301 1957.

TWO-YEAR THORAZINE STUDY: Feldman has reported a study of 371 mentally ill patients who have been treated with Thorazine for two years. The types of illness included schizophrenia, chronic brain syndrome, involutional reaction, manic-depressive reaction, and psychoneurosis. Ninety-six of the chronically psychotic patients have been released from the hospital; of these, eleven have returned. Thorazine is still being administered to 65.5 per cent of the study group who have remained in the hospital. On the basis of this study, these conclusions have been made: the response of younger schizophrenic patients is more likely to eventuate in release from the hospital; behavioral improvement is sustained for at least two years; and tolerance formation does not result from prolonged administration of the drug. Continued medical supervision is necessary for all patients who are receiving Thorazine, because side effects may persist throughout the period of administration. All of the side effects, however, can be controlled, ameliorated, or eliminated by the administration of specific counteractive medication, or by temporary withdrawal of Thorazine.

Feldman, P. E.: Two-Year Fate Study of Thorazine-Treated Patients, Am. J. Psychiat. **114**:237 1957.



The Function of a Mental Health Society

A MENTAL HYGIENE SOCIETY has been defined as "a voluntary agency, with no vested interests, social, political, or economic, which stimulates the interest and utilizes the skills of both professional and nonprofessional citizens in promoting mental health." The functions of such an organization, whether local, national, or international, are essentially educational ones. Through suitable media, scientific facts about mental health and mental disease are widely disseminated, research is fostered, and funds are gathered for furtherance of the objectives of the society.

The mental health society has also a coordinating function, in that it attempts to develop and promote cooperative programs between all groups in the community—whether official or unofficial, lay or professional—that are concerned with problems of human maladjustment. For most effective results, health or welfare agencies, local medical societies, school boards, and other qualified agencies must be enlisted.

This, then, is the ideal of a mental health society. Unfortunately, the difference between the ideal and the existing situation in many communities is still great. Mental health as an entity has not been well defined, and there have been few evaluative studies of mental health education or consultation programs.

A few state mental health societies have planned ambitious programs. Two projects reported from the Illinois Society for Mental Hygiene were concerned with child mental health and orientation in mental hygiene for professional personnel. The Children's Commission of the Society has worked to attain much needed treatment facilities for emotionally disturbed children. Upon the Commission's recommendation, a center was established as a pilot study in Chicago to offer residential psychiatric services for children who could not be treated as outpatients. The society has appealed for support of the child mental health movement through parent-teacher associations, women's clubs, and other organizations whose members are interested in the subject of mental hygiene.

The Illinois society also has developed a program for nursing school educators throughout the state, based on the premise that orientation of nurses and teachers toward mental health would indirectly influence a large number of people. Institutes were planned for nursing school directors, the first of which was given in Chicago. Subsequent institutes were held for instructors in nursing schools.

Even though much remains to be accomplished, those interested in the mental health movement find encouragement in a growing awareness on the part of the American people of the need for action. Such advances as passage of the national Mental Health Act in 1946 and the National Governors' Conferences on Mental Health, the first of which was held in 1954, have helped to educate lay persons on this subject. In some states taxpayers have already matched the funds provided by the state or federal government for the operation of community health services. Many private organizations are engaged in mental health work, but the scope of their programs may be limited and the number of persons reached small.

Obviously the promotion of mental health should begin at the community level. State or national mental health organizations can formulate broad programs and encourage their enaction, but only the interest and work of the local citizens can bring them into existence and maintain them, once they are established. Physicians can do much, both individually and collectively, to promote mental health in their respective communities. More than other citizens they are aware of the enormity of the problem of mental disease and of the great need for preventive action. With their specialized knowledge, they can help to plan worthwhile activities for the mental health society and provide leadership.

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"It is good to be often reminded of the inconsistency of human nature, and to learn to look without wonder or disgust on the weaknesses which are found in the strongest minds."

Macaulay.