MENTAL HEALTH AND MENTAL ILLNESS:
CAUSE, PURPOSE, CURE, AND PREVENTION;
A BIOENGINEERING PERSPECTIVE

BY

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THESIS
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Chicago, Illinois
This thesis is dedicated to the memory of those people who helped me at critical times in my life and who did not live to see the completion of this thesis. They include the following friends: Dave Allaby, Jr. Marcell Bell, Margaret Cortino, Arthur Dahl, Esther Diamond, Martin Diamond, Sidney Diamond, Shelly Dukes, William Eiland, Fr. John Fearon, Dr. Bessie Lendrum, Michael Majewski, and May B. Minor. Also included are my father, Rev. Emerson W. Harris, my mother, Lillian L. Harris, my brother, Dr. J. Don Harris, and my son, Michael W. Harris. Without the unconditional love received from my family, especially from my parents, I doubt that I would have had the strength of faith needed to triumph over the difficulties of my life well enough that this work could have been written. Therefore, this thesis is dedicated in particular to the memory of my parents.
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JBH
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SUMMARY

A model of certain aspects of personality formation has been developed which includes ideas about mental illness and mental health. It is based on the discovery of a principle: No mistake which was made should or could have been avoided, regardless of the nature of the mistake or the consequences of the mistake. The model is derived from evidence that the commonplace view that some mistakes are made which could have been avoided is false. This error, the belief that mistakes are made which could have or should have been avoided, is called "The Fundamental Error of Social Reality." A corollary of the Fundamental Error is the "Law of Learning," which is: Learning occurs and only occurs when mistakes are made. The Fundamental Error of Social Reality and The Law of Learning have been used to design a new model of psychotherapy, herein called "Affirmation Therapy" (AT). The model of AT has a number of properties which contrast with some mainstream traditional views; briefly stated, they are: Mental illness, as defined in this thesis, is not the result of a biological or personal defect. Mental illness is rather a manifestation of identifiable and verifiable subjectively experienced psychological abuse, and the form of the manifestation is determined by biological, social, and personal factors. Subjectively experienced abuse, as defined in this research, occurs when a person is harmed to a significant degree and comes to believe that the harm did not really happen the way it truthfully did. The design of Affirmation Therapy promotes open and honest communication, both intrapersonal and interpersonal, allowing dealing with harm truthfully, and both repairs and prevents abuse. For example, it is not abusive to hurt or harm someone, hurts and harm cannot always be avoided. It is abusive to hurt or harm someone and then make the hurt or harmed person believe that the hurts or harm did not really happen, or make the person believe that he or she deserved to be hurt or harmed. Furthermore, hurts and/or harm are not abusive, according to the model of AT, when the hurt or harmed person appropriately and effectively protests the damage and both the "hurter" and the "hurtee" work together with mutual and self respect to fix the problem.

Personal factors are in the realm of individual choice, and social factors are the result of the combined choices of the many individuals who comprise society. Genetic biological factors are not a matter of choice once conception has occurred. Unlike conditions such as scurvy (which has clearly been shown to be a the result of a vitamin C deficient diet), or Korsakoff's Syndrome (in which alcoholism is often, though not always, implicated), or measles (where a definite microbe has been shown to cause the disease), no deficiency or excess of diet and no causal pathogen has been shown to exist for most mental illnesses. Therefore, according to the model of this research, outside of the practice of eugenics, and given clear
evidence of abuse as a causal factor, the preventable present-day etiology of mental illness is psychosocial. Neurological conditions may or may not be contributory to mental illness, according to the ways a person with a neurological condition is treated by others and the ways the person internalizes how he or she is treated by others, starting in infancy. Treatment by others includes physical, psychological and social factors, medical care (including possible gene therapies), and nutrition. In this model, the mind is neither separate from the brain nor identical to it. Accurate classification of psychosocial and neurological components of a mental disorder may better enable treating aspects having social and psychosocial causation with psychotherapeutic methods and aspects having biological causation with medical methods. AT has been designed as a psychodynamic model. This research of this thesis is directed toward the possibility of scientific identification of preventable and treatable psychosocial factors which contribute to mental illness. What cannot be shown to be psychosocial may be presumed to be biological and/or genetic for the purposes of this research.

The process of discovery of “The Fundamental Error of Social Reality” is described in narrative form, as a sequence of events and vignettes telling of critical events during my (the principal investigator’s) life. All research into personality formation must necessarily involve the personality of the researcher. While brain physiology may be studied in many diverse ways, the only tool available for the study of the mind is the mind itself. AT is not dualistic, the mind is an aspect of the brain in the model of AT. All scientific inquiry into personality is therefore a form of participant-observer research. This creates the possibility of bias as a consequence of the problems of self-reference, in the design and development of AT, every identifiably feasible effort was made, over a period of about eight years, to minimize bias and maximize objectivity. Many of the experimental methods used in this work were designed and developed during the process of removing personal, subjective bias from seemingly objective data to the greatest achievable extent. The narrative describes key events, experimental methods, and data, within the context in which the work was actually done, giving due respect both to reporter accuracy and the need for confidentiality in human-subject research. Many of the experiments were “thought experiments,” (experiments devised and performed only in my mind) which led to experiments involving other people, the results of which led to the next set of “thought experiments,” and so forth. Because much of this work was done during a period of intense crisis, and because this work was instrumental in the resolution of the crisis, a background section is included, to make clear the circumstances that led to this research. All of the experiments involving other people were done during, and as part of, the ordinary course of my life, in naturalistic settings in which the other people were aware of my research interests; none were laboratory experiments, there was no use of intentional deception. It is impossible to deliberately repeat the discovery
process because the work at its onset was not intended as systematic or scientific research. Furthermore, were it possible to repeat the discovery process, doing so would be unethical because of the need to abuse human experimental subjects in replicating the process through which the discoveries were made. Fortunately, during the research, a reproducible and ethical experiment was developed, and it can readily be used to validate the essential findings of this research.

Prior models of personality, and psychotherapies based on them, tend to contain fallacious reasoning, the most common being overgeneralization of data from biased samples of the population. Perhaps the second most common, and the reasoning flaw of the medical model of mental illness (see glossary), is the fallacy of “non causa, pro causa,” (see glossary) because noting that, for example, the changing of biochemical factors with medication and the associated changes in symptoms does not directly indicate whether observed “biochemical imbalances” are causal of mental illness or are symptoms of mental illness. Prior models based on fallacies contain useful information, the problem of fallacious reasoning is that the conclusions do not depend on the premises. Correct conclusions may be reached even if the premises are wrong and the reasoning false. Many of the findings of prior models of mental illness and personality formation were used in the development of the model of Affirmation Therapy designed and developed during the research reported in this thesis.

Details not essential to the scientific accuracy of this research have been changed to meet ethical standards of confidentiality appropriate for human subject research. This has been done to protect human research subjects from possible harm which might arise if their identities could be determined from scientifically non-essential details. However, while I have chosen to set aside anonymity for myself after very careful consideration, I have changed some scientifically insignificant details to protect the identities of some members of the medical community under whose treatment regimens I developed serious iatrogenic complications, including severe dementia.

In my experience, the common view seems to be that humans have two possible responses to perceived threats, “fight or flight.” The model of Affirmation Therapy has four responses: Fight, Flight, Self-defense, and None-of-the-above. The goal of Affirmation Therapy is legitimate self-defense, using the least practical force that is effective, while directing the main effort toward peacefulness, harmony, forgiveness, and cooperation.
The model has been tested in everyday living by the principal investigator and by a few people with whom it has been shared. For the principal investigator, use of the methods of this research has apparently cured a severe chronic iatrogenic mental illness which was given a number of diagnoses at different times, including unipolar depression, bipolar disorder, schizophrenia, schizoaffective bipolar disorder, and multiple personality disorder. The concept of personality used in the design of AT is similar to the object-relations theory of W.R.D. Fairbairn (1963); in that the structure of personality consists only, in psychoanalytic terms, of ego states; there is no "id" and what Freud described as "superego" is a complicated ego structure. The model of AT is based heavily but not exclusively on the work, which also does not involve the concepts of "id" or 'superego," of Dr. Abraham A. Low, founder of the self-help group, Recovery, Inc., and his observation that what he defined as "temper" (see glossary) led to "tenseness" which led to "symptoms," in all of his psychiatric patients, regardless of diagnosis. The biological aspect of the model is simple, it requires only the "all-or-none law of synaptic transmission," and an approximate understanding of neuronal connectivity to account for every form of mental illness. In this work, temper results from unresolved psychological pain, such pain from the subjective experience of abuse, and abuse results from ignorance on the part of society as to what is abusive. To restate for emphasis, ignorance of what is subjectively experienced as abusive leads to accidental subjectively-experienced abuse, which leads to unresolved psychological pain, which leads to temper, which leads to tenseness which leads to symptoms. According to the model, psychiatric practices which are directed only toward palliation of symptoms through medication retard the process of society's learning what is abusive, and are, in the long term, counterproductive. This is because persons whose symptoms are highly suppressed with medication are less likely to express their unresolved psychological pain, making it more difficult for people to learn what causes such pain. The method of AT requires meaningful communication, patients too psychotic to engage in such communication may require medication or other medical intervention, at least initially, for AT to work. Such medical treatment dosage needs to be titrated to the degree that adequate communication is possible, the patient is sufficiently free from distress to be able to concentrate on relevant issues, and symptoms are not so controlled that the patient has insufficient motivation to work on the issues which are the focus of AT. This research is about the origins and prevention of temper. In the model of this thesis, temper directed toward one's self tends to generate clinically-defined forms of mental illness; directed toward one's society, it tends to generate crime; directed toward another society, it tends to generate war. That mental illness, crime, and war may be preventable by replacing mistaken beliefs with ones that are scientifically verifiable is one hypothesis that follows from the model of this thesis.
Affirmation Therapy is a process, described later in this thesis in detail. In principle, processes can be patented, and I understand that at least one patent has been issued for a psychotherapy process. To preclude the possibility of commercially-motivated restriction of the method of Affirmation Therapy, as the inventor of the process of Affirmation Therapy, I give the process of Affirmation Therapy described in this thesis to the public domain.
1. INTRODUCTION

1.1 Initial Concepts and Constructs

A model of certain aspects of mental illness, personality formation, and psychotherapy has been developed which identifies particular psychosocial components of causation and which suggests strategies for therapeutic interventions to resolve the difficulties that are the result of those psychosocial factors. The model includes sociological, historical, psychodynamic, biological, genetic and spiritual components. The major parts of this research were done by the principal investigator as a participant-observer, under circumstances which, to avoid deception or the possible appearance of deception, need to be explained. The form and content of this dissertation are the result of having to balance two requirements which have the potential to conflict intensely. The first is the need in science for openness and disclosure. The second is the need for confidentiality in order to protect the subjects of this research from possible harm. According to the model of this research, unwitting, inadvertent, and unavoidable dishonesty is the foundation of the psychosocial factors found in this research to be causal in mental illness, such dishonesty generates moral dilemmas which consensus social reality denies, yet which are of such intensity as to possibly have, according to the model of this thesis, the capability to cause all forms of mental illness, crime, and war. That is an exceptionally strong statement, yet the research and the scientific arguments of this thesis seem, to the author, after years of diligent and exhaustive searching, without success, for a flaw or possible flaw, to constitute a proof. Whether the proof is truly valid is a matter to be determined in the future, as the ideas of this research are shared with the whole of society. The model stands in contrast to many conventional views of mental illness, for, according to this model, there is no biological or personal defect which causes mental illness. Rather, mental illness, in this model, is actually an aspect of an adaptive life-saving and life-enhancing process, and the biological components are not liabilities, rather, they are assets for not only the person who experiences mental illness, but also for society. The core of mental illness is unresolved psychological pain. It needs to be clear at the outset that, in the experience of the principal investigator, mental illness, in severe and chronic form, ranks among the most terrible of human experiences. This work is directed primarily toward the possibility of prevention of mental illness; yet development of more effective therapies than are currently available, for those who have already become mentally ill, is also a strong concern.

Many of the ideas of this research are presented repeatedly, in varying contexts. This is not an exercise of the "mere exposure effect" in psychology (Deaux, et al., 1993), repeating something so many times that it becomes believable simply because it has been said enough times to have become believed. I have discussed the ideas of this research with many people,
some understand one way of presenting the ideas, but not other ways, and I have tried to use enough ways, enough settings, for ideas which seem to contravene "common sense" that a reader of this dissertation may have a good chance to understand it accurately. The actual research, done as an aspect of the principal investigator's "routine life" was quite recursive, as mistakes occurred and new ideas developed, central beliefs were revisited many times during the refinement and clarification of concepts and constructs. The description of the process of discovery may, at least on the surface, appear to be very repetitious; I have tried, however, to demonstrate accurately how the work was really done, to share the method I developed in case it might be useful to other people. Because I was floridly psychotic during much of the research, I could not design experiments in the traditional manner of normal science (Kuhn, 1996), but I did use scientific and engineering principles to the best of my ability throughout this work. In my experience, both with my own life and with the other patients with whom I lived, psychosis is always focal, though the focus may be very broad. Every psychotic patient I have known had considerable contact with reality, but the non-psychotic aspects of a patient's life are not a subject of therapy. Skepticism is essential in accurate science. Failure to be skeptical about skepticism itself also blocks good science by blinding the scientist to the merits of models which contrast radically with the current state of the art. Correct conclusions may be derived with flawed logic from defective data, but such is art and not science. Although much of the science of this thesis was derived as though through a series of art projects, the scientific validity of the conclusions does not depend on their derivations. The useful truth of this research depends only upon accurate (verifiable) data and correct (fallacy-avoiding) reasoning.

At its core, this work is a study of abuse and resulting psychological compensation and decompensation. For the purposes of this thesis, compensation is defined as the use of reality-distorting psychological defenses in the service of the ego. Such defenses include those classified as mature (such as humor, anticipation, suppression, altruism, and sublimation), neurotic (such as dissociation, displacement, repression, and intellectualization), immature (such as acting out, passive-aggressive behaviors, hypochondriasis, projection, and fantasy), and psychotic (such as delusional projection, distortion, and denial of clearly evident external reality), as described in Vaillant (1977, Part II). Of defenses, Vaillant says, "In this book the so-called defense mechanisms of psychoanalytic theory will often be referred to as coping or adaptive mechanisms. This is to underscore the fact that defenses are healthy more often than they are pathological. (Vaillant, 1977, p.7) Vaillant further defines mental health as the ability to deal with problems in a sound way, it is not the absence of problems. Further, he states, "In this book, "health" will be defined in terms of objective clinical evidence. Men will be considered well adapted in terms of the number of areas in which they function well, rather than in terms of excellence within a special area." (Vaillant, 1977,
3

p.6) In contrast with the Freudian psychoanalytic view of personality in which defenses are grounded in inadequacies of one form or another, and defenses are strategies to survive in spite of personal deficiencies (Webster, 1995), the proposed model of certain aspects of personality of this research is an exploration of the idea that we are fully adequate to the needs of our lives. The tentative model of this research can not therefore be classified as pessimistic. Neither can it be considered optimistic, to whatever extent optimism overlooks genuine difficulties. Rather, I prefer to describe the fundamental nature of the model as realistic, taking into account both problems and opportunities to the fullest achievable extent. If I may be allowed the use of humor (a mature defense according to Vaillant), methinks, if I do not have problems, I had best figure out where the Hell I am, for that is probably where I am if I don't have problems. If I have problems, then I am alive and have something useful to do, if I have the courage to make the mistakes that will allow me to learn how to do what is useful. Without minimizing the difficulties associated with the many problems of contemporary society, I view problems as opportunities for growth.

1.2 The nature of mistakes

I make a mistake when I do something and what results is not exactly, in every detail, what I expected. I learn when I do something and what results is not exactly, in every detail, what I expected. The definition of mistake which I am using is designed to be unbiased. A connection between making mistakes and learning has long been recognized. Low drew attention to this time and time again, an example is Low, 1978, (pp. 201-205). It matters not whether what results is better than expected, worse than expected, unexpected, or even whether I had no expectations. The way I have defined the ideas of mistakes and of learning led me to certain questions. If mistakes are made, what sets the limit to the nature and form of mistakes that can be made? Can mistakes be made about the nature, purpose, and function of mistakes? If, as I learned through making mistakes, that to learn is to make a mistake and to make a mistake is to learn, then learning and making mistakes are the identical process, described from contrasting perspectives. The next paragraph may seem to have a clumsy structure, they are redundant to some degree, but they are is meant to illuminate the predicaments caused by the recursive nature of mistakes made about mistakes. Further, while the ideas in the following paragraph belong to the discovery process described later, I think, based on my experience in trying to explain the essential ideas of this thesis to many people, that there are some who will find very helpful what others see as premature in the presentation of the ideas of this thesis.
To understand accurately the nature and purpose of mistakes requires making enough mistakes about mistakes that enough has been learned to avoid the mistakes about mistakes that are inevitable until enough mistakes have been made to learn enough about mistakes to know that mistakes made neither could nor should have been avoided. Not only that, but more mistakes yet may need to be made to learn that it is always wrong to try to avoid making mistakes because doing so impairs learning about mistakes and so more mistakes are made than would be made if we had learned enough to know not to try avoiding making mistakes. Perhaps that helps make clear the problem of self-reference in the nature of mistakes. Perhaps, on the other hand, it seems merely confusing. If so, further clarification may be justified, although I may be mistaken in thinking this. And, that is another example of self-reference about mistakes.

Whether one considers the model of evolution or of creation, whether one examines the historical or anthropological records, or even if one takes a simple thermodynamic view, it does seem likely that there was a beginning to humanity, and a time before there were humans. A philosophical assumption made as part of the basis of this research is that there was a beginning to human society, and that there has been a finite time for humans to learn about the world in which we live, the physical world to be sure, but no less about the mental world as well. The mental world consists, I find, of ideas, thoughts, emotions, morality and ethics as a minimum. Before there were any humans, the total knowledge of humans was zero because there were zero humans who could have knowledge. This view may seem to rule out evolution, but it does not. Humans have a unique facility for complex language structures; and the intellectual issues of right and wrong, of morality and ethics, of willfully imposed rewards and punishments in response to intellectual analysis are unique to humanity. Questions of right and wrong have tended to be abstractions in human history. As an example, consider the phenomenon of judicial duels. In a judicial duel, it is assumed that the person who wins the duel was in the right and the loser was in the wrong. This assumption is based on another assumption, that there is a force or god or such which will give to the person in the right the power to prevail. If the contested issue was not severe enough to warrant the death of the person who was “wrong”, the duel was often decided by “first blood,” wherein the first person injured to the point of bleeding was determined to have lost and so to have been wrong. For example, I have observed that present day court issues in western societies are often decided by who has the greater financial resources and can afford the more effective lawyers. Such outcomes are still a form of judicial duel. In the model of this thesis, power is a dichotomous alternative to peace. Yet, it is not power which is wrong, but the abusive use of power. And peace has a power of its own. The power of peace is the only effective power I have found which resolves the problems of abuse constructively. Why is it common to substitute power for truth? Because, according to the
model of this research, abuse, as defined in this thesis (see glossary), generates dishonesty, and dishonesty generates abuse, in what seem to me to be viscous cycles. Such abuse is caused by ignorance of what is abusive and by the making of mistakes (involving punishing people for making mistakes) which promote ignorance over learning by making learning painful. From the beginning of humanity, however that beginning is defined, we have had just enough time to make precisely as many mistakes to learn exactly what we now know. To ask that we have more knowledge than the mistakes yet made allow us to have, is to ask for what is impossible. To set standards for performance which are impossible to meet, and punish those caught failing to meet the impossible standards is the central process of psychological abuse.

How is that possible? Consider a child who makes a mistake and something fragile is damaged as a result of the mistake. The child did not know enough to anticipate the possibility of the damage. The fragile object is cherished by an adult who punishes the child for making the mistake, tells the child that the child knew better, and further, that, if the child makes any more such mistakes, the punishment will be much worse next time. What can the child do? Protesting that he or she did not know better will not work, for it will be seen as defiance by the child against the adult's authority and will be grounds for further punishment. What strategy can the child use to minimize future risk of punishment? The one most likely to work is to never admit to making a mistake, to never tell about any mistake. And, this is rather precisely the root of the problem. As long as people believe that they are likely to suffer for telling the simple truth that they made mistakes which they did not know how to avoid, everyone in society lives a shared lie, that mistakes should and could be avoided. And this is circular, it generates viscous cycles of abuse and denial and abuse and denial, because simple honesty is made intolerably costly. Is it possible to devise a practical solution to this predicament?

1:3 Bioengineering and mental illness

I consider engineering to be the use of scientific methods and principles in developing and implementing effective, efficient, and economical solutions to practical problems. This includes bioengineering, the application of engineering to the fields of biology and medicine. This research is an exploration of the application of bioengineering strategies to psychiatry and also to psychology, given that behavior has biological bases. Having searched the scientific literature extensively, I find that some central features of this research are apparently without precedent. The two main techniques of engineering are analysis and synthesis, using methods that are testable, verifiable, and reproducible. Opinion comes into play in engineering only when rigorous methods are unavailable. The predicament that plagues the study of the mind is one of self-reference, for
the mind itself is the only resource available for the study of the mind. Philosophical orientation therefore has a profound impact on the way a particular person models the mind. I have attempted to specify the philosophical positions which were important in this research in the pursuit of possibly objective truth. One philosophical idea used in the model of this research is that truth is determined by scientific experiment and in no other way. What can not be scientifically tested is a matter of opinion, not truth. A second philosophical idea is that truth, determined by rigorous science, prevails, given sufficient time. What can not be observed cannot be tested, what cannot be tested is outside the realm of science, hence is outside the realm of truth. A third philosophical idea is that, as a necessity for science to be of real value, that causality exists, and so everything happens for a reason at a particular time in a potentially understandable manner, whether or not the happening, the reason, the time, or the manner make sense to any person, and therefore, that the apparent duality of subjectivity and objectivity signals learning which has yet to happen. The utility of these philosophical ideas can be determined by the verifiability of the models generated from them.

Perhaps there are ideas which “everyone” “knows” are true as a matter of social consensus, yet which can clearly be demonstrated to be unambiguously false, once a scientific technique has been developed which achieves said demonstration. Kuhn (1996) argues that progress in science occurs in two basic ways. Most scientific progress is the work of “normal science,” in which existing paradigms and models are explored in depth and detail. Such work is built primarily on existing scientific literature, predominantly work which has passed peer review and has been published in scientific journals. From time to time, existing models and paradigms are found inadequate to explain observed phenomena, and new models and paradigms are developed. The research of this dissertation is mostly of the latter type, what Kuhn calls a scientific revolution. Before and during a major paradigm shift, journals do not yet have a relevant body of literature to cite in support of the new model. For this reason, the citations in this dissertation are almost entirely from works other than scientific journals. Also, in the Methods and Data section, I have cited the references I actually used, to make clear the development of the model as it actually happened. During the period of crisis, my focus was on working through the crisis in order to survive it, and not on scholarship intended for a dissertation.
1.4 Experimental work

In 1995, I designed an experiment to validate the findings I had already made informally with a formal experimental protocol; only to discover that the work already done was sufficient proof of the findings. As will be shown later, the key experiment can be performed as a thought experiment by anyone who is capable of understanding the level of science of this dissertation. In this thought experiment, each subject is his or her own longitudinal control in terms of the beliefs expressed at the onset of the experiment and the beliefs expressed at the conclusion of the experiment; the beliefs expressed are retrospective in both instances. Because so much of the research reported herein was done while I was in acute and/or chronic crisis, the precise number of experimental subjects can only be estimated. I kept personal journals during less than half of the crisis period, yet those journals combined with other available records (mostly hospital discharge summaries) have allowed reasonably accurate reconstruction of the discovery process used during this research. About four hundred subjects in total were used in developing the model of this thesis. Most were psychiatrically hospitalized patients, some were hospital staff, some were members of self-help groups, especially members of Recovery, Inc. (Recovery, Inc. is not an anonymous group). Also included were members of religious organizations in which I held membership and in which I was not a member, some of my friends who asked about my work, some members of the clergy, a few mental health professionals, and even some neighbors. Education in the group of subjects ranged from not having completed high school to some with multiple doctorates. Religious faiths of the sample members included diverse Christian sects (including but not limited to Roman Catholic, Orthodox, Baptist, Lutheran, Assemblies of God, Religious Society of Friends, Unitarian/Universalist), Jewish, Muslim, Buddhist, Bahai, and more. Also included were some who were atheist or agnostic. Several were of nationalities other than the United States of America, some were naturalized U.S. citizens. African, Asian, South American, European, and Native American subjects are among the group used in this research. Ages ranged from early teens to elderly. The group was diverse, but, because of the way the data was gathered, no accurate statistics are available to document the extent of the diversity. I am inclined to believe that even the most “primitive” of present day societies has all the concepts at hand to understand the meaning of this research. As best I can tell, it is not bound to European-American culture. Whether this prove true is for future work to decide.

1.5 Stigma

Stigma is a serious problem for many, if not most, people who become mentally ill, in my experience. Because I find the cost of stigma to society to be at least as high as the direct cost of mental illness itself, I deliberately, yet carefully, choose
to disclose personal circumstances as needed to give a scientifically accurate account of the research I did. I experience stigma as a form of abuse, and I observe that abusiveness only survives when it is kept secret. Again, I choose to be open about stigma issues, for openness and honesty combined is the only way I have ever found which eradicates abuse. At the outset, and as a proposition to be defended by the research data of this work, it is my observation that mental illness, as usefully defined, is always an expression of subjectively experienced psychological abuse (See Glossary). That is a strong statement, it allows for no exceptions. I believe that the methods and data of this research are sufficient to demonstrate that mental illness, in every form, again, as usefully defined, is caused by abuse. For the purposes of this research, mental illness as a condition is defined as unresolved psychological pain, and mental illness as a process is defined as the aggregate dynamic effects of such pain in the life of the person who suffers from said pain. I chose this definition because every person whom I have known closely who suffered from mental illness was, in my observation, suffering from such pain and could, given a safe setting, describe the pain and its origins. I also chose this definition because I have known a number of people who have been, for all practical purposes, cured of serious mental illness, and in every such instance, cure came with the resolving of such pain. I have seen no exceptions to those principles, and I have sought out exceptions, to no avail.

Stigma may have even life-threatening consequences. When I was young (in the 1940's), there was considerable stigma about cancer. Even as an adult, I recall people speaking about cancer with euphemisms such as “The big C.” People choosing to be open about cancer, Betty Ford being an example, allowed setting aside much of the stigma about cancer, and, for some people with cancer, reduction of stigma may have allowed earlier treatment, and earlier treatment is often far more effective. For some forms of cancer, preventive measures before cancer develops, may be the only effective treatment. One such form is Gardner’s Syndrome (also called Multiple Polyposis or Familial Adenomatous Polyposis), a genetic condition which causes colon and other cancers. I have a Gardner’s Syndrome diagnosis. I have not had cancer because I have had radical preventive surgeries before cancer developed. I am the first person in my family to have received timely and effective preventive surgery for Gardner’s Syndrome. My father and my only sibling, my older brother, died, in 1972 and 1987 respectively, from cancer from this condition, and I recall my father mentioning that he believed his father had undergone surgery for colon cancer shortly before my grandfather died, when I was about two years old. Stigma regarding cancer was, I believe, a contributing factor in my father’s and my brother’s not receiving timely preventive treatment for Gardner’s Syndrome related cancer. I asked my father’s doctors about his situation in 1972; they did not tell me of the pathologist’s finding that my father had a polyposis diagnosis more than a year before he died. My brother’s doctors, who did not screen
him for cancer in spite of my strongly expressed concerns, would also not screen his children even after my brother had died.

Only after I was recovering from my colon surgery did my dad’s doctors disclose his diagnosis to me, and then it was much too late for my brother.

Stigma about mental illness persists as, I believe, one of the most serious problems associated with mental illness. To me, stigma regarding mental illness signals the presence of shame one way or another. I am not ashamed of having been diagnosed as mentally ill; I refuse to believe that what happened to me was my fault. I am not ashamed of having been treated for mental illness, at the time, the treatment I received seemed to me to be the best alternative actually available to me. It is enough to suffer the terrors and agonies of severe and protracted mental illness; I shall not accept having to suffer for having suffered. The illness was enough by itself. I find no need to add to it by believing that I should be ashamed of what happened to me. But it is the trap of being ashamed of that which could not be prevented which I have seen to cause most of the damage to many people who meet with mental illness. Perhaps the time has come to set about to cease and desist from punishing people whose lives become very difficult through no real fault of their own. I believe such a time is upon us, hence I chose to engage in this work, for the chance that the lives of people, all people, not only those diagnosed as mentally ill, may be ameliorated.

1.6 Concern and science

In the science of the human condition, there surely must be room for the science of passion, of concern, of empathy and compassion. I am a person who engages in science, I am a passionate person who engages in science. I chose to not be ashamed of my life, not alone because it is detrimental to the quality of my life to be ashamed, but also because, from a dispassionate scientific standpoint, the methodology and model of this research disallow any valid justification for being ashamed. Also, in the scientific study of personality and society, due consideration must be given to issues of spirituality. By this I mean a sense of something about a person’s life that is more important than the person himself or herself. I consistently noted that people who suffer great difficulty live better and more satisfying lives if they believe that their struggle has meaning and significance beyond what it is doing to them. Those who have a pragmatic sense of hope based on meaningful spirituality consistently make a greater effort to overcome their suffering than those who lack such purposefulness. For the purposes of this thesis, spirituality is used in the sense of a relationship with "God" as each person understands "God." This is the sense in which the word "God" is used in Alcoholics Anonymous and Emotions Anonymous. By this definition, "God"
may be the betterment of humanity as in secular humanism, it may be the well-being of the children of the next generation, it may be nuclear or extended family quality of life. For this thesis, spirituality is defined as a person having a relationship with some aspect of perceived or interpreted reality which transcends the person alone.

1.7 Personal factors

In 1986, when I was found to have Gardner’s Syndrome at the age of 47, I had completed all the classes for the Ph.D. degree in Bioengineering at the University of Illinois at Chicago, and was working on a bioengineering problem in the field of pediatric cardiology for my thesis. I had, at that time, worked for over twenty years at the University of Illinois Medical Center, Cook County Children’s Hospital, and The Hektoen Institute for Medical Research, in both pediatric cardiology and surgical research departments. I had a strong background in classes about pattern recognition and classification in bioengineering. I had studied the fields of psychology and sociology independently as a matter mostly of curiosity. My brother had his B.A. degree in psychology and had completed his Ph.D. in Sociology a few years before. My brother and I discussed his research in depth; he told several people that I was the only person who really understood his work. At the time I was diagnosed with Gardner’s Syndrome, I had a combination of knowledge in medicine, in bioengineering, in biology, and in social sciences which enabled me to see unfolding events in particular ways. These ways often differed, sometimes markedly, from the conventional views of psychiatry and psychology.

1.8 The fundamental error of social reality

One such finding of this research, mentioned before, is a belief which is very commonly, if not virtually universally held, which can easily be proven false, and the effects of this belief on the human brain and mind may be sufficient to account for the entire realm of mental illness. I choose to call this belief “The Fundamental Error of Social Reality.” It is the belief that mistakes are made which could or should be avoided. The discovery process of the Fundamental Error is described in the Design and Development of Affirmation Therapy section (Chapter 2) of this dissertation. The observed operation of this Error in the formation of mental illness, of criminal behavior, and of warfare is described in the Results section (Chapter 3).
1.9 Relativism, absolutism and culture

A common belief among social scientists is the view that truth is relative, that absolute truth does not exist, or that, if absolute truth exists, it is beyond the reach of humanity. I find this to be a logical contradiction, for, if truth is relative, there is no truth, only whimsey and opinion. In philosophy of this research, truth is determined by, and only determined by, the methods of science. What can not be tested and verified scientifically is not of the domain of truth. While most of the research of this thesis was formulative and not experimental, the process of asking the three questions (Ever make mistakes? Ever make a mistake you shouldn’t have made? Ever make a mistake you could have avoided?) was experimental. I that set of experiments (albeit experiments done within the framework of a naturalistic setting), the null hypothesis was that an example could be found of a mistake which both had been made and could have been avoided; the finding of such a mistake would invalidate the working hypothesis of those experiments, which was that no such mistake could be found.

At first inspection, the research of this thesis may seem primarily formulative, seeking the development of a model of psychotherapy by using the strategies of engineering. The broad spectrum of social scientists may see it primarily as a form of survey research in which a number of people were first surveyed to find out how many believed they had made mistakes they could or should have avoided, asked the questions, and then surveyed again. To me, from the perspective of engineering, the most significant aspects were experimental, especially the design and implementation of strategies to minimize the impact of my personal biases as a participant-observer on the data obtained from others. These methods are described in detail in Chapter 2.

Absolutism is held in poor repute because many people have made authoritarian claims of having absolute truth, and absolutists have tended, throughout history, to become tyrants. I observe, as I live the model of this research in my everyday life, that it is antithetical to tyranny and authoritarianism, for its authoritativeness is vested in the value of life, and in the worth and dignity of each and every person, regardless of circumstances. It is one thing to make such a claim as a matter of personal philosophy, it is another to attempt showing the truth of such a view with scientific methods. In this research, at the level of the overall guiding philosophy, the philosophical null hypothesis is the view that different people have differing intrinsic worth, and therefore, that people can be ranked according to intrinsic worth. Such a view can be generated through a combination of two commonplace errors. “The Fundamental Attribution Error” is “The tendency to overestimate personality factors (dispositions) and underestimate environmental ones (situations) in explaining behaviors.” (Wade and Tavris, 1990,
p.658) The "Self-Serving Bias" is "the tendency of people to take credit for good actions and to excuse or rationalize their mistakes." (Wade and Tavris, 1990, p. 659) Combine these two errors, throw in a few more mistakes, and we have something like this: When I do well, it is because I am a good person, when I do poorly, it is because of fate; because of circumstances beyond the power of anyone to control. When you do well, it is because of totally undeserved luck, and when you do poorly, it is because you are absolutely worthless. Now consider two people who seek personal power and domination over others, and both think that way. No wonder there are wars. Again, at the level of the overall philosophy of this research, I took the position that stigma could only be a directly constructive aspect of the structure of society if it could be shown that one person can have greater or lesser intrinsic worth or merit than another. Only if an objectively-validated scale whereby the intrinsic value of one person can be ranked against others is possible is stigma, in the model of this research, justifiable. During this research, I found that the possibility of such a scale of comparison was an artifact of biases, and that the possibility of such a scale seemed to vanish when I minimized such biases as The Fundamental Attribution Error.

I have used two introductory psychology texts to provide a background in psychology, one, written by two women, states, in the section, "To the Instructor,":

We used to joke with other instructors that for too long psychology was the study of the white male sophomore . . . rat. There was a pervasive feeling throughout our discipline that "hard, scientific" psychology did not trouble itself with "soft, unscientific" matters such as gender, age, and culture. If a Japanese woman or black American man or a white Canadian woman did not respond to an experiment the way a typical young white male American did, then they were ignored.

Two important developments have forced psychology to recognize that universal principles of behavior cannot be deduced from a narrow sample of humanity. One is the growing diversity of college students themselves, many of whom now include older adults (who are often amused by the "findings" based on 19-year olds) and people of every ethnicity (who are baffled by "findings" based solely on Anglo-Americans). A second comes from the increasing number of scientific studies showing that culture is not merely a superficial gloss on human behavior, but a profound influence that affects virtually all aspects of human behavior and possibly human physiology as well. (Wade and Tavris, 1990, p. xix)

The other is a more conventional text written by a man. From the epilogue,

...Modern psychology, for all its accomplishments, has made it utterly clear that thus far we know even less about our own mental processes and behavior than we know about the physical and biological world around us. Here, too, we have to confess that we are weak and ignorant. We can only hope that this confession will have some of the effects of our previous ones, that here again strength will grow out of weakness and knowledge out of folly and ignorance. If so, we may finally understand why we think and do what we think and do, so that we may ultimately master our inner selves as we have learned to master the world around us.

There are few goals in science that are worthier than this. (Gleitman, 1990, p. 833)
Assuming for simplicity, and it is a gross oversimplification, that there exist two main cultures, Eastern and Western; I expect that those of Western cultural origins may believe they find a strong Eastern bias in this work, and those with Eastern origins may similarly believe they find a strong Western bias. Scientific truth must be without bias, it must be truly universal. As best I can tell, there is no past of present-day culture which does not have serious flaws according to the model of this thesis. And there is no culture which has not made significant discoveries which, if shared, would not enhance all other cultures. Anthropologists with whom I have consulted told me that there are two kinds of societies, shame societies (a relatively modern example was Imperial Japan) and guilt societies (such as the United States of America). Put simply, in a shame society there are many rules (folkways, mores, and even written laws) and everyone breaks the rules. It is not important whether the rules are broken, what matters is being found out breaking a rule. In the theoretical model of a pure shame society, even a minor infraction is cause for removal from society through ostracism, suicide, or execution. In a guilt society such as the United States of America, very minor infractions are often overlooked, serious infractions involve punishment, so that the offender pays his or her debt to society, and the most serious infractions are handled the same as in a shame society, such as receiving a death sentence upon conviction for a capital crime. Such records as exist suggest to the author that anarchy preceded shame as the “structure” of society, and that shame was invented because of the inadequacies of anarchy, and further, that guilt was invented to solve the difficulties of shame-structured society. The model of this research is of the invention of a forgiving society, one in which anarchy allows the invention of new social structures, shame allows identification of harmful behaviors, guilt allows identifying who acted harmfully and who was harmed, and forgiveness facilitates learning the lessons from mistakes made and allows repairing the damage done with minimal additional damage. The model developed in this research is not utopian or idealistic, it is practical and pragmatic. It has been used in my personal life for nearly a decade, and by others as I have learned how to share the method of this work without harming others by the tendency of the model to decompensate people. It does not require even average level intelligence, it worked well for me through a period of severe to profound dementia in 1989. I have had repeated contact with the people with whom I have shared this work, none report being harmed as a result of learning about this work. Indeed, everyone, to date, with whom I have shared it has told me that it is helpful in their daily lives.

I can readily imagine the possibility of someone misunderstanding the principle from which this work developed. I can imagine the possibility of someone deciding that, as no mistake made could or should be avoided, that this research is a license for doing whatever one feels like doing for whatever reason one feels like doing it. Nothing I can think of is further
from the truth. In the model of Affirmation Therapy, relativism is variation of absolutism. If everything is relative, without exception or the possibility of exception, then relativism itself an absolute, and, this, to me, is nonsense. In a class in social psychology I took several years ago, the teacher described the relativist position this way, “If you believe it, then it is true.” In the courses I took during my engineering education, there were many examples given, including spectacular and tragic structure failures (for example, the Tacoma Narrows Bridge disaster), to prove that, at least in engineering, truth is not relative. Freedom, in my dictionaries, is usually defined as being without restraint. I think this is dreadfully wrong. To me, freedom is the ability to be truly satisfied, to be at peace, with the life that one can actually live, when one can never know in advance what that life will be like, when one is at peace with one’s life already lived that there is no need to repress or suppress or deny one’s past. Freedom is therefore only possible when each person has sufficient self-respect and respect for others that past abuses are resolved to a degree where the past is easily remembered, where society provides sufficient comfort and caring that there is no need to live in a state of fear about the future, and where, today, each of us has solid access to his or her past as we make plans for tomorrow. Freedom is therefore a state of both society and the individuals in society. When I studied introductory psychology in a college class in 1990, the instructor remarked that it was necessary to choose between free will and determinism, that they were mutually exclusive. I objected somewhat like this, “What if we are predestined to encounter free will as a stepping stone to freedom? What if there is a process that involves both determinism and free will in synergy?” To me, anarchy is as far as it is possible to get from freedom. Dr. Abraham A. Low’s book, Mental Health Through Will-Training, is a manual for freedom from mental illness and a manual for freedom to enjoy socially-appropriate spontaneity, for those who are able to use his work and his method. Will-training is discipline, without discipline, there can be no freedom. Discipline requires punishing inappropriate and harmful behaviors while endorsing and affirming the life of the one whose behaviors are changing.

A person is not what a person does, even though we can only know another person, outside of spirituality, by observing the behaviors of the other person. In a society where we are punished for our mistakes and shamed into fear of exposure, it is truly dangerous to take the risk of sharing our inner lives. About the only thing more dangerous than such sharing is keeping our inner lives secret from each other and ourselves, for grievous misunderstandings are guaranteed to arise from secrecy, and secrecy precludes correcting the mistakes. Given the current international political climate, the suspiciousness of power-elites in some small countries which may be able to develop thermonuclear weapons capability, I find that humanity has a moral and cultural imperative to find ways to avert global thermonuclear war and a nuclear winter
which would destroy the ability of the earth to support human life. Such ways must be based on objectivity, on practical
scientific principles that are not culture-bound to a partisan faction of humanity. I propose that this research may contribute
to such principles. I propose that the ideas of this research are worth testing in the laboratory of the world, in the lives of other
ordinary people such as myself and those with whom this work has already been shared.

1.10 Personal Background of the Principal Investigator

I was born few weeks before the start of World War II. Before marriage, my mother had been a high school teacher,
my father was a protestant minister who was exempted from the draft because of a childhood injury. Unlike many of the
children with whom I played and went to school during the war, I lived with both of my parents. I was three years younger
than my brother, my only sibling. I was encouraged to ask questions at home, I was given strong emotional support and help,
and allowed to set my own pace in learning. I had learned both printed and cursive writing, and had my own library card for
the city library by the age of four. I read many books before I started kindergarten. My father, a liberal, main-line protestant
minister, had strong social concerns. Mealtime conversation often centered on social issues. I remember feeling comfortable
with those discussions—I was not treated as inferior to my parents, yet it was obvious to me that my parents knew much more
than I did. My parents were very honest with me, they did not use deceptive stories such as “Santa Claus brought the
Christmas presents” to manipulate my behavior the way most of my friends’ parents did to my friends. I did not grow up in
a “perfect” home, my parents made mistakes, as do, I find, all parents. Unlike many parents, my parents often recognized
their mistakes, and, upon seeing that I felt hurt, apologized and helped me get over being hurt. I learned that I did not have
to hide my mistakes from my parents to feel safe with them. Having been encouraged to learn at my own pace and being
allowed to make mistakes as a child without fear of certain punishment predisposed me to pursue the research the way I did.
Time after time I made mistakes during the research and picked up the pieces as best I could. As a child, I was taught to
persist diligently if I thought I was working toward a worthwhile goal, and to take setbacks in stride. This will show up time
and time again in the narrative of the discovery process of this thesis.

I was reading college and graduate school level books in my parents’ library on psychology and social sciences while
I was in third grade. During the summer between fourth and fifth grade, I read college level books on electronic engineering.
While in fifth grade, I set up a simple electronics laboratory, initially with old equipment and parts that people gave me and
then started building some of my own laboratory equipment. While in sixth grade, I started an electronics repair business at
home, so I could earn money to buy equipment that was too elaborate to be practical for me to build at home. I learned both theoretical and practical aspects of electronics, and melding theory and practice carried over from decades of work with electronics into the research of this thesis. While I was in high school and my brother was a psychology major in college, he gave me a book on Freud's concept of normal personality (Hall, 1954). My brother thought that Freud's ideas were scientifically accurate, I was skeptical, and we discussed our differing views at length. My own life was, as I saw it, largely driven by curiosity and enjoyment gained from increasing knowledge and competence, and not by redirecting socially inappropriate instincts through psychological defenses. The combination of early reading in social sciences and engineering and the way I went about it, largely self-directed, is another important factor that shaped my research, for I had no mentor who was allied with any particular school of thought. By the time the research of this thesis started, in 1986, I had been studying psychology and such, mostly independently, for about forty years.

After high school, I went to College, Northfield, Minnesota, where I became a physics major. But, in March of my junior year, I nearly drowned in a swimming class, and missed the rest of that semester. Carleton was revising the curriculum in physics, when I returned in the fall, the classes I needed for graduation were not being taught. I left Carleton at the end of that fall semester. My brother was a graduate student in Chicago, living in an inner city apartment, and he invited me to come to Chicago to live with him while I sorted out what to do with my life. I got a job as an electronics technician within a few weeks after arriving in Chicago. For five of the twelve following years during which the City of Chicago was home to me, I lived in primarily African-American inner city neighborhoods. After four years in Chicago, I was hired as a Senior Electronics Technician at the University of Illinois Medical Center in Chicago. The University had just built the Circle Campus, as it was then known, and had started a bioengineering program. I was accepted as a transfer student at the U of I, and completed my B.S. degree in 1970. For the next 16 years, I worked as a combination bioengineer and research technician in pediatric cardiology and surgical research, garnering skills in medical research methods, taking the courses for a Ph.D. in bioengineering, and working on a method of quantifying heart chamber measurements from cineangiograms as my thesis project. My brother had completed his Ph.D. in sociology around 1980; I had discussed his work with him in detail. He told me and others that he and I were the only two people who really understood his research, which was on the dynamics of (Saul) Alinsky-style grass-roots community organizations. I believe that the combined depth and breadth I had in engineering, in technology, in biology and medicine, and in social sciences enabled me to take a far wider view of mental illness than a conventional education would have allowed.
In a book of Norwegian folk tales which I have had since my childhood (Thorne-Thomsen, 1912, pp. 147-153), there is a story titled "The Princess Who Could Not Be Silenced," of a boy, Boots, and his two older brothers. The king of the land in which they lived had a talkative daughter so "cross and crooked in her words" that she "could not be silenced." The king offered his daughter and half the kingdom to the first suitor who could "silence" the princess. On the way to the castle, Boots found several items of junk, and carried them with him in spite of his brothers' disdainful remarks about the things Boots picked up. Of course (this is a children's story), Boots' brothers failed. But Boots used the things he found as props and parried the princess until she has nothing to say, and Boots got the princess and half the kingdom. The research for this dissertation is somewhat like Boots' story. I collected many pieces of knowledge prior to 1986 that were instrumental in this research, yet, at the time I was collecting them, I did not know how or when I might put them to use. For, and this is another key to this work, the sort of curiosity a small child has, a curiosity based more on the enjoyment of discovery than on obvious utilitarian value, has been a strong part of my whole life. In 1986, at the beginning of the research that led to this thesis, I basically accepted the medical model of mental illness, having found the psychoanalytic model severely wanting. With the freedom to question that is characteristic of young children, I found the medical model inadequate to explain what I observed soon after I became a psychiatric patient in the autumn of 1986. I set out much as I had when I was a child, with a focused persistent effort, to understand what was initially incomprehensible, believing that I might succeed in understanding personality in much the same way I had learned to understand what had started out as incomprehensible electronics. In 1986, I had several advantages not available to me when I was a child. I was well trained in science and engineering, and I had read extensively in psychology and other social sciences. From my engineering training, I knew that the presence of a coincidence does not necessarily indicate a causal relationship and that chance correlations, in the broadest possible sense, do not necessarily indicate the presence of processes or mechanisms, and therefore I sought out verifiable causal factors and testable mechanisms to explain my observations. I had already recognized that Freud's ideas of personality were primarily based on coincidences, and soon found that the then-contemporary medical model of mental illness was mostly a matter of correlations, neither of which did I consider, as an engineer, to be trustworthy.

When I was eighteen years old, my father nearly died from a prostate infection that he told me was precancerous. The following year, he told me his father had suffered from both prostate and colon cancer and died from a heart attack shortly after being treated for colon cancer. My father was fifty three when this happened; he told me his father had several years of cancer-preventive surgeries before he died at the age of sixty six. My father told me that both my brother and I might
be at high risk for cancer, and that we should be checked. My brother, three years older, was a graduate student at that time, and no longer lived at home even during summer vacations, so he was not told what I had been told. It would seem from what I remember my brother told me before he died, that my brother was never told by my father about his concerns about cancer risk. When my father told me about his understanding of cancer risk, in 1958, I understood the risk to be significant only after the age of about forty. I believed it would be years before I needed to worry about cancer, if there was a high family risk factor of some sort. I was thirty three when my father died.

My father died in 1972 from metastatic colon cancer, his colon had been removed because of polyps a year earlier, but not quite in time to prevent terminal cancer. I spoke with my father's doctors in 1972; what they told me ruled out the condition that actually caused his cancer, Gardner's Syndrome. His doctors did remark that he had died from the earliest cancer they had ever seen, his colon had been removed a year before he died when the cancer was first detected. From conversations I had with my father, it is clear to me that he never knew what caused his cancer. Two years after my father died, I met the woman who became my wife; we dated for about a year and got married. During the time we were dating, I told her of my father's death, and that, it seemed to me, if I had an inherited cancer risk, I thought I would most likely be able to get preventive treatment in time, given my father's history. When I was forty, I set out as my father had advised, to be screened for possible cancer, hoping that early detection might prevent what happened to my father. By 1980, I had come to believe, based on all the family history I could collect, that my brother and I were almost certainly members of a family with a genetic predisposition to cancer. What I knew of my father's and grandfather's cancer and treatments corresponded to no common type of cancer, but I knew that there are very rare and highly lethal forms that have genetic origins. My brother's family and my family (he and I were both married, with children) had been seeing the same doctors in a family practice setting. When those doctors refused to start screening procedures for cancer, I found other doctors who would screen me for colon cancer, and the tests, for occult stool blood, were consistently negative. A digital prostate examination, part of a routine health checkup, was within normal limits. Beyond those tests, I could not find any doctor who was willing to listen carefully to my concerns about cancer risk and do more thorough testing. I repeatedly advised my brother that he also needed to be screened at least to the degree that I was being checked, but his doctors, the ones I had left, refused to screen him. As I will point out later, with more details, they refused to check my brother's children even after he had died and I was known to have Gardner's Syndrome. The attitudes and decisions of those doctors became, for me, a serious problem as this research developed.
After dating for about a year, my wife and I were married in 1975. In 1977, we decided we were ready to start a family which included children, having found that we had the personal and marital resources to make the kind of commitment of love that a family needs. We knew that there were “special needs” children who needed families. My wife had worked as a schoolteacher for over twenty years, and I had worked in a children’s hospital setting for over ten years. We both enjoyed children and working with children. We went to the oldest and most reputable adoption agency in the state and underwent a home study as prospective adoptive parents. We thought, as part of community responsibility, that it would be a good idea to try adopting one child and having a second child of our own. And, this is what happened. Our son was eleven when we adopted him, our daughter was born about a month after the adoption was finalized. Our son had special needs. His original family was negligent and/or abusive to such a degree that there had been repeated interventions by state agencies before the decision was made that his birth parents were incapable of caring for him properly. He had developed strong coping skills; it took about three years to uncover the fact that his original parent’s neglect and abuse had left him with focal areas of severe to profound emotional disturbance. He was one of seven children in his original family, the second oldest, and his older brother often took control of the family when the parents were unable to provide for the children. Our son was psychologically and emotionally abused by his older brother, according to what our son told me a few months before he and his wife died in an automobile accident in 1996. Among other things, our son told me that his older brother made him steal from stores to get food for the children when the parents were unable to do so. While the older brother took responsibility for seeing that the children had food, he put our son at risk while keeping himself safe. The overall effect of this was to generate severe emotional conflicts and serious problems with dishonesty for our son, problems which were substantially unresolved at the time of our son’s death.

Although my family had problems, as did and does every family, when I was a child, I never experienced anything remotely like what our son lived through in his original family. I grew up in a very stable, caring, sensitive, compassionate family. I grew up in a family where my parents had not only the personal resources to live their lives very well, but had effort and energy to spare in parenting my brother and myself. I grew up in a home where genuine love and caring was abundant. That love gave me the ability to triumph repeatedly over adversity after adversity during my life. It gave me such authentic self-respect that I have not had to prove myself before others to compensate for a sense of personal inadequacy, nor to retreat from difficult problems. Please do not misunderstand me. My parents made mistakes with my brother and myself, and some of the mistakes were serious. My childhood home was far from “perfect.” But my parents never represented themselves as
perfect—they tended to recognize and acknowledge their mistakes. If my mother or father saw that I felt hurt, they would ask me why I felt that way, and if it was because of something they had done, it was safe for me to tell them about it. If they saw that my complaint was reasonable, they would apologize and help me overcome feeling hurt, and they would try to avoid doing whatever had hurt me again. To a remarkable degree, my parents treated me as a real person from infancy. They did not expect of me what I could not do, they did not block my curiosity and will to learn by putting me down with remarks that would discourage my effort to learn.

Our son’s early childhood home’s deficiencies caught up with him by the time he was fifteen, and he was hospitalized for seven months because of depression and other problems. In high school, he was in a special program for emotionally handicapped children, and this was very helpful to him, but there was not enough time between his adoption and his achieving adulthood to reverse all the damage of his early years. My wife and I worked with our son, as dedicated parents, from the time he was placed with us for possible adoption until he died in an automobile accident four days before his 28th birthday. According to the state police report, he was driving well under the speed limit when the car skidded on invisible black ice into the path of a fully loaded gravel truck and, according to an eyewitness, exploded with a loud boom. From the time he was placed with us until he reached adulthood and moved out to live on his own, listening to our son, working with him on self-image and emotional issues, as well as school achievement was, for me, like having a second full time job. It was very hard; without help from community agencies, counselors and therapists, it would have been impossible. From time to time, I found it sadly ironic that some agency people regarded my wife and myself as being at fault for our son’s problems, as though he was born at the age of eleven. This tendency to blame the innocent led to my wondering about the whole issue of blame and responsibility. Had our son misbehaved in ways that parents are held accountable for by law, we would have likely been punished for things we had not done, and that we could not possibly have prevented because we had not met our son when he was abused and neglected in his original family. This awareness, as our son’s troubled childhood surfaced, led to my first clear recognition of standards set by society which are impossible to meet, and the tendency on the part of society to deny the impossibility of the standards and to suppress awareness of the impossibility through threats of punishment for even so much as speaking out against the abuses caused by impossible standards. The massive effort required to be an adequate father for our son took so much of my time and effort that I had little time to pursue my concerns about cancer risk while he lived with us.
In 1984, a testicular lump was found during a routine health check-up. I went to a local urologist, who informed me that the lump was a normal embryonic structure, the appendix testis, and that it had always been there. I knew that it had not always been there, and I checked anatomy texts, and the lump was obviously not the appendix testis. I returned to the urologist and tried to explain the basis for my concern about cancer risk based on family history. My concerns were summarily dismissed without consideration of their merits. I protested that a close friend of mine, who was a patient of the same urologist, was dying of prostate cancer because he did not receive effective treatment soon enough. The urologist became very hostile. I asserted firmly but gently that I wanted to tell of my concerns to get an opinion as to what I might best do, given my family history. The urologist then told me that, if I did not want to have testicles, I should self-induce torsion of the spermatic chord, and could solve my problem that way. I was absolutely stunned. A close friend of mine had the same urologist, and was dying from metastatic prostate cancer. I wanted to avoid needless deaths from cancer, my friend had been diagnosed years earlier, but had been given limited treatment until it was too late. He was given an orchiectomy only after his cancer had spread to his bone marrow. I wanted a better outcome. I knew from studying human physiology as a graduate student that torsion is impossible to induce in normal adult males, and that, were I stupid enough to try such a form of self-treatment, I would have horrible pain, would likely develop gangrene, and might die. The urologist went on to say that he thought my fear of cancer was ridiculous, and that, while he would do nothing to help me, I might find a doctor in a third rate hospital who would do something. I felt very abused by that urologist, I was upset that he had been totally unwilling even to listen to the reasons I had, reasons which I thought were logical and scientifically valid. During the many years that I worked in hospitals, I had seen a tendency on the part of doctors to delay radical cancer preventive surgeries for rare forms of cancer until the cancer was terminal. A very close friend had died of pancreatic cancer because his doctors would not remove his pancreas before there were multiple metastases, because, although the presence of cancer had been observed by one of his doctors, his other doctors did not agree.

The lump was obviously larger, and I went to a second urologist early in 1985. He was just as resistant to hearing my concerns about cancer risk. However, he agreed that the lump was not the appendix testis, but said that it was nothing to be concerned about. He suggested that I had a sexual problem, not a cancer problem, and suggested that I see a psychiatrist who specialized in sexual problems. I was unaware of any sexual problem, but I took his advice, and after seeing a psychiatrist, concluded that I really did have a cancer problem and not a sexual problem. I read about rare cancers and found an article in Ca-A Cancer Journal for Clinicians (Lynch, et al.1985, pp. 95-115) about hereditary colon cancers, in which
testicular cancer had been found to have a possible association with colon polyps. I then began calling urology clinics, to see if I could find someone who had a close relative that had died from cancer and who would consider evaluating the evidence I had for cancer risk objectively. After almost a year, I found a doctor in private practice whose father had died after developing prostate cancer, and who believed that his father's death from cancer might have been avoided with earlier treatment. That doctor was the first to listen adequately to my understanding of my risk of cancer. He understood that I had a long-term concern, that I wanted only to realistically improve my chances to live long enough to see my daughter well into adulthood, as any good father would. I finally found a doctor who took the time to understand what I wanted and why, and that I had a scientific basis for my belief of an unacceptable likelihood of dying from preventable cancer as had my father and many other people I had known. No one knew at that time that my brother already had terminal cancer, nor did he; he was still asymptomatic.

Based on the evidence available, the doctor concluded that a simple bilateral orchiectomy, to prevent the possibility of testicular cancer and to minimize the risk of prostate cancer, would give me the best chance for a long and satisfactory life. My wife and I discussed the situation thoroughly; as we were not going to have more children, fertility was unimportant to us. I also knew from studying physiology that I faced negligible risk of impotence as a result of the orchiectomy, but was threatened with a high risk of impotence, and perhaps untimely death, if I developed a prostate condition such as my father had. The doctor agreed with this. I decided that I would rather be alive than dead, to the extent I had a choice. In early June, 1986, I underwent the bilateral orchiectomy, it was uncomplicated and I was at work the next morning. Because it was not possible to show medical necessity to get insurance coverage for the surgery, as I could not prove beyond doubt that I was at grave risk from cancer at that time, I paid the doctor directly. Both the doctor and I recognized that there are social taboos and medical standards issues about such surgery, and that those were the major reasons why no other doctor had been willing to listen to me. In exchange for a reasonable price for his services, he asked that I not identify him publicly because he received referrals from other doctors as a significant part of his practice, and did not want to be harmed by helping me. My wife and I both agreed to this. It was the right thing to do at the time, but it caused problems later that became, for me, a dreadful moral dilemma. I have known many dreadful moral dilemmas during my life; however, trading fertility I no longer needed for the possible chance for a longer life with my family was never a moral dilemma. That the decision about the orchiectomy was wisely made has never been questionable for me, except when I was experiencing major loss of reality contact in response to medications. It took only days to validate my analysis of inherited cancer risk.
It became tragically clear that my concerns about cancer had indeed been valid when my brother was diagnosed with terminal cancer the very next week. I felt as though I had been psychologically raped by the doctors who refused to listen to my concerns about cancer risk. It had taken so much of my time finding a competent doctor that I had little time to spend with my brother. With the additional evidence of my brother's imminent death, I finally found another doctor, one who was able to understand that I also faced high risk of colon cancer. I thereupon went for intensive testing, not just screening, and was also found to have Gardner's Syndrome, but no cancer, and my colon was removed to prevent colon cancer such as had happened to my dad and brother. The colon surgery was uneventful, but I lost the ability to concentrate on problems of any complexity almost immediately after the surgery. In retrospect, it is clear that I suffered a substance-induced psychosis from morphine given for the post-surgical pain from my colectomy. Once the morphine-induced psychosis set in, I mistakenly came to believe that I could have saved my brother's life if I had only tried harder to get him to understand the risks as I had. Once psychotic, I thought I might have saved his life if I had given more attention to colon cancer and less to prostate cancer. In my grief at his imminent death, I forgot how hard I had tried, for I had tried everything I could think of. The main problem with psychosis is loss of contact with reality. I became too psychotic to recognize that I had not been psychotic until I was given morphine after the colon surgery. Thus began a tragedy of compounded errors both on my part and on the part of the doctors who treated me. It is these mistakes that became the basis for doing the work that turned into this research. After struggling with this psychotic condition for two months, I decompensated to such a degree that I needed to be psychiatrically hospitalized. My situation felt absolutely desperate to me, in response to that feeling, I used every resource available to me to try to understand what had happened to me. I assumed that, if I could accurately understand what had happened, I would probably be able to solve the terrifying predicament which had overwhelmed me. Thus began the research of this thesis.

The belief that I could have done something which would have made it clear enough to my brother and his doctors that he would have avoided cancer in 1986, a belief which created in me great stress in 1986 and 1987, left me forever when, several years after my brother had died, the very same doctors who categorically refused to even screen him for occult stool blood refused to evaluate his children for Gardner's Syndrome. Once they showed, through such a terrible additional medical blunder, that they were totally incapable of understanding the problem, I understood why all the efforts I had made while my brother was alive were doomed to failure. With that understanding, I set out to improve my skills at forgiveness. I remembered one time when my brother had brought up the cancer issue with his doctors. He said they asked him if I was a medical doctor, and he answered that I was not. They told him to tell me to stop acting like someone I was not. Alas, I was
not trying to act like a medical doctor, I was trying to act like the trained and experienced bioengineer that I was. In this research in the fields of psychology and psychiatry, I am not trying to act like a medical doctor, I am acting like the trained and experienced bioengineer-scientist that I am. The doctors who dismissed the scientific arguments I had in the 1980's committed the fallacy of *Argumentum Ad Vericundiam* (the appeal to authoritarian power and not evidence, so authoritarianism will be uncritically accepted). (Werkmeister, 1957, pp. 54-56) They did not know any better; that is their tragedy, not mine.

The combination of stressors which finally reduced my available survival strategies to the last resort of florid psychosis can be summarized compactly. My dad had obviously died from a rare cancer, the evidence was that his father had a similar genetic condition. I had developed a growth that had characteristics of some form of pre-malignancy which my doctors dismissed. I felt that the doctors I had consulted prior to my colectomy regarded me as having a mental illness, not a cancer risk, and that they were very abusive toward me as a result. One week after the bilateral orchiectomy, done under circumstances which were outside the boundaries of appropriate medicine only because none of the previous doctors would listen to me, my brother was found to have terminal colon cancer, as I had feared might happen. I developed very painful and unpredictable spasms at the site of the ileo-rectal anastomosis following my colectomy, the spasms were, years later, attributed to the formation of neuromas at the surgical site which made that area exceptionally prone to spasms. I became psychotic after being given morphine for post-surgical pain caused by the colectomy. I had been talking with my mother about my mental state about three hours before she was struck and critically injured as a pedestrian by an automobile whose driver was blinded by the sun, and thought that what I said to my mother about my mental state could have distressed her so much that she did not notice the car. In the presumably morphine induced psychosis, I felt that I should have been able to persuade my father to have his liver resection at a major university hospital or national status medical facility to minimize his risk of death. Very psychotic, I began to wonder whether I could have saved my brother's life if I had focused more on colon than prostate cancer risk, and so his death was somehow my fault. I was experiencing horribly terrifying hallucinations which I did not remember when I was with other people; they were so starkly dissociated from consciousness whenever I was with other people that I had no real chance to tell about the hallucinations. In the first psychiatric hospitalization, I was told (incorrectly) that my brother and I had a "shared personality," and this was the reason I was so troubled by his impending death. I was psychotic enough to wonder whether, because of the ways he picked on me when I was young, I had only made a half-hearted effort to tell him of the cancer risk, and so was responsible for his death. I wondered whether I did not drive
many hundreds of miles to force my father to go to a better medical facility for his liver resection because I wanted to get even with him for his spanking me as a child. The early psychotherapy, as I understood it while my inner experience was floridly psychotic and I could compensate so well that my psychiatrist was certain that I was not psychotic, had an implicit assumption that I had unconsciously wanted my dad and mother and brother dead. Since I could find no real evidence of this, since I was psychotic, I saw that I had an incredible problem. If I was so dangerous that I had found a legal way to murder my father and brother, and nearly also, my mother, what else was there within me that was perhaps as dangerous of which I could also have no conscious knowledge? In this state, the among the most complex and intense real-world moral dilemmas of which I have ever heard, I set out to guarantee that I would harm no one ever again, to the absolute limit of my capability. In that state of mind, one chance in a billion that I would knowingly and intentionally bring deliberate, malicious harm to someone else was an unacceptable and intolerable degree of hazard. I set out with all of that of heart, mind, soul, and strength I could find to attempt the nearly impossible, trying to regain sound mental health while undergoing psychiatric treatment which made my illness worse, accepting almost certain failure as the most likely outcome. But, I loved my father, my mother, my brother, and, if it were so that I had done them in, intentionally and unknowingly, I decided thereafter to stop short of nothing but massive failure of my personhood in the resolve to prevent anything similar from happening again. Alas, I was so psychotic that I did not see that my efforts had been of heroic proportions in trying to keep my father and brother from dying when and as they did. In my psychosis, I felt ashamed that I had not done enough that my dad and brother had not died. Further, as an aspect of psychosis, I felt that I had not tried as hard as I could have done, and that it was possibly my fault at least in part that they had died. I lost contact with the fact that I had tried to the limit of my ability to get adequate medical care for them. I lost track of the degree of effort I had made, I mistakenly overlooked the fact that, with the other things I needed to do, it was impossible for me to have done more. But, psychotic, I felt I should have been able to do the impossible. There is one little problem with a wholehearted effort to do the impossible, heartbreak is inevitable.

Heartbreak can sometimes heal. I know this. Some day, spiritual grace may be validated scientifically. Martin Buber, in Tales of the Hasidim (Buber, 1975 p. 104), tells the story of The Strong Thief.

The maggid of Mezritch said: "Every lock has its key which is fitted to it and opens it. But there are strong thieves who know how to open without keys. They break the lock. So every mystery in the world can be unriddled by the particular kind of meditation fitted to it. But God loves the thief who breaks the lock open: I mean the man who breaks his heart for God.

Because of my illness, it was given to me to live closely for most of three years with hundreds of men, women, and children who had also broken their hearts for God. That they were, as I was, psychiatrically hospitalized was the evidence of broken
heartedness. By the word “God,” I mean the ultimate reason for all things, whether we believe there is such an ultimate reason or not, whether there is such an ultimate reason or not.

I know now that what I did to prevent prostate cancer was right, considering what I knew at the time of the decision, and also that every more “socially acceptable” alternative would have been wrong. It is wrong, terribly wrong, that men should needlessly die in honor of a false sense of masculinity. Some things need to be said with forceful clarity. I suffered no significant loss of sexual libido and ability, neither would most mentally and physically healthy men, as a result of the reduction of testosterone levels. What I did was right for myself and my family, it was wrong according to what surely are obsolete social taboos. That is the nature of the moral dilemma that plagued me the most. I needed the help of doctors because of Gardner’s Syndrome, and because morphine had made me psychotic, yet I had violated the authoritarian beliefs of almost every doctor I consulted, because I had outperformed them all in recognizing my family risk of cancer and the need for prevention. I was, very highly trained in decision making strategies, having taken courses as a bioengineering graduate student in pattern recognition and classification methodologies which were directed toward the possibility of automated diagnosis. As a bioengineer who had studied ways to automate medical diagnosis with computers, I was vastly better educated in the field of diagnostic strategies and risk assessment than any physician or therapist who treated (or mistreated) me. Even when I was floridly psychotic, I realized that I had been unable to find a way to properly gain the attention of almost every doctor I had seen. I understood the predicament, I vowed that my doctors would have to hear me in the future, and that I would say whatever was necessary to make them listen. I decided with firm resolve that I would never again allow any doctor to overlook a strong concern of mine. This decision shaped many of the experiments I made which developed into this thesis. The manner in which I did the research cannot be told with scientific integrity unless the extreme intensity of the events surrounding the research is clearly stated. Further, the effectiveness of the method of psychotherapy developed through this research will not be evident unless the depth and breadth of the problem it resolved is also clearly stated. I intend to tell the truth about the research, how and why it was done, to the limit of my ability, while protecting the many patients and other people who contributed to it from harm which could result from breaching confidentiality, and while protecting those doctors who made tragic, unavoidable mistakes from being harmed in their continuing practice of medicine. A key to understanding this research is a lifelong personal resolve on my part to try to do what is most helpful when it is possible to be helpful, and to try to do what is least harmful when harm can not be avoided.
2. DESIGN AND DEVELOPMENT OF AFFIRMATION THERAPY

2.1 Introduction

In this narrative of the experimental process through which the scientific discoveries of this thesis were made, information as to settings and circumstances is given to permit the reader to understand the context of the research. This is important for understanding the application of scientific and engineering methods, since ethical factors rule out repeating the experiments in settings comparable to those where the research was done. The participant-observer research of this thesis was done in the ordinary course of the principal investigator's life; what was ordinary for him, given his circumstances, may seem extraordinary without enough context information. The research which is the basis of this thesis would be highly unethical if it were done as part of a deliberate, planned experiment; such an experiment would require seriously abusing people with mental illness.

At the outset, I believe it is important to make clear the reasons for the structure and form of this section of this dissertation. Unlike a well planned laboratory experiment, many of the experiments of this research were the result of accidental combinations of circumstances. The development of the ideas is presented in a somewhat chaotic sequence; however, that is the sequence in which the experiments actually occurred. As will be stated from time to time, many experiments were done while I was intensely psychotic. It is something of a contradiction in terms to expect a floridly psychotic person to be completely rational, or, for that matter, notably rational in any meaningful sense of rationality. The chaos of my life was instrumental in the scientific discovery process, and I am attempting to present the science of this thesis, including, as best I can, scientific analysis of the psychotic episodes of my life. I have struggled with alternative ways to describe the experiments I made and my motives for making them, and every alternative to this form of narrative rapidly ceased to make any sense to me. I am quite certain that, if the science were written in a way that made no sense to me, it would be incomprehensible to anyone else. Perhaps it is best to accept the seemingly chaotic presentation of experiments and discoveries of this section as an accurate reflection of the states of mind in and through and by which major aspects of this work were accomplished. To present a very chaotic process as though it was carefully planned would, I think, verge on scientific fraud. Therefore, I apologize for the effort it may take to read and understand especially this section of my thesis. Rest assured that it was much harder for me to live than to write it, and I am convinced that it will be easier for others to read than writing it has been for me. Within the practical constraints of time and effort actually available to me, this dissertation
is the best I can make it. One way or another, that is, must be, sufficient. What each and every one of us can actually do must be sufficient also, for that is the ultimate lesson of this thesis. So be it.

Research into personality necessarily involves the personality of the researcher. Personality includes the whole of personhood, emotions, attitudes, environment, history, education, relationships with others, spirituality, and more. It is not possible to describe scientifically what one has not observed and understood. The utilitarian validity of a model of personality, I think, may best be determined by the range of phenomena accounted for by it and by the accuracy of predictions made on the basis of the model. As this research explores a model of mental illness which is based on a concept of psychological abuse as the treatable and preventable etiology of mental illness, this section is focused on the principal investigator's lifelong encounters with abuse and abuse resolution. This is not an historical account, although the chronology is accurate as possible. Composite characters and events are employed to clarify the nature of the abuse experienced, to protect the identities of persons who might suffer social harm if they were identified, and to reduce the number of crisis events to manageable proportions. The science of observation and understanding of abuse has not been compromised by the use of the composite vignettes which describe the forms of abuse I experienced and the ways the methods of this thesis resolved those experiences of abuse. Many of the details of the narrative of the discovery process will be repeated, for my understanding of them changed as I made experiments and learned, piece by piece, as though groping in a darkened room with obstacles I could not see until I tripped over them, sometimes clumsily, sometimes as though very efficiently, the ideas of this thesis. It is not the events during which I learned the methodology of this thesis that are most important, it is what I learned that I can share with others that is most significant. At the same time, the research strategies themselves are an exercise of science and the invention of scientific techniques for studying personality, and there is merit to describing the process of scientific invention, such strategies as I used may be useful in future scientific endeavors, in the study of other aspects of personality and society.

2.2 Secrecy and abuse

I have learned that abusiveness can only thrive when it is kept secret. Abuses which are built into the fabric of society in folkways and mores which cannot be challenged without risk of punishment for social deviance create a predicament of intense moral dilemma proportions. I am reminded of the children's story of the emperor's new suit. A pair of schemers came to a new town posing as expert tailors who could make a marvelous new suit of clothes for the local emperor, a very vain man. Exploiting the emperor's false pride, the crooks pretended to be making a suit, which, of course, did not exist. No one dared
say what they saw, each unable to believe that everyone also saw the emperor in his underwear. One small child had not mastered dishonesty, and spoke the truth. Dr. Irving F. Miller, then the head of the bioengineering program at the University of Illinois at Chicago, agreed to serve on my thesis committee several years ago, after he understood the basic nature of my research. He warned me that I was headed for trouble because, if I was proven wrong, I would get squashed because of my error, and if I was proven right, I would get squashed because people would not like what I had to say. He thought the research was worth doing, but if I went forward, no matter what I did, I could expect to get squashed. I thought of the lowly wood tick. Squash one under your heel against concrete, and the tick is stopped while you stand on it. Lift your foot and it goes on as though nothing much had happened. Put one on a steel anvil and smash it with a heavy hammer, and the tick goes on as though nothing much had happened. Then I recalled the remark of my psychiatrist, Dr. B, made in 1986, after he had read the short autobiography I had written to help him with my treatment, “Your life is like you were stepped on like a bug a thousand times and more.” Perchance I have enough of the nature of a wood tick in or about me that I will withstand being squashed, if that is what happens, perhaps I have lots of practice.

As I recall, I was five, my brother eight, and it was late summer in Seattle, Washington. We were walking on the sidewalk up the hill from our house by the vacant lot. Three boys called out to us from the tall grass. They were experimenting with matches and asked us to join them. My brother ran off. I went into the grass and pleaded with them to stop, what they were doing was wrong. They were older than I was, they were bigger, and there were three of them. They told me to get out of there if I wasn’t going to join them in playing with matches. I cajoled them to stop. Finally, the boy holding the match box said, “Just one more.” It started the fire, and they ran off. I ran too, ran home, told my mother, she called the fire department, the fire was put out before it set fire to any houses. The firemen came to our house and asked me what happened. I told them. I named names. I wondered how long it would take for the rain to wash away the bloodstains on the sidewalk where they would surely kill me for tattling. They never touched me. I learned what it feels like to blow the whistle when I was five. Now I am setting out to see what happens if I blow another whistle. The whistle on the false belief that it is proper to punish those who make certain mistakes, including, perhaps myself. I am making a mistake as I write this. I do not know exactly what will happen to society if my thesis model becomes widely understood. The best guess I can make is that life will greatly improve. Until someone makes enough mistakes trying to make forgiveness practical, I truly believe that we will continue to live in a world in which many, if not most, people live in fear of being found out, of being exposed as what they really are, as being seen by themselves and others as ordinary people.
2.3 Faith, personality and science

I started a radio and television repair business, part time, at home, when I was eleven years old and in sixth grade. I had very little test equipment, and almost no parts stock, so I had to buy every part needed to repair a radio. I could not charge for parts I damaged, I could not charge for parts that were not defective if I replaced a good part by mistake, because I knew that doing so would be dishonest. To repair a radio at a profit, I had to find out exactly what parts were faulty before I bought any parts, I could not depend on guesswork without facing economic ruin. My business was profitable because I figured out how each radio was designed to work and what had failed so the design no longer worked. Much of what has been done so far in psychology and psychiatry is like trying to repair a radio without knowing the design, or guessing at the design, or assuming that all radios are alike. With all due respect, most methods of psychotherapy developed to date are rather like trying to repair a vacuum tube radio which has one burned out tube and one shorted blocking capacitor by polishing the cabinet so it looks pretty, but with scarcely any thought of what is really inside the radio. I was emotionally hurt, spiritually impaired, and brain-damaged by psychiatric treatment that was in accord with the highest standards of the day based on the medical model of mental illness. I needed to talk with people who had lived through experiences similar to mine; those people were psychiatric patients. To talk with them, I had to accept medications I knew were causing me physical harm. Without realistic and pragmatic faith, I am certain I would have lacked the capacity to survive. So, this thesis, as a model of personality, also deals with faith from a scientific perspective.

2.4 Participant-observer research

I find that it is necessary in participant-observer research that the personality of the participant (myself) be sufficiently revealed that those who read the writings about the research have access to insights into the participant's circumstances and views, emotions and concerns. None of the scientific arguments in this thesis depend on emotional arguments, indeed I consider all such arguments as fallacious. Used effectively in propaganda, emotional appeals amount to tabloid sensationalism, and are antithetical to scientific research, unless the research is about emotionally based fallacies. Alas, some traditional theories about personality have emotionally based premises at their core, so I find. I was a participant-observer in the research of this thesis, and data so gathered is commonly considered to be subjective. However, I went to great lengths to minimize introducing my subjective biases into the research methodology. Given the strategies used to minimize bias, to be discussed later, I consider certain findings to constitute objective data. An example is the finding that no one could describe an achievable process whereby a mistake actually made by the person could have been avoided. Although I have
premises and conclusions about emotions in this thesis, I intend that all premises, all logic and reasoning, and all conclusions be supported by objective data analyzed with critical scientific reasoning to the greatest practical extent. Therefore, I find it necessary to remark about observation.

Observation is essential to all scientific research, but most observations must be interpreted. From Werkmeister (1957, pp. 445-448),

I. Truth and Falsity of Propositions

In order to understand fully the issues involved in matters of truth and falsity, it may be well to examine once more the difference between generic and empirical propositions.

A generic proposition, as will be remembered, is characterized by the fact that the meaning of its subject term includes the meaning of the predicate term: "All roses are plants," "All horses are mammals," All rats are rodents," etc. Empirical propositions, on the other hand, are of such nature that the predicate term adds something new, something which was not already contained in the meaning of the subject term: "Some roses are red," Some houses are in need of repairs," "Some wise men are wealthy," and so on. Generic propositions are essentially analytical, whereas empirical propositions are synthetical.

The truth of generic or analytical propositions can be determined through an analysis of the terms employed. Four distinct situations are possible (1) If the meaning of the subject term includes the subject term (as the meaning of "star" includes the meaning of "self-luminous"), and if the proposition itself is affirmative, i.e., if it affirms this inclusion, then the proposition is true: All stars are self-luminous. (2) If the meaning of the subject term includes the meaning of the subject term (as the meaning of "red" includes the meaning of "color"), but if the proposition is negative, i.e., if it denies this inclusion, then the proposition is false: 'No red objects are colored objects. (3) If the meaning of the subject term excludes the meaning of the predicate term or is irreconcilable with it (as the meaning of "circle" excludes the meaning of "square"), and if the proposition is negative, i.e., if it affirms this exclusion, then the proposition is true: "No circles are square." (4) If the meaning of the subject term excludes the meaning of the predicate term (as the meaning of "insect" excludes the meaning of "four-legged animal"), and if the proposition itself is affirmative, i.e., if it denies the exclusion or affirms the inclusion, then the proposition is false: "All insects are four-legged animals.

The truth or falsity of analytical propositions can thus be determined entirely from the meaning and interrelation of its terms. If this were possible also in the case of empirical propositions, the criteria of truth and falsity might be incorporated in formal logic and knowledge would become a relatively simple matter. The truth or falsity of empirical propositions, however, cannot be so determined. The truth of such statements as "Some roses are red," "Some automobiles have six-cylinder engines," "Some animals are domesticated," "and "Some men are poor," cannot be derived from the meaning of the terms alone, for the meaning of "rose" does not include (or exclude) the meaning of "red" any more than does the meaning of "white"; nor does the meaning of "man" include (or exclude) the meaning of "poor" rather than the meaning of "rich," and so on. In order to determine the truth or falsity of empirical propositions, the facts in the case must be considered, and they alone decide the issue.

The problem of truth as it arises in connection with empirical or synthetical propositions has led to the development of various theories of truth—such as the "correspondence theory," the "pragmatic theory," and the "coherence theory." It is fortunate, however, that for practical purposes of truth-finding, ultimate agreement on some particular theory of truth is not necessary. The elements common to them all—namely, an implied appeal to observation and the achievement of an empirical context—are sufficient to serve as criteria of truth. But the matter is not quite so simple as it seems to be at first glance.
2. Observation

Reference has just been made to an "appeal to observation." This term, "observation," however, is not without ambiguities; and before the criterion of observation is accepted, the meaning of the term must be clarified.

In its most relevant sense, "observation" means the "act or the result of recognizing and noting" facts or occurrences. But even this restriction in meaning does not make the term unequivocal, for the act of "recognizing and noting" is by no means the same as the result of "recognizing and noting."

When it is said that the truth or falsity of an empirical proposition is determined by observation, reference is made to the result rather than to the act of "recognizing and noting," for the act of observing as an act, i.e., as a psycho-physical problem, can have no bearing upon the content or meaning of a proposition; and yet, the act of "recognizing and noting" is in many instances so intimately bound up with its result that a complete separation of the two seems impossible. This becomes clear the moment the nature of "recognizing and noting" is analyzed.

In the strictest sense, "observation" as an act, means the inspection, recognition, and noting of immediate experiences. Its results are "recognized and noted" elements of first-person experience, such as color differences, coincidences of pointers, variations in sounds, intensities, tastes, feelings, images, and the like. These immediate data, however, are not sufficient to determine the truth or falsity of a proposition; for as mere contents of immediate experience they are as yet unrelated to propositions. They must be interpreted in order to become at all relevant. Even so simple a proposition as "This is red" can be proved true by observation only if the color quale referred to as "this" is recognized as belonging to the class of colors called "red"; the mere noting of the color quale or, rather, the mere color quale as sense-datum (i.e., by itself and unrelated to the universal concept "red") has no bearing upon the truth or falsity of any proposition.

The presence of interpretation in all observation is much more apparent when we consider matters which transcend judgments pertaining to first-person experiences. Suppose that on a certain day we "observe an eclipse of the sun." What we actually see is a curved dark patch increasing in size while the same time a luminous yellowish disk is correspondingly diminished and is altered in shape. The statement that we observe an "eclipse of the sun"—meaning that the moon has moved into such a position that it obscures our view of the sun—is actually an elaborate interpretation of the sense data, involving as it does our whole view of the "solar system" and our understanding of its motions and laws. And still we say, in a broad sense, that we observe a solar eclipse. Observation, therefore, whether we take it in the strictest sense referred to above or in the broad sense of customary usage, is fundamentally an intellectual exercise depending upon interpretation as much, if not more, than upon actually seeing or hearing or perceiving in some other way. Small wonder that the results of observation are so intimately bound up with the act of observing; that they are at least partly determined by the process of "recognizing and noting."

Observation in every field of human endeavor is determined by the extent and nature of the knowledge in the field which the observer possesses. If a person watching a football game does not know the rules of the game and has no knowledge of play formations, he may "observe" twenty-two young men on the "field" behaving rather strangely—lining up in peculiar formations without rhyme or reason, running in many directions, throwing one another onto the grass, carrying, throwing, kicking a ball, and so on. But to him the "game" does not make sense and the most important matters escape his "observation" because he does not know what to look for.

The situation is similar when a student looks through a microscope for the first time and tries to "observe" certain tissue structures. Only if he knows something about the nature of the object he is looking at will he be able to distinguish between what is relevant and what is not, between "blood corpuscles" and "frog's eggs," between "mesoderm" and "ectoderm," or whatever it may be. The accuracy, completeness in detail, and general fruitfulness of the observation depend in each case on the nature and scope of knowledge which the observer can bring to bear. To know what to look for is essential for any differentiation between what is significant and what is not in any observation. A good observer, therefore, is of necessity an active theorizer. He is a man who knows the established facts and theories in his field sufficiently to use discriminating judgment in all observations; a man who formulates hypotheses which suggest new discoveries and who anticipates in his imagination what he expects observation to reveal.

If this is true, then an observation, isolated and by itself, is of no particular significance. It becomes important only as it either confirms or confutes some idea which the observer entertains. It is important, in other words, within a context of ideas. If an observation yields an unexpected result—results,
that is, which contradict a generally accepted idea—it becomes the basis for further investigation. But it is not observation by itself which gives rise to new inquiries; it is rather observation-contradicting-what-is-believed-to-be-so-and-so that results in further search. If, on the other hand, observation yields results which were expected, it serves to establish the observer’s hypothesis as a theory or a law. But again it is not observation by itself which does this; it is observation-confirming-the-hypothesis. Even “chance observations” have significance only to persons who see the relevancy of what they “observe” to some ideas, beliefs, theories, or hypotheses which they entertain at the time.

Given the above understanding that observation and interpretation cannot be totally separated in the “recognizing and noting” of the gathering of scientific data, I define the construct of “directly observable” thusly: That which is directly observable requires a minimum of interpretation. Consider a children’s baseball game, the player at bat swings, loses his or her balance, and accidentally strikes the catcher’s arm with the bat with such force that the arm is broken. Consider a mugger who strikes his victim’s arm with a baseball bat in the attempt to subdue the victim. In both cases, that the arm was broken when struck by the bat is “directly observable.” Going past what is directly observable, we would wisely observe an unfortunate accident in the first case and a malevolent crime in the second. Both elaborated observations would be within the realm of scientific observation. An understanding of the construct of “directly observable” is essential to accurate understanding of this thesis, for the key observations upon which it depends are of directly observable form. There is much of value about personality that merits study which is directly observable, yet outside the boundaries of strict behaviorism. The experience of fear in the presence of evident danger is an example of such a directly observable phenomenon for the person who experiences it. It can also be brought into what is directly observable by others if observer bias is minimized. Consider as an illustration, a person who is experiencing a sense of danger and associated fear. The sense of danger is directly observable by the person whose beliefs have given rise to this sense. Another person may recognize and note evidence of distress of some form. If that person asks the one who is directly experiencing fear, “Is something bothering you?”, and the first one answers, “I feel afraid.”, then the fear of the first person has become directly observable to the second because there is minimal interpretation in the second person’s understanding of the first one’s state of mind.

Participant-observer research is fraught with perils for those who are not acutely aware of the hazards of subjective bias in the gathering of data. The mere exposure effect facilitates interviewer bias, especially when the interviewer is unaware of the hazard. Leading questions can unwittingly corrupt data to the point of making the results of interview-based research meaningless. I did not interview nor survey most of the approximately four hundred people whose answers to the “three questions” made up the data supporting the discovery of The Fundamental Error of Social Reality. I took a number of steps to minimize the risk of interviewer bias. One of the most important was my avoiding defining certain specific words,
especially “mistake,” “should,” and “could...” Perhaps the most important way I tried to avoid bias will seem, to those who have done extensive survey research, to be the antithesis of bias avoidance; it was the way the conversations occurred in naturalistic settings wherein I sometimes expressed strong views. Examples of this are given in the dialogs in Chapter 4 of this thesis. What is not evident in a written transcript of a conversation is inflection, tone-of-voice, facial expression; indeed the entire realm of nonverbal communication cannot well be represented in a transcript. Yet the nonverbal aspect of interpersonal communication is, in the model of AT, at least as important as the words themselves. As can be noted in the dialogs, I disagreed at times with the people with whom I spoke, sometimes my disagreement was expressed strongly. But I had no way to do naturalistic-setting research if I had to be so careful about what I was saying that the conversations were not spontaneous. In the spontaneity, I made mistakes that well might alarm someone who is only used to laboratory experiments. In the manner described by Derlega and Chaikin (1975), I used spontaneous and mistake-prone communication intentionally to establish truthfully my vulnerability; in making myself vulnerable I modeled my belief that being vulnerable was safe within the context of the particular conversation. It was my being vulnerable that, as I observed the conversations I had in developing and testing the model of AT, which, far more than any other factor, enabled the other people to open up about their beliefs and values. To reiterate, in terms of conventional laboratory experiments with people, the way I used self-disclosure may rightly be seen as massive contamination of the data; in the naturalistic work I was doing, any other method would have eradicated most of the data I found. The mechanism for this is simple, if I did not show the other people that I trusted them, I could not expect them to trust me. One key point will be emphasized later; without it, the research I did would have poor validity at best. I used every method I could devise, every strategy I could imagine, to prevent transferences and countertransferences between myself and the other people in the conversations during which the data of this thesis was gathered. Well before I had the colon surgery in 1986, I had clearly realized that the most destructive aspects of the psychotherapy I had after the near-drowning in 1960 were the result of transferences and countertransferences; the recasting of past events and relationships onto the relationship with my therapist massively distorted my interpretation of my past.

Some of the people I spoke with did ask about the meaning of words, with a few, the discussions were detailed. I allowed the conversation to flow naturally, watching only for certain kinds of blunders on my part which I realized from past experience tended to impede openness. Consider, as an example, my remark, “I’m not sure I agree with you about that,” to the man who half-way fell asleep riding his motorcycle (Chapter 4). I spoke in a hesitant and uncertain voice. I did not say, “I disagree with you,” which would have been confrontational. I spoke gently, yet honestly, what I did led promptly to his
disclosure. As in all the conversations, I watched his facial expression and changed what I was saying and how I was saying it in prompt response to signs that what I was doing and saying might be counterproductive. It is the importance of the nonverbal part of AT which makes merely writing about the method an inadequate way to completely describe it; yet, in this thesis, all I have is the written word as my medium of communication.

The Fundamental Error of Social Reality is, I find, directly observable. All that is necessary to observe it directly is to ask, as I did, a number of people the three questions, “1. Ever make mistakes? 2. Ever make a mistake you shouldn’t have made? 3. Ever make a mistake you could have avoided?” Having asked the three questions and having found people who answer, “Yes,” to all three, ask those people what they could have done that they didn’t do to avoid the mistake and then ask why they didn’t do it. If the answer is of the form “Because..., but I could have...,” ask why they didn’t do that. Sooner or later, everyone I did this with realized that they could not have avoided the mistake before it was made. Eventually, all the reasons why the mistake was not avoided took the form, “I didn’t know with perfect certainty what would happen; therefore, I had no way to avoid the mistake that was actually possible.” As a participant-observer during the research of this thesis, I first discovered that I had not known how to avoid any mistake which I had made until after I made it, by which time it was too late to avoid the mistake; it had already happened. That is when it dawned on me that I, like most of the people with whom I have discussed this work, had been mistaken about the nature of mistakes.

2.5 Medical care issues

To reiterate, my colon was removed to prevent colon cancer from Gardner’s Syndrome (the diagnosis at that time was Familial Adenomatous Polyposis) in the summer of 1986, and I was given morphine for management of post-surgical pain. The surgery itself was uneventful, but, as is now clear years later in retrospect, morphine evidently induced a psychosis that was not accurately understood or diagnosed until after 1990. In the summer of 1990, when I again needed major cancer-preventive surgery, I was given morphine for the second time, and again experienced a substance-induced psychosis. Following the surgery in 1986, I was psychiatrically hospitalized for most of the three following years. Following the surgery in 1990, I was psychiatrically hospitalized for two weeks, the first week was used to resolve the psychosis, the second to satisfy the hospital staff that the necessary work had been completed in the first week. What changed so dramatically that it took over three years to resolve the psychosis the first time and only a few days the second is at the core of this work.
With the sole exception of one hospital, Austen Riggs Center, in Stockbridge, Massachusetts, the hospitals where I was treated and the psychiatrists and psychologists, other hospital staff, and patients are named so as to disguise their actual identities. I was treated by more than six psychiatrists and more than three psychologists. I have used composite characters for doctors, therapists, peer patients, and others, where doing so does not distort scientific accuracy, in order to meet proper ethical standards for confidentiality, and to reduce the complexity of writing this thesis to manageable proportions. Also, as part of protecting the identities of the experimental subjects, gender is assigned whimsically to the various people who were experimental subjects, including the doctors, therapists, peer patients, and people with whom I have discussed my work outside hospitals. The Austen Riggs Center is an exception to anonymity for three reasons. The first is that the research I did at Austen Riggs was made possible in large degree only by the open patient community which is the mainstay of treatment there, and there is no other hospital with such a setting; therefore, anyone who is familiar with Austen Riggs would be able to identify it no matter how I concealed its identity unless I so distorted the research done there that became an essential part of this research that what I would have to say would amount to scientific fraud. The second is because of the response I received from the Executive Committee of The Austen Riggs Center regarding making its identity known in this dissertation. "They decided that they would not have a policy for or against such mention. They prefer to make it a matter of individual judgement on the part of the writer." The third reason for mentioning Austen Riggs by name is the need to scientifically validate the method of a therapeutic community, to show how such settings can lead to cure of mental illness, as contrasted with palliation of symptoms which is the principal investigator's observation is the usual outcome from treatment using medication alone or medication with minimal psychotherapy. Personal freedom and responsibility, a central feature of the open setting of the patient community at Austen Riggs, are essential for effective cure, according to the model of this research.

2.6 Psychological abuse

Psychological abuse, as defined for the purposes of this thesis, is possible only after birth. Physical abuse may occur in utero in many ways, including poor maternal nutrition, maternal substance abuse, or even maternal beatings. Physical abuse may have psychological consequences. As defined in this thesis, psychological abuse occurs when a person is required to do what is actually impossible and the person is punished for the inevitable failure. As an illustration, consider the following dramatic and extreme parable. The first child is born to an average married couple, but, alas, the parents were taught, when they were children, that it is very important to be better than almost everyone else. Obviously, by the definition of the word "most", this is impossible for most people. Undaunted by the fact that they have set a goal which is far beyond their grasp,
they set out to prove their excellence as parents. The parents decide that it would degrade their self-image if their child were to crawl or to fall down. They decide to teach the child to walk without crawling or falling, and they punish the child with harsh screaming and bruising spankings whenever they think the child might try to crawl or might stand up in a way such that falling would be even a remote possibility. Such a hypothetical child would probably never learn to walk as long as such lessons persisted. The child could not make the mistakes needed to learn enough coordination and enough of moving about in space to walk.

2.7 Philosophical issues

A personal philosophical assumption of mine which shaped the questions of this research is that there was a beginning to human society as we know it today. I could begin with ancient myths and legends, such as the Babylonian myth of Gilgamesh, or the Greek myth of Pandora’s box, or the biblical story of the fall from grace in the Garden of Eden. However, I prefer to stay within the realm of science, and find it useful to begin with David Hume and his An Enquiry Concerning Human Understanding, written ca. 1748 (Hume, 1956). At the beginning of Section V, titled “Skeptical Solution of These Doubts,” Hume says,

The passion for philosophy, like that for religion, seems liable to this inconvenience, that, though it aims at the correction of our manners and extirpation of our vices, it may only serve, by imprudent management, to foster a predominant inclination, and push the mind with more determined resolution, towards that side which already draws too much, by the bias and propensity of the natural temper. It is certain that, while we aspire to the magnanimous firmness of the philosophic sage, and endeavor to confine our pleasures altogether within our own minds, we may, at last, render our philosophy like that of Epicurus, and other stoics, only a more refined system of selfishness, and reason ourselves out of all virtue as well as social enjoyment. While we study with attention the vanity of human life, and turn all our thoughts towards the empty and transitory nature of riches and honors, we are, perhaps, all the while flattering our natural indolence, which, hating the bustle of the world, and drudgery of business, seeks a pretense of reason to give itself a full and uncontrolled indulgence. There is, however, one species of philosophy which seems little liable to this inconvenience, and that is because it strikes in with no disorderly passion of the human mind, nor can mingle itself with any natural affection or propensity; and that is the academic or skeptical philosophy.

An Inquiry Concerning Human Understanding was first published in 1748 with the title, Philosophical Essays, which was a revision of his first book, Treatise of Human Nature, published in 1737. It was from reading Hume decades ago that has largely led to my advocacy of skepticism, yet not blind skepticism, in the evaluation of the research of this dissertation. For me, the discovery of the Fundamental Error of Social Reality was an exercise of repeated skepticism of the form advocated by Hume. That I was very skeptical, in the sense Hume advocated, may not be evident initially, and I think this point needs emphasis.
My childhood, especially at school, exposed me to the conventions of society, to punishment for mistakes made and the like. When I became psychotic because of the effects of morphine in the summer of 1986, I was initially skeptical that I was psychotic, I thought I was merely depressed because of my brother’s condition. As the intensity of my psychosis increased, I became skeptical of the diagnosis I had been given. When I noticed that the ideas of mental illness I had read about did not seem to fit any of my peer patients, I became about as skeptical of the conventional views I had studied as I was of my own state of mind. This freed me to ask questions time after time that I would have known better than to ask had I not become psychotic. I really doubt that anyone who has not been floridly psychotic can understand the contrast that some very psychotic people experience, with parts of reality contact intact and other parts destroyed. So, as I expect that only those who have lived through such experiences can understand what I mean in saying this, I leave to those who cannot understand it the right to disbelieve me. There are people who hold fast to fixed beliefs in spite of clear evidence to the contrary. My philosophical position that truth must be independent of the observer will surely be seen as an example of such a “true believer” stance on my part by anyone who holds to the relativist school. In my study of social psychology, I have found the common belief that truth is, and is only, subjective. To such a relativist, I ask a simple question, “If believing something makes it true, what happens to you if I believe that you are an absolutist?” To me, a “true believer” decides what is real and what is not based on personal whimsey. But most of the core beliefs I had built up since early childhood were stripped from me when I became psychotic, and I had no way to be a “true believer,” for I had essentially no fixed beliefs left in my repertoire of beliefs. But I do respect those who cannot allow that there is any reality to what I remember from the period when I was psychotic. Before those events happened to me, I would not have believed them possible. And, since I seem to have returned to a semblance of social appropriateness, I find my memory of what happened to feel as though almost outside the realm of possibility. Nonetheless, all I have of my past experiences is what I can remember, however accurately or erroneously I remember them.

2.8 Psychological issues

In 1879, German physiologist, Wilhelm Wundt founded the Psychologisches Institut (sometimes referred to in English as the Institute for Experimental Psychology) in Leipzig. Wundt developed a method of “trained introspection” as an experimental technique to study the mind. It quickly became evident that introspective methods lacked scientific reproducibility, and introspection fell into disfavor. Sigmund Freud’s model of personality was based on the troubled people who came to him for help, and the results derived from Freud’s method of free-association were not particularly more
objectively verifiable than the results of introspection. William James developed the method of functionalism, searching for causes of behaviors and the relationships between behaviors and consequences, but there was no central theory or paradigm which provided predictions which could be tested, and functionalism faded into obscurity also, but not without raising certain questions which led to behaviorism. J. B. Watson (Watson, 1913) set aside aspects of psychology that he thought could not be directly observed, such as the mind, consciousness, and emotions since they could only be studied through introspective or insight based strategies which he considered unsuitable for scientific study for want of reproducible experimental methodologies. Instead, Watson studied only behaviors which were easily and directly observable. Stimulus -Response experimental psychology, initially focused on classical conditioning, expanded to include operant conditioning as developed largely by B. F. Skinner. Unlike Watson, whose behaviorism was limited to inter-personal or public events, Skinner allowed that intra-personal events were a valid subject of study to the extent that such events could be externalized through language. Skinner was a determinist, he considered the experience of free will to be illusory. Mainstream psychology and concepts of personality in the late 1930's when I was born were an amalgam of Freud's psychoanalytic model of personality for internal structure and behaviorist classical and operant conditioning as external structure. What people believe has a large effect upon what people do. But behaviorism places little credence on beliefs, and major aspects of what are recognized in the late 1990's as important aspects and components of personality (affect, faith, memories, abuses, and such) were not considered important by the prominent researchers in psychology at the time I was born. Why is all this significant?

The pediatrician who cared for my brother, and for me after I was born, in Butte, Montana, gave my mother a book which he strongly recommended following, Infant Care, published by the Children's Bureau of the United States Department of Labor. The ideas in this book were based on the latest research as of 1938, on the combination of Freud's and the behaviorists' work as understood by whoever wrote the book for the government. The book advocated letting a baby cry itself out when the baby was crying for no reason, and that this was the way my parents treated both my brother and myself, although my mother said years later that she felt the book might be somehow wrong. But, she told me, in the 1930's she considered the doctors to be experts and she was just a mother, surely what the doctors knew was superior to her knowledge. To quote from that book (United States, 1938, pp. 44-45), because it will help illustrate an important principle, the entire section called "BEGINNING TRAINING AT BIRTH":

The first 3 months of life are perhaps the most important of all. The habit of regularity in feeding and sleeping can be begun almost immediately and, once established, it should not be interrupted or broken for any reason except a real emergency such as illness. If the baby wakes between feedings and begins to cry but has no signs of illness, turn him over, change his diaper, give him water to drink, and put him back
into bed. Do not hold him nor rock him to stop his crying, and do not nurse him until the hour for feeding comes. It will not hurt the well baby to cry. Crying is the younger baby’s one means of expressing his needs and dislikes.

Every now and then when the baby is lying quietly in his crib, awake, the mother or father should pick him up and play with him. The baby will learn before long that he is likely to be picked up when he is not crying and ignored when he is crying.

If a baby is picked up every time he cries he will soon develop the habit of crying each time he wakes until his mother does pick him up and fiddle him or rock him. This is not a good habit for the baby or for the mother. It interferes with the baby’s sleep and with the mother’s work or rest. It teaches the baby that crying will give him control over his parents.

Sometimes crying because of colic will start the habit of crying to be picked up. As one of the methods of treating colic is to pick the baby up and raise him over the shoulder so that swallowed air may escape and as it is difficult for the mother to tell whether the baby is crying with pain or not, it is only too easy for him to form the habit of crying to be picked up. If she is doubtful whether he is in pain, she should try to make him comfortable and then put him back in his bed. Nothing is to be gained by walking the floor with him.

When a baby cries very hard he sometimes holds his breath so long that he gets blue and stiffens out. This breath-holding is one form of tantrum. It is terrifying to parents and usually makes them give in to the baby at once. The baby who has such spells is usually old enough to get satisfaction from the anxiety and excitement he has caused. If he has gained his own way by having this form of tantrum, he will repeat it whenever his wants are not immediately supplied. To handle such a spell, be as calm as possible, put the baby in his bed, leave him alone, but watch him quietly from a distance. He will soon relax and breathe normally. See too it that the spell does not gain for the baby the thing that he wants.

If the little baby learns that crying does not get him what he wants he will not use it to control his parents later. He will learn in the same way that temper tantrums will not get him what he wants.”

The common saying, “Hindsight is better than foresight.”, is not without practical basis. Consider the above as a whole. It says that crying is the baby’s one way of expressing needs and dislikes and then says to ignore the baby’s one way of such expression. My mother kept the booklet, and, in 1986, after I read the booklet, said that the pediatrician told her to ignore my brother’s crying and my crying when he or I cried for no reason. It occurred to me that the writer(s) of the government booklet and the pediatrician both believed that a child sometimes cried for no reason. But I had worked for about twenty years in the Pediatric Cardiology at Cook County Hospital from 1965 to 1986, and I have never seen a baby cry for no reason. Whenever a baby cries, I believe there is always a valid reason for the crying, whether I know the reason or not. But, in the 1930’s, when Infant Care was written, Harry Harlow (Harlow, 1958) had not done his work on contact comfort and the need for such comfort for a baby to thrive. The fact that an adult does not recognize the need the baby feels which leads to crying does not mean that the need is not there. I have a book in my personal library, Cry Sorrow, Cry Joy, of writings of contemporary (in 1971) African writers (Moore, 1971), on the copyright page is a Yoruba proverb, “When the man who knows no disasters hears weeping—he thinks it is a song.”

I find that all of life is experimental to some degree. The process of learning, as defined above, is one of trying something in a situation that has some degree of novelty, and finding out what happens as result. Knowledge accumulates
as we remember what we did in the past. But memory is subject to errors. There are errors of observation, errors of perception, errors of interpretation, errors of understanding, and, at best, one can remember only what one understood. It goes something like this. What I observed is not what happens. What I perceive is not what I observe. I will misinterpret what I perceive. I will misunderstand what I interpret. I will not remember accurately what I understood at the time of the event. Today, I will misunderstand what I remember having understood at the time of the event because things I have learned since the event in question will have changed my understanding of myself and the world. Therefore, in probing the past as the basis for present understanding, it is necessary, as a matter of simple honesty, to allow that I can never know what happened with certainty.

Research on eyewitness accuracy, memory distortions and errors are well documented in psychology texts such as Gleitman (1991, pp. 267-289). As an example, from Gleitman (1991, p. 269), regarding eyewitness testimony,

To students of memory, they (eyewitness errors) underline the fact that remembering is in part a reconstructive process in which we sometimes recreate the past while we try to retrieve it.

A well known example of recreation of the past occurred in the 1994 accusation, later retracted, by Stephen Cook of his having been sexually abused by the late Joseph Cardinal Bernadin, who was the Archbishop of the Chicago Archdiocese of the Roman Catholic Church (Wassil-Grimm, 1996, p. 149). McDermott (1996) demonstrated clear associational aspects of persistent false memories using lists of words in which one very common word was omitted from a list of closely associated words, experimental subjects added the missing word with a high frequency. I want to make very clear that I understand the limitations of memory, and do not claim that the memories I will describe of my childhood, or especially of the period when I was psychotic and hospitalized, or even of recent events are remembered perfectly. At the same time, right now, all I have of the past is what I can remember, using such aids as are available to me, including associations, written records, photographs, or asking what others remember. Fortunately, I understand the Fundamental Error of Social Reality, and know that what I can remember is the best I can do, and the best I can do must be sufficient. Further, as no mistake made by anyone, even, should have been avoided, I do not need accurate memories to guarantee that I do not punish anyone in error because of mistakes in my memories, since one of the main consequences of understanding the Fundamental Error is clear recognition that any punishment (in the ordinary sense) would be abusive. The issue of concern is the problems generated by “false memories” when the goal of remembering is to seek conventional justice. (Wassil-Grimm, 1995) Whatever I remember, however I believe I was hurt in the past, it is enough to forgive what I can remember, it is also necessary to forgive whatever hurts I remember, as I remember them, regardless of distortions, for the sake of my own inner peace. To the limit of my ability to forgive, which, using the methods of this thesis, I find to be formidable, all the hurts and abuses I remember are forgiven as I remember them, and I have reason to believe that this forgiveness probably makes what
I remember sufficiently accurate for the needs of my life. It is unimportant to this dissertation that my memories be exceptionally accurate. The average accuracy of memory is sufficient for the method of this thesis to work.

Although my brother and I became very close and supportive of each other as adults, there was some sibling rivalry when we were young. He was three years older. I remember his wrestling with me when I was a toddler, and feeling scared, even terrified, and being unable to cry about my terror at the time, because, when I did, it only seemed that he frightened me more. From the introduction of *Cry Sorrow, Cry Joy* (Moore, 1971): “The Dutch philosopher, Willem Zuurdeeg, urges us to pay special attention to a cry. ‘A man may become genuinely human when he cries out in anguish, triumph, in furious rebellion, and in joyful reverence.’ Such crying, he says, is an act almost unavailable to Western man because, for us, a cry is not a respectable mode of behavior. He asks, ‘Who can live by a cry? Who can stand to hear such disturbing noise?’ The creative artist can live by crying out in his writing. The creative reader can stand it to listen. As Africans cry aloud in their literature, one can hear them give new personal, social and cultural definition to themselves and to those with ears to listen.”

This dissertation may well be wisely heard, in part only, as one of my ways of crying, as I write it, in 1997. For, I have much to cry about. As I reflect on the lives of the many people I have known throughout my life, so I think; so I feel, do we all. Who will break the archaic, obsolete taboo against crying, the taboo that blocks us from our humanity, our compassion, our empathy, our joy? I will. With whom am I joined in crying? Who will join with me? Who will we all become when we have made enough mistakes, have cried enough over our mistakes, to discover the fullness, the wholeness, of human potential?

From what my mother remembers, from what my brother told me shortly before he died, and from what I remember, my brother was allowed to cry himself out whenever he cried as a baby and small child and the directives in *Infant Care* indicated that good parents would treat him that way. Perhaps he got about half the attention he would have needed before I was born in order for him not to consider me a competitive rival. My mother recently remarked that neither she nor my father had gone to great lengths to prepare my brother for my arrival. But both my biological grandmothers died when my parents were in infancy, my mother was about six months old, and my father about two years old when their respective mothers died. My grandfathers both remarried, but not for a few years. Both of my parents suffered serious neglect in the terms of object-relations theory attachments when they were very young because of the deaths of their mothers. As conscientious and caring parents, both my mother and father tried to be “up-to-date” in their parenting methods, and neither of them had the benefit of continuity of mothering which might otherwise have given them a strong “intuitive” sense of my
brother's need for contact comfort that my brother could avoid seeing me as rival. My brother would sometimes pin me on the floor on my back and drool over my face. Sometimes, he "accidentally" spit on me in the process of drooling. It was, to me, a form of torture. A week or so before he died, I spoke of this with my brother, and he also remembered treating me that way. At that time, in 1986, I was a psychiatric inpatient, afraid of the possibility of suicidal impulses, and I remarked to him, "The joke is on you, you want to live and will die, and, because of how you hurt me, I could not make you understand the risk of cancer, and I am in a psychiatric hospital fending off a sense of possible suicidal feelings." He replied, "Maybe I should not have done what I did to you."

Compared to what I have seen in other families, my brother and I had a very low level of rivalry, my brother was basically a very kind person. But the low level of rivalry may also have partly resulted from the ways I adapted to what I experienced as at least slightly abusive, to me, things he did. When I was about two years old, my father had most of his professional library in a corner of the dining room, in a large bookcase behind his desk, in a form of home office separated from the rest of the room by a folding partition. As best I can remember what happened over fifty five years later, I noticed that he sometimes seemed to have trouble finding a particular book. One day I had what I thought was a good idea, and, as I had been encouraged to explore, ask questions, and try things out, I pushed most of the books to the back of the shelves so the bindings were uneven. I thought, as I remember, that he might be able to find what he was looking for better that way. My father did not understand my motive, and I could not explain it to him before he gave me a spanking for messing with his books. I have always easily remembered that spanking. But I wanted to help him, and tried again to show him that I wanted to be helpful, and pushed the books to the back of the shelves a second time, hoping he would understand. He did not, and I was spanked a second time. I have always easily remembered the second spanking also. I was furious that I could not make him understand, and in a temper tantrum, pushed the books a third time. Until very recently, I did not remember the third spanking. It is, as best I can recall, the first, but not the last, episode of "lost time" which is characteristic of someone with a genuine multiple personality disorder. My dad did remember the whole incident, when I was an early teenager, I was with my father and the parents of a neighborhood friend. My friend's parents were having a problem with some of my friend's behaviors. My father said that spanking is almost always a very bad idea, and that, in his opinion, the only time it could ever be proper to spank a child is when the child is being defiant and will not learn not to be defiant with any lesser measure than a spanking. He told the parents, in my presence, about the one real spanking I got when I was two, and that I was never again defiant. My father's assessment was, I believe, quite accurate; I have not been defiant to a significant degree since that
spanking. What he did not know is that I was not being defiant before I was spanked. His interpretation of my behavior was defiance, but I was not being defiant; I was curious and trying to find a way to be helpful. The third spanking which I do not and do remember was the first episode of lost time in the following forty eight or so years that I suffered from a form of multiple personality disorder. I split into two personalities, who eventually took on the names (in my private inner life) of Jane, the personality everyone knew, and Kane, the one who experienced the spanking. Jane used the alias of “Brian” publicly. I did not like fighting, and, when I was very young, the stereotypes had boys as fighters and girls were not supposed to fight. It seemed only natural, as I remember, to have a name that meant I did not have to fight. When I was two, the personality which bore the brunt of the subjective experience of abuse was identified with my father, he spanked me, and my brother, who treated me early in my life as something of a rival. The personality that did not know about the spanking identified with my mother, who neither spanked me nor did other things which tormented me. As best I can recall, I developed a lifelong abhorrence of violence in response to the triple spanking, and my dislike of violence shaped many of the ideas which developed into this thesis.

I feel that what I now recall of the third spanking is significant. I never lost track of the fact of the spanking, only of how I felt about it. For years, I had two ideas about it which seemed inconsistent to me. One was that my dad had done something really terrible to me, and the other was that what he had done was reasonable and it was somehow my fault that I misunderstood him. I am now well satisfied that both memories are accurate, but they are actually consistent. What I now believe is this. The spanking was physically mild, the physical discomfort I experienced was not serious. My dad said something to the effect that he would spank me harder the next time if I messed with his books again. What got to me was this, as I now remember it. My dad was hurting me because I had mistakenly hurt him. I was afraid of hurting him that way again, and, in a more extreme way than I had used to forget my brother’s roughhousing with me, repressed the feelings I had into a fully dissociated state. I did this because I knew my dad loved me, and I wanted never to hurt him that way again, not only for his sake, but so I would never again make him treat me that way. What did I need to forget so desperately? That I felt enraged that I could not find a way to tell my dad that I had pushed his books back because I wanted to help him. But I could not know that I was enraged or I might feel like doing something deliberately, not by an innocent mistake, that would hurt my dad again, and this possibility was not acceptable to me. This is what I remember now of that event. Is my memory correct? There is no way to tell. What does matter is that I am at peace with what happened as I remember it, and it is this
sense of peace (awareness of forgiveness and of freedom from shame, blame, and guilt) that I have found is the center of the mental health I now have.

When I was about four years old, I read a book, *The Story of Ferdinand* (Leaf and Lawson, 1938). It is a story of a bull who did not like fighting. By mistake, he was taken to the bullfights, as a fighting bull. It was expected that he would fight. Ferdinand had a different idea. He had no interest whatever in fighting, he preferred to enjoy the fragrances and beauty of the flowers in the field where he lived. Put into the bull ring, Ferdinand refused to fight, no matter what was done to try to make him fight. Finally, Ferdinand was understood and accepted, and he was allowed to live the rest of his life his way. I thought, when I was four, how is it that Ferdinand could live the way he believed was right, and I am being teased, made fun of, and told by other children that there is something wrong with me because I can cry like a sissy girl, and I am worthless in a fight? It did not take long for me to see that my life would have been easier had I been a girl, and so I found myself with a form of transsexualism. By form, I mean that I never really thought I had the wrong body, rather that the expectations put on me as a boy by other children and some adults outside my family were wrong because they were hurtful to me, and, had I been a girl, I would have been more respected for my values. When I first read the book, *The Story of Ferdinand*, I observed an irony. We lived then on Ferdinand Street in Seattle, Washington. I resolved to fight for my rights, to be myself while not fighting against those who were hurting me in their telling me that I should be someone else. Ferdinand was a role model for me. Why did I have values so different than the other children I knew? The personality state I developed with the spanking at about age two eventually took on a feminine name, when I was in grade school, because the social norms of femininity (kindness, empathy, cooperation, etc.) corresponded much more with the values of my main personality than did the masculine ones (winning, fighting, competition, etc.) of the time. I recall being at a church mens' group meeting, in 1991, as I recall, at which one of the men asked, truly perplexed, "My wife is talking about her feelings, and asking me what my feelings are. Does anyone here know what she is talking about?" After no one else said anything for quite a while, I volunteered that feelings are a way to be aware of oneself and others that does not need words, that real satisfaction with one's life is very hard if one only has words for making decisions. And that feelings are as important as ideas in living life well.

2.9 Moral dilemma issues

My father was a liberal protestant minister in a mainline denomination. After probing my memory diligently and after speaking with people who are still alive who knew my parents during my childhood, it is my strong opinion that I grew
up in a home of truly exceptional kindness, one in which I was hurt far less than most children of that time. As a result, parts of my life that were too painful for conscious awareness were not deeply repressed, as more intense and repeated painful experiences would have been. To some degree, I remember being afraid that, if I objected very hard when I felt hurt, I might be hurt more. But I find that I learned this far more from peers and in school than from my family at home. Throughout my childhood, I faced a moral dilemma. I understood early on that my parents lives were supposed to be exemplary. I saw that they generally met that standard. But, when I thought that my father had done something wrong which might hurt his exemplary life as seen by others, I tried to protect him from being hurt by what I might do. This is the common problem of "preacher's kids," who, according to tradition, tend to turn out "very good" or "very bad." I resolved to turn out "very good," in large measure because I knew beyond any doubt or possibility of doubt that my parents really loved me, and I really loved them. This created, for me, a moral dilemma, in that, to protect my family and myself from possible harm, I had to do things which put me at risk because I felt it might be too dangerous to speak directly of my thoughts and feelings. I was caught in what I now consider to be a form of moral dilemma.

Lawrence Kohlberg studied moral development extensively and published his findings (Kohlberg 1969, 1987, Kohlberg and Gilligan, 1972). Consider the following moral dilemma, adapted from Kohlberg and Gilligan (1972): A woman was near death from an unusual cancer, and the local doctors thought a radium drug discovered by the local pharmacist was the woman's only hope. The pharmacist was greedy, and demanded ten times what the radium cost him to make before he would sell it. The husband could only get half what the pharmacist wanted, and stole the radium to save his wife's life. Kohlberg, in his research, would ask children whether the husband did was right or wrong. A detailed discussion of Kohlberg's stages of moral reasoning is found in Steinberg (1989, pp. 290-296). Kohlberg identified three levels (preconventional, conventional, and principled) of moral reasoning with two stages each. The stages, in developmental sequence are: 1. Rules are obeyed to avoid punishment. 2. Selfish desires for rewards determine actions. 3. Choices are based on approval of others. 4. Respect for authority. 5. Social contract-consensus of right and wrong is decisive. 6. Universal, though self-selected principles guide choices. I find there is a forth level, also having two stages, the transcendent level, in which the inevitability and value of moral dilemmas are recognized and understood. I propose that stage 7 is the acceptance of moral dilemmas as necessary for learning about morality. And stage 8 is, I suggest, having the practical, everyday understanding that no mistake made should or could have been avoided; and therefore, harmful behaviors are to be punished (the technical sense of punishment) while the person who behaved harmfully is rewarded for sharing with others what is
harmful. Let me state that another way, for clarity. The person whose behavior was harmful is not rewarded for the harmful behavior, but for the helpful behavior of telling others about it, so they have a better chance to avoid it. The punishment of the behavior occurs when others avoid doing it because they know better; they know better because the person who did it told about it. In stage 8 morality, it is always abusive to punish (in the ordinary sense) anyone for anything, because such punishment is an attempt to impose an impossible standard of behavior. I find that the ideas which make up stage 8 are greatly at odds with what most educated people in the United States seem, to me, to believe. Let me try to explain it this way.

If I do something harmful and am not caught, I will not likely tell others what I did if I believe I will be made to suffer for telling and will not suffer if I keep the secret. Likewise, for you, likewise for everyone. As a result, we learn very slowly about what is harmful, for everyone who possibly can do so keeps secret the harmful things he or she has done, to avoid being made to suffer by the punishments which would be inflicted by others if the secret were not kept. In consequence of this pattern, we all do many more harmful things, out of ignorance, than we would do if it were safe to tell others of the harmful things we have done. A stage 7 question is, "Is it right to know what is wrong, and if so, how do we learn what is wrong?" To make sense of this, it is necessary to define "wrong." I propose a simple operational definition, one which is based on direct observations, as previously defined. What is wrong is what is harmful. A dictionary synonym for "wrong" is "harm." (Houghton Mifflin, 1997) Also, for completeness, what is right is what is helpful. A dictionary definition for "help" is "To change for the better," and for "helpful" is "useful." (Houghton Mifflin, 1997) The two previous statements about right as helpful and wrong as harmful are essentially tautologies, as can be shown by checking a dictionary (Houghton Mifflin, 1997). Wrong is given as a synonym of harm, and the definition of help refers to rectify which, in turn has one definition which uses the idea of right. Most of what people do is neither particularly helpful or harmful, is neither right or wrong. Real harm is directly observable, it requires negligible interpretation; this is essentially a definition. Even subtle, but real, abuse is directly observable within the model of AT. What is directly observable is not necessarily directly observed. Inattention, disordered thinking, preconceived notions, and many other influences may prevent direct observation of what is directly observable. Abuse changes behavior; if behavior change did not occur, neither did abuse. Helpfulness also changes behavior; if behavior change did not occur, neither did helpfulness. What is helpful is also directly observable, once it is understood that it is helpful to know what is wrong, and that the only way we learn what is wrong is by doing it. At stage 8, a person who makes a harmful mistake will tell others about it, knowing that sharing such mistakes is the only practical way to reduce their occurrence. What is trivial, neither helpful nor harmful, neither right nor wrong, may or may not change behavior; this is unimportant because trivialities are trivial; what is trivial is, per se, unimportant.
As is generally true in stage theories, one has to have reasonable proficiency with all the lower stages before having the chance to do well with a new stage. Thus, one must know stages 1 through 7 well before being able to develop stage 8 abilities. As best I can tell, I was operating at stage 7 morality when the cancer preventive surgeries began. I could find no medical doctor who understood my thinking about the ethical choices I found confronted me. Most of the doctors seemed to be operating at stage 3, driven there by fear of malpractice suits. The doctor who finally decided to do what I wanted because he knew from his own father's death that my idea of prevention might have merit, was, as best I can tell, operating at stage 5, the highest stage of anyone I had found in seeking cancer preventive treatment at that time. That I was not allowed to explain my concerns and the options I understood were available is in large measure due to stark contrast in the moral and ethical systems the doctors and I were using. I believe I met with a strong paternalistic authoritarianism in most of the doctors from whom I sought help. And I have come to believe, after careful reflection, that my scientific approach was seen as an affront to the doctors' professionalism. This generated a conflict of ultimately shattering intensity for me. I needed very good care from doctors if my estimate of cancer risk was accurate, but whatever I did to try to give the doctors a clear picture of the risk as I saw it tended to isolate me from the people whose help I most needed.

Dr. Abraham A. Low said, that there is no right or wrong in the trivialities of everyday life.

The daily round of the average individual consists in the main of such trivial performances as reading, conversing, working on a job, cooking, washing, cleaning, telephoning, shopping. The person with a settled sense of averageness does these routine chores with hardly any thought wasted on them, without hurry, without anxiety, without the harrowing fear of possible failure. Considering them as routine, he knows they involve no danger and is happily at ease, poised and spontaneous while engaged in his work. It is only on those relatively rare occasions when highly important or emergency reactions must be faced that the person possessed of a sense of averageness may become tense and may suffer a decrease in his spontaneity. Spontaneity means that you are not self conscious, that you are not on your guard for fear of making mistakes. Spontaneity means the COURAGE TO MAKE MISTAKES. In trivial or routine activities no calamity occurs if perchance a mistake occurs. This is the reason why realists, that is, men and women of average aspirations go about their daily tasks with due caution and circumspection, it is true, but without any marked fear of making a mistake. Mistakes made in trivial performances are trivial themselves and their possible consequences are just as trivial and not to be feared. With the fear of mistakes largely removed from the mind of the realist his decisions are reached with ease and his actions initiated without undue hesitation. All this is the result of spontaneity and, in turn, favors its development.” (Low, 1978, pp. 203-4)

Combining the work of Kohlberg and Low, an understanding of the structure of moral dilemmas is possible. What Dr. Low called trivialities constitute the vast bulk of life experiences for typical people. He pointed out that many arguments that disrupt peoples lives center on events where there is no real right or wrong, merely differing views of social conventions. Consider a married couple who are expecting company, and the tea set is on the buffet for the guests. The husband checked the sugar bowl, and, seeing that it was almost half filled with sugar, more than enough for the evening, did not fill it. The wife
grew up in a home where details were paramount, and the sugar bowl had to be nearly full when guests came, so there would be clear evidence of abundance, putting out a half-filled bowl would be a source of severe embarrassment. Except for the belief, the feeling, that it is wrong to not have filled the sugar bowl before the guests came, there is no danger, no right or wrong as a matter fact or statute about the amount of sugar. Change a few unimportant beliefs, and it would not matter if the bowl was put out empty by mistake. The amount of sugar is a triviality, neither harmful nor helpful, particularly if there is spare sugar in a kitchen canister in reserve. What is not trivial is treating a triviality as though it were a matter of actual importance, as, for example, the wife finding out shortly after the guests arrived that her idea of filling the bowl was not assiduously heeded, and starting a fight about it because she felt disrespected by her husband, who, “certainly should have known better by now.” Mis-classifying a triviality as a matter of importance and then destroying the quality of family life in an exercise of brutal power is not a triviality; it is abusive, and abuse is never trivial. When one person in a group is functioning at Stage 3 morality, approval-based choice, and another is using Stage 6 principles, and each person is certain of being right, what is wrong is the failure to communicate meaningfully that arises from cross-purposes. A dialog of the form, “What will other people think?” (a possible stage 3 issue) answered by, “It does not matter what people think.” (a possible stage 6 principle) is irreconcilable unless the dialog is shifted in some manner that each party is not denying the moral system of the other.

The solution to this problem taught in the social psychology class I took in the 1990's was to define truth as relative, “If you believe it, then it is true.” Making truth personal means that no one can challenge another person's truth, for every person has the right to define truth for themselves, but for no one else. There is one little problem with this approach. It undermines every possibility of scientific understanding of personal values and social issues. For me, personally, the difficulty with relative truth, when I first tried to get cancer preventive care was that my father was dead, and it seemed, and still does seem, clear that he would likely have lived many years more if his colon had been removed a few weeks sooner. Not only did I have a very different moral system than the doctors, I was heavily invested in my own life, and strongly wanted to avoid an outcome like my father's. The doctors, as I understand their thinking, figured that most cancers do not warrant the treatment I sought, and most people who develop cancer have the forms of cancer that most people develop. This, alas is the fallacy of circular reasoning. My position, that there was a rare form of inherited cancer was categorically hated as statistically unlikely because most people do not develop rare forms of cancer, or the forms would not be rare. Since this sort of thinking prevailed everywhere I sought help in 1985-86, I faced a stage 7 moral dilemma, and I knew it. No matter what
I did, considering the state of the art of mid 1980's medicine, I was guaranteed to do something wrong. Challenging the medical community perception of cancer prevention was wrong; it alienated the people whose help I needed. Ignoring the risk as I understood it was wrong because I was unacceptably likely to abandon my family by dying. No matter what I did, someone was going to feel hurt or someone was going to be hurt. Dr. Low repeatedly pointed out that feelings are not facts. I made my choices based on the principle that, when hurts are unavoidable, it is better to hurt feelings than people.

2.10 Hospital A, first time

At the end of September, 1986, I first became a psychiatric inpatient, in Hospital A. After major surgery in July, 1986, I had tried to return to work as a bioengineer and medical technologist at the hospital where I had worked for the previous twenty years, but I could not concentrate on my work. And, I could not concentrate, so it seemed to me, enough to find out why I could not concentrate. My colon had been removed in that surgery to prevent cancer from Gardner's Syndrome (then diagnosed as Familial Adenomatous Polyposis), and I had suffered from an inability to concentrate from the time of that surgery. In June of 1986, my brother had been diagnosed with terminal colon cancer and a six month remaining life expectancy. My dad's colon had been removed in 1971, he died from metastatic colon cancer in 1972. The discussions I had with his doctors at that time ruled out a diagnosis of Gardner's Syndrome or Polyposis. In October of 1986, I obtained the surgical pathology reports on my dad from the early 1970's and learned that he had been given a polyposis diagnosis in 1971, but no one in the family was told this at the time. My dad told me in the late 1950's that his father developed colon cancer which was successfully treated circa 1940, but his father died from a heart attack very shortly thereafter. As a bioengineer working in a large hospital, I had observed many instances in which the medical maxim, "First do no harm."

had resulted in treatment that was too late to be effective in preventing cancer. Several friends of mine had also developed cancer, most had died, and the ones still alive had received aggressive and prompt treatment. By the early 1980's I had come to believe, based on all the evidence I then had, that there was some sort of rare hereditary cancer in my family, but could not identify what form it could be because of the information (misinformation, actually) my dad's doctors had given me. Up to that time, my brother and I had been seen by the same doctors in a family practice setting, but I had determined that those doctors did not recognize the familial risk properly. I found another doctor who was willing to screen me for cancer with occult stool blood kits. No evidence of cancer was found with those tests (the absence of occult blood does not mean the absence of cancer) and I did not make clear to my brother, so he told me when he was terminal, the degree of risk I thought we faced. So, my brother's doctors, who had refused to screen me for cancer, refused to screen him, and they first recognized the risk
when they discovered his terminal cancer. My training as a bioengineer had permitted my recognition of very high cancer risk when the doctors my brother (and I, until 1984) saw did not believe there was serious risk. This is very relevant to the framework in which I did the research which formed the basis of this dissertation. It led to my frequently wondering whether the understanding I had of my situation might be far more accurate than that of the doctors who were treating me. Yet, I needed to be seen as sufficiently cooperative by my doctors that they would admit me to hospitals when I thought hospitalization was necessary. The tension between the understanding I had of my needs and some of the treatment I received which I thought was wrong was one of the strongest driving forces in the experimental work I did.

In contrast to a simple rule or set of rules of the form, "First do no harm," I approached complex decisions with a more complex method. Basically, given a decision among several alternatives, each having several possible (on an a-priori basis) outcomes with uncertain consequences, my training led me to estimate the a-priori probability of each outcome and the a-priori quality of each outcome, multiply the probability estimate by the quality estimate for each anticipated outcome for a particular alternative, sum the scores so generated for each alternative, and finally chose the alternative which has the highest score. According to my training, no better strategy is possible in making a decision in the presence of great uncertainty. Four particular factors in my personal background strongly shaped the approach I took, which, combined with the engineering education I had, led to my exploring uncommon viewpoints. The first is my experience of over thirty five years repairing and designing electronic equipment. A property of elaborate electronic apparatus is that things do not have to be exact for a device to work, but there are limits to the tolerance (usually expressed as a percentage variation from the design value of a component) of electronic components, and the device will not function properly if enough parts are out of tolerance. To state this more simply, I had spent years working with things that did not have to be perfect to work adequately, but which had to be within often rather narrow constraints to be useful. The other factors were my education outside engineering, my familiarity with my brother's doctoral research, and having been a child whose father was a highly educated mainline liberal protestant minister.

At the time I was first psychiatrically hospitalized, I was told by Dr. A, in September, 1996, that I was suffering because of catastrophic stress levels. I was having episodes of severe pain ever since the colon surgery two months previously. My brother, with whom I was very close, was very sick and dying. Less than a month before, my mother, as a pedestrian, had been struck by car, was still in serious condition, and had a guarded prognosis. I was struggling with "survivor guilt,"
not only because my brother was dying, but also because I had received timely and effective colon cancer preventive
treatment and had not been effective in getting the same degree of medical care for my brother. Finally, as is clear in
retrospect, I was suffering from an intense morphine-induced psychosis which terrified me. I had also developed a talent for
dissociation whenever my life became very difficult. I was in an acute and severe state of decompensation. Once hospitalized,
I set out with every resource available to me to understand what happened to me, what the mechanisms were that had so
changed my life, and to devise tools to restructure my life so I could again be a functional member of my family and
community. In very short order, I found myself at odds with my treatment team in Hospital A. I was intent on finding the core
of the problem and repairing what was wrong with me at the source. The treatment team seemed to me (I was inwardly very
psychotic and paranoid at the time, as best I can now remember) to only want the problem of my internally-experienced
manifestations of illness, and my expressed concerns about my inner experience, to go away. I kept claiming that my
thoughts were not working right, and, in my psychotic state, was unable to tell others how this was so. I came to believe that
the treatment team would be satisfied if they did not observe any outward signs of my illness, regardless of my inner state.
I decided that this was unacceptable to me, based on what I knew about myself only when I was not with other people.

I set out to talk with the other patients on the unit, telling them of my situation and letting them tell me of theirs. I
began to experiment with self-disclosure to other patients, many of whom reciprocated, once it seemed to me that they felt
safe enough talking with me. I was hoping to find someone who knew what it was like to have the kind of experiences I was
having. The staff of the hospital seemed to me to find my situation incomprehensible. My gross overt behavior was always
appropriate, and I did not seem able to tell anyone on the staff what was troubling me. From the discharge summary from
that hospitalization, I think I was being treated for an adjustment disorder. Dr. A and the other staff seemed unable to believe
me when I tried to describe my psychotic and dissociative symptoms, I felt as though they thought that I was merely seeking
attention inappropriately. The overall effect of this was that I came to believe that I had done something wrong that I could
not yet understand, that my illness somehow was of my own making, and that I had chosen to be mentally ill by mistake.
Only, I was too psychotic to figure out what the mistake was. I tried harder and harder to communicate, with what seemed
like less and less success. Finally, I decided to “try it their way.” And when I tried to do what I thought the hospital staff
wanted me to do, I found that my outer behavior was somewhat better, but my inner life deteriorated drastically. I found this
to be most unsatisfactory. After about three weeks of “psychologically fighting” the staff and what I believed the staff
expected of me, I decided to comply with the goals I thought they had set for me, no matter what happened to my inner
experiences. In short order, I was given passes for out of hospital group activities, and after a total of six weeks, was discharged. During that time, I noticed that the only people who seemed to understand at all what was happening to me and to my life were some of the other patients. Most important, I found that I could talk about my inner experiences with some of the patients, and vice versa, and I was helped by such sharing and those other patients told me that I was helpful to them. I also noted a strong tendency for patients to be far more open in conversations with each other in the day room than in group therapy sessions where the staff largely set the communication patterns. As far as I could tell, I could trust the other patients much more than anyone on the staff.

About halfway through the time at Hospital A, I tried to discuss some of my psychotic thoughts with Dr. A. These thoughts involved my relationship with my brother and my wife, for Dr. A had remarked that my brother and I had a “shared personality”. This was a diagnostic error, my brother and I had lived separately for long periods when we both functioned well, something that is not true for people who have a shared personality as I understand what that would mean. I was too psychotic to recognize this; and at first, the shared personality diagnosis appeared helpful, because it seemed to account for my having become so upset. If we had a shared personality, what would become of me when he died? That thinking turned malevolent. The idea of a shared personality quickly became frightening because I recognized that, if it was true, then I had massively repressed it. I emphasized to Dr. A that I was not ready to talk about these thoughts with my wife or brother until I understood them better. After about six years of psychiatric treatment, it became clear in retrospect, that in 1986, I had been feeling guilty about not having persuaded my brother to be checked for cancer in time, and felt guilty about his situation. Being psychotic, I thought perhaps I had wanted him dead, and had gotten my wish. I then thought that, if my brother and I had a shared personality and I subconsciously wanted him dead, then I must be suicidal. And then I felt frightened to the point of terror, because, if I was suicidal and did not know it, what else about myself that was very important did I not know? My thoughts strayed further, and I wondered, suppose my wife became ill, would her supposed illness happen because I wanted her to become sick, and so her illness would also be my fault? Remember, I was inwardly very psychotic. I knew about the Tarasoff court decision (Kaplan and Saddock, 1995, pp. 2761-2), and the problem it created for therapists in the mental health field. To simplify the impact of the Tarasoff decision to what is essential for this thesis, after Tarasoff, therapists had a obligation to inform anyone the therapist thought might be seriously threatened by a client.
On reading, in 1991, the discharge summary for the time I was in Hospital A in 1986, I recognized that Dr. A mistakenly became concerned that I posed a serious threat to my wife. Whatever Dr. A actually thought is not clear to me, but what happened was the calling of a conference including my wife and myself ostensibly about discharge planning. What happened instead was stunning to me. In spite of my having stressed that I needed to work through the thoughts I was having in a confidential setting, Dr. A confronted my wife and myself with his misunderstood view of what I had told him at the outset of the conference. In a strangely twisted Freudian castration-complex-based misinterpretation, he seemingly believed that, once I had the colon surgery, I knew that the orchiectomy was wrong. This was not true. He then decided, as far as I can tell, that I blamed my wife for being castrated, and intended to avenge the harm to me. This was not true. So, he confronted my wife with the thought that she had done something very wrong, and had put me in danger of putting her in danger. Alas, from the hospital records, it is clear to me that Dr. A did not believe that my father nearly died in 1958 from a precancerous prostate condition. And, therefore, that the effort I made to avert prostate cancer was medically inappropriate and totally unnecessary. Since I was psychotic because of the effects of morphine administered immediately after the colon surgery, and Dr. A did not understand this, he presumed, as I read the records, that my whole cancer-preventive effort was caused by my illness. This is an astonishing paradox. My concern about cancer risk led to preventive surgeries before I developed cancer, and morphine given for the second surgery (the colectomy) caused the psychosis which led to my seeking cancer prevention as much as two years before I was given the morphine which made me psychotic. This is obviously outside the realm of possibility. This is a variation of the fallacy of arguing in a circle, for such a circle to exist, however, there would have to be a time machine which could take the morphine induced psychosis back to the time when I first sought surgery to prevent cancer. I faced a terrible predicament, I was treated as someone who did not know what I was doing or saying because I was psychotic, when, in truth, only certain aspects of my inner life were psychotic, and I recognized which was which. When I pointed this out, Dr. A seemed to take it as proof that I was out of touch with reality in that belief. No matter what I did or said, I found it to be taken as further evidence of my illness. I knew that I presented no danger to my wife or anyone else which would warrant a breach of confidentiality such as Dr. A committed. This situation made a very difficult lesson for me, If I was psychotic and needed help from my doctors, and if I shared my concerns with my doctors, and if they then misunderstood me so badly that they would violate the confidentiality I needed to work my way out of the psychosis; and then, how could I get out of my illness? As I write this in 1997, I would like to point out that it is hard to write of a psychotic experience in a rational way. The essential lesson was that I could not trust the hospital staff, particularly Dr. A, but I could trust the other patients to a reasonable degree.
While in Hospital A, I wrote a short “poem” while trying to cope with the events which had overwhelmed me:

Brian Harris walked on a wall,
Brian Harris took a great fall.
Can all of the doctors and all the staff
help Brian so he can once again laugh?

The answer, for that hospitalization, was, “No.” But I was not inclined to quit. The doctors and staff had made my problems worse, much worse. But talking with other patients helped me so much as to considerably more than overcome the harm done by the doctors and staff. I assumed that my difficulties were somehow of my own making, and that it was my responsibility to fix the mess I had made of my life. But, as I did not know what I had done wrong, I could not yet figure out how to fix it. As I had learned in the prior debacles of my father’s and brother’s deaths, I learned again, and with vastly greater intensity, that I could not depend on doctors for real help. What I could depend on was faith and other patients.

It was the patient population which surprised me the most when I was in Hospital A. To me, all the people seemed to be hurting in ways they could not understand. The patients in the unit I was in at Hospital A ranged from some who had not finished high school to at least one with a doctoral degree. I talked with all the patients, and found that, as I demonstrated respect for a particular patient, the person would start to describe to me how he or she had been hurt. I did not find any patient there whose mental problem seemed to be of biological origin. I knew about the “medical model” of mental illness from prior reading and study, and from knowing a few people who had been treated for mental illness. I thought it odd that I could not find any patient there, except perhaps for myself, who fit the pattern of biological etiology. Everyone else seemed at least potentially able to describe what was bothering them, I alone seemed unable to do so. There was one patient who suffered from grand mal epilepsy and depression. As I spoke with him, I saw how his depression originated with the way people treated him because of his epilepsy. He thought that the medications for his depression made his epilepsy worse, and that depressed him more. Seeing this, I began some thought experiments to try to find if there were possible iatrogenic cause for my illness. I knew of the technique of free association and so tried it out. This did not always generate subjectively “good” experiences. I first felt scared, anxious, then thought, I am somehow sick, this is my problem, it must therefore be my fault. What was I scared of? My brother was dying and it was my fault. Why? Because I got cancer-preventive treatment in time and he did not, and that was my fault. Why? Because I should have made it clear to him that his life was in danger. Why? Because our dad had died from a strange form of cancer. Why did I not try hard enough to tell my brother of the danger? Because of what was making me sick, which was my fault, and it was my fault that I did not know what I had done that made
me sick. That sort of thinking is a trap, but I was psychotic, and did not know better at the time. After I shared some of what I was thinking with the hospital staff, I very quickly concluded, from how I could understand the responses I got, that the staff believed that such thinking was causing my difficulties. So, as the next experiment, I stopped talking about such ideas and it then seemed to me that the staff thought I was making good progress, for Dr. A soon thereafter started talking about discharge planning. What lesson did I learn? If I told the truth, Dr. A would think I was lying, and when I tried lying, Dr. A seemed to believe I was truthful. The trick to being a successful patient was pleasing one's doctor's expectations. But I was still having great difficulty with concentration, I was still trying to find out what had happened to me, that the course of my life had taken such a drastic change. I continued to develop the method of guided-free-association introspection, for it seemed to me that I would never be able to function well until I knew what had happened to me. After I saw how badly Dr. A had misunderstood me, time after time, I decided that I would have to find out what happened to me to cause my illness primarily through my own efforts. Time and time again, the lesson I learned from Dr. A, as from previous doctors, was that I understood my situation far better than my doctors did even when I was psychotic.

2.11 Dr. B

Discharge arrangements were made, including seeing an outpatient psychiatrist, Dr. B, for aftercare. Dr. B asked me to write a short autobiography the first time I saw him, when I was out on a pass specifically to see him two days before I was set to be discharged from Hospital A; I gave it to him on the second visit, as an outpatient. The second time I saw Dr. B, he remarked that I was psychoanalyzing myself, and that my effort was unnecessary because Sigmund Freud had already done that. I immediately answered back, “My personality structure is very different than Freud’s.” Dr. B had undergone psychoanalysis, and remarked that most psychiatrists (unlike psychoanalysts) have not done so. I felt that he was gently suggesting to me that my stated belief was wrong, that it was a part of my illness, and that my personality was made of an id, and ego, and a superego, just like everyone else, as Freud had established about one hundred years ago. Once again, I saw that I probably understood my situation better than my doctor did. But, I could not explain to him how it was that I “knew” that I had a personality structure that was unlike that of Sigmund Freud, yet I could not describe the differences. I had not yet learned how to be aware that I was struggling with a form of multiple personality disorder which I hid very well when I was around other people. For the record, as this is being written in 1997, I no longer struggle with a form of multiple personality disorder, nor have for several years, but I am quite certain that I did so struggle from the time I was about two years old until I was about fifty years old. By my third session with Dr. B, he had read the autobiography I gave to him during
the previous time and he remarked to the effect, “Your life is as though you have been stepped on like a bug a thousand times and more.” I was experiencing more depression, and Dr. B prescribed an antidepressant. My mood improved, the troubling thoughts that so interfered with my ability to concentrate got worse. My mother was still hospitalized as a result of having been struck by a car some two months before, and I began to spend some time at her house, to maintain it, and to have a respite from routine family pressures. My mother had and still has an extensive library in the areas of humanities literature, and social sciences, and I started reading some of her books, seeking help with the problems that plagued me.

Among the first books I read during that time, in the fall of 1986, was Dr. Gregory H. Hemingway’s *Papa* (Hemingway, 1977) about his relationship with his father, Ernest Hemingway. In the last chapter, he tells of his father’s suicide and of the mistake made by the Mayo Clinic doctors who did not listen to Ernest’s wife, Mary, whose intuitions were considered by the doctors to be unimportant compared to their medical expertise. Dr. Hemingway remarks that suicide a week after discharge from psychiatric treatment does not make for a “therapeutic triumph.” I had known people who committed suicide, I knew that I was inwardly depressed even though the medication seemed to help my energy level, and I knew that suicide was a possible outcome for inadequately treated depression, so, I decided that Dr. B would have to hear me, and that I would have to do and say whatever it took to insure that I was kept safe if my thoughts drifted toward suicidal ideation. I saw that my treatment at Hospital A had not been a therapeutic triumph, for I was feeling worse than when I went in, I had learned how to be a better actor, and that was how I got discharged. I wanted no more disasters like the one when my psychotic thoughts were shared with my wife in violation of confidentiality by Dr. A, when it felt as though I had been ambushed. I was very upset that Dr. A had used deception with both my wife and myself about the purpose of that meeting. Dr. A’s treatment of my illness certainly had not been a therapeutic triumph. But, I was alive. Perhaps my treatment was better than that given to Ernest Hemingway. Thinking about Hemingway reminded me of the time I nearly drowned, and I began to cry.

As I now recall what happened next, in 1986, I remembered that there was a lunar eclipse during the night of March 14 to 15, 1960, I had been up most of the night, helping time lunar occultations at the observatory on the Carleton College campus where I was a student majoring in physics. I was rather tired when I went to swimming class after lunch that day. I had been practicing underwater swimming techniques and presumably hyperventilated just before pushing off from the end of the pool near the beginning of the class. I blacked out, and apparently sank to the bottom of the pool. Somehow, I was not
missed until the end of the class, when the last person to leave noticed that the pool did not look right as he was about to turn off the lights. Resuscitation restored breathing promptly, but I did not wake up until after midnight. When I regained consciousness, what I remembered of the time I was unconscious was a form of “near-death experience,” such as described in Moody (1975). During the time I was a physics major, the College embarked on a “Pursuit of Excellence” program, and one effect was restructuring of the physics curriculum. I was majoring in physics, and, after having to drop out for the rest of the spring, 1960, semester to recuperate from the swimming accident, I could no longer get the courses I needed to graduate, so, after one more semester in the fall of 1960, I dropped out. Some curious things happened while I was at Carleton. One semester, I got a grade of “A” in physics, and failed calculus. What is curious is that the skills of calculus are necessary for physics. I had been seeing the college counselor for psychotherapy because of erratic grades, and he had decided the week before the accident that I was not working properly at the psychotherapy, and further that, until I was willing to work properly, I was just wasting his time and mine, and he would not see me. I took strong exception to his position, to no avail, and was somewhat depressed by the loss of his support. I was not, however, consciously suicidal. Whatever else happened, I have always understood, since the near-drowning, that my life is, to a large degree, about something besides myself. This religious-philosophical view shaped the experiments I made during this research. I include this, not to persuade others to change their religious beliefs, but only in the interests of academic and scientific honesty, that what motivated me in the experiments I did during this research may better be understood. I have no test as to what really happened when I was unconscious. One result of the research of this thesis for me personally, is that I do not need to know what happened. What I can remember is sufficient, whether I remember what happened accurately or not.

I next thought, in 1986, about the College counselor, and of how, from his perspective in 1960, he had good reason to believe that I was not working at the therapy. He had a strong belief in Sigmund Freud’s concepts of personality, and I had found that, when I took the counselor’s therapeutic interventions the way it seemed he wanted, my problems became worse. I did not agree even then with the structure Freud described as being accurate, for I found Freud’s ideas of the human condition to be rather dismal. As mentioned previously, some years before, while I was still in high school, my brother, then majoring in psychology at Carleton, had given me a book on Freudian psychology (Hall, 1954), which emphasized Freud’s model of normal psychology. I had been particularly troubled by several aspects of Hall’s description of Freud’s work. First, it bothered me that, as Hall wrote, instincts serve to take one back to an earlier condition, rather than forward to an improved condition. In the chapter on The Development of Personality, Hall (1954) lists the five main factors that shape the growth
of personality in Freud's model. They are: 1. maturation. 2. pain caused by frustrations from outside the person. 3. pain from inner conflicts of the person. 4. the person's own inadequacies. 5. anxieties. Except for maturation, I saw all these factors as signifying, one way or another, something that was not as it should be, something wrong. And, on reading Hall while I was in high school, it seemed to me that, in Freud's view, the only real function of maturation was to enable fulfillment of the death instinct. As I said, I found Freud's model to be dismal. To me, in high school and since, Freud's model being correct would make life pointless, worthless, and meaningless. I could not agree with this because I could not find my own life to have such characteristics. I had read about the teachings of the Buddha earlier, while in high school, and found Freud's views remarkably lacking in compassion. The book I read on Buddhism while in high school lists as guides to a proper life "Four Noble Truths," to wit: "I. Existence is unhappiness. II. Unhappiness is caused by selfish craving. III. Selfish craving can be destroyed. IV. It can be destroyed by following the eightfold path, whose steps are: 1. Right understanding 2. Right purpose (aspiration) 3. Right speech 4. Right conduct 5. Right vocation 6. Right effort 7. Right alertness 8. Right concentration (Burtt, 1958, p. 28). Proper following of the eightfold path leads to Nirvana (Burtt, 1995, p. 29), "a state marked on the positive side by a sense of liberation, inward peace and strength, insight into truth, the joy of complete oneness with reality, and love toward all creatures in the universe." I understood Freud's idea to be empty, that the purpose of life was to return to meaningless non-life. While I had problems in my childhood, and some were quite serious, I never sensed existence as unhappiness. Even so, the ideas I understood the Buddha taught struck me as vastly superior to those of Freud, at least I could find some compassion in what I knew of Buddhism. Not so for Freudianism as I understood it. So, I did not accept Freud's ideas before I saw the Carleton College counselor, and I also found that the Freudian methods and model the counselor used made my situation worse, not better. My psychotherapy with the college counselor was not a therapeutic triumph.

Toward the end of November, 1986, I began looking in bookstores for literature that might be useful in making sense out of my life. I soon found a social psychology book (Derlega and Chaikin, 1975) on sharing personal information with others, and noted that people with poor social adjustment tended to underdisclose or overdisclose aspects of their lives. Given the trouble I was having with my life, I took my situation to be one, at that time, of poor social adjustment, and that I would likely have difficulty with proper disclosure. Talking too little isolated me from others, therefore, I decided to err on the side of talking too much. I guessed that keeping things in had led to my difficulty and I figured I might as well see what happened if I tried talking about what was happening in my life with people who did not have power over me, friends and acquaintances and people I happened to meet. A few friends seemed very uncomfortable, and I stopped talking that way to them. Some
friends, including people who, I learned from subsequent conversations, were struggling themselves, welcomed talking with me and kept on talking, conversation after conversation, no matter how I was doing.

2.12 Hospital B, first time

In mid December of 1986, I returned to work, on medications, continuing psychotherapy with Dr. B, and almost immediately found that I still had no concentration for the duties of my job. After two days at work, I decompensated massively, and Dr. B admitted me to the regular adult unit of Hospital B. My brother had quit work, he was too sick and weak. My mother, who had been discharged from being hospitalized after the accident only a few weeks prior, had a relapse, and was again hospitalized, and I was having episodes of terrible physical pain at the site of the ileo-rectal anastomosis that had been surgically constructed when I had the colon surgery in the summer. By the next morning, I had decompensated even more, and was transferred to the intensive care unit of Hospital B. How I came to be transferred is a story that may help understand the kind of predicaments with which I struggled.

I was experiencing vivid frightening hallucinations when I was alone. When I went to try to tell a staff member about them, I could not remember them, I could not remember why I wanted to talk to a staff person, and so walked away before speaking. Once back in my room, the hallucinations returned. After several rounds of this pattern, I went to a staff person and said that the staff was not watching me closely enough. I was told that I was being watched and cared for adequately. I insisted that I was not. I was told to go to my room and to calm down, while Dr. B was being called. The hallucinations intensified. I finally went out to the nurses' station to protest again about being unsafe when Dr. B came on the unit and asked me what had happened. Desperate because of the hallucinations I could not speak of when I was near other people, I blurted out, “I want to kill myself right now!” This was not true, but it was all I could think of to say to have a chance of getting adequate attention. I was put in the quiet room for the night, which was beside the nurses’ station. I still felt unsafe, and noticed that I could look out into the nurses’ station and the day room by lying with my head at the foot of the bed. This bothered the nurse working at the nurses’ station, and she said that she would close the door if I did not stop staring. I was upset, and stared more, and she closed the door. I examined the quiet room and noticed that the bed was bolted to the floor with one bolt through each leg and a pipe inside each leg set in the concrete floor. One bolt had a flat washer in addition to a lock washer and nut. I found that I could loosen this bolt by slightly rocking the bed. Rocking the bed made noise, and the nurse opened the door and found me with my head and arms hanging over the side of the bed where I was loosening the bolt. She asked me what I was doing.
I saw three scraps of tissue paper on the floor, picked one up, handed it to her, and said, "This piece of paper was on the floor." She took the paper and closed the door behind her. One bolt out, three to go. The bed made noise again when I was rocking it to loosen the second bolt, and another nurse came in to see what I was doing. I gave him the second piece of tissue paper with the same remark. He left like the first nurse had done. Two bolts out, two to go. I had counted the floor tiles to measure the room and bed, and had observed that, if the bed was not bolted to the floor, it could be moved to block the door, which opened into the quiet room. The door was steel, the bed frame was heavy gauge steel, with the door blocked with the bed, the only practical way into the room would be via breaking down a wall. As I worked the third bolt loose, the bed again made noise, and a third staff person came in to find what was going on. I gave her the third piece of tissue paper. Three down, one to go. It would not budge. The bed was no longer creaking with three of four bolts out, but no amount of shaking the bed loosened the fourth bolt. I used the flat washer as a screwdriver and it bent under the force I applied, then, the fourth bolt was free. I had four bolts, four lockwashers, four nuts, and one bent flat washer. I examined the room again, and saw a small hole in the corner of the room opposite the door at floor level, and the hole was just large enough that the bent washer would fit through it. Now I had only the bolts, nuts, and lockwashers, and no evidence of any tool that could have been used to get the bolts out. I had the removed hardware in my hand and tested the mobility of the bed. It lifted easily. I lay down on the bed to think of what to do next, and, almost immediately, yet another staff person came in to see how I was doing. "Not well at all," I answered, "You are not watching me closely enough." Yes, we are." I was told. I replied, "The bed is no longer bolted down." I got up, walked out the door to the nurses' station desk, slammed the hardware down, and said, "If you are watching me closely enough, tell me how I did that." Time and time before, I had found that I was not given adequate attention unless I was dramatic, unless I acted as though my illness was worse than it was. The clatter of the bolts, lockwashers, and nuts finally persuaded the staff that I really was not being watched adequately, something I knew all along. I was returned to the quiet room and a staff person stayed with me. Two or three minutes later, I was told that there was a unit in Hospital B where I would be safe, the intensive care unit. I was told that I would be transferred within ten minutes. And indeed I was.

Once I was in the intensive care unit, I thought to myself, surely here I will find some patients who have real biologically-based mental illness, who can help me understand my illness and can help me work toward making sense out of my life. But, to my surprise, I again found only hurt people, people who could start to talk about their hurts if they felt safe enough. Hospital A was connected with a University and Hospital B was a private, for profit hospital, Perhaps, I wondered if I had encountered a sampling problem, whether it just happened that the real mentally ill people were not in either Hospital
A or Hospital B as a simple coincidence. I brought my concerns to the attention of a staff person I thought I could trust; I asked where the mentally ill people were. He looked at me with astonishment, “Don’t you know where you are?” I immediately told him the name of the hospital and the unit. I knew where I was. I did not know quite who I was. This, I saw as a serious problem, and I set out to solve it. I talked with the staff about my concerns, I made journal notes, and I was put back on precautions. Dr. B worked with a psychologist, Dr. C; both did psychotherapy with me for three one-hour sessions a week. Dr. B’s methods tended toward psychoanalytic, Dr. C’s techniques were largely cognitive. The two forms of psychotherapy complemented each other, and I was able to take the insights from one method and explore them with the other. In this setting, I came to recognize one of the most serious limitations of individual psychotherapy, the trend for the therapist to project his or her personality on the patient. I further noted that the psychoanalytic approach pointed me toward recompensation without actually identifying the problem.

Dr. B had recommended that I read about defense mechanisms, and specifically suggested reading Adaptation to Life (Vaillant, 1977). Dr. B took the position that everyone needs defenses to function, and that I was wrong to try to eradicate my defenses, as he correctly noted I was doing. I had studied defenses years before, and was troubled by the definition of “defense” that I then had. I understood a defense to be a reality-distorting mechanism used in the service of the ego to reduce inner stress. What was hard for me to accept was the idea that reality needed to be distorted to be acceptable. Something was demolishing my ability to concentrate on work, and I took the philosophical position that it surely must be some distortion of reality that was making my life so hard. In opposition to the advice of Dr. B, I set out to learn which of us was right, or even if we might both be wrong. After reading Vaillant (1977), I set out with renewed effort to probe deeper, to find out what would happen if I tried to set aside the defenses I was using that I thought might be at the core of my struggle. I began to experiment with techniques of analysis of the psyche. Note, for simplicity of language, that I will use the word, “psychoanalysis,” as a generic term in the rest of this dissertation, all analytic methods of understanding the psyche, not just Freudian, will be included. When I make reference to Freudian or neo-Freudian psychoanalysis, they will be specifically identified as such.

I probed deeper with my method of psychoanalysis, what I describe as “guided-free-association-regression.” This involved identifying what seemed to be troubling me the most at the moment, and then imagining a story that would put an imaginary character in a similar predicament. After I had the fantasy story reasonably completed, I then let my mind drift
through the story to see if anything I imagined could be similar to events in my own life that I had repressed or suppressed. My outward condition deteriorated as I did this, and I was soon in restraints. Then something surprising happened. My body was safe, I was free to let my thoughts wander anywhere, and I would survive. I began to struggle against the restraints with all the strength I could muster. It was like a dream, my arm and feet were held down and I could not get free. No matter how hard I tried, I could not get free. Suddenly, I felt as though free, even though I was in restraint, and I relaxed. Then it hit me.

My Carleton roommate was in the same swimming class, and he had told me what happened after I was pulled out of the pool. He said that I was taken out to the room outside the locker room and put on a table and given oxygen by the college physician, whose office was in the same building. I began to move, and, to keep me from falling off the table, the doctor asked several students to hold me. I started to struggle, the people were told to hold on tighter. By this time, the campus policeman had arrived, he weighed over 250 pounds, and he took hold of my feet so some of the students could go to their classes. My roommate said that, several times, lying on my back, I lifted the policeman off the floor. The struggling weakened, the doctor noted that I was getting stiff, decided I was going into a calcium-imbalance tetanus, and injected calcium. The struggling became more intense than ever. Finally, after over half an hour of struggle, the group took me into the next room, where there were wrestling mats on the floor, and let go. In a minute or so, I was lying still, and the doctor arranged for an ambulance ride to the college infirmary. It now seems likely, based on my physical and mental condition the day after the accident, that I would probably have been able to return to classes the next day if I had not been restrained so that I became physically exhausted. If so, then I was forced to drop out of Carleton because of the iatrogenic exhaustion.

The process of discovering my past continues. As I am writing this, in 1997, I have again used the psychoanalytic method I developed, and what comes to me is that I was trying to get back from the “near death” experience, and, confused and at the most barely semi-conscious, felt that I was being held back from returning to the world of the living. (My struggling was not willfully intentional, it was entirely or almost entirely a mid-and lower-brain activity.) As I let my thoughts probe what memory I have of the incident, is why “I” fought so hard, “I” wanted to come back, and it seemed to me that “I” was being stopped. And that is why, once “I” was released, “I” stopped struggling. From the standpoint of science, in 1997, what is the truth of that memory? There is no way to test it. I do know that, had I been cognizant of what was happening, I would not have struggled. I have never found any possible way to perform an experiment in the past. The effect on me here and now is to be reconciled to the way I was treated immediately after the drowning. For, it was how I was treated that led to my dropping out of Carleton. It seems most likely that, had I not been held down, I probably would not have struggled so
intensely. Had I not struggled so intensely, I believe I would have been back in classes the next day. It was recovering from the muscle damage caused during the struggle (I could not walk at all without help for more than a day after I regained consciousness, it took over a week before I could climb even the few steps of the college infirmary, and almost a month before I could climb enough steps to be capable of functioning as a student in a college with three and four story buildings that did not have passenger elevators) that made me miss too much of the spring, 1960, semester to have any chance to graduate with my class. Regarding the question of mistakes, it might seem that I made a mistake in struggling so intensely. By the definition of mistake used in AT, this is not so. I made a mistake if I hyperventilated and so lost consciousness. The higher conscious centers of my brain which have the capacity for willful actions were not functioning. My body's behavior was basically reflexive and reactive, it was in no manner whatsoever willful. There is something I can test, however, and that is whether or not what I remember, whether or not accurately, and how I interpret it now, takes me in the direction of inner peace and community involvement (I personally find those to be the same in my life), or away from inner peace and community involvement. I now understand inner peace and community involvement to signal a correct understanding, and inner turmoil and isolation to signal incorrectness in some form. The Carleton College physician made a terrible mistake in how he treated me after I was taken from the swimming pool. He could not have known better, or he would have done better. It was not his fault, with his training and experience, he did the best he knew how to do. Alas, what he did in having me held down so long was wrong because it was harmful to me. He obviously did not realize this soon enough for serious harm to be avoided. When his treatment did not work to his satisfaction, he did change his method. It took time for him to evaluate what was happening and decide what do to about it. It was what he could do, it must be sufficient in my mind if I am to be at peace with my life. He could not have avoided the mistake, it was not his fault, I forgive him.

A story may help illustrate the principle. Consider living in a landscape of hills and mountains and the higher one lives, the better life is. Consider that you are on one of the higher hills, and you see a mountain nearby. You know that life would be better for you and that you would better able to serve other people if you lived on the mountain. The only paths available go through the valley between the hill you are now on and the mountain. To get to the mountain, your life will get worse for a time, and will not be as good as it is now until you have climbed the mountain to an altitude comparable to the hill you now are on. You have never taken one of these paths before, you do not know how long it will take, what difficulties you will encounter on the path you take. Indeed, while you are on top of the hill, you can not even be sure that you will even make it to the mountain, and even less can you be sure that, once you start down, your life will ever be as good as it is right
now. Consider that you know how to live atop the hill, and that leaving the hilltop will mean great uncertainty. What would you do? A person of little faith will wisely stay on the hill. A person of much faith will embark on the path, taking the chance that it will be possible to get to the mountaintop. I find I am to whom faith has been given. Many times in my life, life seemed good, it was like living atop a high hill. But I could see the mountains. And, when I was given morphine for post-surgical pain in 1986, it was as though I was flung off the hilltop into the abyss, and I did not know or see any path back to the hilltop. And it was as though, in the abyss, I could not even tell in which direction I would have to go to find the familiar hill. But I could occasionally glimpse the mountain. For me, the hilltop was the adaptation I had made to life before the surgery. The mountain was a way to understand my life far more completely, that I might no longer be baffled by so many of my motives and behaviors. In the imagery of this story, I set out for the mountain. But, the abyss itself contained chasms, and I fell into some of these on my way toward the mountain, I climbed down into others. Always, my goal was to get to the mountain, to climb it, to find again a decent way to live, not by going back to the way I had been, rather forward to the way I thought, as an act of faith, I might become as a whole and intact, complete person.

In Banished Knowledge the introduction, pp. 2-3, Miller (1990a) writes,

...every child depends on others for the satisfaction of his needs because he cannot look after himself. Although he can scream for help, he relies entirely on those around him to hear his cries, take them seriously, and satisfy the underlying needs rather than, in an excess of hatred, punishing the screams or even preventing them by means of tranquilizers.

The only possible recourse a baby has when his screams are ignored is to repress his distress, which is tantamount to mutilating his soul, for the result is an interference with his ability to feel, to be aware, and to remember. "The repression of past torments and its cost render people deaf to the screams of children and blind to the obvious connections."

I had not read this in 1987, it had not been published. But I recognized back then that some part of me had to be aware of something intensely problematical in my past for my life to have become such a shambles. (I did not realize, in 1987, that my life was a shambles largely because of the side effects of the medication I was given for my illness, which was the manifestation of those side effects. This only became clear in 1989. Overall, my life has been very good and satisfying, but severe mental illness is, and is also, a manifestation of disordered thinking, and disordered thinking of the type I was experiencing made my past life seem of poor quality, when, in fact it had not been so. Yes, I had encountered difficulties, everyone does. I had triumphed over them time and time again.) And, I thought, if I could devise a suitable method, I would likely find the source of the problem, and then I would have some chance to fix it. I had an intense drive to avoid simply recompensating as I thought Dr. B believed would be best for me, because I thought his plan would simply make me as
vulnerable as I was prior to the colon surgery. In retrospect, it was as though part of me was screaming deep down inside, for cause, and I really wanted to know why.

Many things can be repaired if one only knows how. In 1986, I had been repairing electronic equipment for over 35 years, and was very proficient, so much so that other repairmen sometimes brought equipment to me that was beyond their ability to fix. Some electronics repairmen who do not have good “troubleshooting” skills change parts until the problem goes away; their choices of what parts to replace is made by “intuitively correlating” (see glossary) the problem at hand with previous repairs. My basic method in repairing electronic equipment was to analyze the circuit until I understood the design and then identify the defective part or parts precisely, and replace only what was actually defective. The first method is based on correlations and often only achieves palliation of symptoms, the second is based on identifiable and verifiable mechanisms and generally results in curing the problem. As I struggled with episodes of psychosis, I decided to approach my illness in much the same way I approached repairing a complicated electronic device, not by correlations, but by scientifically accurate understanding of the mechanisms involved. It is one thing to understand a electronic device, it is quite different to understand a person, especially when the person to be understood is oneself. To the staff in the intensive care unit at Hospital B, it surely appeared that what I was doing was wrong, for it only made my condition worse. I was intent on finding what was bothering me so much, and was certain that it would be found somewhere in my past. As I regressed in the guided free association method, I kept finding things that were bothering me, and the things I found hinted at more to be found farther back in my life. I explored the same incidents time and time again, so much so that Dr. B told me that my “ruminating” was largely what was making me sick. I began to remember events that seemed out of character for me, and became afraid. It was early January, 1987; I remembered clearly feeling very scared, as though someone huge was pinning me down, and was put in restraints again. I had remembered aspects of such incidents all my life, but there seemed to be gaps that needed to be filled in. This time, I felt like a two-year old, and realized that my brother had pinned me down on my back when I was very young and then had tormented me by drooling in my face. For the first time that I could remember, I finally knew how I felt when by brother treated me that way. I felt, when I was two, as though it was my fault that he was treating me the way he did, that I had deserved it. It felt like it was my fault and I didn’t know why it was my fault, and that was also my fault. Then I began to think, if I was wrong, and it wasn’t my fault, then it wasn’t my fault for thinking it was. And, I thought, still in restraints, that I need to find a way to restrain my thoughts so I would not need to be in restraints. And then I realized that it was my interpretation of what happened when I was two that was the real problem. I felt angry and did not know why. After I was
out of restraints, I called my brother on the telephone and asked him if my memory could be accurate. He said he remembered treating me that way. I thought I had solved the problem that was bothering me so much, that I had wanted my brother to die because of the way he mistreated me when we were young, and the struggle in the swimming pool had been a recapitulation of my being held down by my brother. My symptoms largely went away, and I was transferred to the regular adult unit in preparation for discharge. Once on the regular unit I called my brother to tell him that I was better, that I appreciated his help. But once he was on the phone, I surprised myself by remarking that the joke was on him. He, who wanted to live, was going to die, and his mistreating me made me stop short of an effective effort to tell him what I knew, and furthermore, I could live because I did have surgery in time, only what he did to me had pushed me toward fear of suicidal ideation. He answered back, that maybe he shouldn't have done those things to me. I was scheduled for discharge a week after that pass, my brother died four days later; I was discharged two days earlier than planned so I could attend his memorial service. Dr. B and I decided to start the process of returning to work in a couple weeks, since I seemed to be okay at last. I believed that I had found the problem that had bothered me so long, and had it properly fixed. I was mistaken; I revisited that incident and many others, perhaps some of them hundreds of times in my memory and imagination before I found everything that needed to be forgiven. As with Freudian psychoanalysis, the method I had developed seemed to work, but, from the standpoint of an engineer, it seemed dreadfully inefficient.

There is a tendency in psychotherapy and psychiatry to assume that the absence of observable symptoms indicates the absence of illness, and, therefore, whatever it takes to make the observable symptoms go away constitutes appropriate treatment. But, is that not comparable to changing parts in a radio without understanding the design of the radio? Given the common experience people have of knowing the idea for a word but not quite being able to say the word, hence the saying, "It is on the tip of my tongue," the evidence is unambiguous that it is normal to have knowledge which is not immediately accessible to consciousness. Allowing, therefore, that there are real mechanisms of suppression, repression, denial, and such, it becomes obvious that there are at least two contrasting ways to achieve an absence of observable symptoms. One is to drive the experiences or whatever is the source of the symptoms so much deeper into repression or suppression or even psychotic denial that the symptoms can no longer be observed. Another is to bring the issues causing symptoms fully into consciousness, and then, with an effective and efficient psychotherapeutic method, resolve them into an adaptive condition such that the issues are no longer symptom-generating. The former method has hazards, for the strategy of compensation used to drive the issues deeper may leave the person vulnerable to decompensation if the person's circumstances change so that the issues are
again forced to the surface. This may be one of the greatest hazards of short-term issue-focused psychotherapeutic inter-
ventions designed to create the superficial appearance of conflict and issue resolution merely by the absence of observable symptoms. Alas, such symptoms are almost always highly interpreted, they are far removed from what is directly observable. In the introduction of the DSM-IV is the caution that correct clinical judgments require both appropriate clinical training and diagnostic experience. But such clinical judgments require extensive interpretation, such judgments are far removed from what I have defined as being directly observable. By itself, consensus about diagnoses may arise because of scientific accuracy or because of shared misinterpretations which blind diagnosticians to what might otherwise be obvious.

The symptoms that had prevented my working faded under Dr. B's treatment, which was directed toward strengthening my psychological defenses, so I would no longer suffer too much from symptoms. The belief that I was mentally healthy enough to return to work was false, but I did not realize this at the time, for I felt that I was able to work because I was not experiencing the symptoms that previously interfered with working.

That illusion lasted about two weeks, and I decompensated more than ever just prior to starting the return-to-work process. I knew then that I had been mistaken about what caused my illness. I was still psychotic. Dr. B admitted me to Hospital C, another private, for-profit psychiatric hospital, to a unit for lower-functioning patients. At first, I was confused as to where I was, as to the time of year, as to why I was where I was. Within a few days, however, I became oriented enough for transfer to a unit for higher-functioning adults, although still on close observation. I had to decide whether to accept the treatment Dr. B advocated or whether to continue my method of regression through guided free association. Dr. C, I thought at that time, believed that my method might work, and it seemed to me that I made more progress with his therapy, than I did with Dr. B's methods. Dr. B put me on a combination of medications, including a neuroleptic, an antidepressant, and one to control neuromuscular side effects of the neuroleptic.

Neither my doctors nor I understood that the biological etiology of my illness was iatrogenic. I was still suffering from subjectively catastrophic levels of psychosocial stress. I was stressed because of my brother's death and my inability to have made him understand the need for cancer-preventive screening. I was stressed by what was happening to my brother's remaining family. I was terribly stressed by my inability to solve the problem of my illness so I could return to my work and my family. I was stressed by what one nurse called "unbearable pain" from spasms at the site of the ileo-rectal anastomosis that was surgically created as part of removing my colon, at that time, the spasms were unpredictable and unpreventable. I
could not tell whether my illness was caused by the stress or a basic biological or genetic defect which the stress had
unmasked, I observed that the medications did control some symptoms, and so the medical model seemed to fit what was
happening to me. In 1987, I assumed that what can now be clearly recognized as iatrogenic side effects were chronic disease
states against which I had successfully used psychological defenses until I became too stressed to maintain them. I had also
come to see clearly that the doctors who refused to treat my father, my brother, and myself properly as members of a cancer
family had been wrong, dreadfully wrong, fatally wrong. I also recalled how the psychoanalytically based treatment I received
from the college counselor at Carleton had been harmful, and how the cognitive treatment at the community mental health
center had been very constructive. I thought of the many mistakes I saw doctors make during the about twenty years that I
worked at Cook County Hospital, I recalled friends who had died from cancer because their doctors had denied the danger
until it was too late, just as had happened with my father and brother. I needed my doctors’ help, I knew that doctors often
did harmful things because they did not know better, I had to cooperate with my doctors diagnosis and treatment enough that
I would not be labeled “treatment-resistant” to such a degree that I would be denied treatment. I was caught in a conundrum.
Medications I had been given caused biochemical imbalances, which generated many of my symptoms. The cause of these
symptoms was misunderstood by both myself and my doctors. I misunderstood largely because the medications caused
biochemical imbalances which so impaired my thinking that I could not understand what was happening to me nor what I
could do about it. I could not explain clearly to my doctors what I could not understand myself. It was like a convoluted form
of "Catch 22." What I needed to function well was denied to me because I did not have what I needed to function well. What
did I do about this? I hung on to dear life for the sake of dear life no matter what, as long as I was reasonably sure that what
I was doing to survive was not harming others more than it was helping me to survive, and as long as what I was doing to
survive was not, as I understood while psychotic, likely to cause serious harm to others.

It is normal to do desperate things in a desperate situation. My situation seemed very desperate to me. Having learned
that simple, direct, honest sharing of my concerns generated damaging misinterpretations time after time, and that I had
generally understood my life, my circumstances, and my needs better than anyone from whom I received medical or
psychological care, I tried various strategies. One was trying to figure out what I would have to say and to receive effective
and efficient care and therapy. I realized that what I said that was direct and simple was almost always filtered through clinical
judgments derived from "appropriate clinical training and diagnostic experience," which so distorted what I was intending
to communicate that I was frequently brought to the brink of despair that I could ever get well. I started saying a variety of
wild and bizarre things, trying to learn how what I was saying became so distorted in the minds of my therapists. I figured, as an engineer, that, if I could understand the process that generated the distortions by probing it with extreme ideas, I might finally learn how to distort what I meant to say in a manner that the distortions of clinical judgment reversed my intentional distortions with the result that I would finally have a chance to be understood with at least fair accuracy. Of course, I could not tell my doctors what I was doing without ruining any success I might have, for their clinical judgment would, so it seemed to me, distort my efforts to the point of failure. I found that, in order to tell the truth to my doctors, I had to tell them lies because they misunderstood me; to tell the truth about things I considered important in a way that they seemed to understand, I had to distort what I was saying about things that I thought were less important. This kind of predicament was a very large aspect of my research into ways to set aside to the greatest extent possible, complex interpretations that required such elaborate and complex training that most people would find the interpretations incomprehensible.

My thinking about theories of personality and personhood was heading for that of Miller (1984b, p. 8),

"...It is only the (limited) acquaintance with my own unconscious and the recognition of the repetition compulsion that makes it possible for me to understand the subjectivity of another person. This subjectivity is then revealed to me in everything the person says, does, writes, dreams, or flees from. The analyst’s ability to be aware of his or her own subjectivity is a prerequisite for understanding the patient, and the resulting insights into the patient’s life are anything but subjective speculation. They are the analyst’s attempt to understand the meaning of the concealed of a unique life against the background of a specific childhood with the aid of enactments prompted by the repetition compulsion in the transference and countertransference.

From my studies of various case histories it is clear that insights of this nature can be tested for their validity. Feeling does not necessarily exclude scientific accuracy. I even believe there are fields (such as psychoanalysis) whose scientific nature would be enhanced by the acknowledgment of feeling, if only to expose the profusion of false assertions that can be defended over a long time with the aid of incomprehensible theories. Only a feeling person can grasp the way an empty theory may function as a means to power, for he or she will not be intimidated by incomprehensibility.

Parker (1962) describes the problems a psychotic person can have trying to be accurately understood by his or her doctor(s); Parker’s patient was schizophrenic and Parker had to learn his language before she could communicate effectively with him. I could not comprehend how to live the way Dr. B seemed to think I should, but I could not teach him the language of my psychosis either; unlike Parker’s patient, I did not know how to speak it. The psychotic personalities I had in 1987 were mute. In retrospect, I consider it as likely that my theories were incomprehensible to Dr. B as his somewhat Freudian-based ones were to me.

I tried to argue that I had a variety of multiple personality disorder; my doctors assured me that I did not. The more I pressed for that diagnosis, the more I found my self-analysis being treated as a primary symptom of my psychosis. This
generated another form of trap. I stepped out of that trap by recognizing that I had never observed a small child during the two decades of working around children in pediatric cardiology that was born with anything resembling Freud's concept of the id. I saw that what Freud misunderstood as the id had to be aspects of ego that a person has to somehow make-believe do not exist to avoid intolerable psychological pain. I saw that what I was trying to do was treated as though it was a frontal attack on the psychological defenses of my doctors. Dr. B remarked that everyone needs defenses to survive. I asked him why people need to distort reality to survive, for that seemed like a contradiction in terms to me. He told me that my attempts to banish reality-distorting defenses were misguided and wrong, and were causing my illness to get worse. I kept probing my past as I could remember it, believing on faith that I would find the problem somewhere in my past if I only tried long enough and hard enough. My outward behavior deteriorated further, and I was put in full restraints. This time, I remembered a sense of struggle, as though I was drowning and could not get free. I fought against the restraints, and remembered an almost-semi-conscious state where I was being held down and could do nothing to get free, and suddenly I was free. This was like a waking dream of the time I nearly drowned at Carleton, and was held on a table while resuscitation attempts were made.

While I was still in restraints, I wondered why I had fought so hard at Carleton. Since I could not remember, I made an experiment. I decided to make up a story about why I would have fought that hard. The story was of a giant monster that tied me up with many arms so I could not move and then poured water on me so I could not breathe. The monster was absolutely terrifying, and I had to please the monster in some way that I did not understand before the monster would release me. And I feared that the monster would hurt me if I did not do what the monster wanted, and I could not understand what the monster wanted, what I needed to do to be set free. It felt like infinite terror. I had not yet developed the method of AT, I was enmeshed in symptoms I could neither understand nor reconcile.

I thought of an experiment I made several years earlier. A friend came to me with a problem. He had loaned his car to his brother, his brother sometimes got drunk. His brother had stopped at a neighborhood bar in Chicago for a couple drinks and then had driven my friend's car into an unfamiliar neighborhood, parked, walked several blocks, and then had gone into a bar he had never been to before. A fight started and my friend's brother, an innocent bystander, was attacked and tried to defend himself. The police came and my friend's brother was arrested for drunk and disorderly conduct. He could not remember where the car was. My friend and his brother searched for the car for several days before my friend asked me for help. The three of us got into my car and went to the neighborhood bar where the incident began. I asked the brother where he had parked near that bar, and he easily remembered. I drove to that place and then told him, "Pretend that you have been
drinking and just got into your brother's car and are starting to drive. Make up a story of what you would do, where you would turn, and tell me the story while I drive." The brother protested, "I can not remember what I did that night." I answered, "It does not matter whether you can remember or not, all I am asking you to do is to make up a story now, and, as long as you do not have me breaking the law, whatever story you make up is good enough. I am not asking you to remember what happened, I am only asking you to make up a story." I started driving. The brother said he would turn left, and I made a left turn. We drove several miles this way, making many turns. Suddenly my friend burst out, "There is my car!"

It is well documented that the left hemisphere of the brain has linguistic skills, and the right hemisphere spatial skills, in most normal right-handed people, and that the hemisphere roles are commonly reversed in most normal left-handed people. This role specificity is very clear in people whose corpus callosum has been transected to control severe epilepsy. The experiment which led to finding the car was based on my realizing that someone who was rather drunk might pay no attention to street names, and so would have no verbal, left brain knowledge of the car's location. However, the person had driven the car, and might well have right brain spatial memory that was sufficiently intact to find the car. The strategy of "making up a story" was my attempt to provide a way to allow such spatial memories to be brought to verbal consciousness well enough to find the car, and it worked. Had I insisted on verbal recall of street names and addresses, had I started at the bar where the fight happened and tried to work backwards to the location of the car, I am quite sure that we would not have located it except by pure accident.

While it is easy to invent a story by rearranging and modifying remembered events, and using fantasy to project remembered and mis-remembered events into impossible situations, there is no way for a person to tell a story that is not made of real, distorted, and imagined aspects of the person. Everything anyone ever does is, one way or another, an exercise of self-expression. If I seem to say something about you, what I am actually doing is telling about what I have internalized, one way or another, about you. Therefore, on careful reflection, it is obvious that I can only tell about myself; however, "myself" includes everything that I have internalized about external phenomena of all kinds. Perhaps it is wise to consider what used to be called "neurosis" or "psychoneurosis" as the symptomatology of unsuccessful internalization of distortions taken in from external social (consensus) reality (as a transference directed toward the self), and psychosis as the symptomatology of unsuccessful externalization of those internalized distortions (as a projection back onto social reality). If so, then mental illness is a function of the structure of society and the effects of said structure on the individual, and not an expression of an
intrinsically flawed person as such. Fantasy is one way to defend against future assaults on the self from distortions of social reality by inventing anticipatory strategies to manage future possible psychological pain by minimizing the foreseeable risk of damage.

I had previously used fantasy to remember past events, and was surprised, as in the way we found my friend's car, by how accurate memories recalled through fantasy could be. In early spring, 1987, I experimented with deliberate fantasies as a way to explore affective memory and bring it into verbal awareness. I made up a story about why I would be attacked by a monster, and what the monster might represent. The story I made up that time was of two monsters, one huge and the other smaller. The smaller one was the more frightening, it seemed more like myself than the bigger one. The smaller one was almost always near me and often wrapped itself around me and I was very frightened, then it would let me go and would be good to me. I imagined that there was something I did that made the smaller monster change from being good to bad, and I did not know what it was that I did, only that it was my fault that the smaller monster changed. The bigger monster was almost always good to me, but sometimes I would do something bad and the bigger monster would hold me until I would cry, then would let me go. Having imagined these stories, I began to wonder what they meant. Almost immediately, I recognized the smaller monster as representing my brother, when he would roughhouse with me when I was very young and could not fight back. The bigger monster was first my dad, who spanked me on rare occasions. Then it was the principal of the grade school where students were sometimes paddled. Then it was the boy who bullied me when I was in third grade. My brother frightened me when he overpowered me, that I remembered. But he did not really hurt me. My dad, when he spanked me, the principal with the paddle, and the bully who pummeled me all hurt me. The big monster represented everyone who had hurt me. My dad had spanked me when he thought I was being defiant in ways that could lead to danger, we talked about my having been spanked when I was a young adult, and I recalled his saying that he thought spanking was always wrong unless a child was being defiant and there was possible risk to life as a result. In second grade, I remember being sent to the principal's office for paddling two or three times because I was not paying enough attention in class. I never knew when I would be found guilty of not paying proper attention, and this worried me enough that I paid so much attention to whether I was paying attention that I sometimes did not pay enough attention to what was happening in class and was sent for a paddling. When I thought of this in 1986, I realized that the teacher had been making demands on me that were impossible for me to meet, it was not my fault at all that I was distracted; the teacher's punishing me for not paying attention was a tremendous distraction by itself.
2.13 Recovery, Inc. methods

Having done all this work in probing my past, I again thought I had worked through the critical problems, and soon thereafter was discharged from Hospital C. I had read about the self-help group, Recovery, Inc., in the newspaper several times, Ann Landers sometimes mentioned it in her column, and I also knew that Recovery Inc., meetings were held in the church of which I was a member. I still had some problems remaining and wanted to avoid being hospitalized again. The Recovery method, intended by its inventor, Dr. Abraham A. Low, to minimize relapses in psychiatric patients was, I quickly recognized, largely a cognitive approach. I was rather desperate to find a way to stay out of hospitals, and undertook to see if there were any flaws in Dr. Low’s method. Believing that I was most likely suffering from a form of multiple personality disorder, and having found no evidence that Dr. Low ever knowingly treated a multiple personality patient, I set out to see whether I could prove that the method of Recovery, Inc. had some flaw such that it would not work for me. I set out to try to prove that Dr. Low was wrong, because, if I could do so, then I would look elsewhere for help without wasting too much of my time with the Recovery method. By this time, I had studied the DSM-III-R in depth, and noted that Dr. Low and the DSM-III-R had totally different diagnostic approaches. Dr. Low had a unified system, based on the practical abilities of ordinary people to make choices. Low wrote, in the Preface of Mental Health Through Will-Training (Low, 1978),

The present volume is meant to give an account of the psychotherapy methods evolved in the past fifteen years by Recovery, Inc., a non-profit group whose purpose is to train post-psychotic and psychoneurotic patients in the practice of psychiatric self-help...

The contents of this book are in the main reproductions of panel discussions conducted by the ex-patients and group psychotherapy interviews conducted by the author with his private patients in the years 1944 to 1949. Several essays on ‘sabotage’ have been added, describing the manner in which patients offer resistance to the physician’s instructions. The bulk of the material was previously published in the ‘Recovery Journal’ and ‘Recovery News,’ issued by Recovery, Inc., and edited by the author. It deals with a system of group psychotherapy evolved by the writer since 1933.

Psychotherapy, individual or group, is invariably based (1) on a philosophy, (2) on techniques. In years past, the field was dominated by three main philosophies and techniques: Freud’s psychoanalysis, Adler’s individual psychotherapy, and Jung’s approach which, because of its vagueness and mysticism, defies precise classification. More recently, the psychoanalytic doctrine has taken the lead and all but crowded out its erstwhile rivals. It established its hegemony in universities and philanthropic foundations and gained unquestioned prominence in the province of psychotherapy. The doctrine appears to be in firm control of the official psychiatric organizations, in the mental hygiene activities of the national government, in the veterans administration, presumably also in the hospitals of the armed forces. Official psychotherapy, in the United States today, is essentially psychoanalysis.

The author rejects the psychoanalytic doctrine both as a philosophy and therapeutic technique. In point of philosophy, he cannot share the view that human conduct is the result of unconscious drives, sexual or otherwise. To his way of thinking, adult life is not driven by instincts, but guided by Will. In emphasizing the priority of Will over Drives he is merely echoing the principles and teachings of the late Professor Emil Kraepelin, founder of modern psychiatry, and those of the late Professor Wilhelm Wundt, father of modern psychology. Quite proudly he claims also to echo the voice of common experience and common sense. Whatever may be meant by drives, be they instinctual cravings (the favorite psychoanalytic term), or emotional trends, desires, wishes, yearnings, and leanings, they all eventuate in impulses, acting
or ready for action. To the author, it is inconceivable that adult human life can be ordered without a Will holding down impulses. What precisely is meant by the term Will is amply demonstrated in the text." (of Mental Health Through Will-Training - see APPENDIX A of this thesis - jbh)

During the two psychiatric hospitalizations I had which preceded checking out Dr. Low's method, I had observed that there was a definite pattern among patients being discharged. Some uncovered attitudes and beliefs that were hurting them, had made significant changes in their belief systems, and they were the ones that struck me as having found a form of happiness. Others covered over what was troubling them. I made a simple poster describing how I felt about the latter technique. The text is,

Covering up your feelings
is like putting a bandage on a bad sliver,
it is still there,
it will continue to hurt.
Covering up your feelings
may seem easier right now,
but your whole life
will be more painful.

The Recovery method seemed too simple. It is based on the idea that symptoms come from tenseness and that from temper, temper being very carefully defined and described. Angry (or aggressive) temper comes from believing one has been treated wrongly. Resentment, impatience, indignation, disgust, hatred, etc., are forms of angry temper. (Low, 1978, P. 20) Note that temper is not a feeling, anger is a feeling, temper is a far more complex behavior which not only includes interpretations but is expressed in a way that may be harmful. Fearful (or retreating) temper arises from feeling that one has done wrong. Discouragement, preoccupation, embarrassment, worry, sense of shame, feeling of inadequacy, hopelessness, despair, etc. are forms of fearful temper. (Low, 1978, p. 20) According to Dr. Low's system, temper is to be found in every person who suffers from psychiatric symptoms. This made testing the Recovery method simple in principle. It would take my finding only one person with mental illness symptoms who was without temper as defined by Dr. Low. I thought back to all the patients I had known in Hospitals A, B, and C, and readily recognized temper as present in every case. I watched television programs in which there was struggle or conflict of one form or another, and every character whose role had symptoms had temper built into the role. I thought back over my whole life to see if I could find evidence of having known, met, or heard of anyone who had symptoms of mental illness which were not accompanied by obvious aspects of temper. I found none. Every way I could find to prove that Dr. Low had been mistaken about temper failed.
Dr. Low used many words in very precise ways, with definitions clarified through examples taken from his practice. As an aside which may help in understanding Dr. Low's attitude about mental illness, he used real first names and real initials for last names in examples, and the actual words spoken as accurately as possible. Recovery, Inc., is not an anonymous organization, Dr. Low observed that the acceptance of stigma caused fearful temper in his patients, and so taught them not to fear stigma. By learning the language of Recovery, people change their attitudes and beliefs as they adapt to the thinking patterns that allow using "Recovery lingo." Dr. Low wrote about the group self help process in the section "A Concise Outline of Recovery Self Help Techniques" of Mental Health Through Will Training (Low, 1978, pp. 19-23):

THE SYMPTOMATIC IDIOM

If the patients are to help and teach one another they must be instructed to use a language which is not confusing. This is particularly important because language, if used glibly, tends to be alarmist and defeatist. By dint of defeatist insinuations, language frequently engenders tenseness which reinforces and perpetuates symptoms. To avoid the fatalistic implications of the language used by the patient the physician must supply a terminology of his own in matters of health. There are many languages. Features and gestures speak. So do symptoms. Their language is a one word idiom: DANGER. This is called the "symptomatic idiom." Accepting the suggestions of the symptomatic idiom the patient considers the violent palpitations as presaging death. The pressure in the head is due to a brain tumor. The tenseness is experienced as so "terrible" that the patient feels he is going to "burst." His fatigue does not let up "one single minute" and "how long can the body stand it?" In these instances, the implications of the symptomatic idiom are those of an impending physical collapse. If phobias, compulsions and obsessions dominate the symptomatic scene the resulting fear is that of mental collapse. After months and years of sustained suffering the twin fears of physical and mental collapse may recede, giving way to apprehensions about the impossibility of a final cure. This is the fear of the permanent handicap. The three basic fears of the physical collapse, mental collapse, and permanent handicap are variations of the danger theme suggested by the symptomatic idiom.

THE TEMPERAMENTAL LINGO

Another source of defeatism is temper. The patients are taught that temper has two divisions. The one comes into play when I persuade myself that a person has done me wrong. As a result, I become angry. This is called the angry or aggressive temper, which appears in various shades and nuances: resentment, impatience, indignation, disgust, hatred, etc. The other variety of temper is brought into action whenever I feel that I am wrong. This gives rise to moral, ethical and esthetic fears or to the fear of being a failure in pragmatic pursuits. I am afraid that I sinned, failed, blundered, in short, that I defaulted on a moral, ethical or esthetic standard or on the standard of average efficiency. This is called the fearful or retreating temper which may express itself in many different qualities and intensities: discouragement, preoccupation, embarrassment, worry, sense of shame, feeling of inadequacy, hopelessness, despair, etc. The fearful temper is likely to lead to either a feeling of personal inferiority or to the sentiment of group stigmatization. Whether it be of the angry or fearful description, temper reinforces and intensifies the symptom which, in its turn, increases the temperamental reaction. In this manner, a vicious cycle is established between temper and symptoms. The temperamental reaction is kept alive mainly by the unsympathetic and unthinking attitude of the relatives. By means of coarse statements or subtle innuendo they provoke loud explosions or silent agonies on the part of the patient. They tell him to use his will power, implying that he makes no effort to get well. With this, they indict him as a weakling, worse yet, as purposely shamming disease. They urge him to "snap out of it," indicating that the symptoms are so easy to deal with that a mere snap would shake them out of existence. Other insinuations frequently leveled against the psychoneurotic or former mental patient are equally disconcerting. Complaining of fatigue, he is told not to be lazy; mentioning his "awful palpitations," he is admonished to be a man. The net result of this concerted environmental assault is that the patient is continually angry at his detractors and, gradually accepting their insinuations, becomes ashamed and fearful of himself.
In telling the patient that wrong was done to him or that he is wrong his temper speaks to him. The language which it uses is called the temperamental lingo. Its vocabulary is limited to the terms “right” and “wrong.” Unless the patient learns to ignore the threats, warnings and indictments of the temperamental lingo he will be the victim of angry outbursts and fearful anticipations. His tenseness will be maintained and intensified; new symptoms will be precipitated and old ones fortified. Temper is most dangerous when it plays on the symptom itself. By labeling sensations as “intolerable,” feelings as “terrible,” impulses as “uncontrollable” the lingo discourages the patient from facing, tolerating and controlling the reaction. The very sound of the labels (“intolerable,” etc.) is apt to arouse fear and defeatism. All a patient has to do is call a crying reaction by the name “crying spell,” and no effort will be made to check the burst of tears. The word “spell” suggests uncontrollability. Make the patient substitute “crying habit” for “crying spell,” and the impossibility of stemming the flood at least will not be taken for granted. Similarly, if the patient raves about the “splitting” headache, the dizziness that “drives me mad,” the pressure that “I can’t stand any longer,” the fatalism of diction is bound to breed a despondency of mood. In order to prevent the temperamental response the patient must be trained to ignore the whisperings of his temperamental lingo.

THE RECOVERY LANGUAGE

The combined effects of symptomatic idiom and temperamental lingo are checkmated if the patient is made to use the physician’s language only. The members of the Association call it proudly the “Recovery language.” The most important parts of its language are the words “sabotage” and “authority.” The authority of the physician is sabotaged if the patient presumes to make a diagnostic, therapeutic or prognostic statement. The verbiage of the temperamental lingo (“unbearable,” “intolerable,” “uncontrollable”) constitutes sabotage because of the assumption is of a serious nature which is a diagnosis; or, that it is difficult to repair, which is a prognosis. It is a crass example of sabotage if the claim is advanced that, “my headache is there the very minute I wake up. I didn’t have a chance to think about it. It came before I even had a chance to become emotional. How can that be nervousness?” A statement of this kind throws a serious doubt on the validity of the physician’s diagnosis and sabotages his authority. Likewise, it is a case of self-diagnosing and consequently sabotage to view palpitations as a sign of a heart ailment, of head pressure as meaning brain tumor, of sustained fatigue as leading to physical exhaustion. Once the physician has made the diagnosis of a psychoneurotic or postsympathetic condition the patient is no longer allowed to indulge in the pastime of self-diagnosing. If he does he is practicing sabotage. Patients are expected to lose their major symptoms after two months of Recovery membership and class attendance. If after the two month period the handicap persists in its original intensity the indication is that sabotage is still in action. The patient still listens to the suggestions of the symptomatic idiom fearing impending collapse and permanent handicap. Or, he gives ear to the verbal vagaries of the temperamental lingo, feeling helpless in the face of suffering. Clinging to his own mode of thinking, he sabotages the physician’s effort.

Contrary to expectation, it is comforting to the patient to be called a saboteur. Considering himself as such he knows that he has “not yet” learned to avoid resisting the physician. The “not yet” is reassuring. It suggests that in time he will learn. The patients encourage one another to wait until they get well. They warn one another against impatience. The slogan handed down from veteran to novice is, “Wait till you will learn to give up sabotaging.”

THE ‘SPOTTING’ TECHNIQUE

If the patient is to check his sabotaging propensities he must be trained to “spot” the inconsistencies and fallacies of his own language whether it is merely conceived in silent thought or given formulation in vocal speech. To this end, a system of “spotting techniques” was evolved by means of which the members learn to reject the suggestions of the symptomatic idiom and the temperamental lingo whenever a symptom or a temperamental reaction occurs. An extensive though necessarily incomplete description of the spotting technique is furnished in part 3 of this book.

1Recovery, Inc., has also been known as the Association of Nervous and Former Mental Patients.
There are several constructs developed by Dr. Low that need to be clearly understood for accurate recognition of the Recovery method. Among the most important is recognition of what is trivial and what is not. Dr. Low said (on a tape of a presentation given at the University of Illinois which I heard at a Recovery meeting) that there is no right or wrong in the trivialities of everyday life.

Average life consists of trivialities mainly. Average home life, for instance, calls for buttons to be sewed, dishes to be washed, children to be watched, pain and discomfort to be endured. All of this routine, offering little stimulation or excitement and providing a great deal of irritation, a good measure of drudgery and some amount of suffering. Occasionally there is a birth or wedding, sickness or death. Then the routine is interrupted by an exceptional event but is resumed in all its deadly monotony as soon as the event has passed. The irritation incidental to this sort of routine life is patiently borne by persons who are not too irritable. But nervous patients are unfortunately blessed with an excess of irritability. As a result, the average irritations of routine existence are well nigh "unbearable" to them. They hate the routine chores. Routine, to them, is an infliction. It inflicts disturbing sensations, confusions, doubts and anxieties.

To the average housewife the breaking of a glass is a plain occurrence not to be fussed over. It causes a mild irritation that is easily disposed of by the consideration that the loss is trivial and replacement easy. But to the nervous housewife the breakage may suggest that she is inadequate, that all effort is futile, that the inefficiency, incoordination and lack of attention revealed by the dropping of the glass are beyond hope. She may now become provoked at herself and work herself up to a pitch of excitement and emotionalism. Or, she may bring into play the sentiment of self-pity and condemn herself as a neglectful person, oblivious to duty and responsibility. The sentimentalism of self-blame may finally produce a panic. Then sentimentalism and emotionalism join hands to create exceptional fury in response to an event of average triviality.

The excessive irritability of my patients predisposes them to a grotesque hatred of routine. With the average housewife, sewing buttons and darning socks do not figure as exalted tasks or sources of great excitement. They are chores, devoid of thrill and inspiration. But the darning is done for the husband, the sewing for the son. Being meant for the ones she loves the activity acquires a significant meaning in the eyes of the housewife. Every stitch and every patch has the meaning of doing something necessary, useful and valuable. Life is still a chore and unpleasant routine, but the routine is now meaningful, important, perhaps even vital. The inherent meaning of the work creates enjoyment. The enjoyment provides stimulation, gives a sense of living, a feeling of accomplishment. Added to the feeling of joy and satisfaction is the realization that the mending and patching constitute a duty performed and responsibility discharged. In this manner, the feeling of joy is supplemented with the sentiment of dutiful and responsible action. Life of this kind is one of sustained feeling and interest. It is vibrant, stimulating, perfused with zest and interest." (Low, 1978, pp. 72-73)

It is not the intention here to duplicate Dr. Low’s work, rather, to cite a few examples of his method with sufficient detail that his technique may be understood well enough to give him proper credit for his contributions to this thesis. Among the ideas that merit mentioning, and for a full understanding of which, studying carefully Dr. Low’s publications is essential are: “Undesirable exceptionality” leads to temper because it sets standards for accomplishment which are impossible to meet consistently. Dr. Low said to his patients, “If you lower your standards, your performance will rise.” Having standards of undesirable exceptionality, his patients put much of their effort into feelings of hopelessness and such feelings led to temper which so consumed a patient’s capacity for effort that little effort was available for the task at hand. Lowering standards to the point of being satisfied with what is actually achievable means that far more effort is available for the task at hand, and
it can be accomplished more readily. I recall a few times when my life seemed to be in great turmoil, and I felt that I urgently needed sleep to have the rest necessary to resolve the turmoil. So, I put effort into trying to get to sleep. Alas, making a conscious effort contravenes sleep, and I learned long ago that I would have to let go of my concerns if I was in a state of turmoil and intended to sleep. Among examples of "Recovery lingo," in short phrases, are, "Objectivity terminates a panic" (Low, 1978, p. 99-107), "Feelings are not facts" (Low, 1978, pp. 92-98), "You need to have the courage to make mistakes" (Low, 1978, pp. 201-205).

I noted that every patient I met was angry, and that every patient showed the temper which Dr. Low described, myself included. I had noted also in both Hospital A and Hospital B that every patient who seemed to become well, to the extent that they became well, found some way to handle their "temper" in such a way that symptoms were reduced. Many peer patients improved their coping skills, as I observed, by strengthening reality-distorting defenses so they became less "irritable," to use Dr. Low's term. Some peer patients found what was troubling them and changed their beliefs so the events which previously were problematical became significantly less troubling. I noted that there was nowhere in any of Dr. Low's writings a case which resembled the life I was living, for, by this time, I was quite certain that my correct diagnosis was multiple personality disorder. If I was truly in the realm of multiple personality, how could the Recovery method work if a personality not in executive control of me was causing my symptoms? There was further the question in my mind as to the source of the "irritability" described by Dr. Low. While his explanation of the nervous patient having a "weak nervous system" as in Low (1967, p. 15-17),

There are two types of patients. The one is easily wounded, ruffled, and upset; the other is of a coarser fiber and relatively immune to irritations...millions of people suffer disappointments in love, failure in examinations, losses in business without experiencing a mental break. Obviously, environment alone is not sufficient to account for mental disease. Another factor must be considered—that factor is constitution.

There are no clear descriptions in Dr. Low's writings that signal to me that any of his patients met the standards for multiple personality disorder, as described in the DSM-III-R or dissociative identity disorder as described in the DSM-IV. At issue is the presence of Criterion C. as "Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness." (American Psychiatric Assn., 1994, p. 487)

But Dr. Low did write this:

*Everybody Is a Dual Personality With a Dual Viewpoint*

You do not have to wait for a shakeup in a street car in order to observe the dual character of "human nature." In the peaceful precinct of your own privacy you can make similar observations; if your daughter or maid breaks a dish you become enraged at their carelessness; if the breakage happens to you
it is an accident which is instantly dismissed from your mind without comment. Your guest’s late arrival is inexcusable and “just an outrage,” while your own failure to be on time is unfortunate and unavoidable. If your fence is damaged by the neighbor’s little son you burn with indignation at the atrocious manner which “some people bring up their children.” If the damage is done by your own boy to the neighbor’s fence you excuse the act on the grounds that “Charlie is just a child and doesn’t know what he is doing.” In the case of an offense committed by another person, your subjective predisposition is always ready to condemn; in your case, your objective attitude is ready to condone. You are—and everybody seems to be—a dual personality with a dual viewpoint. At times you advance the subjective viewpoint and become emotional and temperamental; at other times the objective viewpoint is favored and emotion and temper are controlled. “It all depends on the way you look at things,” and your temper will have free reign if you cultivate the subjective way of looking at things while it will be kept in reasonable control if the objective view of things is given the right of way. (Low, 1967, pp. 152-153)

On reading this in 1987, I wondered whether there can be more than two “personalities” in normal people, and whether the hurts I had observed in other patients in Hospitals A and B had indeed caused divisions of personality, and the illnesses I saw originated from the inability of one personality division to dominate the person. I learned the Recovery method through reading Dr. Low’s writings and by going regularly to Recovery meetings, once and often twice a week. I noted that temper, as defined by Dr. Low always led to symptoms via tenseness (or anxiety) in every person I met, even those who would be deemed psychologically normal. I could not agree with Dr. Low’s idea that psychiatric patients such as myself had weak nervous system, or that I was overly sensitive, or that I had a weak or inadequate constitution, nor did I find that to fit any of the other people who I met at Recovery meetings. What I did find was a high sensitivity to being hurt, a high sensitivity to real hurts which were inflicted, often in ignorance, by those who were less sensitive, those “of a coarser fiber,” in Dr. Low’s language.

I was quite certain, as an exercise of faith, that my illness was the result of things that had happened to me, that I was not a defective person, and that, given enough time and effort, I could learn what had happened to me and could deal with it and would become mentally healthy. The one thing I did, and I recognized this very early in reading Mental Health Through Will Training, which contrasted starkly with Dr. Low’s patients’ self diagnoses, was believing that my self-diagnosis carried a far more favorable and optimistic prognosis than the diagnosis made by my psychiatrist. There were, in the limit, two possibilities: I was born flawed, defective, not able to meet the appropriate and realistic standards of society and had suffered because of my inadequacies; or I was born adequate and competent but also naive, innocent and vulnerable, and suffered because I had been badly hurt because some of the standards of society were unrealistic as they were applied to me. Dr. Low’s observation that his patients’ performance would rise when they lowered their standards strongly suggested to me that the flaw was not in people, rather, in what people believed that was wrong. About this time, I made up a poster which said, “Running into a brick wall does not hurt any less if you pretend that the wall is not there.” But, it was not so simple. The fact
that I felt that something had happened to me which caused my illness did not make it a fact that what I felt was true. In other words, my sincere belief that my illness was caused by things that happened to me outside my control and not by something basically and inherently wrong with me, was not, of itself, evidence that my sincere belief was true. Dr. Low wrote of this aspect of belief and fact in many examples; also, "Feelings are not facts," as mentioned a few paragraphs ago. I was psychotic, but could control my psychosis so it was not obvious to most people around me, sometimes it was not even apparent to my psychiatrist, Dr. B. I understood that my psychosis could be a symptom of anxiety caused by inadequate objectivity on my part, and I had found that what Dr. Low called "trigger spotting" (Low, 1978, pp. 246-247), recognizing the earliest conscious manifestations of temper and using objectivity as a way to reduce anxiety led to averting strong psychotic symptoms time and time again. The process of trigger spotting failed only when I could not identify anything of or about objectivity in my situation because I was too psychotic to recognize anything with objectivity.

By the summer of 1987, I was well satisfied that temper leads to tenseness and tenseness to symptoms, and that Dr. Low had been accurate in his observation that this is true for every psychiatric diagnosis. But it was just as clear to me that this was not the entire truth, for I could not accept, based on my own life, on having observed many children at Cook County Children's Hospital, and all the psychiatric patients I had met, that temper was caused by personal inadequacies. I speculated that the problems of the mentally ill were the result of their being sensitive to the harm done by those who are insensitive to harm. From the standpoint of evolution, this was a stunning recognition for me. It would mean that evolution would favor sensitivity to harm as an adaptive species survival process, and, if there was any genetic flaw to be found, it would have to be in the so-called normal people who were insensitive. If increasing sensitivity was adaptive in terms of evolution, then there would have to be a period of time when the sensitive people were a minority and the insensitive majority would control society. Only after natural selection bred out insensitivity to a sufficient degree could the sensitive people have meaningful control of society. Keep in mind that I was rather psychotic when I was exploring these ideas.

I set out to see what would happen if I unleashed my imagination. Is psychosis a loss of contact with reality, or is it a loss of contact with the standards of society? On checking with several dictionaries, I noted that a delusion was a fixed belief held by a person and not held by the person's society or by an organized religious body. This troubled me. If it was true, the truth was defined by power, by tradition, by consensus, but not by scientific methods. I thought, "What if the dictionary definitions of 'delusion' are themselves shared delusions of the members of society?" If that were so, then
psychosis could be stepping outside social reality, but not necessarily outside reality. Psychosis could, perhaps only on rare occasions, be a way to find aspects of reality that society did not yet recognize.

2.14 Hospital B, second time

Such thinking had a tremendous effect on me. It drove me to a far greater state of decompensation than I had thought possible, and I crashed into my fourth psychiatric hospitalization, back at Hospital B. I was admitted directly to the intensive care unit. Once there, in a very floridly psychotic state, I saw that I had never had a problem concentrating, I was concentrating with all the effort I could muster on solving the problem of what happened to me to make me psychotic, and had been doing so for over a year, ever since I had been given morphine after the colon surgery. I imagined my situation in this manner: My life had been decent and productive before the colon surgery, and then something absolutely awful happened to me. It was as though people live in a mental space of hills and valleys, mountains and chasms, not so different in a way from the physical world. In the mental world, one's quality of life is better the higher one's altitude. It was as though I had been living near the top of the higher hills before my illness, and my illness had flung me into one of the deeper chasms. On the hilltop, I could see the mountains in the distance, but could see no way to get there. One mountain was higher than all the others, and it looked beautiful beyond words. It was uninhabited. I could see paths into some of the chasms from the hilltop, but the paths looked so steep in places that it surely appeared to me that, were I to embark on a trip to a mountain, and as the only visible paths all went into chasms, I might never again live as well as I was doing already. Although I could see the mountains and knew that my life could be even better were I to get there, the journey seemed too perilous to undertake deliberately. But, once I found myself in a deep chasm, my perspective changed. I had a choice to make, and, one way or another, I would make a choice; not choosing was not an option available to me. I could choose to stay in the chasm, I was marginally surviving there. I could try to get back to the hilltop that was familiar to me, and, from the depths of the chasm, it did seem that there were just enough places to grab onto the steepest portions of the pathway back to the familiar hill that I could probably get back there if trying to do so was my decision. I explored the chasm. I was not alone. I found other people in that chasm. Some were exploring the ways that might lead to the mountain, some were heading back to the familiar hill.

From a very few places, I could catch a glimpse of the mountain that had fascinated me for most of my life. But the only path I could see that had any chance of leading to the mountain was replete with even deeper gorges and precipices. Going back to the hilltop seemed to be the safest route, and my doctors (M.D. and Ph.D.) and therapists (hospital staff and peer patients) seemed to favor that choice. But the mountain intrigued me. Against almost every sort of advice I was given, I set out for the
mountain, to see what was there, because it was there, at least in my fantasies. In my imagination, I saw footsteps on the path toward the mountain, others had tried it. But there seemed to be as many footsteps coming back as there were going. I slipped, tripped, stumbled, grumbled, jumped, leaped, flung myself into deeper and deeper chasms. Even though I knew that the quality of my immediate life was deteriorating severely as I did this, I also saw that each clumsy step had to be one step closer to the mountain, and I had no proof that I could not get there if I persisted long enough with sufficient effort. In a very deep place, like a crevice with such sheer sides that it could only be traversed along its bottom, so narrow that I could scarcely squeeze through, I met with a flash of terror. The only footsteps I could see were mine. It was as though I had come to a place no one had ever visited before. I knew the way back to the hilltop, I did not know the path to the mountain, on faith alone, with no evidence, I decided to try for the mountain. I had no intention of being foolish, I had no intention of failing, and it was as though I had taken one particular item of safety equipment in addition to climbing ropes, a walkie-talkie like two-way radio that could reach some of the people in the previous chasms rather well and occasionally even people on the hilltop. It was as though I was by myself, but not really alone. The only encouragement I got to proceed toward the mountain came from those in the depths; no one on the hill, even those near the bottom, seemed to favor what I was attempting to do. In reading a mystery book, I have sometimes found it helpful to read the ending after reading the first chapter, the better to understand the structure and purpose of the plot. Not to spoil the story, but to help understand the structure and purpose of the course I plotted through my illness, I will tell the ending now, as I know of it ten years later during the writing of this dissertation.

Any and every way I can test this, I got to the top of the mountain safely, although the trip was arduous and perilous. And I got there because I was somehow given a faith that never broke, that never failed me, regardless of my situation, faith such that I could get there with an achievable effort. In the state if mind I was in, which was psychotic and perhaps grandiose, I found no evidence that any ordinary person had ever visited the mountaintop before me. Perhaps I missed the evidence, perhaps it had weathered away. But I know that the effort to get to the mountain was worth it to me, for I find that the view from the top of the mountain is a view of real community made of ordinary people, each doing what they can that is decent, making mistakes and learning, in a framework of kindness and safety. Within the context of the quality of life terrain that I just described, I think it best to understand this dissertation, as a whole, as a preliminary and tentative attempt to build a bridge from the hill to the mountain, so others may get here to the mountain more easily than I did. At least I know the trip is worth the trouble many times over.
Back to 1987. I had seen how I understood the risk of cancer not only accurately on an a priori basis, but had seen the need for adequate preventive treatment as well. About this time, Dr. B asked me for my thoughts about a patient of his who was also in intensive care. I remarked that this person had the fastest mood swings I had ever seen, sometimes changing from severe depression to wild mania and back in a fraction of a second, and that there seemed to be hundreds of mood swings per hour. Since I did not see a practical way for neurotransmitter levels to modulate so rapidly and completely, I suggested that she was switching between subpersonalities, which I thought could happen as fast as she changed moods. Dr. B said that he found me to be as good at diagnosis (remember my bioengineering education included theoretical and practical methods of diagnosis), but that I had a different system than he had. To which I answered, “Yes, the difference is that my system works.” I had decided by then that some things had happened in my childhood which were shattering to me, and, if I could find them, I would be mentally well. Also, if I was right that things happened to me to cause my illness, they were deeply buried, and I would only find what had ambushed me in the deep chasms of the mental geography of my mind. I was certain that, psychotic or not, I had consistently understood my situation better than anyone treating me. Dr. C, the psychologist who was doing about half of my inpatient psychotherapy, had remarked when he first saw me that, “The eye cannot see itself, neither can the mind. As the eye can see itself only with a mirror, so the mind can see itself only when mirrored by another mind.” As I pointed out the difficulties of my life and the problems that I thought needed to be overcome, Dr. C frequently reminded me that, if I could not do something that seemed to need doing, it was because I was not ready yet to do it, that there was more to learn first. The only diagnostic category I could find that fit my experiences was, in 1987, from the DSM-III-R, multiple personality disorder. Dr. B told me that there was no evidence of the sort of sexual abuse, repeated or not, that causes people to become multiple. I needed Dr. B’s support, I could not be too treatment resistant or I would not qualify for being hospitalized, and I found Dr. B’s treatment, based on his use of the medical model of mental illness, to be abusive in some ways.

I persisted, against Dr. B’s firm advice, to probe my past with the form of “guided free association regression” which I had found most helpful in finding my past. I would like to describe the process in some detail, with a fictional example that I think adequately illustrates the method. I would let my thoughts wander, making note of them with the least practical effort that allowed my remembering what I had been thinking. I would, in that manner, gently direct my thinking toward the feelings that went with the symptoms that were bothering me the most. Then I would make up a story about someone who was having a problem similar to mine, and the story would include what happened to that person to make the symptoms. After a few such
stories, I would remember something about my childhood that had really bothered me at the time, and which I had pushed out of conscious awareness. I felt afraid, extremely afraid, one day while I was in the intensive care unit of Hospital B, so afraid that I was soon in full restraints for my safety and the safety of the staff. Once in the restraints, I fought against them with my full strength, even to running some of my muscles into anaerobic metabolism and some spasms. It felt like I was about one and a half years old. It felt like my brother had wrestled with me, and had me pinned on my back while he sat on my legs and held my arms. I then felt a sense of terror beyond any words I can say or write. While I felt terrified, it was clear to me that I had not broken into being multiple then. The break happened in some other situation. What I learned is that I was not at all a weak person, nor had I been as a toddler. No, contrary to Dr. Low’s interpretation, I had a robust constitution, although it was made of fine fiber and not coarse. After being in restraints a few more times, I became functional enough for my first hour on a regular adult unit, to see if I could be transitioned out of intensive care.

That hour was during group therapy, and the staff leader remembered me from my first time at Hospital B almost a year before. She asked me to describe my situation briefly. I spoke for about five minutes. One of the other patients started looking at me as I spoke. The more I spoke, the more intense her expression became. As I finished, her mouth was open in an expression of amazement. She said nothing during the group session, but came to me immediately afterward. She said, “Are you a multiple personality?” I answered, “My doctors ruled that out.” I did not say I had ruled it out. She said, “No one else ever described the world I live in before, I am multiple.” She asked if I had experienced lost time. I answered, “No.” This was what puzzled me the most, I did not remember having lost time, for the personality of mine who answered her question was unaware of lost time. Later on, I discovered that I had a lot of lost time during my life. We spoke for several more minutes and then she said, “I switched you three times while we were talking.” I answered her, “I know that.” Then it was time to go back to the intensive care unit.

When I told Dr. B about that event, he said, “What is her training, what does she know about it?” And I answered, “She lives it.” I felt like saying to Dr. B, “What training do you need that you don’t have yet so you can actually understand your patients?” I did not say that because I trigger spotted that it would be an inappropriate exercise of temper, and my Recovery training allowed me to control my impulses. When I reported the same incident to Dr. C, he asked, “Why do you want to be so rare? You are rare enough already.” And I replied, “I don’t want to be rare, but every person is unique. I just want to find out what happened to me so I can go home to my family and live decently.”
I thought back to Dr. C's remark about the mind needing another mind as a mirror, and thought of the trick mirrors of a circus side show, how severely a mirror may distort an image. The people whose lives included experiences like mine seemed to mirror myself most accurately. I spent more of my "free time" in the day room talking with other patients, sharing with them what I knew and vice versa. My changed tactics did not exactly please the staff, but the other patients generally said they appreciated the conversations I had with them.

About this time, as I was having longer visits to the adult unit, the intensive care unit head nurse told me that she wanted to talk with me. She told me to sit in one of the day room couches and she pulled up a chair and sat in front of me, and the conversation began. Whenever she sensed that I was getting off the track, she reprimanded me, and it did not take very long before I figured out what she wanted me to do. The conversation lasted about fifteen minutes, at the end of which, she said that what had just occurred was the best conversation she had ever had with me, that I finally stayed on the subject. I answered her, "I appreciate what you did, you have helped me greatly. That conversation was the emptiest and most meaningless conversation I have ever had in my entire life. The jumps in my thinking to which you object are the bridges I must build to become whole. If I do as you want, I will be forever trapped in my illness. I am grateful for what you did, for now I know with certainty that I must not do as you want." She walked to the nurses' station and, when she turned around, her expression suggested to me that she thought I wanted to be sick. Not so. She did not believe me any more than the doctors who did not realize the risk of cancer had. Once more, the understanding that I could trust myself and other patients far better than the staff was strengthened.

In one way, I was using the Recovery method the way Dr. Low intended, I was using it to stay out of temper whenever I felt temper. Alas, I did not feel the temper of the personalities that were not in control, and could not spot it because I could not be consciously aware of it. I continued to have the feeling that I had feelings that I could not feel. I interpreted Dr. Low's saying, "feelings are not facts," (Low, 1978, pp. 92-98) to mean that there were two possibilities about the feeling that something real happened to me that I could not remember because it was too painful to remember, and was too painful to or that I had misunderstood something that happened in my childhood and it was because of misunderstanding that I could not remember what it was that was bothering me. And, I saw the apparent paradox — how could something I could not remember affect me so profoundly years later. The only solution I could find is that some aspect of me was vividly aware of something in my past that felt too painful to know about. That raised the question as to whether this feeling was a fact. If
something happened to me that felt too painful to remember and was too painful to forget, and the pain was in the past, so there could be no present danger, what kind of thing could perhaps have happened? If my symptom was the inability to consciously remember something that was having a profound present-time effect, was my inability to remember the result of an exercise of temper? Once again, for clarity, I want to demonstrate the kind of thought processes I had in 1987, as I remember them and as they were documented in journals written in 1987 as I was having these kinds of thoughts.

My situation seemed paradoxical in many dimensions. I decided to explore the phenomenon of paradox—do real paradoxes exist, or are they the result of incorrect (disordered) thinking? I had long realized that the famous paradoxes of Zeno of Elea as described, for example, in the eleventh edition of The Encyclopedia Britannica (University of Cambridge, 1911) were all the result of mathematics and physics having not developed the tools to accurately analyze infinitesimals of differential and integral calculus, and because Zeno confused that which is infinitely divisible with that which has infinite magnitude. Consider, as an example, "Zeno's Achilles paradox, which goes like this. For a moving object to reach a certain point at a distance from where it starts, it has to first travel half of the distance to that point. Therefore, if Achilles were in a race with a tortoise, and the tortoise had a head start, Achilles could never catch up with, much less ever pass the tortoise because, when Achilles got halfway to where the tortoise was, the tortoise would have moved farther. Therefore, no matter how long Achilles might run, he could never catch up with the tortoise. Which is absurd. But I had studied calculus, I understood Zeno's error, but Zeno had no such opportunity, calculus was not invented until Leibniz and Newton lived, about two thousand years after Zeno died. All of Zeno's paradoxes signaled inaccurate understanding of reality. I remembered two paradoxes that I thought were considered unsolvable. I wondered if they were, like the paradoxes of Zeno, indicative of a misunderstanding, and so my problems could perhaps be solved if I found misunderstandings in my beliefs which had caused my illness.

The first paradox I thought of was the one I think is commonly called Bertrand Russell's Barber Paradox. As I remembered it in 1987, it went like this. "There is a town where there is one and only one barber. In this town, the barber shaves every man who does not shave himself. Who shaves the barber?" Superficially, the paradox works like this. If the barber is one of the men who shaves himself, he is not shaved by the barber, and if he does not shave himself, he is one of the men who is shaved by the barber. The solution that the barber is a woman who does not shave is the easy way out, and merits being rejected if the paradox is truly to be resolved. There is another solution. To find it requires thinking. Incidentally,
to the best of my knowledge, having read about paradoxes over some time, this solution is original with me. The solution is actually very simple. The word “barber” refers to a profession, and not a person. The Barber” refers to the profession of the man who is the barber and only incidentally refers to the man himself when he is engaged in his professional work, and not at other times. When he is not barbering, he is the man in the town whose occupation and profession are that of the town barber. The man who is the town barber shaves himself at times when he is not engaged in his profession, even though his professional skills may be used to his advantage when he shaves himself. Not so different than Zeno, the barber paradox signals a mistaken understanding, only this time the mistake is made in confusing what a person does with what a person is. Or, if you please, confusing a person’s role with the person’s identity.

The most difficult paradox I could recall was one involving self-reference, which removes the kind of errors of Zeno’s paradoxes or the barber paradox. The mind analyzing itself is a problem of self-reference, and I recognized that, if real paradoxes could exist in situations of self-reference, then I might well find it impossible to solve the puzzlement of my illness. The knottiest paradox I could remember was this: Consider the truth or falsity of the following proposition, “This sentence is false.” It is simple to see the problem. If “This sentence is false.” is true, then “This sentence is false” is false; if “This sentence is false.” is false, then “This sentence is false.” is true. Superficially, “This sentence is false.” is its negation, which is obviously impossible...unless there is something called “time.” Consider the words in quotes which follow, “This sentence is false.” What is actually on the paper of the original of this dissertation are black marks on a white background. Those marks become words only when they are read by someone, at other times, they exist only as marks on paper. The marks represent words, they are not words, words exist only in the mind. As evidence, consider someone who can only read Hebrew. The marks on this paper will not convey meaning to that person. But the same idea can be expressed in Hebrew by someone fluent in that language. In the mind, there is a process. Every time the proposition, “This sentence is false.” occurs in the mind, it changes from true to false or false to true. Consider an electrical switch such as is common on modern consumer electronic equipment such as the computer which I am using in writing this thesis. It has a power switch which, depressed and released, turns the computer on if it was off or off if it was on. Ah ha! The solution to “This sentence is false.” is simply, it is like the power switch on the computer I am using. It is a binary divider, like a clocked flip-flop in the language of electronics. When I depress and release the power switch on the computer, I have changed its state twice, from out to in and from in to out, while the computer changes its state only once, either from off to on, or from on to off.
Satisfied that the appearance of paradox always signals misunderstanding, and that this is true for even the most dramatic examples including the problems raised by self-reference, I decided that there was a realistic chance that an achievable solution for my predicament could be found. But my position was rather like that of Zeno, I did not have any tools that I could find to unriddle myself. Perhaps I would have to make them. At least I no longer had reason to wonder whether my illness was hopeless. There remained the problem of spotting temper in personalities which did not share consciousness with me. It felt, when I was the most floridly psychotic, that my illness was a concatenation of diverse panic attacks outside the realm of my will. But, if my will could be trained, such attacks might be brought under control. It seemed like a good working hypothesis. With both realistic hope and unbroken faith, my condition improved and I was transferred to the regular adult unit of Hospital B. There I improved more as I talked in depth about being multiple with the one and only person I had ever met to that time who understood what my inner life was like, the woman who was multiple herself.

She let me read a book she had borrowed, *Childhood Antecedents of Multiple Personality* (Kluft, 1985). From Kluft (1985, p. x), "While some multiple personality patients function adequately or even exceptionally, many are more or less incapacitated. All suffer. The cost to the afflicted individuals, their loved ones, and society is immense...it is the stark misery of these patients and the ordeals they have endured that concern the experienced clinician." I thought back to Dr. B's early remark after reading my short autobiography when I first began seeing him, that my life was like I had been stepped on like a bug a thousand times and more. Then I recalled a remark Dr. C had made when I was seeing him on an outpatient basis. He had said that I was like a chameleon, he could never quite be sure who I was. I began to speculate. Perhaps when my brother picked on me when I was little, that set the stage for a full dissociative break when I was spanked for rearranging my father's books when I was about two. Perhaps, once multiple, I broke again and again, when teachers found fault with me, when other children teased or tormented me, when I did something that I thought was not good enough. Then I remembered something that shocked me. Many times in my childhood, when I felt that I had done something that caused someone else to be critical of me, I would hit myself when I was alone, not enough to cause bruises, but enough to cause discomfort sufficient that I would generate another personality state to manage what I thought or felt I had done wrong. After some early help from my brother and one episode from my father, I had become the one who perpetrated the abuse that made thousands, by my best estimate, of dissociated personality states. And, I had done so to prevent hurting back the people who hurt me. And, further, that the strategy had been successful for everyone but myself. If I hurt myself, I hurt myself back because I was multiple and could not stop doing such things.
I tried to explain what I had learned to Dr. B and Dr. C, but met with zero apparent success. From Goodwin, in Kluft (1985), I understood my difficulty with doctors. Dr. Goodwin addresses the problem of incredulity on the part of physicians in response both to child abuse and multiple personality disorder. Goodwin (Kluft, 1985, pp. 2-3) wrote,

> The credibility problems in multiple personality epitomize the difficulties faced by the abuse victim within the mental health care delivery system. In these cases, professionals are incredulous not only of the existence of the disorder and of the patient's narratives, but most physicians also have difficulty believing even the most commonplace, concrete, and prosaic of the patient's statements. This incredulity is created by the patient's own habits of concealment, adaptive for survival in a traumatic childhood, but terribly confusing when they operate outside of awareness in adulthood.

What a relief, momentarily, when I understood that. If I was multiple, my unwitting and unavoidable behavior as a person with multiple personality disorder would have, as though automatically subconsciously made the doctors who had not listened to my assessment of cancer risk incredulous about my reasoning. The relief did not last. Dr. B and Dr. C would not be able to believe me unless I found a way to force them to understand. What could I do so they could overcome their incredulity?

Perhaps I could try acting. Many years before, I had played the role of the farmer in my high school junior class play, George Washington Slept Here. My father had both acted in plays and directed plays as an amateur, and he understood the theater well. He told me about stage presence, about choosing mannerisms and such that I felt would be appropriate for the farmer, as I understood his “life.” I decided that the farmer had recently been bitten by a mosquito on his right hand, and it itched and he scratched the itch from time to time, uncorrelated with the action of the play. I decided that he was very time-conscious and had a large pocket watch that he checked very frequently because he worried about getting things done on time. I decided he would have an occasional mannerism, also not correlated with the action of the play, wherein he would take his right hand and push his hair back even indoors, a habit generated when he was plowing and the wind blew his hair over his face, for he did not like to wear hats. The play was performed only once before an audience. Unlike any of my fellow student-actors, who had not heard of stage presence, nor had a father who understood it very well, I started out in character. Alas, I noted something that bothered me. During the dress rehearsal, none of the teachers who were observing the play made any comments about my stage presence tactics. But, with the live audience, I found that what I was doing caused the audience to chuckle at times which seemed to rattle the other student-actors. Seeing this, I dropped out of character, so as not to compete with the other players. As a patient in Hospital B in 1987, I figured I knew enough about acting to have a decent chance to act in a way that my real condition would be accepted by Dr. B and Dr. C, and my treatment might be more effective and efficient. I did not expect what happened next.
It seems that my changed behavior patterns worried some of the unit staff so much that they reported what I was doing to the hospital administration. Again, keep in mind that, while all this was going on, I was inwardly and outwardly very psychotic. Should you, the reader, find it impossible to believe that a floridly psychotic person could think so rationally, I guarantee you that it is not only possible, it is rather easy for someone who is genuinely multiple. It was easy for me. Remember what Dr. Goodwin wrote about incredulity if you are incredulous about this. I had been talking at length in the day room with the other multiple personality disorder patient, and saw that becoming unified through hypnotic means was definitely not acceptable to me. I was quite certain that some of my immediate difficulties stemmed from inadvertent countertransferences originating from Dr. B. I also believed that some of my personality states were so starkly contrasting that unification would be impossible, that I would have to permanently lose important parts of my life if I were unified. I had in mind quite a different strategy, developing co-consciousness to such a degree that my whole life would be readily available to my conscious awareness. It was this to which I had been referring when I told the head nurse in the intensive care unit that the jumps in my thinking to which she objected were the bridges I needed to build to become whole. I had graduated with a B.S. in bioengineering with high honors as someone who was multiple, hence, surely I was among those who had functioned exceptionally, and, I believed I could again function exceptionally well as a multiple personality if I found what of my life was still misplaced into lost time amnesias.

2.15 Hospital C, second time

Dr. B came to see me at an uncharacteristic time. He told me that the Hospital B utilization review committee had decided that I was too disturbed to be a proper patient there, and I would have to be discharged immediately. Dr. B arranged for my transfer by ambulance to Hospital C. I was suddenly taken away from the only person I had ever met who had been able to share with me the experience of being multiple. She helped me find many important episodes of lost time in my life. There had been a couple master’s degree staff members at Hospital B who seemed to have a glimmer of understanding, and it was as though all my hard work in finding someone who could mirror my life without serious distortion was lost. I felt as though I had been stepped on like a bug. Again.

At Hospital C, I knew I had to be careful to avoid making the kind of mistake I had made at Hospital B. But, alas, I became more psychotic, and desperate. I was taking anti-psychosis, anti-depression, anti-anxiety, and anti-Parkinsonism medications. While I felt better with the medications, I observed that I was doing worse. I could not tell whether I was doing
worse because of the medications or because of my self-analysis technique or both, or even neither. Hospital C had an “assertiveness group” in which the staff leader repeatedly remarked that we are not born assertive, we have to learn to be assertive. Assertiveness was defined as expressing one’s objective assessment of the situation, one’s feelings about the situation, what one wanted, and what would likely happen if one’s wants were not satisfied. For example, consider first two people in a conflict situation in which assertiveness is absent. Let one be aggressive and the other passive-aggressive. A made-up conversation between these people might go like this: “How many times have I told you not to slam the door?” “I didn’t mean to slam the door, the wind caught it.” “Don’t you know by now that you have to hold the door more firmly when it is windy?” “I hadn’t thought about it.” “What do you have a brain for, anyway?” Now consider two assertive people, one of whom is just as bothered by slamming doors as the aggressive person in the previous case: “I heard the door slam, I have asked you not to slam it because it bothers me.” “I’m sorry, the wind caught it and I did not expect it to slam.” “OK, but next time it is windy, you might consider holding it more firmly.” “Good idea.” In this example, what might happen if the door slams again is implicit, not explicit, but the second person surely realizes that the first person will be disturbed by future slamming of doors, and as a matter of courtesy, will likely be more careful in the future. In the first case, however, the passive aggressive person is likely to retaliate by slamming the door every time there is enough wind that the “wind made it slam” story is believable.

I had one particular problem with the idea that we are not born assertive. I had observed many babies at Cook County Children’s Hospital, and every one of them struck me as perfectly assertive, though not verbal, if they were young enough. Aggressive or passive patterns seemed to develop only in response to a sense of unmet needs. So, after hearing how we are not born assertive several times over a few weeks, I raised an objection, stating clearly the ideas of the two previous sentences. The staff leader of the group took strong exception to what I had said. I dropped the issue. But, at the next meeting of the group, the leader started out, “Brian was right about what he said last time. We are born assertive, and that can make learning to be assertive now easier. As Brian said last time, all we have to do is to remember how to be assertive, we knew it when we were very young.”

I still had a problem. I was still not credible, as I saw how Dr. B and Dr. C reacted to me. This was becoming serious because my inner symptoms were getting worse and I was having more difficulty controlling my behavior. I decided to use my acting ability to persuade Dr. B and Dr. C that I was really multiple. At the time I set out to prove my point, I was in a
state of florid psychosis, the most intense I had ever known. I made a mistake. I meant well, I was only trying to get effective help. What role could I play that could not be ignored? Saturday morning, the weekend before Thanksgiving in 1987, Dr. B came to see me. Part way through the session, I changed my voice, deliberately as a willful act, and said, “The staff is not listening to me. This is wrong. It will change. You and the staff no longer have the option of not listening to me because you will hear me one way or another. If you continue to choose to not hear what I am saying, you will hear my actions. If you do not listen to what I am saying, a hospital staff member will soon be dead. I will give you and the staff a little time to make your decision, but there is not much time left, probably less than a week.” I had no intention of harming anyone, I only wanted the staff to stop hurting me by really listening to what I was saying. I thought that Dr. B would believe that another personality, one that was capable of criminal violence was trying to take over, and so he would finally see that I really was struggling with a form of multiple personality disorder. I knew that the law would be on my side, I was so psychotic as to be legally certifiable as insane. Dr. B saw me next the following Tuesday. He had a totally new song to sing. It had worked, so I thought. To make sure it would keep on working, at the end of that Tuesday session, I told him of the plan I had made to kill him that night if he had not decided to listen. It was a clever plan, clever enough that Dr. B realized that such a plan could work. I had no intention to use the plan for any purpose except getting adequate attention brought to bear on my being multiple. Dr. C saw me the next day, and he was singing a similar song. I had finally broken through my doctors’ barrier of incredulousness. Now, perhaps, I could get effective help in solving my problems. My acting was so good I was back on close observation precautions, and could not sleep in my room; I had to be observed by staff at all times. What happened that night remains, as I can remember it, one of the strangest and most remarkable experiences of my whole life.

I do not claim to remember with historical accuracy what really happened. All I have as I write this are the memories of that night and the next day, and the journal entries I made at the time. I went in and out of character in the journal. Part of what I wrote was acting, because both Dr. B and Dr. C sometimes read my journals, and I wanted what I wrote to support the character role I had made up. Therefore, there are portions which, misunderstood as being real and not acting, suggest that I really was at risk of killing someone. A paragraph or so later, it is made clear that such was not true. I thought that I might be more successful in getting effective treatment if Dr. B thought there was real danger of violence. In retrospect, in a psychosis-free state of mind, what I did was foolish, if not downright stupid. But, alas, I was very psychotic, and very psychotic people sometimes do foolish, if not downright stupid things. Otherwise, psychosis would not be a problem worthy of much, if any, attention. What I remember, however, accurately matches what I wrote in my journal. I made some journal
notes around ten o'clock, noted the time, and promptly fell asleep. About five minutes later by my watch, I woke up and realized that I had been dreaming, that I had experienced some fragments of a dream, and that it might be a good idea to remember it. I thought about the dream fragments to make them stick in my memory, and almost immediately fell asleep again. Another five minutes or so and I was again fully awake with more fragments to remember. This process repeated until about four o'clock in the morning. With each cycle of sleep, dream, wake, and remember, I became more and more depressed. Just before four, I was the most depressed I have ever been. About five minutes later, I woke up, the dream was complete, and my depression had vanished. And, I was not psychotic. What was the dream about? How did dreaming one night so change my life?

The next morning, Thanksgiving day, 1987, I described the dream to the one staff member who best seemed to understand and accept me. I told her that it had been like putting a thousand piece jigsaw puzzle upside down, so it was impossible to see the picture until the puzzle was complete and could be turned over. The puzzle was the puzzle of my life, of its fragmentation. Once I could see the picture, several things were obvious. The first was that I am an ordinary, run-of-the-mill person, that there is nothing special about myself. Also, in the picture was clearly shown that what had just happened to me was extraordinary indeed. I saw on one piece of the puzzle an absolute, eternal, unchangeable truth, an immutable law of the universe, and it was shown in two ways. The first way I previously called "The Fundamental Error of Social Reality," the second was previously called "The Law of Learning." To repeat, The Fundamental Error of Social Reality is the (mistaken) belief that it is possible to make mistakes which should or could be avoided. And, The Law of Learning is that learning occurs and only occurs when mistakes are made. I saw in the puzzle that I was hardly the first person to see this puzzle piece and also that no one before me had understood it properly. I saw that I, as others before me, had a chance to see what I could do with the ideas that The Law of Learning would generate. And, I saw that my life would be easier if I turned away from The Law of Learning as had others in the past. I also saw that, if I undertook to explore where the Law would lead, that life for others in the future might possibly become easier to vastly greater degree, in total, than my life would become harder. I decided to accept the challenge. The piece of the puzzle that contained the images of The Fundamental Error of Social Reality and The Law of Learning was at the pinnacle of the mountain I previously described metaphorically.

What had happened was clear to me; at least it seemed clear in my state of mind at the time. I was being given a once-in-forever opportunity if I accepted it. The Ten Commandments exist, they came into existence somehow. Perhaps there
really was a burning bush that Moses saw, perhaps the "finger of God" directly engraved stone tablets. Perhaps Moses dreamed of a burning bush so vividly that he could not know that it was just a dream. I was not there with Moses, and the picture of my dream did not answer the question. I did see that, if The Law of Learning and the Fundamental Error of Social Reality could be proven with robust and indisputable scientific rigor, that they together would form one of the truly great discoveries of all time. I wondered how Moses felt, assuming that Moses really existed, and that he first knew the Ten Commandments. In scripture, Moses is an extraordinary person. As I know myself, I am not. I was, however, to put it mildly, amazed and astonished. I set out to devise scientific experiments to validate or refute The Fundamental Error and The Law.

I quickly saw that the first experiments would have to be made with myself as both scientist and subject, since I considered it unethical to experiment on anyone else if I could prove the ideas wrong by myself. I set out to redesign my life in accord with my newly acquired knowledge. At the time these things were happening to me, I was deemed floridly psychotic, not only by my doctors, but also myself.

The following is excerpted from my journal writing on that Thanksgiving day, edited only to meet proper standards for confidentiality.

Psychotic illness is self-love and not self-hate, it is a way to save as much of oneself as one can. So I can have hope. There is no blame for me, for my parents...for anyone. (name edited out) said some people are duds and no one needs them. But there are no duds either, although people who believe there are duds perhaps come close.

In 1987, I had given the name, "Jane" to the personality with which I was born because, when I was a small child, boys were assigned the role of fighting and girls were assigned the role of being sensitive to themselves and others. Given that, and that I am not bisexual or transsexual, and that I used the name "Brian" for the facade I presented to others to conceal my being multiple, what I also wrote may be understood,

Brian decided he could trust Jane now so Brian died last night so Jane can be free now to grow up. Schizophrenia is feeling one way and thinking another. Jane is a complete person. Jane (me) chooses to have a male gender role and to be in that role heterosexual. Who is writing now—the Monitor (a personality that watches over the whole bunch of me)... Jane will keep the Monitor because, through the Monitor, Jane can keep the memory of Brian. I (Jane and the Monitor) can be happy now because we can get our needs met now—our needs are food and shelter and self-expression... Jane loves herself and is grateful to Brian for his help over the years. It is a neat experience to be able to pick and choose a personality, not as a child does by trial and error without experience, but as a child with adult memories and experiences available through the Monitor. I own myself, no one can ever again tell me that I am wrong about myself or my illness, I do not own my life, nor do I need to... I will remember Recovery's "The return of the symptoms is not the return of the illness," now that I am well, for I can make mistakes, I can have symptoms and it will be OK. Dr. Low said, "The last thing to change will be your beliefs," changing beliefs is being well when the beliefs are real.

On Thanksgiving day, I was well. I was at peace with my life, past, present, and future. I knew that every mistake made was necessary for learning what we, the whole family of humanity, need to know to build a kind, cooperative, decent
world community. I knew that I could remember my past, could find all the missing pieces, if I was patient, (Dr. Low had said, “If my patients had patience, I would not have patients.”) and made a proper effort (Dr. Low advised his patients to endorse themselves for making a proper effort). And, on that day, I was well, truly well, as well as I am now. But it was not to last. Dr. B decided to change my medication. He put me on a different anti-depressant, which had a tragic side effect. It flung me from mental health into full blown mania within a few days. And that led to my being given lithium carbonate. Which, alas, may well have turned slowly into an even greater, but largely ultimately reversible tragedy. With the new combination of medications, I was on the road to a severe to profound dementia.

Recovery saved me from disaster after disaster, for I had learned well how to trigger spot temper so well that I rarely showed psychotic or manic symptoms. I no longer had a schizophrenic psychosis, but I cycled in and out of mania. When I was manic, I often thought I was schizophrenic, for, to use another phrase of Dr. Low, when I was manic, my “imagination was on fire.” The use of the Recovery method did not address all of my difficulties when I became manic. In retrospect, I find the evidence clear that I had indeed become mentally well on Thanksgiving day in 1987, and that my subsequent illness was caused by and perpetuated by the medications I was given thereafter, for, when the medications were discontinued in 1989, I was “free of depressive or psychotic psychopathology,” according to the neuropsychiatrist who took me off the medications. For a couple days in 1987, I was cured of my mental illness. Alas, Dr. B misinterpreted my situation again, and changed medications. Alas, once again, I was regarded with incredulity when I accurately described my situation. Lithium apparently took away the mania seemingly caused by the new anti-depressant medication. It also seemed to take away my ability to recognize the nature of my illness, giving me some internal symptoms which were so severe that I came to sincerely believe that I needed the medications to keep from being totally overwhelmed by even stronger symptoms. The main symptom was a near total loss of a sense of being able to control my life combined with an inability to tell about my inner experiences in a way that anyone else could understand. I was not feeling psychotic, I was not feeling depressed, I was not feeling manic, I was not feeling happy, I was not feeling sad, I was not feeling. Without access to feelings, I had lost my “delusion detectors,” and was floundering without being able to understand or know why.

Without feelings, my outward behavior improved, and I was discharged from Hospital C. A few weeks later, I returned to work. For the first time in a year and a half, I could concentrate on my work. Alas, I could not perform my work at anywhere near the level I had worked at before the colon surgery, but I could work. In retrospect, I could work, albeit at
a poor level, because the combination of medications I was taking so muted my awareness that I was untroubled by my poor performance. Without working delusion detectors, I began talking about some of my psychotic experiences at work in ways that were massively inappropriate, in ways where I told of some of the fantasies and acting strategies I had used in attempting to be heard as though they had been real events instead of imaginings. This aberrant behavior was extremely upsetting to some of my co-workers, who began to wonder whether it was safe for me to be working around children, and brought their concerns to the attention of their and my supervisors. I have spoken to one co-worker recently, and it is clear that I was unable to convey what was troubling me accurately. I was asking for help without being able to know what help I needed or why I needed it. I was so concerned that I could become inappropriate that I became inappropriate because of the only ways I could find to express my intention to not become inappropriate. The biochemical imbalances caused by the medications I was taking so disrupted my ability to reason and to express myself cogently that, even though I had attained a good degree of mastery of Recovery methodology, I was powerless to use it much of the time. Put simply and directly, I was concerned that my deteriorated mental condition might lead to my behaving in ways that could “freak people out,” and the only ways I could find to express this valid concern, because of the effects of my medications, with the sole intention of preventing freaking out people, inevitably freaked out the people I most wanted to avoid freaking out. I had finally come across what seemed, every way I could test it in my poor mental state, a real paradox. Of course, I now know that the paradox was yet another delusion, I needed the time it took for someone to recognize that the medications were the cause of my illness and take me off them to have enough access to my delusion detectors to see the distortions that gave my life the subjective appearance of paradox. And, in 1989, the medications were discontinued and my mental illness slowly proceeded to vanish. In early 1988, when I was discharged from Hospital C, I could not know this, the future had not happened yet.

The problem of my inappropriate behavior at work grew and compounded. I was going regularly to Recovery meetings, trying to learn how to trigger the temper that led to my inappropriateness, and I could not find it. I began to question Dr. Low’s method for the second time. I understood very well that Recovery, used well, would tend to prevent rehospitalization, and I could not use it well enough. It was obvious to me that my situation was unlike anything Dr. Low had ever seen in some important aspects. The medications I was taking were not available in his time. He could not possibly have seen a patient in my condition. He could not possibly have understood what I needed because I was unlike anyone he had the chance to treat. I would have to base my life on what would be average behavior for someone like me. Only, I could not find evidence that there ever was anyone like me such that an average standard of behavior could be determined which fit my
situation. At work, my performance continued its downward spiral. Most of my inner experiences were becoming too bizarre to use as Recovery panel examples, so I could no longer use Recovery meetings as a way to improve my contact with reality. In the summer of 1988, I was again admitted to Hospital B, admitted directly to the intensive care unit.

One thing stuck with me through the entire winter, after Thanksgiving, and spring of 1978-88. It was the realization that I, like everyone else, was actually doing my very best at all times, once proper consideration was given to a total view of my circumstances. This is a corollary of The Law of Learning and The Fundamental Error of Social Reality. Regardless of my state of mind or my external circumstances, I stayed centered on the knowledge that whatever I could actually do would be good enough, no matter what happened.

2.16 Hospital B, third time

It was my sixth psychiatric hospital admission in less than two years, and Dr. B was concerned that I might be among those who never regain social competence and so require institutionalization for the rest of their lives. He called in several consultants who evaluated me and reviewed my record. He reported that there were some things that had not yet been tried, including electro-convulsive therapy (ECT), but also that the consensus of the consultants was that I might well be among the very few patients who would constructively benefit from a prefrontal lobotomy. He indicated that such treatment would be done only as an act of compassion, to relieve me from the horrible terrors of my psychosis, and would only happen if all else had failed. He indicated that he thought that I was most likely going to be institutionalized for the rest of my life, but there was some chance of avoiding this. Dr. C told me that he thought my last hope to avoid spending the rest of my life in a back ward of a state hospital was entering a long-term program for the severely chronically mentally ill, and that there were three programs he thought worthy of consideration. The closest was at the Menninger Clinic in Topeka, Kansas. The second was at Chestnut Lodge, in Baltimore, Maryland, the hospital where Hannah Green/Joanne Greenberg lived the events of her book, I Never Promised You A Rose Garden. (Greenberg, 1964) Incidentally, I had read her book shortly after it was first published. The third long-term hospital was Austen Riggs Center, in Stockbridge, Massachusetts. Dr. C said he thought Austen Riggs would be the best place for me, but it was relatively small and selective. Applications were sent to all three, all three indicated willingness to accept me as a patient. The decision was made to go to Austen Riggs, and I was discharged from Hospital B so I could go to Riggs.
2.17 **Austen Riggs Center**

Hospitals A, B, C, and E are made up identifiers, in chronological sequence. Except for Austin Riggs Center (which, if its identity were concealed, would have been designated as Hospital D), I have no permission to identify them, nor would it be proper to do so. They all were truly excellent facilities during the times I was in them. The staff members were genuinely caring and concerned people, and those hospitals were adequately staffed. I met many patients who had been in state hospitals, before getting into Hospitals A, B, C, or E, and they told me that conditions were terrible in the state facilities. In the fall of 1989, I briefly did volunteer work at one of the nearby state hospitals, and the conditions were as the patients had said. I had been assigned to work in a children's unit with the computers in the hospital school's computer lab. Hospital regulations required that a staff member be present whenever a volunteer was working with children. But the staff left me alone with the children. I pointed out to my immediate supervisor that this was illegal. It turned out that the main reason the school staff wanted someone to volunteer to work with the children and computers was to get time away from the children, and if that was not going to happen, they had no need for a volunteer. I have decided to mention Austen Riggs by name to give proper credit to the Center, so that the merits of the unique aspects of treatment there can have a better chance to be properly recognized by those in the fields of psychiatry and psychotherapy. Austen Riggs is unlike any other psychiatric hospital I have ever heard of, to the best of my present knowledge, it is utterly unique, and uniquely effective for some patients, who, after having been treatment failures time after time elsewhere, do achieve essentially full recovery at Riggs.

After I was admitted to Austen Riggs in the late summer of 1988, I was advised that I would probably be there for three to five years, based on my history, but that I would probably get well within that time frame. I was the oldest patient there while I was at Riggs, and, as far as I could tell, the most impaired. I was discharged ten months after I was admitted because my overall condition had deteriorated so severely that I was no longer safe in an open hospital setting, and my mental abilities were so poor that I seemed unable to benefit any more from treatment there. When I was discharged, outward appearance would have it that I had once again been a treatment failure. Outward appearances can be deceiving; they often were in my case. The psychotherapy treatment I received at Riggs was near-optimal for me and it worked superbly, but it took about a year after I had been discharged for this to become obvious. To understand what happened while I was a patient at Austen Riggs, the experiments I made while there and the results of those experiments, I think a fair amount of context is essential.
The core paradigm of treatment at Austen Riggs is psychoanalytical, although the concepts of personality and the techniques of psychotherapy bear little resemblance in significant ways to Freud's model and methods. Austen Riggs is an open hospital, the patient rooms are neither locked nor, for that matter, lockable. There is no need for such locks, one of the rules at Riggs is respect of other people and their property and privacy. And, there is ordinarily little problem with such respect, it seems to be natural in the open hospital setting at Riggs. While I was there and shortly before I arrived, there were two fires, both arson, the first one seriously damaged one patient room, the other caused minor damage to The Lavender Door building. Locking rooms would not have prevented the fires, but would have destroyed the sense of community that makes Riggs an effective therapeutic community. After the second fire, the identity of the arsonist was rather obvious, based on who had been where at the time of the fire, and the formal, established hospital grievance management process, which was the mainstay of conflict resolution among patients or between patients and staff, was used successfully to preclude any more such fires. Austen Riggs does not take children as patients, although many patients are older adolescents. Patients are told upon arrival that they will be personally responsible for most of their lives while at Riggs, and that increasing responsibility will accompany increased capacity for responsible behavior. The most troubled patients are treated as real and valid persons from the moment of their arrival.

When I was there, Austen Riggs had a patient handbook, named the Orange Book for simplicity, as that was the color of its cover. It was a reasonably detailed manual about how to live successfully at Austen Riggs Center. Near the beginning of the Orange Book was a section about the philosophy of the Center. My understanding of that philosophy is: As children, people develop patterns and habits which are dependent on their particular circumstances and which allow the child to function in his or her environment. In adolescence or adulthood, circumstances sometimes contrast with those of childhood to such a degree that the adaptive strategies developed in childhood no longer are an adequate basis for functional life. At the Austen Riggs Center, living in the patient community, with realistic responsibilities, people can replace no longer adequate habits and patterns with ones which are adequately functional. Erik H. Erikson worked at Austen Riggs from 1950 to 1960 (Kaplan and Sadock, 1995, p. 484), and his "epigenetic" theory of psychosocial stages of ego development was a large influence at Riggs when I was there. Erikson's stages (Steinberg, 1989, pp. 248-261) are of the resolution of developmental crises, each one dependent to a degree on the successful mastery of prior stages. Unlike Freud's psychoanalytic model, in which development essentially ceases in adolescence, Erikson noted that growth and development can and usually do continue throughout the whole of life. Freud assumed that development was deterministic. Erikson recognized that choices strongly
influence development, and therefore psychotherapy can effect meaningful change in personality structure even in late adulthood in troubled people. The first stage is between being trusting or mistrusting. Trust enables having a realistic sense of hope. Mistrust is the basis of psychosis, addictions, and depression. Trust enables an effective perspective of time, mistrust causes confusion regarding time. Trust permits mutual recognition between persons, mistrust, at the extreme, leads to autistic isolation. The second stage is between an adequate sense of autonomy or an inadequate sense of selfhood because of shame and self-doubt. Autonomy allows a viable will to effort, shame and doubt form the basis of paranoia, compulsions, obsessions, and impulsiveness. Autonomy allows effective self-confidence, shame and doubt cause self-consciousness. The third stage is between having initiative or guilt. Initiative allows a useful sense of purpose, guilt is the basis of conversion disorders, inappropriate inhibitions, psychosomatic conditions, and phobias. Initiative allows experimenting with new roles during further development, guilt leads toward fixation of roles. The fourth stage is between industry or inferiority. Industry leads to a sense of competence, inferiority is the basis of inhibition of creativity and emotional and intellectual inertia. Industry allows learning work skills as though in an apprenticeship, inferiority leads to a paralysis of learning work skills. The fifth stage is between an adequate and dependable sense of identity or identity confusion. Adequacy of identity leads to fidelity, identity confusion is the basis of delinquency, gender identity disorders, and psychotic episodes. The sixth stage is between intimacy or isolation. Intimacy leads to effective capacity to love oneself and others, isolation is the basis of schizoid personality disorder, distimulation, and racism. The seventh stage is between generativity or stagnation. Generativity leads to caring, stagnation is the basis of mid-life crises and premature invalidism. Generativity enables leadership and followership, stagnation leads to abdication of responsibilities. The eighth stage is between integrity or despair. Integrity leads to wisdom, despair enables alienation. Integrity, allows commitment to ideals, despair to confusion about values. The explicit and implicit assumption built into the methods at Austen Riggs Center was that learning is possible at any period throughout life if the circumstances are favorable to learning. Further, that mental illness is an expression of learned behaviors which can be unlearned in a suitable setting and replaced with more effective and efficient learned behaviors. Freud’s attributions about personal difficulties were dispositional, he tended, as I see it, to blame the victim almost mercilessly. Erikson’s attributions about personal difficulties were primarily situational, thus changing situational factors would allow overcoming the difficulties. Based on my life and my observations, I can put it very simply. In essence, Freud was very wrong, and Erikson very nearly correct. The Fundamental Error of Social Reality and The Law of Learning are situational, not dispositional, and I can and will demonstrate how such situational factors are capable of causing every form of what we usefully called mental illness.
Before I arrived at Austen Riggs, I thought that, in a hospital where there are patients who, like me, had repeatedly been treatment failures at very good ordinary hospitals, I thought I might finally find one or more patients whose illness did not have primarily psychosocial etiology. I was mistaken, I could see the unresolved psychological pain which led to illness in every patient at Riggs, except, perhaps for myself. I realized that my illness started with morphine given to me because of pain after my colon surgery. I was unwilling to be taken off the medications at Austen Riggs, in an open hospital setting because I could not be certain that I could control my behavior enough without the medications. The medications had been very carefully titrated by Dr. B, balancing symptoms, and I continue to believe that it would have been malpractice to discontinue them in an open hospital setting, given my history.

At Austen Riggs, the main experiments I made were in exploring what my life would become as I put into everyday practice the idea that no mistake made could or should have been avoided, regardless of the nature of the mistake or its consequences. I had wondered whether putting such a belief into everyday practice would tend to turn me into a hedonistic narcissistic anarchist, or whether it might lead me toward a more meaningful, cooperative, and caring life for myself and those around me. It seemed to me that if Freud’s model were correct, the belief that no mistake could or should have been avoided would push me toward the first direction, toward self-worship in service of the pleasure principle, and if I had correctly observed that every young baby I had ever observed was faultlessly assertive, and so newborn babies minds were only naive ego, then I would head for the second direction, toward the building of decent community. I collected all the observations I could remember about the human condition, and several things became obvious. Everything a person learns is yet to be learned prior to conception, and at some point, perhaps at conception, perhaps not until the embryo stage, perhaps not until the fetal stage, but somewhere, learning begins. It does not really matter where or when. No one can learn that which their circumstances disallow coming to know. All scientifically supportable cosmologies suggest a beginning for the universe, and all the historical, archeological, and anthropological records support the idea that there was a beginning for humanity. During the time when there were no people, the aggregate total of human knowledge was zero because there were zero humans who could have knowledge. Conversely, if humanity has been around forever, we would have learned everything that can be learned long ago. It is directly observable that new knowledge is discovered on a regular basis. What sets the boundary of knowledge but the amount of time that has been available for the garnering of knowledge? I found that, as I learned how to put into everyday practice the belief that no mistake made could or should have been avoided, I became more aware of myself.
and others, more caring and concerned and more hopeful. I found that I was coming to accept with equanimity the life I could actually live. I became inwardly more serene and at peace and more involved in my environment.

It was helpful to have more inner peace, for I found that things I used to be able to do easily were becoming hard. I started having trouble calling home, I could not keep track of dialing a telephone number. For this, I found a temporary solution, a telephone which could be programmed to place a call home by pushing a single button. My psychiatrist began talking about “my dementia,” and its being the reason I had trouble dialing a telephone. I collected my thoughts and realized that Dr. Low had been accurate, every patient at Austen Riggs had a problem with temper which led to symptoms. I ran the regression process to what seemed to be preverbal times. It occurred to me, in talking with other patients at Riggs, and from what I had learned previously, that temper is always grounded in a combination of mistrust, shame and doubt, guilt, inferiority issues, identity confusion, isolation, stagnation, and despair. If so, then mental illness always had psychosocial etiology. Most people I have asked have assured me that they do not remember their very early childhood and infancy. I set out to see whether this was correct or an error. It seemed to me that, if one does not remember early childhood, from where does the ability to speak language come from, why are we not all mute? When I ran regression earlier than about a year and a half, I found a paucity of word memories. I found instead kinetic memories, spatial memories, memories of feeling safe or feeling unsafe, memories of feeling comforted or feeling alone. It occurred to me that the reason people believe that they do not remember their early childhood is because they are looking for words and word-associated memories, which would not be created prior to sufficient acquisition of language skills.

Erik Erikson gave the following approximate typical age ranges for each psychosocial stage of his epigenetic system. The trust/mistrust issue is the focus from birth to about 1 ½ years. Autonomy/shame-doubt is the issue from about 1 ½ to 3 years. Initiative/guilt is the concern from around 3 to 5 years. Industry/inferiority is the stage from about 5 to 13 years. Identity/identity confusion is the stage from about 13 to 21 years. Intimacy/isolation is dealt with from about 21 to 40 years. Generativity/stagnation is from about 40 to 60 years. After around 60 until death, integrity/despair is the final stage. What is noteworthy is that the trust/mistrust stage is mostly done during the child’s pre-verbal time, according to Erikson. Since people vary in degree of trust versus mistrust, and, outside of an experience or set of experiences of sufficient intensity and duration that the first stage is revisited and reformulated, the tendency for trust or mistrust acts as though it is a stable personality trait. For people who can not accept the idea that preverbal memories are vividly remembered in adulthood in
terms of such traits, those traits will appear to be biologically based because the person will be blind to the psychosocial etiology of the traits. Non-verbal communication, the only communication available to a newborn since the associations between real objects and verbal symbols has not had time to develop, continue throughout life, supplanted but not replaced by verbal language. Early in my psychiatric hospitalizations, I had noted that many people who had a schizophrenia diagnosis conveyed very different messages verbally and non-verbally at the same time, if the mood of the two messages contrast sufficiently, this condition is called “inappropriate affect,” in the DSM-III-R and DSM-IV, inappropriate or flat affect is one of the diagnostic criteria for disorganized type schizophrenia. There is evidence that for most right-handed people, verbal-intellectual knowledge is a left-hemisphere function and affective-artistic knowledge is a right hemisphere function.

The psychoanalysis I received at Riggs was rather like an ordinary conversation in most respects. The analyst and the analysand were free to look at each other at will, and both verbal and non-verbal communication were important. Sometimes my analyst would speak about an idea he thought helpful for several minutes at a time, a very effective strategy that in no way resembled the Freudian style analysis I suffered from as a Carleton College student. Austen Riggs Center is sited on Main Street in Stockbridge, the workshop facility is in the central business district of Stockbridge, not quite a block from the Austen Riggs campus, and it has a store-showroom for articles made by patients and, sometimes, former patients. The store-showroom shop building looks like a regular commercial enterprise from the outside, and is named The Lavender Door. Stockbridge is a major tourism site, Norman Rockwell, the artist, lived there and the Norman Rockwell museum is one of many nearby attractions. The Lavender Door store-showroom is run by Austen Riggs patients. The patients went about their activities in much the same way as other people who lived in Stockbridge, with the exception that they lived and usually ate at the Center. While at Riggs, I observed quite a few patients become, for all practical purposes, cured of schizophrenia, and every single person who achieved a state of cure had replaced the beliefs that made them ill with ones that made them well. There were no patients at Riggs whose illness had any form of biological etiology other than the ability to adapt with their particular form of mental illness as an adaptive survival strategy earlier in their lives, and they became ill when the changing responsibilities of the child to adult transition left them without the skills to function adequately and appropriately in the role of a grown-up. Again, there were no exceptions to this that I could observe.

There may indeed be people whose illness is biologically caused, and who would have become ill regardless of circumstances, but I think such people would have such severe and obvious neurological deficits that they would be regarded
as retarded very early in life. One problem, one catastrophic problem with the classification system of the DSM-III-R and DSM-IV is the blurring of experiential environment and biological environment. I would like to comment on this briefly, as a short side trip. Stephen Matthysse, Ph.D. in the chapter, “Overview and Discussion” of Watson (1996) states,

When I first became interested in schizophrenia, people were still pursuing will-o-the-wisps like ceruloplasmin and taraxein. We are not chasing ceruloplasmin and taraxein any more, nor are we studying wasting cells, double binds, or synaptic slippage. (Italics added - jbhh) Schizophrenia research is no longer an embarrassment, because it has achieved a healthy relationship with basic science.

That schizophrenia is caused by double binds can clearly be demonstrated once a psychotherapy method has been invented which resolves the pain of double binds and so allows a patient with schizophrenia to change the beliefs which are schizophrenogenic to ones which are “mental-healthy-ogenic.” To understand this, it is necessary to understand what happened on the lives of those who have achieved robust mental health after a long episode of severe schizophrenia. An example is Dr. Carol North, of Washington, University, St. Louis, Missouri, who wrote the book, Welcome Silence, about her experience with schizophrenia and her subsequent mental health. She believed that some blood factor was causing her illness, underwent dialysis, and became well. In her book, she hypothesizes that the filtration membrane was just suitable to do the right filtering, but I note that she describes the changing belief process in detail without apparently having been consciously aware of quite what she was writing. Until there is a method which unambiguously and accurately classifies both psychosocial and biological-genetic factors, psychiatrists and psychologists and other researchers in mental illness will chase after will-o-the-wisps, sincere in their beliefs that they are not doing so, and tragically mistaken. The profound flaw in all correlation studies is that one cannot discern the horse from the cart, one cannot determine what is cause and what is consequence.

Consider the common observation that enlargement of the cerebral ventricles is correlated with schizophrenia. Van Horn, et al. in Watson (1996, p. 406),

Examinations of home movies from families with a child who later became schizophrenic have indicated that the affected sibling can be reliably identified among other children on the basis of soft neurological signs and patterns of social interaction. These studies indicate that the neuropathologic changes associated with schizophrenia are likely to be present long before the onset of debilitating illness.

If a child learns that mistrust is a more satisfactory adaptive strategy, because of environmental neglect and abuse, than trust, and this lesson is mastered in pre-verbal times, the neuropathologic changes would be initiated so early in life as to mimic biological dispositions. First of all, the term, “enlargement of cerebral ventricles” is a euphemism for “loss of brain tissue.” I hear a bias here, enlargement sounds so much better than loss.
Van Horn, et al. continue,

Current models of the etiology of schizophrenia generally propose that a subtle abnormality during fetal development, possibly occurring during the latter half of pregnancy, affects the development of cortical structures. Although only circumstantial evidence currently exists to support this notion, animal data have suggested that developmental cortical lesions, especially involving the limbic cortex, is the best animal model of schizophrenia.

Lesions induced in rat brains with ibotenic acid, causing significant brain damage, can not quite be what happens in utero with human fetuses. Among the greatest logical fallacies of the medical model, in its many variants, is the confusion of condition and cause. As an example, if poverty caused crime, all the poor would be criminals. With only correlations for a basis, there is no way to tell whether schizophrenia causes brain damage or brain damage causes schizophrenia. To tell the horse from the cart, it is essential to understand the mechanics of the process under analysis, correlations alone simply cannot do this. The medical model of mental illness, without more than “circumstantial evidence,” is only an exercise of the “Petitio principii type I form of Begging the Question, wherein the premise is repeated in the conclusion under the guise of a logical argument.

I am certain beyond doubt that biological factors have a profound role in severe mental illness; at issue is not whether such factors are important, rather, the question is what role they play. By the time I went to Riggs, I was well satisfied that the medical model of mental illness was gravely in error. I had come to suspect that the real biology of schizophrenia was the neurological capacity to protest subjectively experienced abuse in ways that others interpret as signs of schizophrenia. If so, and if, without such genetically allowed expression, the abuses that I thought could be causal for schizophrenia would be impossible to find and correct. I am not a pessimist. A pessimist, so the story goes, sees a glass filled halfway with water and bemoans the sad fact that it is half empty. Of course, the optimist sees it as half full. The problem with pessimists and optimists is that neither can see the whole of anything, both are out of touch with reality. A realist, seeing the same glass, reflects on his need for both air and water, and notes that the glass is full of things which can meet his needs. The medical model is, to me, massively pessimistic; barring eugenic genocidal measures such as psychiatrists in Nazi Germany tried, without achieving significant subsequent reduction of rates of mental illness in Germany; barring a practical way of gene-splicing to profoundly modify large regions of the brain; barring the availability of a useable brain prosthesis— I find the medical model to be very disparaging of purpose and meaning in human life. The model I was developing when I went to Riggs was based on real and observable opportunities, on the directly observable capacity of humans to learn, and seemed to point toward a future where life could have higher quality than at the present. I did not deny the difficulties, I was not an
optimist; I did not deny the opportunities, I was not a pessimist. I went to Austen Riggs as a realist, one whose reality was soon to undergo dramatic modification.

I had read about Erik Erikson's work years before I went to Austen Riggs, and thought it made vastly more sense than any other psychoanalytic model I had heard of. I then set out to see whether mental illness could be accounted for by known biological mechanisms, without resorting to hypothetical entities whose existence is only speculative. At the time I had studied physiology, electrotonic conduction was considered not to be a significant mode of transmission of information between neurons in the brain. More recent information allows some electrotonic effects through the action of amacrine cells, which lack axons. (Berne and Levy, 1993, p. 103) Using what I knew in 1988, I saw, on a biochemical basis, three variables which would have the main effects on central nervous system (CNS) inter-neural transmission. For a particular synapse, they would be the nature of the post-synaptic receptors, which determines whether a particular neurotransmitter will be excitatory or inhibitory, and the synaptic junction inhibitory neurotransmitter level, and the synaptic junction excitatory neurotransmitter level. Synaptic CNS transmission is an all-or-none response mechanism (Berne and Levy, 1993, p. 39) such that synaptic transmission depends roughly on the difference between inhibitory and excitatory neurotransmitter levels. The third variable in CNS transmission is the connectivity of the neurons, and this, in the human brain, is mathematically intractable with present-day computing capabilities. There are too many cells in the brain and vastly too many possible dendrites to have any chance to understand overall brain connectivity to the degree necessary to understand in precise and accurate detail how the interconnectedness of the brain affects mental illness. From neurology studies, however, there has been coarse mapping of the brain. In addition to numerous articles in Science and Scientific American, I had read Oliver Sacks' The Man Who Mistook His Wife for a Hat and Other Clinical Tales. (Sacks, 1985). Allowing for the moment that the connectivity determines which cells can communicate with each other, and that learning probably involves modification of synaptic connectivity, there is a basis for information to be arranged in the brain in a structured manner as shown by the effects of brain trauma as studied by neurologists. I wondered, since physical trauma damages the brain by changing its connectivity, could psychological trauma damage the brain as an evolutionary adaptive process that tends to minimize overall damage? I had seen many patients diagnosed with schizophrenia and given anti-psychotic medications develop serious side effects, including one person, a good friend of mine at Riggs, who had severe tardive diskinesia. I reflected, if anti-psychotic medications correct a fundamental genetically-based biochemical imbalance, why do not most people have tardive diskinesia? Clearly, if the
medications correct imbalances in some parts of the brain, they create serious imbalances elsewhere, at least in those people who develop serious and harmful side effects.

Having worked in pediatric cardiology, I knew about atrial and ventricular fibrillation from more than studying physiology. Atrial fibrillation is commonly not life threatening, ventricular fibrillation is rapidly fatal unless it is stopped, I had seen several patients who had gone into ventricular fibrillation and were successfully defibrillated. Fibrillation was described in the physiology courses I had taken as a “circus rhythm,” in which excitable tissue excites nearby excitable tissue in a cycle that roughly repeats in local regions of cardiac muscle, preventing the heart muscle from acting in synchrony, and thereby preventing the heart from functioning as an effective pump. The brain consists in large measure of excitable tissue connected to excitable tissue. This led to speculating about the merits of the double-bind theory of schizophrenia as an explanation of the not only the biological mechanism of schizophrenia but also of the side effects of medications given to control schizophrenia. If a double bind were to set up a circus rhythm in the CNS, the circus rhythm could lead to biochemical (neurotransmitter) imbalances. Furthermore, if a psychotherapy method could be invented which modified the structure of the brain through learning new habits of thinking and so broke the structure that enabled the circus rhythm, this would target only those parts of the brain that were imbalanced and would not affect the rest of the brain. I had a clue in knowing that no mistake made could or should have been avoided, and I knew that believing otherwise tends to lead to abuse. I let my imagination wander and recognized that schizophrenia could possibly be caused by subtle forms of a pattern, which, simplified, creates an obviously impossible situation. Suppose a child comes to believe that those who, in the transactional sense of Eric Berne (Berne, 1964), are commanding him or her, “Don’t do what I tell you to do, or else, and, if you disobey me, I will make you suffer until you learn to do as I tell you.” Put that way, it is ludicrously absurd. What would subtle forms be like?

A child being given corporal punishment is told, “You should never hurt people, you hurt me, so I am going to punish you, so you learn not to hurt others. I am spanking you for your own good, it hurts me more than it hurts you.” That happened to me (the words are not exact, but close) when I was in second grade and objected to being verbally abused by my teacher. She took me to the principal’s office at the end of the school day and paddled me while the principal watched. I had not learned enough about abuse to understand this incident until I was at Riggs, that is why I relate it here in detail.
I had missed two or three days of school because of a bad cold, and it was my first day back. Shortly before I had become sick, I had made some art projects of colored paper that I thought were very pretty and which I meant to give to my mother. The school desks were the sort which have a hinged top and a storage area under the top where books, papers, and other personal school supplies can be kept. I had several pencils in the storage compartment. At the beginning of the day, the teacher gave me the art work and told me to put it away. I had forgotten about it when I was sick and looked at it for a few seconds before putting it away. The teacher loudly reprimanded me for disobeying her. I put the artwork away, and went on with my work. The pencil I was using got dull, and, rather than get up and go over to the pencil sharpener, I lifted the top of my desk to get another pencil. The pencils were underneath the artwork, I had to move it to get another pencil. The teacher again loudly accused me of willful disobedience and gave me no chance to protest that I was simply getting another pencil. She warned me not to play with the artwork again. I got involved in the lesson and the seatwork that went along with it, I became so engrossed in what I was doing that I pressed too hard with the pencil and the tip broke. Unaware of the imminent consequences and focusing on the task at hand, the lesson, I again lifted the desktop to get the third pencil so I could keep working on the lesson. The teacher shouted at me for my utter disregard of the need for obedience, strode over to my desk, grabbed the artwork, tore it up before the whole class and said something like, “Now you know what happens to people who are disobedient.” I protested that I had only been getting a pencil. She retorted, “I know better than that. You are going to get a paddling.” As I am writing this, I pause from time to time to put to rest the remembered rage and frustration of that time. The memory is vivid. But, now I know that the teacher did not know any better, that she could not have done any better because of things that happened to her over which she, when younger, was powerless. I think she scapegoated me with the frustrations of her life because she had no better way to cope with the psychological abuse of her own childhood. True forgiveness is a remarkable thing, so I find. I can freely remember the intensity of feeling of that incident, and can feel that intensity fully right now as I write this sentence. But I know that the harm is in the past, it has no present danger for me, I no longer need to fear those feelings and so can accept them as an important part of my life. For me, forgiveness gives me the freedom to remember any event that comes to mind from my past, no matter how badly I was hurt, and I am not hurt now by the memories. Quite to the contrary, being free to remember is the one way I have to experience genuine inner peace in the present moment.

I find there are numerous litanies of the form, “Don’t do as I tell you to do, or else...” Among them are: “You should have known better.” (The impossible standard, one has to know something before the chance to learn it came along) “I’m
ashamed of you, what will other people think?" (An example of The Fundamental Error of Social Reality) “Why didn’t you do your best?” (A violation of The Law of Learning) I observed the following several years ago. A young father was outdoors with his two year old son shortly after it had rained but before the puddles had dried up. The boy splashed though a puddle, which he had never done before, and found his feet were wet and uncomfortable. When he complained to his dad, the father replied, “You should have thought of that first.” There is a curious thing about scientifically true laws of nature. They do not break. Try hard enough to break a law of nature and things break instead, people break instead. In the early days of psychedelic drug usage, I heard a story of a person who, in an LSD induced florid psychosis, decided that human flight without an airplane or such was now possible, and tested this by jumping from a height of about sixty stories. The flight was approximately parabolic, influenced somewhat by prevailing wind and even more by approaching terminal velocity. One could surmise the person thought, while traversing the height of the first story, “So far, so

It stops there. The last sentence of the prior paragraph is complete, it was a death sentence. That is angry humor. Yes, I feel angry. But anger signals something wrong that happened in the past that has not yet been resolved. On the psychotropic medications which I took in compliance with medical advice, I deteriorated to a mental function level not a lot higher than the person in the story who jumped and never got to finish the thought which would have been, mistakenly, of course: good.”

When I was on the medications at Riggs, I knew that it would be medically inappropriate to discontinue them in an open hospital setting. The dementia I developed is not a recognized side effect of the medications I was taking, according to the information in several editions of the Physicians’ Desk Reference. But I did become demented while taking psychotropic medications, and the dementia largely reversed when the medications were discontinued. In May, 1989, I was discharged from Austen Riggs because of the dementia.

2.18 **Hospital E**

A few weeks later, I came under the care of a neuropsychiatrist, Dr. E, at Hospital E. I could not add 5 and 6 the first time I was given a battery of psychological tests shortly after admission. Over a period of about two weeks, all the psychotropic medications were discontinued. My intelligence began to climb. I remembered something of how to add, and worked on addition tables in my head. After a few days, I started on multiplication tables and learned again how to multiply numbers. I practiced in my mind dialing a telephone until I could hold seven digits in “short term memory.” I started thinking about electronics and electronic parts and how to use them. I worked fiercely, persistently, putting together my fragmented
memories, for, off the medications, I could learn and relearn things faster than they were disappearing. During the last month of two at Hospital E, my IQ score climbed to 78, which a staff member described as "the difference between night and day," comparing my condition then with how I was when admitted to Hospital E. When I was discharged, Dr. D said that I was capable of self care, which was not true when I was admitted, also that I was free of depressive and psychotic psychopathology. In other words, I was mentally healthy, and had intelligence within the range considered normal. In mental retardation, mild retardation is an IQ of 50-55 to about 70, moderate 35-40 to 50-55, severe 20-25 to 35-40, and profound an IQ below 20. With the medications, at the age of 50, I was less functional than most five year old children, less able to do arithmetic, less aware of who or where I was than a typical kindergarten student. It would seem that the medications caused for me profound impairment. About a year after I was discharged from Hospital E, I returned for neuropsychiatric testing, my IQ score was 140, sufficient, barely, to qualify for Mensa membership.

What happened during that year? I studied engineering books I had used in my undergraduate and graduate education, I read extensively both familiar and new books, I worked ten to twelve hours a day on regaining enough functional intelligence to see if I could do scientific research on the things I had learned while I was psychiatrically hospitalized. Shortly after I was discharged from Hospital E, I went to the state Department of Rehabilitation Services to seek rehabilitation assistance. They evaluated my history and eventually told me that I was too impaired to benefit from any of their programs. So, it was up to me, and I set out to devise a rehabilitation program on my own. While I was at Austen Riggs, the equipment and data thus far gathered for the bioengineering Ph.D. cardiology thesis research had been discarded. Nothing was left from over three years of thesis effort. Further, while I had been away, the position I had held for almost twenty years was eliminated by the hospital administration. I had no thesis left, I had no employment except what I could do as a self-employed person. I owned a computer bought in 1983, it used the CP/M operating system was thoroughly obsolete in 1989, and my mother helped me get a modem (in 1989) computer so I could become familiar with computers that people were actually using. During the fall of 1989, I learned about the operating system of the computer and developed proficiency with several application programs. I applied to the Master's Degree in Education program at the University of Illinois and was accepted. I took two classes in the spring of 1990 and received an "A" in one class and a "C" in the other, not too bad for a former "imbecile," all things considered.
2.19 Hospital A, second time, major surgery

I registered for the summer, 1990 quarter, to continue toward the M.Ed. degree, only to learn that I had developed a duodenal polyp on the ampulla of Vater because of Gardner’s Syndrome, and that it needed to be removed promptly to prevent cancer. For the second time, I underwent major abdominal surgery, this time at Hospital A in a surgical unit. I was told that, depending on the pathology assessment of the margins of the polyp, I might need Whipple’s operation, which includes removal of the duodenum, usually the pancreas, and gall bladder, and often the lower part of the stomach. Fortunately the margins of the polyp were normal cells, and I only had a polypectomy. For the second time, I was given morphine for post-surgical pain; for the second time, I experienced a morphine-induced psychosis. As in 1986, the psychosis had features that generated, as I experienced them, intolerable levels of anxiety. I told my surgeon that I needed anxiolytic medication. He did not agree. Perhaps he thought that psychotropic medications would cause me to revert to a demented state, I am not sure. I protested that he needed to call my psychiatrist. He did, but he told the psychiatrist that I was doing fine without such medication. He was wrong. But my psychiatrist, on being told that I was doing fine without medication, and having been the one who initially prescribed the medications which evidently caused my dementia, concurred with the surgeon. I had developed a subcutaneous infection in the abdominal incision, and, because of the morphine-induced psychosis, was experiencing unmanageable flashbacks to the time when I was becoming demented, I feared it would start all over again. After several days of pleading for help with the anxiety, when one of the doctors came in to change the incision dressing, I told him, “I have told you time after time that I am having impossible-to-manage anxiety. I am at the point where I will no longer be able to control my behavior.” Once again I was treated (mistreated) with incredulity. The doctor gave me a mild sedative and changed the dressing. I seemed to fall asleep while he changed the dressing, and did not “wake up.” After about half an hour, the doctor left, and my mother, who was visiting me, came into the room. I was removing the nasogastric tube and the feeding tube because they seemed to trigger the flashbacks when I tried to rest. Only, I was not taking out the tubes, an entirely new personality was. Years before, shortly after my father’s liver resection, when his doctors mis-diagnosed peritonitis as a bowel obstruction, he had pulled out his nasogastric tube in a semi-alert state, and it was a horrible experience for him when it was replaced, in part because his throat had become very sore from being rubbed by the tube. I had promised myself that I would never pull out any such tubes, no matter what. I would not break that promise under any conditions. So, when it appeared to me that I would soon be in an agitated catatonia with totally unpredictable behavior that could be violent enough to be lethal, I made a new personality that had made no promises in response to subjectively catastrophic stress. My mother noted that “I” was being very careful in what “I” was doing, but she asked, so she told me later, if she should get a
nurse. She told me, "In a voice I never heard before, you said, 'You better not.'" She went out to the nurses' station anyway, where she was told that they were busy, and "Your son will have to wait." However sincere the nurse was, she was wrong, I was not waiting. I could not wait. I know I could not wait because I did not wait. To believe otherwise would be to regard The Fundamental Error of Social Reality as though it were "The Fundamental Truth of Reality." This I would not do then, this I will never do as long as I have any significant capacity to reason and understand.

The statement, "I knew I could not wait because I did not wait." merits, I think, clarification. It is commonly thought that we make choices and so could have done differently than we actually did. Thus, we punish people in courts of law for making mistakes which should not have been made. The so-called "insanity defense" is based on the idea that some people are insane and so cannot be held accountable for their behavior. From Kaplan and Saddock (1995, p. 2764), regarding the mental competence of a criminal defendant, according to the M'Naghten rule,

The important point here is that the proceedings resulted in a definition of insanity as a defense against criminal responsibility. A person, according to the ruling, is not responsible for an otherwise criminal act if, by virtue of mental disease or defect (two archaic but persistent legal terms for mental illness and mental retardation, respectively), he or she did not know the nature and the quality of the alleged act or did not know that the act was wrong.

The irresistible impulse rule is also described by Kaplan and Saddock (1995, p. 2764),

The irresistible impulse standard is sometimes applied in conjunction with the M'Naghten rule as an ancillary theory of the insanity defense. According to the irresistible impulse standard, a person who succumbs to an irresistible impulse leading to the alleged act is not responsible for that act. Certain crimes of passion may fit that model.

One problem with the rule is immediately apparent; how to distinguish an impulse that was truly irresistible from an impulse that was simply, for whatever reason, unresisted. That concern has led to some public and scholarly dissatisfaction with the standard.

Consider that I may have experienced an irresistible impulse when I pulled out the tubes. How can I know whether the impulse was resistible or not? There is a simple way to tell, but it makes a shambles of some of the practices or contemporary jurisprudence in the United States. I know the impulse was irresistible because I did not resist it. It was resistible until I ceased to resist it, and, at that time, the impulse became irresistible. An impulse may be resistible at one time and not at another because of changing circumstances. As a definition, I consider all impulses which were not resisted to have been irresistible at the time they were not resisted, and all resisted impulses to be resistible during the times they were resisted. This is simple, but it disallows punishing people for making mistakes when impulses are not resisted. To presume that a person who resisted an impulse for a long time, but somehow lost the ability to resist the impulse for a possibly short period of time
is to deny that circumstances affect how a person can behave, it sets an impossible standard, one which no person ever meets. It is only by accident, I find, that some people seem to have the ability to resist impulses to which others succumb. I have come to the view that people who judge others harshly, believing that an impulse which was not resisted should and could have been resisted have, themselves, succumbed to an irresistible impulse to find fault with others, and that this impulse is itself a response and a reaction to being held to impossible standards.

I can state my belief more forcefully. All impulses not resisted were not resisted because, at the moments of irresistance, they were irresistible. All impulses resisted were resisted because, at the moments of resistance, they were resistible. This is true for every impulse and for everything which experiences impulses. There are, there can be, no exceptions, so I find. Further, I observe that to believe otherwise is to succumb to an irresistible impulse to be delusional. Was I delusional when I believed I might develop, in response to the subjective experience of unbearable stress, an agitated catatonic state which would have endangered me physically? Perhaps so, perhaps not. There is no way to tell. Yet I know that I was rationally concerned about being so delusional that I could be in real danger. And, I set out to avert the danger to the best of my practical ability at the time. How do I know this? Because I note that everyone does their best all the time, when every factor that affects how a person does is taken into proper account. I saw, whether delusionally or rationally, that there seemed to be imminent danger to my life, and I set out to avert the danger as best I could, just as I set out to avoid dying at a relatively young age from cancer. Back to the narrative.

I had waited long enough that the duodenum had healed enough that there were no complications from pulling out the tubes. My new personality had to have a name, and, as Dr. Low repeatedly said that humor is one's best friend, I set out to find a name. I recalled when I first lived in a major city as an adult, there were newspaper advertisements for television repair service in the home. The ads typically gave the price of a service call as three dollars plus parts. No honest repairman could afford to do that, such people were sneaky dishonest. They would come into the home with a large "tube caddy" filled with hundreds of vacuum tubes. In those days, there were no solid state television sets, all used vacuum tubes. The repairman would start replacing tubes, starting with ones he was quite sure were not causing the problem. Each time he changed a tube, he would check whether the set worked. Sooner or later, he would replace the defective tube, if there was one, and there almost always was, and the set would work. He never put back the good tubes that the customer owned, but would point out that it took, say, nine tubes to make the set work. A typical tube cost two dollars or so at wholesale and would be sold to the
customer for about six dollars, well above the manufacturer's list price. Nine tubes at six dollars plus three dollars for the service call made for a typical bill of about sixty dollars. The repairman would take the one bad tube and the other eight that were probably good enough to work in another television set back to the shop and test them, clean them, and put them into the cartons in the caddy for the next customer whose set used those type tubes. A repairman could do about eight sets a day with this method. Allowing a cost for the one bad tube of two dollars and perhaps eight dollars for other expenses, fifty dollars an hour was a fabulous income in the early 1960s. Such thieves were called "Tube Pullers" by the honest repairmen because they only pulled the customer's rightfully owned tubes out of the set and never put any of the good ones back. My new personality was not going to put the tubes back, so his name is now "Tube Puller." The humor of the name is a way to remember how badly I was abused by the doctors who would not listen to me, when they were wrong and I was right, because of the incredulity problem of multiple personality. I need to remember for two reasons. The first is to be truly able to forgive the doctors for the harm they and their beliefs caused me. The second is to remember so I can try to find more effective, assertive ways to prevent being so harmed in the future.

The treatment plan I had devised and implemented because of my multiple personality disorder was the development of co-consciousness, and not integration into a single personality. There were two reasons for this. The first is because I wanted access to the whole of my life, and some of my experiences contrasted too greatly to abide in a single personality or personality state. The second was that I wanted to avoid future dissociation and the sort of inner conflicts and difficulties such had caused in my past. All that hard work had been sabotaged because, once again, I was not believed when I was telling the truth in a simple and direct way.

Because I could not get the medications I needed, the morphine-induced psychosis got worse. After about a month following the surgery, recovering at home, spending most of my time resting in bed, I started having hallucinations so intense that the room would vanish from my awareness. This I could manage. Then I started having headaches so severe that I could not tell whether they were real or hallucinations. At this point, I saw that I was heading for very serious trouble.

2.20 Hospital A, third time

My wife took me to the emergency room of Hospital A, where I was almost immediately put in restraints for my safety. After about an hour, I was finally given a medium injection of Haldol. In less than half an hour the psychosis had
vanished, but I still had terrible anxiety and a nearly unbearable headache. Since one of the factors that was thought to have caused my loss of mental capacities while on the psychotropic medications was multi-infarct dementia and since a previous Computerized Axial Tomography (CAT) scan had showed a “left capsule lacunar infarct,” a CAT scan was done, using iodine-based contrast dye, which caused an allergic reaction for the first time. I had been given so many CAT scans previously that I had become allergic to iodine. Because I had been psychotic in the emergency room, I was admitted to the same psychiatric unit at Hospital A where I had been the very first time I was a psychiatric inpatient. While I was in the emergency room waiting to be transported to the psychiatric unit, I developed the treatment plan for this hospitalization. Since the psychosis was gone, the remaining problem was severe anxiety. I would need anxiolytic medication at my discretion for a few days, I thought, and then would be okay. When I got to the unit, I told the nurse that I would need to be there from one to two weeks, and also what medication I needed, and it was prescribed, only at a fixed dosage not at my discretion. I saw that this would mean that I would soon be seen as resisting my doctor’s orders, when I needed less medication, and persuaded the nurse to call the doctor and change the prescription order to “P.R.N.” (pro re nata, in Latin, translated in English, as needed according to circumstances), and this was done. After four days, I no longer needed any medication. After three more days to be sure that I had resolved the crisis adequately, I wrote a detailed discharge plan which included a pass to see my psychiatrist, Dr. B, as I had made a tentative appointment with him for two days prior to the planned discharge date. One of the staff members on my treatment team told me that the hospital psychiatrist had remarked at the clinical conference to plan my discharge, “This is a very good discharge plan. Let’s use it.” I have never heard of another psychiatric patient who so accurately and in such detail planned his or her own treatment and discharge plans, but there may have been others. Nonetheless, I think what I did, did with scientific accuracy, is quite rare.

2.21 Volunteer work and substitute teaching

By the time I had recovered enough to return to school, the fall term had started, and I worked on ways to explain my understanding of the causes of mental illness to other people. I began asking everyone who was willing to discuss the matter the three main questions which led to the proof of The Fundamental Error of Social Reality and of The Law of Learning. I sought out religious leaders and lay people, psychologists and other therapists, college professors and other highly educated people. I searched out the people I thought would have the best chance to show a flaw, an error of fact or reasoning, a mistake in the research. I asked people who had not graduated from high school, foreign nationals, immigrants. I asked born again Christians, Jews, Muslims, Buddhists, atheists and agnostics. The questions, mentioned previously, were: 1. Do you
ever make mistakes? 2. Have you ever made a mistake you should not have made? 3. Have you ever made a mistake you
could have avoided. As with these questions when I had asked them earlier, no one could describe an achievable process by
which they could have avoided any mistake. Everyone eventually recognized that they did not know what would happen when
they initiated the action that led to the mistake with enough certainty to avoid the mistake. Once the mistake had been made,
everyone told me that he or she knew what would have to have done to have avoided the mistake, and why the mistake was
truly unavoidable. I noted that the way most of the people explained this was quite different than the way I would have, and
took this to indicate that the people were not intimidated into telling me what I wanted to hear. The next problem was how
to share the consequences to society of the Law of Learning. This was much more difficult.

Since I was not in school, I volunteered some of my time at a state psychiatric hospital, and was assigned to one of
the children's units to help in the computer lab of the hospital school. On the first day, I was introduced to the first class of
six adolescent students. There were four computers around the periphery of the room, and a central table. We all sat at the
table and I proposed some basic rules to make things easier. The first rule is that behavior which could damage the equipment
or harm any person was unacceptable. The second was, if a student wanted my attention, to hold up one hand, and, if I did
not notice the raised hand within half a minute or so, to call out my name. The third was, given the first two, to see what we
could learn. End of rules.

Two students went to one computer one each to the other three computers, and one of the girls stayed at the table
in the middle of the room. Within seconds, a hand went up. I dealt with the question. Another went up, same result. This
happened several times more. Then the student farthest from where the computer programs were stored asked if she could
get another program to try. That was fine with me. A hand on the other side of the room, a more complicated question. As
I finished with it, I heard a commotion behind me. While the student who had asked for permission to get another program
was away from the computer, the student who had stayed at the table had moved to the unused computer and was simply
sitting there. The girl who asked permission, "You took my place." The girl who had moved in, "You left it, its mine now."
The first girl, "I had permission." The second, "So what!" It looked to me like things were escalating, an undesirable situation,
to say the least. I remarked, and that situation is, in my mind, one of the very rare sort where it is best to say what one doesn't
think, "This is my first day here and I don't think I can handle a fight. What can you do so there is no fight?" I omitted
speaking the middle sentence which was in my mind, and which actually reversed the meaning of the first, "I know I can
handle a fight if I have to, but I would rather not." The best way to not have to handle a fight was to make it the students' responsibility to avoid fighting. After a few seconds, the one girl got up and the other resumed her place at the computer she started with. The girl who got up headed back to the table with the remark, 'I won't do anything,' and started to sit down. I then asked her, "What can you do so there is no fight and you don't quit?" The student I had been working with at the onset of the conflict was using a program meant for two people. The girl asked him, "May I work with you?" The answer, "Yes!"

For the rest of the class, a good time was had by all. I used my Recovery training well. I saw that the event itself was trivial, devoid of right or wrong, but it would be wrong to facilitate a fight, as would have been possible had I approached the matter with a judgmental attitude. Since the two girls were in conflict, I saw no reason to make a triangle, it would only complicate matters. I also took it for granted that the two girls would readily solve the problem themselves if they were given a chance to do so. And, they did. I used the method of Affirmation Therapy to validate their abilities to solve their problems in a realistic way, helping them learn useful living skills in the process. I did so by redefining the situation in their minds so that the circumstances which were causing the girls to have irresistible impulses to escalate the temperamental deadlock that was forming were changed to circumstances under which the girls could readily resist the impulse to escalate their temperamental expressions. Perhaps I could amplify this with the observation that what I meant to do was to make the impulse toward peaceful cooperation irresistible.

With the recommendation of Dr. B, I had obtained a provisional substitute teacher certificate, and did a small amount of substitute teaching. My first assignment was in an autistic classroom for Monday, Wednesday, and Friday of the last week of summer school. I will describe what happened in considerable detail, to illustrate the method of Affirmation Therapy in an actual case. There was a teacher aid and there were five students, one of whom, according to her individual educational program (IEP in teacher jargon) was mute and almost totally uncooperative. She was absent on Monday, but was in school Wednesday. I will call her by the name, Lynn, which is not close to her real name. The children were bussed to the school and had arrived before I did on Wednesday. Lynn was sitting on the grass against the fence in the front yard of the school when I arrived perhaps ten minutes before the start of school. Lynn sat stiffly and seemed not to notice when a boy ran into her quite hard. The four children who were at school Monday knew me, and I took charge of them and let the teacher aid get Lynn to the classroom. When we got to the room, the other four went to the desk for some cereal, part of the program for the autistic children both for nutrition and as an activity. At the far end of the room was a play area with some toys, a rug, and a large low table which served to divide the play area from the rest of the room. When the teacher aid let go of Lynn, she
headed over to the play area and sat against the wall much as she had a couple minutes before been sitting against the fence. As soon as the other four children had settled down reasonably and the teacher aid was able to manage them, I went over by the large low table and said, "My name is Brian. I am glad you are here today, Lynn." And then I walked away and worked with the other four children for a while. Lynn did not move visibly except for her breathing. When the teacher aid and I had arranged the next activity for the bunch of four, I went back to the large low table and started stacking some blocks into a structure typically three blocks high at the most. I then said to Lynn, "I'd like it if you would help me with this." I stacked more blocks and more blocks and more blocks. Then Lynn got up, came to the side of the table nearest her, and started stacking blocks with me. When, about fifteen minutes later, a group activity for the whole class was scheduled, I said, "Thank you for helping me, Lynn. It's time for the group now." The teacher aid had a look of slight surprise as Lynn came over to the group of her own volition. According to the IEP, she was not capable of such.

Then it was time for morning recess, and we went out to the playground. One of the boys had taught his teachers to play a game. I had noticed mention of the game in his IEP, and had decided not to learn it, which meant that he would be unable to teach it to me. The game was, if I run, you will have to run to catch me. I understood such exercise of power was harmful to this boy. The teacher aid had told me that this boy would run to the drinking fountain in the playground and then would run away to the farthest corner of the fenced in area of the school playground. Guessing what route he would take, I walked behind him while he was drinking, and, lo and behold, after a few steps, he saw that I had foiled his plan. I escorted him over to the teacher aid and looked for Lynn, who had gotten away from the aid. Lynn had gone to where some Head Start children were doing some water play. Lynn did not play like normal children, and the children seemed to resent her presence. One picked up a turkey baster that was among the water toys, filled it with water, and used it to drench Lynn, who seemed not to notice. I said to Lynn, "These children are not treating you nicely, and it is hot out here in the sun. I think there are some things we can do over in the shade." Lynn seemed to not respond. Another child filled the turkey baster and blasted Lynn, who seemed not to notice. I took the turkey baster and put it quite far away and came back to Lynn and repeated, "These children are not treating you right. I would prefer to do something with you over in the shade. I think we would both be more comfortable there." No obvious response from Lynn. One of the Head Start kids had reclaimed the turkey baster, refilled it, and snuck behind Lynn and blasted her back. I said, "I would be more comfortable in the shade, and I think you would be, too." No evidence of a response. I reached down and took Lynn's hands and lifted them. She went limp. I moved her about a foot and gently set her down, then said, "I'm sure we both would be more comfortable over there in the shade."
No sign of a response. I took her hands a second time and she went limp. I moved her another foot toward the shade and set her gently down, and then said, "It's hot out here and I would really prefer to be in the shade." No response, oops, after twenty or so seconds, Lynn stood up, took my hand, and led me over to the monkey bars. She let go and climbed up and leaned toward me. I moved closer, so she couldn't fall, and she reached out around my neck and gave me a hug. I set her down and she climbed back up and the process repeated.

After about six hugs, the bell rang and it was time to go to the school cafeteria for lunch. As Lynn had just started hugging me for the sixth time, when the bell rang, I said to her, "I will give you a ride to the light post in the middle of the playground, and then you can walk the rest of the way. I had noticed that the teacher aid had more than adequate control of the other four children. When we got to the pole, I set Lynn down and she reached up to take my hand and show me how to get to the cafeteria. She did not know that I had been there two days before. I had no idea what Lynn's language skills were, the information in the IEP suggested they were minimal at best. That is why I chose to talk to her with biological-age-appropriate language, to see what she could understand. She seemed to understand everything I said very well. During lunch, I saw that her milk was gone, and asked if she wanted more, since I was going back for something. Lynn said, "Yes, I would." I answered, "OK." and got the milk for her and some more water for myself. I did not say, "Lynn! You can talk!" I carried on as if her speaking a complete and well formed, if simple, sentence was nothing out of the ordinary. The afternoon went well, Lynn spoke two more complete sentences to me. I was resolved not to push her for performance, but to allow her to set her own pace.

The last half hour of the school day for this class was an adaptive gym period in another room. According to the IEP, Lynn would almost always just sit against the wall, much as she had done against the fence in the morning before school started. When we got to the gym room, sure enough, that is what Lynn did. After a few minutes, I said to her, "I would like to see what you can do with one of these tricycles." After about half a minute, Lynn got up and rode a tricycle very appropriately and carefully, and did so until the end of school that day. On Friday, I had brought some Popsicles™ for an end-of-the-term treat, to be given out during the adaptive gym time, since the only freezer in the school happened to be in that room, and I put them in the freezer before it was time for the children to go into the school. Then I watched Lynn, who was again sitting against the fence, only, this time, she looked up at me with a happy expression and, when a child bumped into her accidentally, used her arms to protect herself.
I had brought a talking teddy bear to use as a prop during the morning group time. This teddy bear had a microprocessor, and would store about ten seconds of sound when its left paw was squeezed. It would replay the sound after about a five second delay after the recording time had ended. When we got into the room, Lynu stayed with the rest of the children, and had some cereal without any prompting. When morning group time came, all the children sat in the circle of chairs that had been arranged for this activity by the teacher aid. I began, “This is a talking teddy bear of mine. It doesn’t really talk, it records sounds and plays them back a little later.” I pressed the switch in the paw, said something trivial, and the bear repeated it. One of the boys reached out and I handed it to him, showing him how to squeeze the paw to make a recording. He tried it, and it worked. Another boy wanted to try it, it worked again. Every child tried it except Lynu, who was clearly paying attention. I held it close to my mouth and softly said, “I like you, Lynu,” then held it about a foot from Lynu. When the bear repeated my words loud enough for Lynu to hear clearly, she looked slightly scared, threw up her arms, and said, “NO, NO, NO!” To which I replied, “I am sorry if the bear scared you. Most bears don’t talk like this one does. But, I think it is a nice bear.” After about fifteen seconds, Lynu reached out, squeezed the left paw, said something, and the bear repeated it. After she did this about four times, I said, “We need to share the bear, who else would like to try it again?” One boy put out his arms, and Lynu handed the bear to him. The bear was passed around, and every child used it several times.

Then it was time for morning recess. I saw two obvious routes the boy who liked to run could take, and guessed that he would try the other one. Good guess. Same result as Wednesday. By the time I got him into the care of the teacher aid, Lynu had found an adult ten speed bicycle propped against the fence and was starting to climb onto it. I scurried over to her, took hold of her, and lifted her off the bicycle. She objected. I said, “This bicycle is only leaning against the fence, it could fall over and you could be hurt. I don’t want you to get hurt.” I then showed her that the bicycle could fall easily. She reached up, took my hand, led me to the monkey bars in the shade, climbed up, reached out, hugged me, and said, “I love you.” It was obvious to me that Lynu was a loving and lovable child, but one who was exceptionally sensitive to unjust criticism. I never said or did anything that she could interpret as finding fault with her, but I made it clear that I was concerned with her well-being.

Recess over, we all went to the cafeteria, where she said several sentences to me, all of which were complete and meaningful. During the adaptive gym period, Lynu started playing with things immediately. The boy who liked to run darted out of the room when my back was turned for a moment. I went out to the hall where he tried to tease me into running after
him. I declined. I told him that what he was doing was not fair to the other children, to me, or, for that matter to himself. He walked back into the room. Other teachers had put treats in the freezer, when one of them came in to the gym room to get her treats, the boy ran for the door, since that teacher had left it open. Lynn was faster. Seeing Lynn take off, the other teacher reprimanded her, "Don't do that, Lynn, you have to stay in the room." Just after Lynn had gotten to the door and closed it, even before the other teacher finished her sentence, I interrupted, informing the other teacher, "Lynn is helping me keep George (not the boy's name) from running out into the hallway." The other teacher, who knew of Lynn's reputation, looked befuddled to me.

Then school was out. The driver of Lynn's bus was in a hurry. Lynn was going at her usual pace, which was fast enough for me, but not for the driver. The driver decided to save time, perhaps five seconds at the most, and grabbed Lynn by one arm and the best way I can describe it, more or less tossed Lynn onto the bus. I reflected, "I wonder if that impatient bus driver just undid almost everything I had accomplished?" I recalled Dr. Low's remark, "If my patients had patience, I would not have patients." If the world had less psychological impatience, would we not have fewer psychiatric inpatients? What did I do with Lynn that others didn't do? I allowed her to go at her pace and let her know that what she could do was good enough. And, I never punished her for making a mistake, for not doing what I wanted, nor for taking the time she actually needed for a particular task.

The central goal of Affirmation Therapy is to give the client a way to be at peace with his or her life, the life that has been possible, is possible, and will be possible. To be at peace is a pro-active process, it is not passive. Indeed, passivity tends to rule out peace, for it tends to lead to ignoring real harm and danger, and so destroys peace and the possibility of peace. Things happen, I see harm and feel anger. Anger is not a peaceful feeling. But I am at peace with feeling anger from time to time, for, without anger, I would have no adequate way to know of harm, and therefore, would have no way to repair the damage caused by harm. Without anger, I would be trapped in harm and harmfulness and would have no method to know what to forgive or what harm to repair. Part of the peace I have about my life stems from the belief that my life is not exclusively about myself. If the struggles and difficulties of my life were only about myself and myself alone, then my life would not be worth living, it would have been difficult beyond its worth. When I look at the world as a system, of which I am a part, then I can see merit to my life, for I see change and the possibility of improving the human condition. This aspect of life is not entirely physical, as I note, it has what I call a "spiritual" part also. What is not immediate, physical, and concrete
is, to me, of spirituality. Thus the ideal of the "common good" is, for me, spiritual, as is "the future" as I consider future possibilities in the present moment.

2.22 Faith and Fellowship

One observation I had made time after time, and it was consistent, was that people with mental illness tend to do much better when their lives have a meaningful spiritual aspect. Those who believed their lives were only about themselves tended to do far more poorly. By spiritual, I refer to any realistic, to the person, transcendent aspect of life that makes the person's life significant in a larger context than the person and the person's immediate situation. Secular humanism, free of sectarian religion, provides such a sense as it brings the attention of a person into awareness of others and to the value of community. I heard of a group at a church in Oak Park, Illinois, Faith and Fellowship with the Mentally Ill, which was initiated by a member of the parish who had a chronic mental illness. I met with the leader, Connie Rakitan, a staff member of the church, St. Catherine-St. Lucy Roman Catholic Parish. I joined the group as a "partner-catechist," as one of the regular people from the neighboring community, and not as a person with mental illness, although, at the time, I was still under the care of Dr. B, but only for psychotherapy. About half of the members of Faith and Fellowship were partner-catechists, the others were "residents," as most of that part of the group lived in nearby intermediate-care institutions as chronically mentally ill people. In Faith and Fellowship, I noticed that there was a kindness and sharing and open honesty that was even greater than at Austen Riggs. The partner-catechists learned from the residents and vice versa. The residents made suggestions, many of which were excellent and the group accepted them. It was a setting where each person was valued and respected as he or she was. In such a setting, it was very clear to me that the residents were people who had been very badly hurt, and were coping with the pain in their lives to the very best of their abilities. Most of the residents had schizophrenia diagnoses, all were on medications which had both beneficial and harmful effects. The purpose of Faith and Fellowship was improving the spiritual quality of community life through sharing and kindness and it worked. I did not use my scientific skills to do psychotherapy in this group, other than to model what I knew from my own life as an example. By design, since most of the partner-catechists had no mental health professional training, but were a group of average neighborhood residents, intentional therapeutic interventions were against the principles of Faith and Fellowship. I respected the goals of Faith and Fellowship, having no need to prove any point of mine. I did observe that the residents' quality of life, as they told of it, was much improved by their participation in the group. I saw the same patterns in the residents as I had seen everywhere else with mentally ill people. When a person felt safe enough, the person would begin to speak of the abuse that led to their illness.
Even in the people who could not live independently enough to meet the requirements of Austen Riggs, I could not find anyone whose illness was not of mainly psychosocial etiology.

2.23 Issues regarding personality

The second step of twelve step group programs such as those of Alcoholics Anonymous and Emotions Anonymous is accepting the reality of a Higher Power than oneself. Such a Higher Power, for the purposes of twelve step groups may be some traditional organized religious body' definition of God, it may be of natural forces, society, or anything at all that can be accepted as being greater than a person. The potential well-being of the generation next to be born will do. It is when a person has no outside reference, no place of stability in their view of the world, that life turns meaningless. A complete understanding of personality must include not only overt behavior, but motivation and meaning. To omit emotion from the study of personality is to disregard perhaps half of personhood, rather like a patient whose corpus callosum was transected to control severe grand mal epilepsy, generating a “split brain,” and who thereupon develops the phenomenon of “alien hand.”

Consider that both hemispheres can observe each other, but only the left hemisphere has the capacity to express itself verbally. The right hemisphere may object to what the left is saying, and may have as its only means of expressing dislike for the left hemisphere activity symbolically strangling the left hemisphere with the left hand which is controlled by the right hemisphere. If, alas, the right hemisphere were to succeed, it would strangle itself as well.

A person with a “split brain” needs a sense of inner community and inner peace for one hemisphere to not try to sabotage the other. Peace, to me, partly a spiritual phenomenon. Anderson (1991) has written about communities that are controlled by nationalistic power, he considers such communities to be imaginary and not real. I agree with Benedict’s main tenets, and that real community only exists when the basis is peace and cooperation, not power. The impact of power against peace, within the framework of the Recovery method is described in detail in Low (1967), in which he gives numerous examples of the ways in which power generates harmful situations when it is an exercise of temper, and how peace results from avoiding or averting temper.

The character, Christopher, in the book about a multiple personality patient, Voices, (LaCalle, 1987, p. 53) has a personality named James, who does not like Christopher.
(LaCalle, to James), "So what is it with you and Christopher?"

"Hell if I know. I get so damned depressed sometimes. He'll never do what I tell him to. Then the dumb shit gets depressed because I'm depressed—but he's so dumb, he doesn't know what's causing it. I wish he'd get depressed enough to kill himself," James said as dispassionately as a Mafia hit man, I thought. James's brutal manner put me at a disadvantage. I was no match for him. "He never listens to me about that, either. Too chicken to jump out the window. I'd love to be rid of him."

(LaCalle) "Then what would happen to you?"

"Me? I'd be fine. I'd go out and pick up all the little tricks at the gay bars. He couldn't interfere."

I was astounded that James failed to realize that if his wish came true, he'd die along with Christopher.

The nosology of the DSM-III-R and, I think, even more the DSM-IV, in an attempt to generate reproducibility of diagnoses, commits the fallacy of bifurcation, of polarizing what is actually a continuum. Having noted that young enough children have naive ego, and that the id does not exist at birth in any baby I saw, and I saw hundreds at Cook County Children's Hospital, it became obvious to me years ago that what Freud called the "Id" was actually the place where we put the hurts, the abuses, we have to believe did not happen to have a tolerable life. That would account for a description of the id as a "cauldron of seething impulses," as a writer I read years ago and whose name I do not remember now described it. The id, therefore, created in the service of a functional and socially acceptable ego, is a collection of dissociated ego states, as, to a lesser degree, is the superego. Allowing that the plasticity of the brain allows both the formation and the removal of dendrites, it is simple to see how dissociated ego states could arise. The consequence of this is that most people have far more than two "personalities" or subpersonalities (Rowan, 1990). If we take the transactional roles if Eric Berne's Games People Play (Berne, 1964) of child, parent and adult, and allow for left and right brain interdependence, there are six mental states in ordinary adults. That there are independent aspects of the two hemispheres has shown clearly in split brain patients (usually those in which the corpus callosum has been divided in surgical attempts to control severe epilepsy). That there are two aspects of the brain is represented in the old notion of the heart as the seat of emotions, since emotional "thoughts" tend to be prominent in the right brain and verbal "thought" are more prominent in the left. A person who has the three transactionally defined ego states of child, parent, and adult in verbal thoughts will also have three ego states in emotional thoughts, for a total of six subpersonalities in every person who can function intellectually and emotionally in the role of child and parent and adult. Berne's principal error was to neglect the separation of functions in the two hemispheres of a normal person, and therefore missed the phenomenon of mixed messages, in which one player in a psychological game may be intellectually adult and emotionally child. Such can generate catastrophic misunderstandings, I suspect, from observing some troubled marriages, that two people in a marriage who commonly use mixed messages in attempting to communicate with each other have alarming potential toward for domestic violence.
Rowan's expressed philosophy is flawed, so I find, for he wrote,

When I was twenty I discovered Spinoza: his philosophy seemed to take me to on to a high mountain from which I could see everything very clearly. Then when I was twenty-five I met Harold Walsby, a deeply versed Hegelian who later went on to create a dialectical algebra: he initiated me into the philosophy of Hegel, and particularly into a version which emphasized that nothing is absolute. (Rowan, 1990, p. 5)

As argued previously, I regard the laws of nature as absolutes, they are not dependent on human authority. It is important to realize that a law of nature is not the same as a human description of the law, our descriptions are only models for the convenience of our minds, and perhaps also our lives.

I take the philosophical position that it is a property of a law of nature that such laws are intrinsically unbreakable. The law of gravity cannot be disobeyed, can not be broken. An equation describing masses, forces, distances, and a gravitational constant is not the law of gravity, it is a mental model of the law in mathematical form. A model is not identical to what it describes. Consider an ordinary drinking glass. Dropped onto a soft floor, it may not break, or will probably break into relatively large pieces. If it breaks, some of the kinetic energy gained through gravitational attraction to the earth as the potential energy of the glass decreases is converted into new surface of the fragments of the glass. To generate a lot of new surface, i.e. to break the glass into more pieces, it might be necessary to drop it onto a hard floor. In this case, more of the kinetic energy is made available for new surface as less is spent in deforming the floor, whereas more energy was dissipated in deforming the soft floor of the first situation and so less energy was available for making new surface. A champion athlete who uses his full strength in flinging a similar glass onto a massive block hardened steel will be able to produce far more new surface than would be made in merely dropping the glass onto an ordinary household floor. The law of gravity is a way to account for the falling of a dropped glass. In the introductory physics books I have, the law of gravity is modeled in terms of force, mass, distance, and a constant. At a far more advanced level, gravity has been modeled as a curvature of space-time, and the concept of force is not needed in this model of the law of gravity. The behavior of a dropped glass is independent of the model we use, it is our understanding of the behavior which depends on the model. The laws of physics, laws made up by people, are but models of nature. This philosophical position is important to understanding why I consider the "Law of Learning" to be a possible law of nature. But, at the same time, my description of it, in words, is but a model of that law, presuming, of course, that the Law of Learning is real.
Werkmeister's thoughts about observation and interpretation, quoted earlier, may again be helpful. I recall a group of students at Carleton College, when I was a sophomore and planning to major in physics. We were in the room of a senior who was a physics major, and there were philosophy majors and math majors present as well as physics majors. The question turned to the probability of the sun coming up the next day. The question itself was trivial, the interpretations made were not.

From a statistical point, said a math major, one could count the number of days (every day) on which the sun rose and the number of days (none) on which the sun did not rise, and do a statistical calculation based on the observed data. But a physics major pointed out that the rotation of the earth is not a stochastic process, so the statistical calculations are not the correct model to use; rather what is relevant is conservation of angular momentum combined with the relative constancy of the dimensionality of the earth and the mathematical indeterminacy of the sun rising, based on calculating the "Heisenberg uncertainty" for an object of the mass and velocity of the earth, is an infinitesimal. One of the philosophy majors started out with a relativist position, that both the statistical model and the physics model were adequate, even if they provided very different answers to the probability of the sun coming up tomorrow. It did not take long before he realized the difficulty of his view, for he had not understood the difference between stochastic processes, such as tossing of a coin or perhaps even, given genetic variability, response to a medical treatment; and non-stochastic processes such as the rotation of the earth.

It is my position that the relationship between learning and making mistakes is non-stochastic, that is, to make a mistake is to learn, and to learn is to make a mistake, given the definition of mistake I have supplied in the glossary of this dissertation. To put it unambiguously, I consider making mistakes and learning to be identical except for the perspective or viewpoint from which mistakes-learning is interpreted. I directly observe that I do not learn when I do not make a mistake, and I always learn when I do make a mistake. This statement is of the absolutist school, and, as will be shown later in more detail, I have taken this position because, once I have made a definition of "mistake" which is as free of bias as I can make it, I find that allowing even one iota of learning outside the presence of a mistake opens the door to psychological abuse as I have observed such abuse. It took me years after first thinking of the idea that mistakes and learning are identical before I became comfortable with the ramifications of this idea. Initially, I wondered, if no mistake made should or could have been avoided, and this means that every decision is really and truly the best possible decision at the moment of decision, would believing this make the believer lazy, lackadaisical or lethargic, or would it give the believer renewed energy and effort? After all, if I always do my best, why make an effort? If I make no effort by choice, then that is the best choice I can make. This thought led me to proceed with caution. But I remembered the many infants and small children I had observed at Cook
County Children's Hospital, and how very young children work even to the point of exhaustion at learning about themselves and their world. I have come to believe, from discussions with many people, that it is subjectively experienced psychological abuse that stifles the curiosity and effort of those small children who lose the sense of vitality and adventure that I noted in every very young infant I have ever seen. But, is this a subjective view, or is there objective evidence to support it? What if the loss of curiosity and vitality I have observed in many children as they grow up is the result of a dissociative process, one in which that of the mind and brain that is curious is split off into a predominantly unconscious area, a subpersonality as Rowan’s ideas support, where it mimics what Freud thought was the “id.”?

Recall Rowan’s remark (1990, p. 5), previously mentioned, in which he was initiated into a version of Hegel’s philosophy in which there are no absolutes. If there truly are no absolutes, and if, therefore, truth is to the believer, then there can be no truth, for, all it takes for the existence of truth to be impossible is for one person to so believe, and this truth becomes absolute for everyone. There is a contradiction in relativism, for, if there are no absolutes, then there can be absolutes, and there will be absolutes. Why? For there to be no absolutes, that is itself an absolute. Ultimately, relativism is self-contradictory. Therefore, the question worth asking is not whether there are absolutes, rather the questions to ask are, whether we can ever come to know such absolutes as exist accurately at least some extent, and how we can distinguish what is absolute from what is not.

Nonetheless, relativism can be a very useful step on the way from beliefs based on the fallacy of Argumentum Ad Vericundiam (appeal to authority) to fallacy-free reasoning, by allowing discarding inculcated and indoctrinated errors of fact, and therefore allowing authority of truth as established by verifiable and reproducible scientifically valid experiments.

But perhaps it is best of all to say with Beahrs (1982) that dissociation is not an either/or phenomenon, but exists along a dissociative continuum. At one end of this continuum are fluctuations in mood, interpreted as a state of mind organized around a particular emotion... At the far end of this continuum are the very dissociated states, characterized by fugue and amnesia, which come under the heading of psychiatric states of dissociated personality. These have been dealt with in terms of standard psychiatric categories, because they are very serious and disabling. But we are not concerned in this book with multiple personalities as such, because they are too extreme. In this book we are dealing with people who are as normal as you and I. (Rowan, 1990, pp. 9-10)

Like Rowan, I do not find any evidence for a boundary which separates normal personality structure from multiple personality other than as an arbitrary, if not downright whimsical social convention.
As for Beahrs (1982, PP4-5),

This leads to the central philosophical issue, which will be raised again and again throughout the book: • When is it useful or not useful to look upon an individual as a single unit, a 'Coherent Self?' • When is it useful or not useful to look upon any one as being constituted of many parts, each with an identity of his own? • When is it more useful to see ourselves as part of a greater whole?

I use the term 'useful' rather than 'true' since all are true—simultaneously and at all times.

After describing in detail the progress in the field of psychiatry since Freud, Beahrs goes on to say,

Yet, I cannot escape the feeling, despite the importance of our increasingly massive burden of knowledge, that something very basic is often overlooked. What is missing?

In our effort to work out the complexities of observable reality, I believe that we often overlook the simple facts, which otherwise would be staring us in the face. There are observable facts of life known even to the ancients—empirical observations about our basic biology, psychology, and spiritual needs—which are often overlooked by mental health practitioners. Not only does it feel better to me, but I also believe that it works better in helping troubled patients ‘get better,’ to keep things as simple as we can, even at the risk of being too simple or simplistic. It is too simple, however, only if the rest of our knowledge is ignored or the data contradicted, neither of which am I suggesting that we do. (Beahrs, 1982, pp. 5-6)

As for the unconscious,

The concept of the unconscious is as critical to my work as it is to Freud’s (1916), though my concept is quite different from his. Hypnotherapists do not see the unconscious as a teeming cauldron of untamed fury almost crying for suppression so that society can survive, to be dealt with by a hierarchy of 'defense' mechanisms. Rather, the unconscious is seen as the source of all life and growth. Being a repository of all our prior learning and experiences, it must clearly contain information far in excess of what is usually available to awareness. (Beahrs, 1982, p. 7)

If we make allowance for prior experiences which contained subjectively catastrophic pain even in people deemed psychologically normal, the nature of the continuum of dissociation is easier to understand and accept. If we further allow that both growth and diminishment of dendrites in the cerebrum occur, if we allow for excitatory and inhibitory neurotransmitters, there are biological phenomena which are sufficient to allow both consciousness and unconsciousness.

Without associations, consciousness would be limited to the immediate moment and such of the recent past as can be held in “working memory,” or, as it used to be called, “short-term memory.” With associations, there is access to the past and the possibility of planning for the future. With associations and without dissociations, the effect would be to have all one’s thoughts concurrently. As anyone, such as myself, who has lived through a period of “loose associations” and come back to reasonable sanity knows, life with loose associations is unmanageable. And, as anyone, such as myself, who has lived through a period of a paucity of associations and has come back to reasonable sanity knows, life without associations is empty. As indicated previously, I was allowed those experiences through the medical care I received, medical care which was in accord with the highest practical standard of the period. It is not because I received poor quality care that I developed a
severe iatrogenic psychosis, it was because the superb quality care I received was wrong that I had such an illness. At the time I was receiving such excellent and excellently wrong care, neither my doctors nor I knew how wrong the care was. What it took to understand what had been happening to me was stopping the medications and observing that my mental illness promptly proceeded to vanish. But, what had caused my mental illness. While the medications triggered it and sustained it, and finally were, by any means I can test, its only remaining cause, the medications alone are not sufficient to explain what happened to me. My experience profoundly supports Beahrs' argument that the unconscious is the repository of the whole of our past to which we have the possibility of access.

I find there is more to creativity than just what is in our prior learning and experience as stored in the repository of dissociated unconsciousness. From the perspective of a scientist, I find that the past alone, stored, perhaps imperfectly, in individual human brains is not alone sufficient to account for creativity. James (1902) wrote,

Thus the divorce between scientist facts and religious facts may not necessarily be as eternal as it first seems, nor the personalism and romanticism of the world, and they appeared to primitive thinking, be matters so irrevocably outgrown. The final human opinion may, in short, in some manner now impossible to foresee, revert to the more personal style, just as the path of any progress may follow a spiral rather than a straight line. If this were so, the rigorously impersonal view of science might one day appear as having been a temporarily useful eccentricity rather than the definitively triumphant position which the sectarian scientist at present so confidently announces it to be.

I have mentioned the spiritual aspect of humanity before, and will again. For now, I would like to point out what I find to be the most fundamental flaw in the notion that the universe is entirely mechanical, as a closed system in the sense of thermodynamics.

The laws of thermodynamics can be put rather simply, the first law has been put as, "You can't lose." It is conservation of mass-energy, and, according to the first law, although energy may change to mass and mass to energy, the total of mass and energy is constant and unchangeable in a closed system, and, of course, if by the term, "Universe," is meant all-that-is, and all-that-is is physical, then the sum total of all-that-is is unchangeable. The second law has been put, "You can't win." Entropy, the measure of sum total disorganization in a closed system never decreases. The third law has been put as, "You can't get out of the game." The third law is that a closed mechanical system is bound by the first two laws.

Given thermodynamics, what can we say about the universe in which we live? Lucretius, in Of The Nature of Things, argued that, since the universe is eternal, the atoms cannot change, or they would be gone by now. It seems he understood
the laws of thermodynamics well. If Lucretius was right, there is good news and there is bad news. The good news is that nobody died in Hiroshima, Nagasaki, or Chernobyl. The bad news is that there is no sunlight. People died when atoms changed; without sunlight, there would have been no people to die. As the atoms are not all gone by now, the universe has not always been here. Simple physics and astrophysics seems to leave no alternative to the universe as having a beginning at a finite time prior to the present moment. The common escape strategy from this predicament by astrophysicists is to propose something of a "big bang" from whence the universe came. At the time of the big bang, the laws of physics as we know them today did not apply. For lack of a better description, the "big bang theory" sounds to me like a spiritual explanation devised by people who had a psychological desire to avoid spirituality. I observe that very narcissistic people I have known have consistently denied the value of spirituality, and that, when such people allow meaningful, as contrasted to magical, spirituality into their lives, their narcissism tends to fade as their subjectively experienced quality of life increases. What is extreme narcissism except a profound disability to trust, a failure of nurturing in the first year and a half according to Erik Erikson's work?

Ernest Becker, in *The Structure of Evil*, subtitled, *An Essay on the Unification of the Science of Man*, writing of both nineteenth century enlightenment combined with Freud's work, wrote,

If we add Freud's contribution to that of the nineteenth century, we can proceed to a fairly complete theory of personality. But for a long time Freudian dogma itself kept us from unifying the nineteenth and twentieth century social psychology. In order to continue the Enlightenment view of man, Freud's instinct theory had to be overthrown, which is exactly what was accomplished: we know now that the child has no innate aggressive and sexual drives—he has only a need for closeness and continuing affection and protection. Freud had spoken of man's unconscious, which he thought was a reservoir of primitive drives and antisocial urges. But when the instinct theory was abandoned, this led to a radically different view of the mysterious 'dynamic unconscious.' What is the dynamic unconscious if man is free of instincts? It can no longer be the 'seat of instinctual life,' as Freud called it. The unconscious now refers simply to the fact that in his early training each child is formed into a particular world view; this kind of training leads him to distort or obliterate certain perceptions—perceptions not pleasing to the parents, or taboo in the particular society in which he is brought up. Today we speak of the unconscious in quite matter-of-fact terms; it has lost its mystery. Instead of being a fatal subterranean core which we inherited from Paleozoic times, it refers to the particular skewing of our world view and of our capacity to act, which occurred during our early training or mistraining. Man is not saddled with a phylogenetic fate, but rather with his own early choices, which themselves are designed by his parents—by their tyranny, impatience, or simply their own limited world view. In other words, with the overthrow of instinct theory, Freud's biological problem has again been reconverted to a social and historical one.

For one thing, when we take out the heavy deterministic weighting of instincts, human action again becomes neutral. (Becker, 1968, p. 154)

In the preface of that work, Becker refers to Arnold Toynbee's remarks advocating the value of daring in scholarship in *A Study of History*, vol. 13 (Becker, 1968, p. xv), which I recall reading parts of some years ago. I take strong exception to
some of what I earlier quoted from Becker, but I agree that no real progress can be made in finding ways to prevent mental illness unless someone dares to question some of the underlying concepts and constructs of current models. Becker also wrote,

A scientific work is, after all, inseparable from its social and historical context: the content is part of the intellectual and editorial fabric of the work itself.” (Becker, 1968, p. xv)

With what do I take exception to Becker? As much as the “heavy deterministic weighting” of Freud’s model, based on the very incomplete understanding of physics and biology which existed at the time Freud developed his theory, was much in error, no less is Becker’s ‘social relativist’ view that it is correct that human action is neutral. Further, I observed many children, and children definitely display instinctive behaviors, what I observe to be instinctive in newborns is a will to live, to learn, and to have the company of others, and to avoid pain. If pleasure is the absence of pain, as I find it to be, then a case can be made for an instinctive pleasure principle, but I find calling the avoiding of pain “the pleasure principle” is a seriously reality-distorting euphemism. Such a distortion is not so different than calling significant loss of brain tissue “enlargement of the cerebral ventricles.” But the most harmful error I find in Becker’s work is his relativism. A few years ago, I took a college course in social psychology. The teacher was a “true-believer relativist,” as far as I can tell. I asked some awkward questions, awkward for him, not me. Referring to Dr. Low’s work, I related that, while most of life activities are trivial, that is, neither right nor wrong, I found it helpful to know what is hurtful so I could deliberately and knowingly avoid hurtful actions. I added that I had found that what is hurtful is what is wrong, what is helpful is what is right, and that it would therefore seem to be right to do what is wrong in order to learn what it is. He replied, “You are an absolutist!” He had made the remark many times that absolutists are always wrong because truth is always an individual matter, “If you believe it, it is true,” was a frequent statement he made. I answered, “I only wonder if there are any absolutes in social reality, and if so, how we could come to know what they are.” At the time I took that class, I had found no possible exception to The Law of Learning nor any evidence of a mistake made that could have been avoided, but I was not yet “absolutely” certain that none could exist, for I had not exhausted all the ways I had in mind to test The Law of Learning and The Fundamental Error of Social Reality.

In the preface of Banished Knowledge: Facing Childhood Injuries, Miller (1990b) wrote,

It is quite simply not true that human beings must continue compulsively to injure their children, to damage them for life and thus destroy our future. When I wrote The Drama of the Gifted Child, while under the influence of psychoanalytic thinking, I still believed that such a cycle of abuse was inevitable. Now I know that that is not true. Infectious diseases need not spread if the virus is known. Injuries can heal and need not be passed on, provided they are not ignored. It is perfectly possible to awaken from sleep and, in that waking state, to be open to the messages from our children that can help us never again to destroy life but rather to protect it and allow it to blossom.
Not to take one's own suffering seriously, to make light of it or even to laugh at it, is considered good manners in our culture. This attitude is even called a virtue, and many people (at one time including myself) are proud of their lack of sensitivity toward their own fate and above all toward their own childhood. I have tried to show in my books why the fatal belief that such an attitude is desirable can so stubbornly persist, as well as the tragic conditions it helps to conceal.” (Miller, 1990b, p. 5)

I found Miller's arguments convincing in their scope, depth, compassion, accuracy and relevance to the observations I had made year after year regarding abuse and mental illness, and thereupon set out to describe and test my understanding of Affirmation Therapy in greater depth and detail.
3. RESULTS

3.1 The model of Affirmation Therapy

3.1.1 Philosophical basis of Affirmation Therapy

Affirmation Therapy (AT) is, in many of its properties, mechanisms and processes, a new method of psychotherapy, invented by the author, in which certain specific philosophical assumptions are predominant. It is based on the author's discovery of a principle, called herein “The Fundamental Error of Social Reality.” The philosophical perspective is one of giving a sense of personal adequacy and self-respect to the patient, regardless of the patient's past experiences or behaviors. It recognizes that some things are harmful and are best not done when they can be avoided, that some things are helpful and are wisely done when possible, and that most of life consists of what Dr. Low (1978, pp. 40-44; 1995, pp. 135-141, 261-279) described as “trivialities,” in which there is no right or wrong. AT allows for no mistake which was made to be deemed as having been avoidable, and that, therefore, punishing a person (self or other) for making a mistake, any mistake, is wrong, regardless of the consequences of the mistake. AT is based on directly observable reality, not on theories of entities which are at best a matter of speculation or fantasy. The “self” is taken to be directly observable and is the focus of AT, constructs such as “id” or “superego” are not, and do not have significance in AT. For the purposes of AT, personality structure has six main elements, after Berne (1964), there are three roles based on development, Child, Adult, and Parent, but, unlike Berne’s model, each role has a cognitive and an affective part, making a total for a normal adult personality of six separate roles. By “personality,” for the purposes of this thesis, I mean a reasonably consistent pattern of behaviors and viewpoints such that the combination of elements which make up the pattern has the capability of functioning in a coordinated and directed manner toward a particular task.

In AT, it is assumed that people can be quite versatile, and may have developed many personalities over the course of life depending on the nature of the tasks toward which the person has directed effort. In AT, everyone is assumed to be multiple because of the degree of versatility needed for high functioning in modern society, and inner conflicts arise in all normal people because of the differing viewpoints which can be brought to bear on an unfamiliar task or on an old task which has not been satisfactorily resolved. Internal conflicts can be projected onto other people, and interpersonal conflicts may arise. In AT, intrapersonal conflicts are the focus of attention, although it is acknowledged that they have their origins in
interpersonal conflict, because they can be brought into the realm of willful choice for the particular person who is in therapy; unlike interpersonal conflicts, which necessarily involve the wills of other people as well.

3.1.2 Habits of thinking and psychiatric disorders

I have observed many instances of disordered habits of thinking during the course of my life. To me, a classical example of such thinking, one that is addressed by AT, is of the form, “You didn’t. You could have. You should have. It is your fault that you didn’t. That is why you are suffering.” The approach of AT, by contrast, is, “You didn’t. There was a reason for that, whether or not you know it now. Because of that reason, you couldn’t. If it is important enough, the reason can probably be found. More likely than not, you were not perfectly certain what would happen, and only found out afterwards. Life often brings new experiences and situations, ones in which past experience is not enough to know what to do. That is how we learn. Are you still suffering? What can we do now to make things better?” In AT, all forms of psychiatric disorder occur because of disordered thinking, the disorder of thinking may be cognitive, affective, or, in my experience, usually both. The thinking disorders which cause psychiatric disorders may have physical, biological, medical, or psychosocial causation, in any combination. AT focuses its effort on psychosocial factors and their resolution. Specifically, AT is not a “Theory of Everything,” it is not designed to be a panacea. To believe otherwise would, in my opinion, be an example of a thinking disorder. In the model of AT, there are no panaceas except as tricks of the mind, such as fantasies or wishful thinking. AT is designed to facilitate contact with and understanding of objective, directly-observable reality.

In AT, as in Recovery, fear is a belief. It is the belief that there is danger. (Low, 1995, pp. 265-269) By definition danger is best avoided, therefore fear, as a belief, stirs an avoidance reaction, which is of the form of an “emotion.” Whether or not there is danger in a situation, if harm is not yet in progress, is an interpretation which may or may not be correct. In AT, fear properly signals the possible presence of danger, and gives rise to the question, “Am I being appropriately careful?” Therefore, in AT, fear, as a belief and behavior is wisely employed to preclude preventable harm and damage, but this is only effective if the interpretation of danger is sufficiently objective. Without objectivity, unabated fear tends to generate viscous cycles of increasing fear and decreasing objectivity, the ultimate form of which is panic. And panic is antithetical to objectivity in the absence of real, clear, and present actual danger. In the model of AT, the belief that fear is and is only an affective state is an example of disordered thinking. In Recovery, all feelings are basically beliefs. (Low, 1966, pp. 16-21) This is also true in the model of AT. A number of words commonly considered to be emotions are defined in terms of beliefs
in the glossary. These include anger (the belief that something happened that shouldn’t have), resentment (the belief that one has a right to retaliate or get even somehow), and hostility (the belief that one has the right to judge someone else harshly). In Recovery, beliefs which generate temper are habits (Low, 1995, pp. 38-39), and this is also true in AT.

Dr. Low wrote (1966, pp. 69-70), “The reason for our almost fanatical preoccupation with the subject of beliefs is that it is they which either order or disorder the lives of mature human beings.” Dr. Low wrote this in 1951. Some ideas appear, seem to be wrong because they do not prevail, and reappear because people were not ready to accept them at first. Peck (1997, p. 42) writes,

When I was in psychiatric training, schizophrenia was labeled a thinking disorder, or a thought disorder. Since that time, I have come to believe that all psychiatric disorders are thinking disorders. Individuals at the extremes of mental illness, as in some forms of schizophrenia, are clearly the victims of disordered thinking and may be so far out of touch with reality that they cannot function well in day-to-day activities. Yet we have all met narcissists, obsessive-compulsives, and passive-dependent people in our social and work lives. Their mental health may be fragile, but they manage to appear “normal” and get by. The fact, however, is that they, too, are disordered thinkers. Narcissists cannot think about other people. Obsessive-compulsives cannot think about the big picture. Passive-dependent people cannot think for themselves.

In every psychiatric condition I have worked with over the years, there was some disorder of thinking involved...

But, according to Peck, it is not only those who are psychiatric patients who suffer from the consequences of disordered thinking:

Given the imperfections in our society and the apparent downward spiral of spiritual and moral values in recent years, thinking has become a grave issue. It is more urgent now—perhaps more urgent than anything else—because it is the means by which we consider, decide, and act upon everything in our increasingly complex world. If we don’t begin to think well, it’s highly likely that we may end up killing ourselves.

That is, to me, a political statement in addition to a psychiatric one. Neither Recovery nor AT is about politics, it is about individual persons. Nonetheless, society is comprised of individuals and the ways individuals think ultimately determines the structure and function of society. While AT is directed toward well ordered thinking in individuals, there is an implicit presumption that a society made up of people with well ordered thinking will be a well ordered and highly functional society which will be of great benefit to its members.

3.1.3 Biological considerations

From the standpoint of biology, in a typical right-handed person whose language skills are primarily a left-hemisphere function and whose spatial skills are primarily a right hemisphere brain function, the cognitive roles are of the
left hemisphere and the affective roles of the right hemisphere. The specialization of function between the cerebral hemispheres has been shown many times in persons who have been treated for severe epilepsy by corpus callostomy (surgical transection of the corpus callosum) (Kaplan and Saddock, 1995, p.206). The specialization of specific areas of the brain is also clear from people who have suffered physical brain damage in accidents or through disease or strokes (Gardner, 1974). Peck (1997, pp. 28-31) discusses the implications of specialization of hemisphere functions.

The research on split brains represents, I believe, the most formidable advance in the field of epistemology, suggesting that we have at least two ways of knowing, and that obviously we will know things better if we use both left-brain and right-brain thinking. (Peck, 1997, p. 29)

One of the principal goals in the design of AT was the development of practical mental tools to bring left-brain and right-brain thinking into a state of functional cooperation. Low (1966, p. 17) wrote,

...Lillian’s behavior was governed by two contradictory wills, the one group-oriented and the other starkly individualistic. This accords well with what I have stressed repeatedly, namely, that in this imperfect world of ours, there is no purity of character, personality and will. The average human being who is neither saintly nor heroic nor angelic, is served by two wills, ruled by two characters and obsessed of two personalities. The average person is dual, not unified.

Low also wrote (1967, p. 152),

You are—and everybody seems to be—a dual personality with a dual viewpoint. At times you advance the subjective viewpoint and become emotional and temperamental; at other times the objective viewpoint is favored and emotion and temper are controlled. “It all depends on the way you look at things,” and your temper will have free reign if you cultivate the subjective way of looking at things while it will be kept in reasonable control if the objective view of things is given the right of way.

From my perspective as a bioengineer, I note that there are two ways to understand the duality described by Peck and by Low. The first is of hemisphere function, as in Peck. The second is a matter of hemisphere isolation or cooperation as I find is what Low described. In the model of AT, temper may result from conflict between differing cognitive and affective views of the two hemispheres; such conflict produces subjectivity if either hemisphere view overwhelms the other. In AT, objectivity predominates when the left-brain and right-brain thinking described by Peck function symbiotically and cooperate in the effort toward achieving mutually-set goals.

What psychosocial factor can cause conflict between the hemispheres? Consider the following as an illustration of a possibility. Suppose a child is repeatedly told things like, “You knew better than that. You are so stupid. When will you ever learn?” This is a mixed message if ever there was one, so I think. It has four parts. The first, “You knew better than that,” is, let us say, since this is only an illustration, left-brain-thinking-acceptable but right-brain-thinking-unacceptable. The left brain says, to this message, “OK,” the right “Not so.” The second, “You are so stupid,” similarly is, say, left-brain-
unacceptable and right-brain-acceptable. So, to this, the left brain says, “Never,” and the right, “What the heck.” The third, “When will you learn?” may well be deemed a fair question to both hemispheres, but no answer seem possible. The fourth message is subtle, indirect, unspoken and almost certainly never recognized for what it is; it is of the form, “I love you, that is why I am hurting you this way, I am doing this for your own good; it is how I was raised.” In the conversations I had with peer psychiatric inpatients, I heard many stories which had this form.

Affirmation Therapy is a psychological process which involves the brain, while the focus of attention is the mind, the mind is considered to be an aspect of the brain. Therefore, AT was designed in conformity with known biology. The brain structure is vastly too complex to model in fine detail with sufficient accuracy to account for a particular thought based on biology. Patterns of thinking are more tractable. For the purpose of AT, the brain is presumed to have the following properties: Synaptic transmission is assumed to be the only way of communication between neurons. The “all-or-none” law applies to synaptic transmission in the brain, transmission either occurs or does not occur according to the properties of the post-synaptic receptors and the neurotransmitters and neurotransmission-modifying chemicals present in the synapse. Whether a particular neurotransmitter is excitatory or inhibitory depends on the post-synaptic membrane receptors. The brain is assumed to have at least some plasticity throughout the whole of life. By plasticity, I mean that synapses may be formed or deleted, the strength of transmission across a synapse may vary over time, possibly in response to past activity. The structure of the brain is intimately associated with learning and memory, therefore, learning new habits and unlearning old habits involves physical changes in the brain structure, at least at the molecular level. Large changes in behavior patterns involve significant modification of the brain and take time to accomplish. In AT, the time required for a task is determined by the time actually found to have been needed when the task has been accomplished; prior to the completion of the task, all that is possible are estimates. In the framework of AT, all deadlines are therefore tentative, because of the indeterminate nature of discovery and learning. I came to the recognition of this through listening to many stories told to me by other patients. Time and time again, people told me how they could do one thing well, but not another. But parents and teachers often expected uniform performance in all areas, and the people who told me these stories often did accomplish the tasks at which they were not so good, but it took much longer than tasks at which they were good.
The main features of the model of Affirmation Therapy

The following are the central tenets of Affirmation Therapy at present.

1. There was a beginning to the human species, and therefore also to human society, at a finite, though undeterminable, time in the past.

2. Before the beginning of the human species, the total mental knowledge (cognitive and affective) of humanity was zero because there were no humans who could have knowledge.

3. Since the beginning of humanity, precisely as much as possible has been learned; at no time in the past, the present, or the future, has more or less knowledge been possible than actually existed, exists, or will exist.

4. The human species is unique on the earth in being concerned with the creation, evolution, discovery, and understanding or moral and ethical issues, prior to the beginning of the human species, morality and ethics did not exist.

5. Morality and ethics concern the problem of right and wrong behaviors and beliefs. What is not of right and wrong, of morality and ethics, is, to use Dr. Low’s word, “trivial.” This does not mean that trivialities are unimportant, they are quite important, for most of human life consists of trivialities according both to Dr. Low’s Recovery method (Low, 1995, pp. 135-141) and AT.

6. At the “moment” of the beginning of the human species, morality and ethics existed only as possibilities to be realized in the future.

7. Learning, according to AT, occurs and only occurs, when mistakes are made, but, for this to be correctly understood, the definitions of learning and mistake must be very precise and as unbiased as it is practical to make them.

8. A mistake is made when someone does something and what happens as a result is not, exactly in every detail, precisely what was anticipated. This happens every “moment” of a person’s life, for it is beyond the realm of possibility to anticipate exactly in every detail precisely what will happen in response to an action. This is true, if for no other reason, because the limitations of knowledge and behavior set by the physical limitations brain chemistry, which rule out the possibility of the brain’s functioning in a purely deterministic manner.

9. Everything happens at a proper time, in a proper place, for a proper reason. This does not contradict the idea of item 8, for, without the opportunities presented by indeterminacy, and mistakes, there could be no human
creativity. Believing that there is a proper reason for everything is the mental antidote to the false, according to the model of AT, belief that something was done that should not have been done, or something was not done that should have been done. It provides an escape from viscous cycles of shame, doubt or self-doubt, punishment or self-punishment, guilt, and ensuing shame.

10. No mistake made could or should have been avoided, regardless of the nature of the mistake or its consequences. AT allows for no exceptions to this principle, for even a hint of an exception opens the door to the destructive rationalization of abuse as necessary for proper discipline. It is therefore wrong to punish (in the ordinary sense, not the technical sense of the word, “punish”) a person for any behavior. In the model of AT, a person is not what a person does; it is possible and desirable to punish a behavior while affirming the life and worth of the person whose behavior is punished. It is wrong not to punish (in the technical sense, see the glossary) harmful behaviors and it is also wrong not to reinforce helpful ones, according to the model of AT. Yet, until enough mistakes have been made to learn about the true, objective nature of mistakes and learning, it is necessary to make harmful mistakes in order to learn what they are. Trying to do otherwise generates harmful viscous cycles, wherein, for example, a child who receives “corporal punishment” for failing to meet an impossible standard, and who comes to believe, in response to “corporal punishment” that he or she could and should have done differently, will tend, as a parent to treat his or her children similarly; also by mistake, also harmfully.

11. No person has the actual ability judge another, regardless of the common belief to the contrary; for no person can possibly know enough of the details of another person’s life to make a meaningful judgment. Neither is it possible to judge behaviors with meaningful accuracy. What can be done adequately, however, is to directly observe behaviors and to recognize and note (Werkmeister, 1957) behaviors which are harmful and punish them to the extent that such punishment is not abusive, as well as to recognize, note and reinforce behaviors which are helpful and therefore merit reinforcement.

12. For society to function in a decent way for its members, cooperation must always take precedence over competition. In the model of AT, people are basically cooperative, and competition against other people only arises because of abuse (maltreatment or neglect). Within a cooperative framework, given a task of importance, however, competition is useful to determine who has the best skills and circumstances for a particular task. In such a situation, competition facilitates, rather than destroys, cooperation.
13. The whole range of human experience is "normal," there is no valid boundary between normal and abnormal behavior except as an inherently whimsical social convention. Enforcing such whimsical boundaries on people for whom the boundaries set impossible-to-meet standards is abusive if the person is harmed thereby. When every factor that bears on a decision is taken into proper account, including indeterminacy, every decision, at the exact moment of decision, is the best possible decision. This does not exclude free will or freedom, it is not a deterministic stand. What it means is, given what a person actually knew and was truly able to do at the precise moment of decision was at the limit of possible performance. This is a mental antidote to thinking-disordered (according to AT) statements such as, "You should have tried harder." Perhaps even within a fraction of a millisecond of the making of a decision, hindsight reveals another decision which would have resulted in a supposedly better outcome. As has been shown by conflicting eyewitness reports, human memory is subject to time confusion, which allows a person to sincerely, yet falsely, believe that another choice would have been achievable. Accepting the limitations of human memory is a mental antidote to delusional, in AT, belief systems of the form, "I didn't..., I should have..., I could have..., It's all my fault, and that is why I need to suffer."

14. Some aspects of life are best understood as deterministic, some as of choice, and AT is designed to facilitate the freedom to recognize which is prevalent in a given aspect of a particular situation. In a dichotomous system, which AT is not, either determinism or free will guides behavior because they are mutually exclusive. In AT, the presence of choice is deterministic, the choices made are not. The goal of AT is not so much freedom from symptoms as freedom to enjoy life in a practical, constructive, and pragmatically spontaneous way.

15. It is the purpose of pain, whether physical or psychological, to signal something that is best not done. Different people have differing sensitivities to and tolerances of pain. What is "unbearably painful" to one person may be insignificant to another. Pain is always a subjective experience, AT facilitates not only having "the
courage to bear discomfort," as in the Recovery method, but also to assertively attempt to change the environment when environmental factors are causing pain. In this regard, AT may pose a direct challenge to some religious teachings. Consider, for the purposes of this thesis, only as a myth, the story of the “fall” in the Bible in the book of Genesis. I have heard it argued that it would have been better if Eve had not eaten the fruit of the tree of the knowledge of good and evil. AT teaches otherwise. Staying within the context of the story as myth, Eve made a mistake. Alas, until she made the mistake, she had no knowledge of good and evil and had no possible way to know what a mistake was or what would happen. But, according to the model of AT, it was not Eve who made the first mistake, it was “God.” This realization on my part led to my taking considerable time to explore with a wide range of clergy, not limited to “Christians,” the social and religious ramifications of AT. I set out to try to find people who would be most likely, in my view, to demolish the perspective of AT. No one has, so far, been able to do so. According to the model of AT, the whole of humanity was naive at the beginning of the species regarding ethics and morality. Further, according to the model of AT, it is harmful, and therefore wrong, indeed abusive, to hold present-day people as though accountable for the consequences of “original sin.” Doing so imposes an impossible standard, one that not even the clergy who teach such a belief have, can, or will ever meet. In the model of AT, all religious teachings which induce pain in the practitioners of the religion are delusions, signaling lack of contact with objective, directly-observable reality. At the same time, using the method of AT, which is designed to not be sectarian, I have found value and truth in every religion I have studied. AT is not anti-religious, it is anti-abuse of course, but it is very much pro-life and pro-quality-of-life. Knowing what is best not done improves quality of life.

16. In AT, all disorders of thinking originate with misunderstandings, such misunderstandings go back to the origins of the human species. If, and this is a basic premise of AT, there was a beginning to humanity, there was a time when the development of human language skills was very limited compared to the present time. It is assumed in AT that humans are the inventors of ethics and morality and that the development of systems of ethics and morality depend upon the adequacy of available language to understand and express ethical and moral principles. All the mistakes necessary in inventing a decent system of ethics and morality must be made before enough can be learned about ethics and morality to develop such a system and its associated vocabulary. Mis-communication is deemed inevitable in AT, the concern is how to rectify
misunderstandings when they are not trivial. The language of AT, much as that of the Recovery method, uses some precise definitions, many of which become clear only when told in story form, and this is essential to avoiding the types of misunderstanding which are causal factors in psychiatric disorders.\(^3\)

17. Once it is understood that no mistake made could or should have been avoided, the interpretations a person makes of the affective states of shame and guilt are changed. Shame becomes a signal of the presence of some sort of wrongfulness, guilt identifies who was wronged and who was the wrongdoer. Since no mistake made could have been avoided, and every lesson is necessary, according to the model of AT, all mistakes are inherently forgivable. ALL MISTAKES ARE FORGIVABLE, without exception or the possibility of exception. Without shame, harm would go unrecognized. Without guilt, there would be no way to know who was harmed and who acted harmfully. Without such knowledge, there is no practical means of forgiveness, for there is no way to know what or whom to forgive, and no way to intentionally repair such damage as the mistake caused. It has been proposed that the way to deal with harm is to “forgive and forget” (Smedes, 1984), and, without the method of AT, this may be the best strategy. AT, however, offers a practical way to forgive and remember, for it is designed to heal the pain of past memories to such a degree that the pain of the past, when remembered in the present, is of the past. In AT, genuine forgiveness allows remembering the past, allows choosing to avoid patterns of the past which were harmful but, outside of methods which accomplish authentic reconciliation with the past, would be repeated because of repression necessitated because the past seems too painful to consciously recall.

18. AT is designed to bring a person to a practical sense of wholeness, in which no part of the past is too painful to remember. As an example, this is not the same, for someone like me who seemingly suffered from a form of multiple personality disorder for over forty years, as being “integrated.” Using AT, I have no need to be “integrated,” for I have developed a degree of co-consciousness which enables me to live a life of vastly better quality than would be possible were I integrated or fused into a single personality. An analogy may have illustrative merit. Consider a group of, say, thirty people at a meeting at which there is being discussed an exceptionally difficult problem of great and real importance. Consider that every person truly believes

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\(^3\)For the record, I have never found even one person who had a psychiatric diagnosis whose thinking was not directly observable, at least part of the time, as being disordered and out of contact with objective reality. Indeed, I find this applies, although generally to a much lesser degree in people without psychiatric care needs, to everyone I have ever met; none of the eight people who answered, “Yes, No, No” to the three questions seemed to understand the full implications of their responses.
that his or her solution is the only viable one, and that everyone else who disagrees is massively wrong. The meeting is less organized and less productive than a classical barroom brawl in a B-grade Western motion picture. Power is the only means used to try to accomplish a solution, and no one will concede. The meeting goes nowhere. Now consider a similar size group in which everyone respects the others, listens attentively and carefully, and works toward forging a cooperative consensus. Before my psychiatric treatment, I functioned largely like the first group, as I find do most people. With the Recovery method and the techniques of AT, my life is like the latter. The experiences of my life are too disparate to fit into one “personality,” to be integrated would be to lose important parts of my life, parts to which I have free and easy access now.

19. The model of AT allows only self; constructs such as “id” and “superego” are not allowed. Recovery is a self-help method, it also does not allow for anything but self, and it is the will of the self that is trained by the Recovery method. Fairbairn also concluded that there is only self (Fairbairn, 1963), however split, in the nature of personality. In AT, a child is born with a naive self (naive ego in Fairbairn’s system), and, as in Fairbairn’s theory, the self becomes split. In contrast to Fairbairn, however, splitting of self is considered an essential aspect of normal human personality, it may occur in response to frustration, deprivation or abuse, but it will also occur in the normal and worthy process of developing competence and versatility in a variety of productive social situations. This can be understood by considering what happens to a person who has “loose associations” as in certain forms of schizophrenia. Structured and productive thinking toward external tasks is impossible if one’s mind is flooded with thoughts to such a degree that concentrating on a task is impossible. The normal function of self-splitting can be seen also by contrast to a person with a form of schizophrenia in which the mind is essentially blank, it is just as impossible to concentrate on a worthy external task if one cannot concentrate because one has essentially no thoughts as it is if one is overwhelmingly flooded with thoughts.

20. The goal of AT is to give a person a sense of inner peace about the life the person has been able to live, is living, and will be able to live. This sense of inner peace, serenity, if you will, is anything but passive. It is, in its essence, a vibrant sense of enjoyment at the possibilities of a decent, kind, and cooperative life. When dreadful things happen, they are fully acknowledged as such, and effort is directed toward dealing with the problems and learning what may be done in the future to prevent or preclude such things, including for
other people. Affirmation Therapy breaks vicious cycles by allowing only the difficulties of the problem to be understood as the issue, questions of "deservingness" or blame are seen as delusional and harmful. Self-punishment, as an internalization of external punishment, is thereby set aside, and all the concomitant self-abuses of internal disrespect and inappropriate self-esteem can be resolved.

21. As an extension of Fairbairn (1963), abuse is taken to be the cause of aggression, whether directed toward self or toward others. Aggression is a form of angry temper, not a symptom of it. Resolution of abuse resolves aggressive tendencies and facilitates cooperation.

22. AT is not a diathesis-stressor model, in that there is no diathesis; there is no fault or flaw in those who develop mental illness. Rather, mental illness is an expression of sensitivity to abuse; without sensitivity to abuse it is impossible to consciously recognize what is abusive. But insensitivity is not a good solution to abuse. A useful parallel exists, I find, in terms of physical pain sensitivity. Some people are born without sensitivity to physical pain (Brand and Yancey, 1993), and they tend to live very tragic lives. They have no way to learn to take precautions against even devastating physical harm, since they are essentially unaware of it. There is, as I saw in the hundreds of children I observed while working at Cook County Children's Hospital, considerable variability in sensitivity to psychological discomfort as well. The position taken in AT is that sensitivity to pain, both physical and psychological, is beneficial, and that, as with physical pain, insensitivity to psychological pain is a liability and not an asset. In the model of AT, if there is a genetic flaw that contributes to mental illness, it is presumably expressed in the insensitivity of those people who seem not very aware of psychological pain in themselves or others.

23. The focus of AT is on the whole person as a member of society. AT is neither pessimistic nor optimistic, it is designed to be realistic. Pessimists tend to overlook opportunities and optimists tend to overlook difficulties. As an illustration, consider the old story of the drinking glass filled half-way to the top with water. The pessimist sees it as half-empty, the optimist as half-full, neither sees the whole reality. But AT is about realism. The realist looks at the same glass, recognizes that he or she needs both air to breathe and water to drink, and notes that the glass is actually full. Gold (1987) states that about 20 to 25 percent of psychiatric patients suffer from a medical condition which mimics a psychiatric condition, and that such conditions often go untreated because they are not correctly diagnosed. AT is about realism, it is not intended to replace psychiatry and medical treatment, rather, it is meant to enhance the effectiveness and
efficiency of psychiatry via improved classification of medical/biological and psychosocial factors in mental illness. In the model of AT, it is no less abusive to treat a medical condition with psychotherapy than it is to treat a psychosocial condition with medication. The model of AT makes the general presumption that both biological/medical and psychosocial factors are present in mental illness.

24. The design of AT is meant to enable more accurate classification of what is biological and what is psychosocial, of what is trivial and what is not, of what is of objective reality and what is of opinion or whimsey. The model of AT allows that intense moral dilemmas are a commonplace phenomenon in present-day society, and that many situations arise in which it is necessary and right to do what is wrong for lack of a better achievable alternative. To illustrate this, the old saying, "If it is worth doing, it is worth doing well." becomes, in AT, "If it is worth doing, it is worth doing poorly, although, if it can be done well, that is better." This is not, however, situational ethics as in Fletcher (1966) in which ethical issues are settled on a pragmatic basis. In AT, abuse is always wrong, but it is not wrong to do what is wrong to learn what is wrong, so as to be able to learn how to avoid doing what is wrong. Until someone can show how it is actually possible to have avoided, via an achievable process, a mistake which was made, the mistaken idea that there are mistakes made which could and/or should have been avoided is not a negotiable issue in AT.

25. In present-day criminal law, the question may arise as to whether an accused criminal acted in response to an "irresistible" impulse or whether a resistible impulse was not resisted. (Kaplan and Sadock, 1995, p. 2764) The method of AT solves this puzzlement with the direct observation that an impulse that was not resisted was objectively and actually an irresistible impulse at the moment of the impulsive behavior. To believe otherwise is an example of disordered thinking, it is to believe that a mistake made could and/or should have been avoided, and this is an example of The Fundamental Error of Social Reality; it is intrinsically and inescapably false according to the model of AT. To restate this for emphasis, using direct observation, an impulse that was not resisted was clearly irresistible; the evidence for this is the fact that it was not resisted. Similarly, an impulse that was resisted was clearly resistible, and the evidence for this is the fact that it was resisted. Resistible impulses which are not resisted do not exist except as a delusional state of imagination; they constitute a form of disordered thinking; they are never real.

26. The model of AT shows why punishing (in the ordinary sense, not the technical sense) people for making harmful mistakes causes more harmful mistakes to occur. Consider the following illustration. If I make a
mistake that is harmful and for which the norms of society such as ours require that I be punished (again, in the ordinary sense), and if I am not “caught,” it is against my best interests to tell anyone else about my mistake. But this is true for everyone in a society a society such as ours. As a result, harmful behaviors which put a person at risk for being punished (in the ordinary sense) are kept secret as much as is possible. One person cannot learn from another’s mistake if the mistake is kept secret. In consequence of secrecy, there are many harmful behaviors which everyone has to pretend do not happen, and thereby the punishment (in the ordinary sense) of people for making mistakes reinforces (in the technical sense) harmful behaviors. Conversely, if it were safe to tell about any and every harmful mistake, safe because there would be no revenge, no retaliation, reprisal or other punishment in the ordinary sense, we would more readily learn from each other’s harmful mistakes and therefore the frequency of such mistakes would be reduced simply because more people would know about them beforehand and would have the willful option of trying to avoid them. The model of AT shows why strategies of law that increase penalties for violations tend to increase infractions of law. In AT, ignorance of the law is not an excuse, it is a valid reason why violations occur which cannot be prevented and for which ordinary-sense punishment is therefore inherently abusive.

27. Safety is a paramount concern in the model of AT. Therefore, there is no problem in AT with incarceration of people who have shown seriously violent and destructive behavior. Appropriate and effective incarceration prevents such behaviors and therefore punishes (technical sense) them efficiently. But incarceration, in the model of AT, can only be used for the purpose of safety; safety for the person with the behavioral problem and also for the rest of society. Incarceration for the purpose of punishing (ordinary sense) the person is abusive and wrong. Since the incarcerated person serves a valuable purpose in society by bringing out to awareness the harm abuse causes, such people are, in the long run, assets to society. It is inappropriate to let a person free who has acted violently and destructively to such a degree that incarceration is warranted unless the person has truly come to terms with the abuse which led to the problem behavior(s). Yet it is also true that many impulsive behaviors are associated with a particular unique situation which is so drastically altered by the impulsive behavior that it is impossible to repeat the behavior. When there is no significant chance for repeating an inappropriate destructive behavior, the behavior has been, de facto, punished. An example would be a spouse who has been subjected to extreme chronic abuse by the marriage partner and
who, in a transient psychotic episode, in self-defense, kills the abuser. The method of AT shows promise, as I now see it, for repairing the damage done to the survivor well enough that, in many cases, such a person might need only short term incarceration before appropriately returning to society. The present practice of law is largely nonsense from the perspective of AT; for one thing, the law allows many people to be free pending trial during a time when there are no precautions taken against further inappropriate behaviors.

28. In the model of AT, people never fail; people can never fail. The appearance of failure signals the presence of an impossible standard, one that could not be met under the circumstances in which failure became manifest. It is the beliefs, the values, the expectations, which fail, not the person or people. In the model of AT, the possibility of personal failure does not exist because no mistake made could or should have been avoided. The only possible outcome from enforcing an impossible standard, however, is failure. When factors properly ascribed to circumstances are given personal attribution, the disordered-thinking false belief may arise that the person is at fault. The method of AT is designed to enable a person so harmed to forgive those, including self, who erroneously found fault with the person.

3.2 Testing and evaluating the model of Affirmation Therapy

3.2.1 Introduction

The testing and evaluation of Affirmation Therapy was concurrent with its design and development until the model was essentially complete. Some of the information in this section also occurs, in different form in Chapter 2. It is repeated here for the sake of continuity in the descriptions in this chapter, and to avoid the need on the part of the reader to refer frequently to the previous chapter for details.

3.2.2 Testing prior to the discovery of The Fundamental Error of Social Reality

In April of 1987, I joined Recovery, Inc., which met at a church of which I was a member. I had read about Recovery in Park and Shapiro (1976) in addition to knowing about it as a member of that church. I was feeling desperate, but not hopeless, and first set out to see if I could find a flaw in the Recovery method such that the Recovery method would not help me. If so, I would try something else; if Recovery was helpful, I would try the Recovery method in a serious way. Initially, from reading Low (1978), I thought that Dr. Low had never treated someone who was clearly multiple, and perhaps his
method would work with other conditions but not mine. What first impressed me was realizing that Recovery had not only survived its founder's death, but had grown tremendously instead of vanishing as many grass-roots organizations do when their "organizers" depart. My brother's doctoral dissertation was about grass roots organizations, and Recovery was, I recognized, truly extraordinary in terms of my brother's research findings. I took this as an indication that Dr. Low had probably discovered something very real and significant. Ordinarily, as I then thought, people with serious mental illness are not capable of the sustained level of cooperation and organization which was, very obviously to me, present in Recovery.

As I came to understand that a basic tenet of the Recovery method was that temper leads to tenseness, and tenseness to symptoms, the phrase, "Temper, tenseness, symptoms," was spoken several times by Recovery members almost every meeting during the first few months I was in Recovery. As an engineer and electronics technician trained to look for inadequacies of design, I set out to see if I could find any evidence of any person with mental illness who did not have temper as described by Dr. Low. Not only did I find that temper was indeed present in every person I met with mental illness, but it was present in everyone else as well, though it was better controlled in those who were apparently not mentally ill. This led to examining the question as to why some people with temper became mentally ill and others did not. The phrasing used in the Recovery meetings to describe Dr. Low's understanding was that nervous patients have weak nervous systems. This idea is discussed in Low (1967, pp. 15-25) in terms of "individual resistance" as a matter of a person's constitution to "environmental irritation." In that chapter, Dr. Low describes how a person with low resistance may become mentally ill in almost any environment, a person with high resistance only develops mental illness in an environment of unusually high levels of irritation.

In working with electronic circuits for, in 1987, more than twenty-eight years, the idea of resistance as the personal aspect of the problem of mental illness troubled me. One common electronic component is called a resistor, and resistors sometimes fail. Sometimes, but very rarely in my experience, there is a manufacturing defect in a resistor which leads to failure. Almost all resistor failures I had seen were caused by aspects of circuit design, most commonly some other part was out of tolerance, either because of a manufacturing defect in that part or circuit design which caused that part to go out of tolerance because its operating conditions were beyond its ratings at least occasionally. My training in electronics predisposed me to see the issue of resistor failure to be a system problem, and I wondered whether the question of personal resistance to irritation was not also a system problem.
What I had noted among the people I had met with mental illness was not weakness but sensitivity. Continuing the analogy with electronic circuitry, I realized that the reason that circuits are designed in ways that fail is because, for one reason or another, the designer is not sensitive enough to possible failure modes. From the contact I had with electronics engineers and technicians in industry, I knew that it was common for an engineer to design a circuit which "looked good on paper," but which would not work when built. From personal contact with many electronics engineers and technicians, I had learned that in many electronics industry firms, some of the technicians were very cynical about engineers because of the "stupid mistakes" that engineers often make. Yet technicians usually do not have enough education to do sophisticated circuit design. With all these thoughts as background, the first question I decided to test was whether the people who become mentally ill have some sort of flaw, like a defectively manufactured resistor, or whether the central question, a systems issue, was a matter of sensitivity. As an amateur radio operator, my philosophical position was that sensitivity was desirable; given two amateur radio receivers essentially the same except that one is noticeably more sensitive than the other, I am inclined to consider the more sensitive one as being superior. I grant that this may be only a subjective bias, but no one can step entirely outside the effects of past experiences, no matter how great the effort is made to be objective. Perhaps the wiser thing to wonder about is whether my subjective biases predisposed me to see mental illness from a comparatively new vantage point, allowing my recognizing aspects which had not been seen as accurately before.

I tried approaching the panel examples I gave at Recovery meetings from the standpoint of sensitivity to real problems, specifically that my sensitivity was a desirable quality, even though it made me more uncomfortable than less sensitive people. The effect was dramatic, I found the 'spotting' other people did about my examples was much more constructive and supportive, but also tended to draw more attention to the things I had done poorly which I might improve in the future. About the time I concluded that sensitivity was a strong factor in mental illness, in the middle of the summer of 1987, I began to decompensate severely again and was psychiatrically hospitalized for the fourth time. While I had found no serious flaw with the Recovery method, I was, so to speak, going in two very different directions. Someone who is truly multiple may do that. One direction was that of Recovery, spotting temper and avoiding symptoms thereby. The other was puzzling over why I had so much temper to spot that spotting temper sometimes took so much of my time that I could not work appropriately at my job. In Recovery lingo, I endorsed myself for making the effort to "trigger spot" temper and avoid having symptoms to such a degree that I developed a viscous cycle of temper about needing to trigger-spot temper so much...
that I could often do little else. What I did not recognize then, nor did this become apparent until the early summer of 1989, was that the medications prescribed for my illness were the main cause of it.

3.2.3 Testing during the discovery or Affirmation Therapy

Once again as a patient in Hospital B, the first hospitalization since I joined Recovery, I searched diligently, trying to find even one patient whose mental illness was not a function of temper. There were no such patients I could find. In group therapy sessions, I began speaking about my thoughts about sensitivity and other patients began giving examples of how they were more sensitive than other people. I then searched for even one patient whose temper was not the result of sensitivity and found none. Sensitivity was, I found, a central issue; the next questions I had were about the nature of the irritations to which people with mental illness are sensitive. I found that the group therapy at Hospital B was directed toward making people less sensitive, and thereby, presumably better able to function outside the hospital. As with amateur radio receivers, I thought more sensitivity is inherently better than less, and directed my personal efforts toward increasing my sensitivity to the extent it seemed to be a matter of choice. It had become clear to me, even though I knew that I was quite psychotic, that the problems I was having with my doctors and other members of my treatment team were largely the result of their insensitivity to my inner mental life and experiences. In Hospital B, in the fall of 1987, I began talking about “feelings” of self-respect openly; using the understanding I had gained from Derlega and Chaikin (1975) that sharing personal experiences that would leave me “vulnerable” would tend to make other people more willing to share similar aspects of their lives. I figured that, since I was psychotic, the staff would probably interpret my behavior as a sign of my illness and not as an aspect of research into mental illness; I had read Rosenhan (1975) when it was first published. Rosenhan’s experiment involved getting mentally normal people admitted to psychiatric facilities by feigning a symptom of possible schizophrenia. The people in his study acted normally once admitted. If, as Rosenhan’s research revealed, normal people doing normal things would have their normal activities interpreted as signs of illness, I figured I could say almost anything that was not actually hurtful to other people, and would not be stopped. This was largely the case.

In revealing myself and facilitating revelations on the part of other patients, I found that they could easily describe the sources of their temper when they believed there would be no danger in doing so. I modeled the process of self-disclosure and the other patients realized that their self-disclosure to me was also not dangerous. As a peer, without power over other
patients, I was potentially much less threatening than doctors or other staff. This realization became a key aspect of Affirmation Therapy. Even if a therapist has real power in terms of access to insurance for treatment and access to treatment itself, using such power as part of the process of psychotherapy tends to distance the therapist and client and may generate fearful (retreating) temper in patients, and is thereby harmful to the effectiveness of therapy. I tested the use of self-disclosure as a facilitator of therapy and found that, as long as I was largely able to avoid setting up transferences and countertransferences, self-disclosure was remarkably effective in bringing people to recognize the sources of their temper. Since I believed that transferences and countertransferences are generated in therapy as an effect of the power the therapist has over the patient, I set out to test whether effective and efficient psychotherapy was possible if transferences of all sorts were minimized. The motivation behind this was to bring the focus of effort into insights about the origins of temper onto their original sources as directly as possible.

During this time, I was in an intensive care section of Hospital B, and the head nurse decided that I really needed her help. She noticed what I was doing and, as I understand from what happened next, decided that it was time to teach me a lesson. I described this event in detail in Chapter 2, what I want to point out here is that, using the Recovery method, I was able to withstand what she did without developing temper over it. She had decided to teach me to stay on a particular subject, and I played along with her so well that she thought I was finally learning how to live properly. I thanked her for her help, telling her that she had made it very clear why I must not do as she thought or I would be trapped in my illness for the rest of my life. Using the Recovery method, I was able to avoid finding any fault with her as a person while avoiding what I believed would be harm to me if I did what she told me I should do. Eventually I was transferred to a regular unit at Hospital B, during the transition, I used self-disclosure in conversations with the staff, and found that it worked well for me when I did not rattle the psychological defenses of the staff very much. I kept pushing the boundaries of disclosure with both staff and other patients and found that, when the basis of disclosure was clearly self-respect and mutual respect, such disclosure was not dangerous.

In Chapter 2, I described the first visit to the regular unit, when I first met the MPD patient who recognized that I was multiple. That patient remarked that no one else had ever described the world he/she lived before. That person had a copy of Kluft (1985) and let me read it. Kluft (p. 206) cites a personal communication from Thomas Gutheil, M.D. in which Gutheil describes MPD as a “pathology of hiddenness.” This led me to a stunning (at the time and in my psychotic state) recognition.
Every patient I had ever met was suffering from a pathology of hiddenness, and temper was its visible manifestation. I recognized, at that level, all psychiatric disorders are the fundamentally same; all are disorders of thinking which generate temper. And I saw that the Recovery method, by spotting and averting temper, automatically reordered thinking, but did so rather serendipitously. I began talking with other patients in a new manner, disclosing events that I thought might have led to temper in my past, and noted that I had experienced a sense of having been abused in every one I remembered. When I tried this type of disclosure with other patients, they also began describing a similar sense, but the details were always very different. My concern was whether I was planting a sense of having been abused in other patients or was bringing an already sense of having been abused out of a state of hiddenness. I took the observation that the stories other people told were so different in details to indicate that I was not inducing the beliefs about having felt abused in other patients. I noted that every story I heard involved having felt abused, having felt hurt in ways that had not been forgiven, and I saw those unforgiven hurts as unresolved psychological pain. The model of mental illness I had just prior to Thanksgiving in 1987 was that subjectively experienced abuse caused unresolved psychological pain, which was manifested as temper, which led to tenseness and symptoms. What I did not understand was why abuse occurred. I believed that abuse was wrong, and that it was wrong to do abusive things to people. I believed that this was the reason that people are punished for wrongdoing, to learn better to avoid wrongdoing.

I began talking about this idea with other patients, about whether it was right to feel bad because of having done something wrong if, considering, as most people said to me, we make mistakes because we are not perfect. One thing Dr. Low said was, as it was spoken of at Recovery meetings I attended, “If you lower your standards, your performance will rise.” When I first heard this, it sounded like nonsense. I set out to test it. I noted that, when I set personal standards beyond what I could meet, I had a sense of personal failure, and this sense of failure diverted my attention from the task at hand. Further, I noted that my response before I learned the Recovery method was to raise the standards I set for myself, expecting my achievement to rise accordingly. Looking back, I saw that this had never happened except by accident. I then began exploring the effect of the idea, “What I can actually do has to be good enough; to do better than I can actually do, I would have to be someone else, and that is impossible.”

The dream I had on Thanksgiving eve and morning of 1987 is described in Chapter 2. With it, the basic core of the model of mental illness of my research was complete, Abuse occurred because the human species had not been alive long
enough to have learned how to not be abusive. Abuse occurs because of ignorance; we make mistakes because making mistakes and learning are the same phenomenon—only described from different perspectives. The ordinary idea of mistakes, it seemed to me, suggested inadequacy, the interpretation of mistakes as the way, indeed, the only way, learning occurs suggested adequacy. That Thanksgiving day was very busy for me. I made many thought experiments. I will describe a few of the most important of them, as I now remember them.

The first was about the seeming paradox that, if I always do my best, and that is not a choice; if I strongly feel that I make real choices, is that feeling a fact or is it an illusion of a purely mechanical life? If life is mechanical, then effort is an illusion, a trick of the mind, so it seemed to me. And, were that so, then it would not matter whether I tried to do things or not, because there was no choice in the matter and therefore no decision. I thought back to the many babies I had observed at Cook County Children’s Hospital, and the effort even a baby soon to die from an uncorrectable congenital condition made. And I saw the way out of the seeming paradox. As Dr. Low noted, effort matters greatly, and I noted that the only reason people do not make the same degree of effort compared with intrinsic ability that newborn babies make is because older people have been taught by mistake that they make mistakes they should not make; and this sets an impossible standard, one that no one actually can meet as an exercise of will. This results in people coping with a sense of fear of making mistakes and people becoming afraid to learn by making mistakes because of anticipation of being punished for making mistakes. Only, in the dream I had, one cannot learn without making mistakes, if one defines the word, “mistake” properly. It seemed to me so very simple. If making mistakes and learning are actually identical, teaching a person not to make mistakes is teaching the person not to learn. The next question that came to me was, “What could be more abusive, subjectively, than that?”
3.2.4  Testing during the design and development of Affirmation Therapy.

I set out as the first order of business after the Thanksgiving dream to test whether it is possible for a mistake made to have been avoided. I began talking with other people, both patients and staff, and also friends outside the hospital, about making mistakes and what it takes to avoid them. The questions I asked were tentative at first, since I did not know what would happen to people's lives if I made it clear that I thought that no mistake made could or should have been avoided. I began talking with other people, both patients and staff, and also friends outside the hospital, about making mistakes and what it takes to avoid them. The questions I asked were tentative at first, since I did not know what would happen to people's lives if I made it clear that I thought that no mistake made could or should have been avoided. I started speaking of mistakes I had made and how I felt about having made them, especially mistakes that turned out to have bad outcomes. As with other forms of self-disclosure, my taking the lead resulted in other people speaking about their experiences. Thus began the set of three questions that formed the informal, participant-observer experimental field research of this thesis, all of which was done during the ordinary course of my life. The nature of the experiment was, "What happens if I try to prove to people who believe otherwise that, their sincere belief to the contrary notwithstanding, there is no such thing as a mistake that could or should have been avoided?" I was struggling with this question in my own life, and I was floridly psychotic (as previously indicated) and my psychosis was evidently, in retrospect, largely the result of medications prescribed for my illness, as demonstrated by the cessation of the illness with the discontinuance of the medications in 1989. While I was still hospitalized, for the second time in both Hospitals B and C, I began asking these three questions, in a variety of forms, but the basic nature of the questions was consistent. 1. "Ever make mistakes?" 2. Ever make a mistake you shouldn't have made?" 3. Ever make a mistake you could have avoided?" Over the following eight years, I asked these questions of about four hundred people, as indicated in Chapter 2. My purpose was to find whether anyone could describe a mistake which he or she could have avoided by use of an achievable and practical method. As indicated before, eight of the four hundred answered, "Yes, no, no." to the three questions; the rest answered yes to all three questions. With those who answered "Yes" to all three questions I followed with a request, the form of which varied according to the content of the conversation which preceded the three questions. Typically, I said something like this, "Think of a mistake you made that you could have avoided. I don't need to know what it was, but tell me what you could have done to avoid making the mistake." Every one of the "Yes, yes, yes" people readily thought of an example and told me about it. But no one could describe a way to have avoided a mistake that was made without invoking some form of unrealistic (disordered in the model of A1) thinking. After the particular person told me what they believed they could have done to have avoided making the mistake, I asked a form of "Why didn’t you?" Everyone realized, perhaps after several "Why didn’t you?" questions on my part, that they had not, in fact, known how to avoid making the mistake until after the mistake was made. No one could describe an achievable way to have avoided a mistake, any mistake, which had been made.
The following examples of conversations about the three questions are composites of actual conversations, with changes made to protect the identities of the people with whom I discussed these questions. Except for changes made to insure confidentiality and combining several conversations into composites to make the method clear, the essential content of these examples is as accurate as I can make it. What is missing in these examples is the whole gamut of nonverbal communication. Keep in mind that these conversations occurred in naturalistic settings, wherein I was myself, an ordinary person who makes mistakes. One reviewer of a draft of this thesis remarked to me that the long "speech" I made, in the first example, which starts, "Let me see if I understand what happened..." seemed like a harangue. But I was watching the facial expression and other forms of body language while I "delivered that lecture." I noted that the person showed strong interest in what I was saying and every sign I could recognize encouraged my continuing. That I was reasonably accurate in that assessment is made clear in the way the conversation ended. It is normal in ordinary conversation to express strong opinions from time to time, not doing so would mean the research was not naturalistic, and that would distort the data far more than some ordinary human clumsiness on my part.

I think this issue is of such paramount importance that I will restate it, please pardon the repetition. Ordinary human conversation is spontaneous; it is impossible to do naturalistic research into beliefs by talking with people if the conversation is not spontaneous. I did experiment with planned conversations, but found that the other people invariably sensed that the conversation was somehow "rigged," and then set out to try to "please me" by trying to guess what answer I wanted. It was only after I threw out every rule I had ever heard of regarding proper "laboratory" survey research and interview research and became very spontaneous that I was able to avoid people guessing what the "right answer" was.

In the fall of 1995, I recognized that I had enough data from naturalistic research and set out to design a laboratory experiment to confirm my findings. To minimize observer bias and maximize objectivity, I designed a computer program, based on a decision tree structure, to study people's responses to questions about mistakes. I had never found a person who said they never made mistakes, but had to allow for this response in the computer program. I had to allow for many responses which I never got from any person, as well as for every one which had occurred. When I had the design of several of the main branches complete, I came to the recognition that the very presence of the decision tree structure would massively bias the data. I saw that I had no chance whatsoever to generate data from a supposedly-objective interview structure, computerized
or otherwise, which had any chance of being as free of bias as the data I already had gathered naturalistically through spontaneous conversations.

A man had grown up in a South American country, near the ocean. There were high cliffs near the village where he lived, and one of the “rites of passage” for the youth of his community was diving off these cliffs, about twenty meters high, into the ocean. One day, this man decided to really prove his masculinity and dove from a higher cliff several kilometers farther down the ocean front, an area where people from his village did not dive. The cliff was about thirty meters high there, the man persuaded a couple friends to come along to witness his bravery. He dove, he survived. But there were rocks projecting from the cliff underwater which he did not see. He grazed one of them and received a deep scratch on his head. I met this man at a community gathering; after talking some about his work, he asked me what I did. I told him I was trying to complete my Ph.D. in bioengineering. He asked some more questions and seemed increasingly interested. Finally, I said that I could tell him about my work in more detail by asking him three questions, with his permission. I said to him that most people I had asked the questions of before had found them unusual but harmless, and that I expected the questions would be harmless for him as well. The conversation:

“Ever make mistakes?”

“All the time.”

“Ever make a mistake you shouldn’t have made?”

“Lots of them.”

“Ever make a mistake you could have avoided?”

“How much time do you have to listen to me tell you about them?”

“Think of a mistake you could have avoided. I don’t need to know what it was, but I would like you to tell me what you could have done to have avoided making it.”

“I don’t mind telling you about the mistake.”

He then told me the story of diving into the ocean.

“What could you have done to have avoided making that mistake?”

“I could have decided not to dive there.”

“Did you ever dive there again”
“No.”

“Why not?”

“It was too dangerous.”

“Did you ever dive off the cliff near your village after you were scratched?”

“No, I was too scared.”

“Did you ever tell anyone that you were too scared before?”

“No, I wanted the people in the village to think I was exceptionally brave, which they did after the dive off the high cliff.”

“Why didn’t you avoid making the dive off the high cliff before you dove?”

“I didn’t think anything would happen to me. That is what being brave in my village was about, pretending to be invulnerable.”

“So you did not avoid making the dive because you did not know what was going to happen before you dove?”

“Yes.”

“Let me see if I understand what happened. Tell me if I have misunderstood what you told me. Every young man in your village was expected to dive off the cliff to prove that he was adequately macho. Macho courage was highly valued in your village, it gave people status. You did not grow up in a village where macho courage was unimportant, you believed it was very important to prove your courage because everyone in your village believed this, and you were told it time and time again. Macho courage was so important in your village that you set out to get exceptional respect from others, and it worked. But, had you been a centimeter or so farther from the underwater rock, you would not have known it was there, a centimeter or so closer and you would have been killed. Until you grazed the rock, the beliefs you had been given in your village culture led to your doing things to prove yourself. Only after the dive did you realize the degree of danger, only after you realized the degree of danger had you learned about such real dangers well enough to avoid such diving in the future. You could not have avoided diving because you were not able, given your culture and your past experiences, to anticipate the actual risk you faced well enough to decide not to dive. Other people did not dive there, you would have to have been one of those other people to have avoided the dive, that was and is impossible. Other people in your village knew that you had been
hurt, and now know not to dive there. To put it simply, you could not have avoided that mistake because you did not expect what would happen.”

“I see what you mean. Until after I made the mistake, I didn’t know that it was going to turn out to be a mistake.”

“What happens to how you feel about yourself if you believe you should have avoided an unavoidable mistake? It seems to me that you have felt for years that you should not have made that dive, that you should have known better first, even though that was not possible, given the circumstances of your life.”

“I felt bad about myself for being stupid. But, with what I knew when I jumped off the cliff, it felt like I would be stupid not to dive. I only learned that the dive was stupid after I did it. I didn’t realize that before today. You know, I feel much better about myself now than I did before we talked about this.”

“It seems to me that all mistakes are like that, because a person really only knows when a mistake has been made after it happens. It is not a mistake, to me, to do something bad on purpose and what happens is bad as expected. That is either a crime or sabotage or some such, but it is not a mistake. If you can think of a mistake you made that you could actually have avoided, for real, and not only in your imagination, would you tell me about it?”

“Sure, glad to.”

I have spoken to this person a number of times since then; he has never been able to think of a mistake he made that he could have avoided, and has put into practice in his daily life the recognition that it is wrong to believe that people should do what is impossible. He has mentioned several times that he is very grateful for the conversation we had.

That composite conversation is characteristic of every one I had with people who initially thought the correct answers to the three questions were all “Yes.” I did not pursue the questions all the way to a clear recognition that the belief that there are mistakes made which could have been avoided is false with people whose mental state I sensed was fragile. Consider this as a composite example of a conversation with such a person. To open communication who was initially somewhat reluctant to speak, this version starts with a leading question, something I used only rarely in talking with the four hundred or so people.
I had known the actual person on which this example is mostly based as a fellow patient for about three weeks prior to this conversation and we had spoken with each other many times.

"Sometimes, after I have made a mistake, I have felt bad about myself. Anything like that ever happen to you?"

"Oh, yeah, lots of times."

"I have often wondered why I have made so many mistakes. Maybe I am making another one now, but, if you don’t mind, there are some questions I have been thinking about."

"Go ahead."

"I remember being paddled in school when I was in second grade because the teacher decided that I had done something wrong that I shouldn’t have done."

"My father used to beat me when he thought I did something wrong."

"How did that make you feel?"

"I felt bad inside, but I knew I deserved it because I was a bad child. Since I have been in the hospital, I learned that I was really not a bad child; I did not always know what he wanted, and I did things he told me were bad because I did not understand what he wanted me to do or not do."

"Did you ever make a mistake that you should not have made?"

"That's why I am in the hospital."

"Did you ever make a mistake that you could have avoided?"

"All the time."

"I'm not sure I agree with you about that. Do you think talking to me about mistakes is a mistake?"

"No, talking with you is cool, I like you. I don't feel safe talking with the nurses, but I do with you."

"I'd like you to think of some mistake that you could have avoided. You don't need to tell me what it was, but I would like you to describe what you could have done to avoid making that mistake."

"No problem. I ride a motorcycle to work, and, on one day, I had to work two shifts the day after I stayed up late to watch a movie on TV. Going home after the second shift, I kind of fell asleep on the
interstate, and woke up about thirty miles past my exit, going ninety miles an hour on the shoulder a couple feet from a guardrail. I went to sleep a couple minutes after I got on the highway."

"Had anything like that ever happened to you before?"
"Never."

"Did you think you might fall asleep on your motorcycle after you left work?"
"Of course not, it was the first time something like that happened to me."

"Did you know that people sometimes fall asleep while driving?"
"Sure, but I didn’t feel that tired."

"Did you ever have to work two shifts after that time?"
"Yes, but I take a taxi now if I am tired."

"So, if I understand you right, you only learned that you can fall asleep on your motorcycle when you are tired only when it happened, and not before. Do I understand you right?"

"That makes sense to me."

"After the mistake, did you feel that you should have avoided making it?"

"Of course. Wait a minute. That’s why I felt so bad about it. What you just said, I couldn’t have avoided the mistake because I did not expect it to happen. It doesn’t make any sense that I should have done what I could not have done."

"I think it is like that for every mistake. I think we make mistakes because we can do things we have never done before. Some of them turn out good and are worth doing again, some turn out bad and are worth avoiding. But we never know for sure which is which until after we make the mistake. Does that make sense to you?"

"Let me think on it. If I think I have to do what I cannot do, I am going to feel depressed, right? I’m in the hospital for my depression. You suppose, if I change what I think, I won’t be so depressed?"

"I don’t know, but it might be possible. Can you think of any mistake you ever made that you could have avoided, now?"

"I don’t think so."

"How do you feel about what we have been talking about?"
“I never had a talk like this before in my whole life. But I feel much better, it is like a heavy weight has been taken off me.”

I had been searching for any possible way for anyone to have avoided any mistake that they had made, and did not see how this was possible unless the definition of a mistake was having done something that could and should have been avoided; and, according to what I had learned, that would mean that it is impossible to make a mistake. I was very careful to avoid defining the meaning of the word, “mistake” in the questions I asked. Sometimes I used a leading entry into the questions, as in the second example above, but not often. Allowing each person to use his or her own definition without having to state what the definition was, except by its use in the example given, was my strategy for minimizing the putting of my personal biases onto the other person’s interpretation of the word “mistake.”

3.2.5 Testing with people in the larger community

About 250 of the people of whom I asked the questions were inpatients. I never raised the questions in a direct manner in any Recovery meeting, because I wanted to avoid confusing people with whom I might not have enough follow-up contact to be reasonably sure that what I said did not turn out to be harmful. I also wanted to avoid doing anything which might sabotage the effectiveness of the Recovery method for Recovery members by my injecting new concepts which contrasted with Dr. Low’s work into the meetings. This was, for me, an important aspect of keeping my work ethical. I was involved in other activities, talking with neighbors and friends, people who belonged to a church of which I was a member, and people I happened to meet. The form of the questions I asked, as well as what I said, became more consistent. The following is characteristic of a conversation with someone who had never been a psychiatric patient, whom I met by chance, and who expressed curiosity about what I was doing. This one starts with the other person.

“What do you do?”

“I do engineering work for some radio stations and I am trying to finish my Ph.D. in bioengineering.”

“Bioengineering? That’s like making artificial hands and things like that?”

“Yes, but bioengineering is more than that. I am working on some ideas about mental illness.”

“What does that have to do with bioengineering?”
"What are you trying to do to me? It was the first time I did anything like that. But I could have been more careful."

"Why weren't you?"

"Because I was in a hurry to get home. But I could have taken more time and still have been home soon enough."

"Why didn't you?"

"Because nothing quite like that ever happened to me before. But I could have decided not to be in a hurry."

"Why didn't you?"

"How many times do I have to say it, because I did not realize that I was going to make the mistake."

"Did you notice what you just said?"

"What do you mean?"

"You stopped saying, ‘Because..., but I could have...’"

"What’s your point?"

‘You finally noticed that you made the mistake because you did not know in advance that you were going to make it; and so did nothing to prevent it, and you did so because you had other things to do besides making perfectly certain that you could not possibly make such a mistake. I think you would have made a far greater mistake, so to speak, if you lived in such a way that you always read all the fine print on every grocery store shelf label, so you could never make such a mistake. There are too many things like that to keep track of, I think no one can live according to the standard of, ‘but I could have...’ You know, I think you made a much more serious mistake than the one about the price, and I would like your opinion. I think your decision that the price was worth arguing about because you were right and the clerk was wrong was actually the only important mistake you made in that event as you described it to me. Suppose someone who was, for some reason or other, somewhat addled, had been in the store shortly before you were and picked up a wrong box, realized the mistake a little later, and unwittingly left the item you wanted in the wrong place. To me, that is a triviality, a minor inconvenience at the most, and it is certainly not
worthy of an argument. I am not picking on you, I don’t find fault with you, but I think you were rather
unkind to that clerk.”

“You know, you may be right about that. I certainly would not have wanted to be in her shoes
when I was so upset.”

“Remember the old saying, ‘Haste makes waste.’? I think some of your self-respect got wasted
by your sense that you had to be right and the clerk wrong, when it was you who was wrong, wrong in
more ways than one. Have you learned the lesson that being hasty tends to make for more mistakes than
being patient? I have found that I usually get more done when I am patient than when I am impatient. A
psychiatrist, Dr. Abraham Low, whose work is a lot of the basis for my research remarked, ‘If my patients
had patience, I would not have patients.’ I think he had a good idea, what do you think?”

“This is interesting. You seem to believe that there aren’t any mistakes that can be avoided.”

“Almost, but not quite. If I learn from other people, if I learn that some things I do are wrong, then
I can anticipate the results of what I am doing better, and can avoid making mistakes I would make were
I not so careful, caring, and willing to learn from other people. What I am talking about is not mistakes that
may happen, but ones that already have. The past has already happened, it is over. The future has not
happened yet, The more I am willing to learn today, the better my life tomorrow is likely to be, at least that
is how it seems to work for me.”

“I need to mull this over, it sure isn’t what I was taught. So far, I don’t see where what you have
said could be wrong, though.”

“If you can, I’d like you to do me a favor. If you can think of any mistake you or anyone else ever
made that could have been avoided through a realistic process, something a person could actually have
done, not just as a fantasy or as wishful thinking, I sure would appreciate your telling me about it. If you
can do that, you can shoot down the whole rigorous scientific basis of my thesis, and I can perhaps do
something else. But I also need to tell you that I have asked quite a few people to do the same thing, and
have talked with them several times since, and not one of the people has, as yet, been able to give me even
a clue as to where the idea that ‘mistakes made could not have been avoided’ might be wrong.”

“I’ll get back to you.”
I have spoken repeatedly to almost all of the 150 or so people, who were not psychiatric hospital patients, of whom I asked "the three questions," since first asking them the questions. Most of these people reported to me that they had tried hard to find an exception to the idea that no mistake made could have been avoided, none could find an exception. With this evidence that my work and findings might be scientifically valid, I set out to design a laboratory experiment to confirm or refute this. I needed to find people who would be the most likely to be able to demolish my argument, people who were highly educated and informed, whose backgrounds were diverse, and with whom I could ethically discuss my concerns. Since my research concerns beliefs, since the role of clergy is centered around questions of beliefs, since clergy can be consulted ethically about personal concerns, I set out to find if any member of the clergy to whom I had ethical access could refute my evidence. My purpose was to gather, within an ethical and appropriate framework, and as part of the ordinary course of my life, enough additional knowledge to design a computer-based interview-survey-experiment to test the model of my research as a laboratory experiment. By the time I had done most of the design of the experimental protocol and procedures, in the fall of 1995, I realized I already knew the outcome of the experiment with all the certainty I would ever need. I had asked people who were far more likely than a random sample of the population to be able to counter my evidence during the design of the experiment. Further, on recognizing this, I saw that it would be unethical to waste people's time doing a formal laboratory experiment which would not add anything significant to my work.

3.2.6 Testing and evaluating the model with clergy

The discussions I had with members of the clergy started with people I had known before I was first psychiatrically hospitalized, including my own pastors. All the clergy involved were experienced in practice of counseling, none were naive about the basics of psychology. I began with members of the clergy I already knew and asked them for references to other clergy who might best be able to find a flaw in my findings. I selected such people in order to stay within my understanding of the ethical considerations relevant to my research. All the clergy were people I sought out primarily in searching for resolution of my own personal issues, but I always informed the members of the clergy about the nature and purpose of my research. I did everything I could identify to avoid any semblance of deception. The discussions I had with clergy explored many aspects and ramifications of the significance of The Fundamental Error of Social Reality, including such things as the idea of "original sin" and its relevance to contemporary society. Among protestant clergy, the range went from "ultra-liberal agnostic" to "bible-literalist, born-again" fundamentalist, from "total absolutists" to "social-consensus relativists," from "completely confident—my faith is unbreakable" to "flooded with doubts—my faith often fails me." Among Roman Catholic
clergy, the range went from "Cannon law is nearly infallible" to "I have often heard other priests preaching obvious heresies in their homilies." Jewish, Islamic, and Buddhist clergy were among the group with which I discussed my findings. The clergy members with whom I spoke about my work included ones with multiple doctorates, college teaching backgrounds, doctoral-level training in psychology, some in their first pastorates, and seminary faculty. To put it directly, I set out to identify those people to whom I had access whom the clergy from whom I sought references reckoned would be the most likely to be able to show how a mistake made could have been avoided. No one has yet been able to do this.

As a "preacher's kid" whose childhood home life was centered around "the gospel made practical in everyday life," and as a member of a Christian congregation who had read the Bible cover-to-cover several times in different English translations, and who had studied many works on theology and religion, I found that I was essentially at parity with the clergy in discussing theological and religious issues. A number of the clergy invited me back for repeated additional discussions. Because many aspects of contemporary American society have origins in the Judeo-Christian-Islamic tradition, I will give one example of the ways in which the model of Affirmation Therapy interacts with religious belief.

Consider the story of "The Fall" in the book of Genesis in the Bible. From my conversations with self-identified fundamentalist Christian clergy, I believe a fair representation of a general fundamentalist view of "The Fall" is something like this:

God made a perfect world because God is perfect. God made Adam and Eve, who, because they were made in God's image, also had a form of perfection, but they also had the opportunity for choice. In the center of the Garden of Eve, which God had made to be perfect, was a special tree, which God told Adam and Eve to leave alone. Eve disobeyed God when tempted by the serpent, ate of the fruit of that tree, the tree of the knowledge of good and evil, and thereby sinned. She should not have done this, she was wrong to do it, she should have known better, it was her fault that she made the mistake, and, as a result of her mistake, the whole of humanity has suffered ever since. It would have been better had Eve not made that mistake.
The model of AT reveals a problem with this interpretation. It is an example of The Fundamental Error of Social Reality. It is the claim, disordered thinking in the AT model, that Eve made a mistake she could and should have avoided. The interpretation of the same story, as I understand it from my present perspective of the method of AT is like this:

There is as yet no clear scientific proof as to how the world came into being, but this question, by itself, is unimportant in AT because the focus of AT is on the present and what can be done now so the future can be good; whatever happened in the past is over now, but the past, as we can remember it, is the foundation for the decisions made now which will affect the future. Taking the story as written in the Bible at face value, with minimal interpretation, the only way Eve could come to know that it was a mistake to eat the fruit of that tree was to eat it. She had to make the mistake, assuming it was a mistake, before she had a chance to know it was a mistake. She could not have avoided making the mistake, assuming it was wrong to do so, because it was not until after she ate the fruit that she could have knowledge of good and evil, of right and wrong. To expect someone to know something before the opportunity, in a realistic and achievable way, has arrived is to set an impossible standard, one that can never be met. Given, for the sake of the logical argument, that what Eve did was a mistake, the graver mistake, by far, is to believe that she should not have made it. Believing, by mistake, that mistakes made should have been avoided enables the greater mistake of punishing people for not avoiding supposedly avoidable mistakes, since supposedly avoidable mistakes exist only in disordered, unrealistic thinking. It is appropriate to be grateful, again, taking the story at face value, to Eve for making that mistake, for it opened the door to the whole realm of ethics and morality, and genuine learning, and, ultimately, is a magnificent gift to humanity, although that may not yet be very clear to most people. The method of AT not only affirms Eve as a person, whether real or fictional, but also affirms her choice.

The traditional story of “Pandora’s box” of Greek mythology suffers from the same problem as I recall that story, it gives the impression that the world would have been better had the box not been opened. While AT is about the present, the myths of the past continue to exist in folkways and mores of society and are reflected in consensus reality and jurisprudence. The method of AT does concern the present-day effects of ancient myths. From Campbell and Moyers (1988, p. 47),

MOYERS: In the Christian story, the serpent is the seducer.
CAMPBELL: That amounts to a refusal to affirm life. In the biblical tradition we have inherited, life is corrupt, and every natural impulse is sinful unless it has been circumcised or baptized. The serpent
was the one who brought sin into the world. And the woman was the one who handed the apple to the man. This identification of woman with sin, of the serpent with sin, and thus of life with sin, is the twist that has been given to the whole story in the biblical myth and doctrine of the Fall.

MOYERS: Does the idea of woman as sinner appear in other mythologies?
CAMPBELL: No, I don't know of it elsewhere. The closest thing to it would be perhaps Pandora with Pandora's box, but that's not sin, that's just trouble. The idea in the biblical tradition of the Fall is that nature as we know it is corrupt, and the female as the epitome of sex is a corrupter. Why was the knowledge of good and evil forbidden to Adam and Eve? Without that knowledge, we'd be a bunch of babies still in Eden, without any participation in life. Woman brings life into the world. Eve is the mother of this temporal world. Formally you had a dreamtime paradise there in the Garden of Eden—no time, no birth, no death—no life. The serpent, who dies and is resurrected, shedding its skin and renewing its life, is the lord of the central tree, where time and eternity come together. He is the primary god, actually, in the Garden of Eden. Yahweh, the one who walks there in the cool of the evening, is just a visitor. The Garden is the serpent's place. It is an old, old story. We have Sumerian seals from as early as 3500 B.C. showing the serpent and the tree and the goddess, with the goddess giving the fruit of life to a visiting male. The old mythology of the goddess is right there.

Now, I saw a fantastic thing in a movie, years and years ago, of a Burmese snake priestess, who had to bring rain to her people by climbing up a mountain path, calling a king cobra from his den, and actually kissing him three times on the nose. There was the cobra, the giver of life, the giver of rain, as a divine positive figure, not a negative one.

In AT, beliefs which refuse to affirm life are recognized as wrong, regardless of the tradition of their origin. It is for this reason also (not only because I had ethical access to clergy) that I sought out such people to explore the possibility of disproving the validity of The Fundamental Error of Social Reality. I thought that fundamentalist Christian clergy would be more strongly motivated than others to try to find how my work was wrong.

I have gone at a careful pace in checking out the model of AT, in large part because I find it very unethical to take away a person's psychological defenses unless one has first given the person something that will unambiguously serve the person better. On Thanksgiving day in 1987, I saw that the discovery of The Fundamental Error of Social Reality posed a significant threat to many well-entrenched beliefs, both religious and secular. What I did learn from the clergy was that I could explain AT to people who I thought might be disturbed by its ramifications and such people readily incorporated the essence of AT into their beliefs without suffering evident decompensation. Finally, in the fall of 1996, I was given the first chance to test, in a way I found to be safe and ethical, the full extent of AT with a person who had suffered from severe chronic mental illness. I was willing to do this because I had seen no signs that the method of AT brought harm to anyone with whom I had shared any aspects of it, and because the particular circumstances of this person's life allowed me to do so ethically.

3.2.7 An example of the method of AT with a person with mental illness

In early October of 1996, just over a week before I passed the oral examination for my Ph.D. in bioengineering, a person who had heard of my work "through the grapevine" came to me and asked me to explain my research and findings.
Changes have been made in what I say about this person and this person’s situation for the purpose of confidentiality, but the important facts regarding AT are all accurate. This person is a mental health professional involved in the treatment of patients with a private practice. This person has a history of more than twenty years of severe and chronic, at times psychotic, depressive episodes. As a mental health professional, this person has had access to the highest standards of psychiatric care generally available in this country. This person has typically been hospitalized three or four times a year for over twenty years, and electro-convulsive therapy (ECT) was the only method of treatment that had ever brought even temporary relief. This person came to me about four days after being discharged from a psychiatric hospital after a full series of ECT treatments, and was scheduled to receive a series of follow-up ECT treatments about a week later. This person’s private patients do not know of the history of severe, chronic mental illness, and the person considers it necessary to keep this information from the patients. Therefore, having tried, unsuccessfully because of this person’s position and the grapevine contacts which got us together, to generate a simulated conversation that would both demonstrate the way I used AT and also would guarantee confidentiality, I will describe what happened in rather general terms in many respects.

I will give the person male identity for the purpose of describing what happened, whether the person is male or female is confidential, and no valid inference can be drawn from what I am writing here. The person is married. He came to me about noon one day and asked me to explain my work. I answered that I was very busy, but that I would be willing to use the method of my research, Affirmation Therapy, with him, no holds barred. I remarked that, as he is a mental health professional, there would be no problem of informed consent. I remarked that, as he had come to me of his own accord as a result of knowing about me as part of the ordinary course of both our lives, there would be no problem with ethical considerations. I remarked that, as he was under the care of a psychiatrist, there would be no problem with after-care. And then I remarked that, while this was not a promise, it was my best opinion that, if he agreed to what I said, within a week, meeting once a day for perhaps an hour or two a day, he would never again need ECT, and would never again need psychiatric hospitalization. I repeated that this was a hypothesis to be tested and not a promise. He agreed and called his spouse. The three of us met for about ninety minutes that day and ninety minutes the next. At the end of those three hours of working with the method of AT, the person said, “It will work, I can see how it will work and why it will work.” That ended the sessions. Later that week, he canceled the follow-up ECT treatments. We spoke by phone about a week after our two sessions; he told me that he had been right, he had learned the method in the two days, and it was continuing to work better day by day. He also reported that his psychiatrist’s opinion was that the ECT had finally, after so many years, finally
worked, and he was somewhat troubled by his psychiatrist's unwillingness to acknowledge that the change had come because of AT. I told him that, from what he had told me in the two sessions, his psychiatrist would likely need time to understand what really happened, and that he (the mental health professional) would be wise to humor his doctor until the doctor had time to realize what made the change. It is now about ten months after the two sessions, and we have spoken by phone about once a month. He recently told me his psychiatrist now accepts that the method is really working, his medications have been reduced to a very low dose, and there has been no sign of the need for either ECT or hospitalization. He has been through some very difficult personal experiences, not psychiatric nor work-related which, he said, would have been enough to force hospitalization in the past, but with the method of AT, he has managed these difficulties well, and without significant psychiatric symptoms.

To "cure" someone of severe and chronic mental illness in two ninety minute sessions with the spouse present and participating may seem too good to be true. While it is what actually seems to have happened, there are some important factors to consider. The person was a mental health professional, I could use psychiatric and psychological jargon efficiently; this saved a lot of time in the sessions as compared with someone without such high-level training in the field. Because of the way he heard about me, trust was established within a few minutes when we first met, this cannot be expected to happen much of the time. His psychiatrist, while wisely skeptical, was also very open to anything that clearly worked, and has been very supportive. At the time he came to me, his circumstances, the very recent hospitalization notwithstanding, allowed him to make a strong effort to put AT into routine practice in his daily life without being too distracted by other tasks. What are the key elements I used from AT to help him accomplish such a state of wellness?

AT involves a process, the process is iterative. Spotting temper, as in Recovery, is one key. Realizing on an ongoing basis that no mistake made could or should have been avoided, no matter who made the mistake or what happened because of it permits forgiving harm, no matter who was harmful or harmed.. Forgiveness resolves psychological pain and aids in remembering the past. Remembering the past brings past psychological pain to conscious awareness, so the hurts can be forgiven. Because no mistake made could have been avoided, all mistakes and their results are forgivable. Forgiving others facilitates forgiving oneself. Forgiving oneself facilitates forgiving others. Accepting the discomfort of remembering past hurts allows forgiving them and resolving the pain of the hurts. All feelings of psychological discomfort signal the presence of some sort of false belief, when beliefs are correct, life is basically pleasant; for pleasure, in the model of AT, is the absence
of pain and discomfort. Having the will to bear discomfort (Recovery lingo) is necessary for real forgiveness, which is the only valid way out of discomfort.

In daily practice, AT works this way. Assume that life is pleasant for a time, and then something happens and there is discomfort which begins to initiate temper. Spotting the temper (Recovery lingo) allows checking into what happened that stirred some mistaken belief. Perhaps it is of angry temper; something happened that shouldn’t have. Perhaps it is of fearful temper; something may happen which shouldn’t. When the mistaken belief is found and corrected, the discomfort goes away. In AT, discomfort is the delusion detector, it can be quite sensitive if given the chance, and even subtle mistaken beliefs (ones which are considered far below delusional intensity) can be ferreted out and replaced with better ones. Endorsing oneself for the effort (Recovery lingo) in correcting mistaken beliefs reinforces the will to use the AT method. This process generates an “anti-vicious cycle.” In contrast to the vicious cycle of temper-tenseness-symptoms-more temper-more tenseness-more symptoms, etc., of mental illness, the anti-vicious cycle of AT is spotting temper, accepting discomfort, recognizing mistaken beliefs, changing beliefs, finding serenity, spotting more temper, accepting discomfort, recognizing additional mistaken beliefs, changing beliefs, finding more serenity, etc.

The process of AT not only gets the person suffering from mental illness ‘off the hook,” but it gets everyone “off the hook” back to the beginning of human society, and it will get everyone “off the hook” for the foreseeable future. One of my friends from the time I was a patient at Austen Riggs, when he understood the method of AT well, remarked to me, regarding mental illness, “What you say makes more sense than anything else I ever heard in my whole life.” The method of AT needs further testing before the full range of its effects can be known. To date, I have been very careful to avoid hurting people with whom I have discussed the AT method. I use about as much non-verbal communication as verbal communication in AT, I have used considerable personal disclosure about my own hospital experiences as “ice-breakers” in initiating conversations about the AT method. But everyone has made mistakes of one sort or another, and almost anything will do as an “ice-breaker” as long as what is said is reasonably neutral and the way it is said is affirming of everyone present. Making unavoidable mistakes in using the AT method, and then applying the AT method to those mistakes is one way of modeling how AT works in a real situation. “I’m sorry,” “Perhaps I said that poorly,” “I’m not sure I understood what you meant,” “Perhaps what happened to me the other day will help you understand what I am trying to say,” “This is how I felt when...,” “I don’t think so, but I may be mistaken...,” “If I were in a situation like I think you describe, I might try...,” “What do you
think of...?,” “I respect you, but I think I have a problem with what you say you did,” and such are things that happen in AT. The conversational style of AT is free-form, it is spontaneous with the caveat that anything the Affirmation Therapist says or does needs to be considered from the standpoint of whether it is likely to harm the patient, either by being abusive or by setting up transference relationships which take the conversational style of AT away from a peer-to-peer structure. The peer-to-peer aspect of AT means that all parties are granted full respect, and this respect includes realizing that the therapist almost certainly knows more about AT than the patient(s) and the patients know more about themselves than the therapist. Based on my experience to date, I believe that the usable group size for AT is from one-on one to a group of about ten people at the most. With more than ten people, there is little chance for including everyone adequately, and I am inclined to speculate that the optimum size will be about five to eight.

What is next in the testing and evaluation of AT? I have been back at Austen Riggs several times during the design and development of AT, and have shared the concepts of AT with some of the staff there. I have been told, based on what I have written to staff members at Riggs, that, I will be welcomed there to do research if I can get the necessary funding to cover the costs incurred to the hospital. This is standard procedure at Riggs, as I understand, for people who are not on the staff and want to do research there. One way or another, I plan to test Affirmation Therapy further, to find what adaptations may enable it to be effective with a wider range of people than it has been developed with so far. It works for me in my daily life, I have tested it as thoroughly as was practical on myself in my own life before trying it with other people. So far, it appears, by every test I have been able to make, by every thought experiment I have been able to devise, to be valid and true. Time, and the lives of people who use the method of AT will finally determine its true usefulness.
4. REVIEW OF LITERATURE

4.1 Introduction

The idea that mental illness is biologically based goes back a long time. From the *Encyclopaedia Britannica* (1771, Vol. III, p. 149),

Melancholy and madness may be very properly considered as diseases nearly allied; for we find they have both the same origin; that is, an excessive congestion of blood in the brain: they only differ in degree, and with regard to the time of invasion. Melancholy may be looked on as the primary disease, of which madness is the augmentation.

The idea that mental illness affects a person's capacity to be socially appropriate is old, it is described in detail in the above reference. Nowhere do the authors of that article hint at the possibility that "melancholy" or "madness" might have its roots in abuse. The problem of mental illness was acknowledged but no one today who is well trained in medicine would tend to think that mental illness is caused by an excessive congestion of the blood in the brain.

Because the mind is the main tool we have to use in making sense of mind, there is a problem of self-reference, study of the mind is rather like the eye trying to study itself without a mirror, it cannot see itself directly. There are, I believe, mental mirrors; they are the minds of other people. But, how do we see ourselves accurately if the only mirrors we have contain distortions?

According to Webster (1995), (Sigmund) Freud was strongly influenced by his understanding of the physical sciences of his day, which he understood to describe a deterministic world. Freud was also strongly influenced by Darwin's work and the ideal of evolution. Freud, as others (Lorenz, 1966) tended to see the human condition pessimistically in terms of competitive "survival of the fittest" members of the species against each other. Olson (1971, p. 142) has another view of the meaning of evolution, one that is much more constructive.

The primary error of those who have distorted Darwin's theory beyond all recognition is one of stupendous magnitude. It consists of ignoring entirely the existence of the physical universe! The cause of progress is assumed to be, not the struggle of man with his environment, from which he gets food, clothing, shelter, and all other necessities, but the struggle of man with man, a struggle which is by its nature unproductive and fruitless.

I have heard "the law of the jungle" described as "eat or be eaten" in some television commercial(s) a while ago. While eating and being eaten does occur in the jungle as elsewhere, it puts a dismal cast on life, so I find. If the law of the jungle is, "eat..."
or be eaten" in a competition against other life, why is not the jungle a monoculture? I think there is a better way to understand the jungle, and that way is part of the philosophy I have used in developing AT.

To me, the law of the jungle is sharing and cooperation as a system. Sunlight and rain come and plants grow. Herbivores eat the plants and become food for carnivores. Carnivores die and are recycled into nutrients for the plants which grow as the sun shines and rain falls. I recall hearing a story attributed to the Eskimo, "The wolf and the caribou are one, for the caribou feeds the wolf and the wolf keeps the caribou strong." In the design and development of AT, I took the philosophical position that things happen for some valid reason or other, whether or not I can recognize or understand the reason. The work of this thesis was arduous, many of the literature items contained hope and suggested opportunity, rather than despair and melancholy.

The bibliographies by Schmitt (1991a, b) of work by and about Dr. Low and Recovery indicate to me that the Recovery method was outside mainstream psychiatry as a method prior to 1990 or so, and I have found no evidence of meaningful appreciation of Dr Low's work in the publications of mainstream psychiatry since. The almost three thousand page Comprehensive Textbook of Psychiatry, Sixth Edition (Kaplan and Saddock, 1995, p. 1830) has this, and only this, to say about Dr. Low and Recovery, Inc.

...Among the best-known self-help groups are Alcoholics Anonymous, founded in 1934; Recovery, Inc., formerly the Association of Nervous and Former Mental Patients, started in 1936 by a psychiatrist, Abraham A. Low; and Gamblers' Anonymous, founded in 1957. There is no way anyone could have even the foggiest notion of the Recovery method from that, nor why the group is among the best known of self-help groups. There is no mention whatsoever in Kaplan and Saddock (1995) of temper as described by Dr. Low, temper tantrums have four short mentions, but the Recovery method is not really about tantrums. For all practical purposes, mainstream psychiatry seems all but totally ignorant of the significance of Dr. Low's work, based on the many works listed in this thesis and the several times more than that which I read in getting background information for this thesis.

I come to suspect that the difficulty stems from a phenomenon I experienced in my own psychiatric treatment, the tendency of people who work in the mental health field to have personal problems which involve temper. I found only two psychiatrists among the many who were involved in my treatment in whom I did not see a serious problem of temper, the first was my psychiatrist at Austen Riggs Center, and the second was Dr. E, the one who discontinued the medications which
seemingly were causing my illness. For now, I shall surmise that it is the denial of many psychiatrists about their own problems with temper that blinds them to the merits of Dr. Low’s findings. Dr. Low worked on refining the Recovery method up to the time of his death. No one of his caliber was available to continue developing the method, but it is a remarkable testament, in my opinion, to the depth, breadth, and quality of his work that Recovery, Inc., is a vital organization more than forty years after his death. The psychiatric community needs, in my carefully considered opinion, to wake up.

There are many aspects of mental illness which are in the active psychiatric literature, and I will summarize my literature research findings by categories of concern, from shame and guilt to Recovery and affirmation. There is no literature I can find about the method of Affirmation Therapy or the Fundamental Error of Social Reality.

4.2 Shame

From Wermser (1981, p. 52),

Obviously the affect of shame is profoundly unpleasant. As I mentioned initially, it has as a central ingredient a form of anxiety that spans the range from mild anticipation to crushing panic.

One fears one will be punished by “shaming” procedures after the exposure. What these procedures have in common is the affect tone of contempt, a specific type of rejection, regardless of whether this shaming consists of looks, words, certain tones of speech, or outright pillorying. Yet what is the exact nature of this anxiety itself?

“Shame sets one apart,” as Hawthorne remarked about Hester Prynne in The Scarlet Letter: She was under “the burden of her ignominy,” “as much alone as if she inhabited another sphere.”

The threat shame poses is isolation from others, as Wermser makes clear. The issue of stigma regarding mental illness is a shame issue, also. Many of the patients with whom I lived while I was hospitalized seemed very scared about what would happen to them if other people found out about their psychiatric treatment.

The descriptions of shame and its impact are much the same in Colt (1991), Nathanson (1992), Okano (1994), Kilborne (1995), Alessandri (1996), and Gilbert (1997). Montagu (1978) is a collection of descriptions of “primitive” societies in which violence is either very low or absent. Yet every one of the societies described there uses shame as a method of social control. Shame appears to be a universal phenomenon, as far as my reading reveals. However, in AT, shame is used, not to isolate people, but to acknowledge the presence of harm and thereby strengthen community.
Ashby, et al. (1997) point out that interest in shame in psychiatry is recent, most of the work has been done in the past decade. Yet, from my study of anthropology years ago, as well as my noting the stigma problem of peer psychiatric patients, also about a decade ago and since, shame is among the most important psychosocial aspects of mental illness. It is worthy of note that Dr. Low connected shame with fearful temper well over fifty years ago.

Ashby, et al. studied the distinctiveness of shame and guilt, but they consider these conditions only as affective states and not, as in Recovery and AT, as beliefs which generate affective states as a side effect. From Ashby, et al. (1997, p.62), the results of the study support the assertion that the affective states of shame and guilt can be accurately distinguished... These results indicate that, without a great familiarity with the shame/guilt literature, practicing psychologists share distinct working definitions of shame and guilt. The experts who helped to develop the shame/guilt recognition instrument had more difficulty agreeing with each other than the psychologists sampled.

They seem to totally have missed the idea of classifying shame as a belief.

4.3 Guilt

Guilt is more of a concept of law than of psychiatry according to the number of recent journal articles I was able to locate. Gilbert (1997) addresses guilt, along with shame and humiliation as aspects of “social attractiveness”, and I find that he identifies the main difficulty with guilt in terms of the shame and humiliation it tends to produce in a person who is identified as guilty but wants to not be isolated from mainstream society. This contrasts also with the view of both Recovery and AT that guilt is first and foremost a belief. AT offers resolution of guilt through practical ways of forgiveness, Gilbert does not address this issue.

4.4 Punishment

Chamberlin (1996), Colvard (1996), Howard (1996), Hyman (1996), Lazolere (1996), Bauman (1996), Straus (1996), McCord (1996) Bauman (1996), and Graziano (1996) were presentations at a conference on punishment. All use the technical definition of punishment, and the most make the point that corporal punishment (the term they used to cover the physical aspect of what I have called punishment in the ordinary sense). Except for Bauman and Colvard, the position taken is that corporal punishment is always a poor idea which usually is counterproductive. Colvard is not convinced that there is harm in spanking little children, and Bauman takes the position that the data does not support a blanket stance against
corporal punishment. The position of AT is that hurting people is wrong, and that the only appropriate use of corporal punishment would be when it would almost certainly accomplish prevention of significantly greater harm.

Skiba and Deno (1991), clarify the technical definition, they state directly that, if reduction of the behavior does not occur, punishment did not occur. Carey (1994) addresses what I also believe is a serious misinterpretation of the biblical reference to “sparing the rod,” in which the rod, Carey suggests, is a shepherd’s staff which is used, not to beat the sheep, but to extend the reach of the shepherd in guiding them. Carson (1994) shows how people, as adults, carry out the tradition of punishment in judging other adults, with generally harmful results.
4.5 Abuse

There is a vast literature on abuse, the series of books by Alice Miller is a development of increasing clarity as to the nature and effects of abuse on children and adults who suffered childhood abuse. Miller's focus is on the psychological damage of abuse, which strongly tends to turn into abusive behavior toward children when abused children become adults. Miller deals with subtle abuse of forms not generally recognized as such, but the kinds of abuse she documents are the kinds of abuse peer patients reported to me during my hospitalizations, I find her work to be very accurate and in agreement with the ideas of abuse of AT.

The model of AT, however, takes strong exception to Miller's ideas of guilt,

The more forthright I become in my statements, the more I learn from the reactions of others. Some reactions challenge me to further thought and precision. One such reaction has to do with the innocence of the parents. People's questions run something like this: "But surely you don't mean that parents are guilty when they mistreat their child out of desperation? After all, you've said in your books that parents are compelled to transfer the unconscious traumas of their childhood to their own children and, as a result, mistreat, neglect, and sexually abuse them.

This kind of reasoning makes me realize that I must now take a step I did not dare take in my first books. I will proceed from the following, very simple, virtually unquestioned perception: Any person who destroys human life renders himself guilty. This perception is in accord with our legislation, on the basis of which people are condemned to years of imprisonment; and no one can claim that this is a universal ethical principle or our society... But in times of peace, destruction of human life is not permitted and in fact is a crime that is punished. With one exception: Parents are permitted to destroy the lives of their children with impunity. Although this destruction is in most cases repeated in the next generation, it is far from being forbidden. All that is forbidden is to call it a scandal. (Miller, 1990a, pp. 19-20)

The "universal ethical principle" mentioned by Miller is inherently unethical in the model of AT, it denies the meaning and significance of The Fundamental Error of Social Reality. In AT, unlike present day statutory jurisprudence, the purpose of guilt is not to enable punishing the guilty, it is rather to identify who acted harmfully and who was harmed, so the damage can be repaired as much as is practical, and forgiveness can then take care of the rest.

Storr (1990, p. 99) raises what is a central question in the model of AT,

I shall argue that human violence and cruelty are predominantly concerned with power relationships. Although the study of aggressive personality disorders and sadomasochism throws some light on these distasteful aspects of human nature, we must turn our attention to the question with which this book began. How is it that so-called "normal" people can be persuaded to treat their fellows with barbarous cruelty?

The model of AT solves this puzzle. The mere exposure effect (something told often enough becomes believed, regardless of what it is, merely because of the repetition) combined with the fact that humanity has had a limited time to learn of right and wrong, meaning that we are still learning about behaviors that are wrong because of their harmfulness, but have not yet
had time to learn how to avoid them. Further, in AT, violence and cruelty are not part of human nature, they are in opposition to human nature, and that is why they are problematical. Further, the whole of Low (1967) is about the destructiveness of power versus the constructiveness of peace.

The ideas of Holt (1964), Terr (1990), Forward (1989), and Celani (1994) also are in strong agreement with the concept of psychological abuse of AT. But Dershowitz (1994) takes a very opposite stand, in the model of AT, his position is of strongly disordered thinking, for he holds people accountable who, in the AT model, were so badly abused that their capacity to act willfully in avoiding wrongdoing was destroyed. Dershowitz clearly believes that there are mistakes made which could have been avoided and resistible impulses which were not resisted, contrary to the model of AT.

Maitra (1996) comes close to some aspects of AT, in raising the question, in terms of cultural settings, as to whether abuse is a universal aspect of psychiatric diagnosis.

4.6 Multiple personality

The literature on multiple personality, multiple personality disorder (DSM-III-R category) and dissociative identity disorder (DSM-IV category) spans the range from McHugh and Putnam (1995) in which McHugh takes the position that MPD or DID is an artifact to Chase (1987) who, according to her story and my experience, lived it. MPD or DID is not unique to western society. Paris (1996) and Chitalkar (1996) provide clear evidence of this. The tendency of people who have the experience of being multiple (I have known four people so far with the diagnosis) to be disbelieved by therapists was shared by all of four of those people and myself as well. Franklin (1990), Kluft (1985), LaCalle (1987), Beahrs (1982), Rossini, et al. (1996), Ellason (1997), Brenner (1996), and Kennerly (1996) all describe aspects of MPD or DID in formidable detail. I am inclined to believe, from both reading and my own experience, that dissociation, to some degree, is almost universal, and that psychiatrists and psychologists who use dissociation as a significant defense in their own lives may be blinded to it in others.

Fairbairn (1944) under the heading, “A Multiplicity of Egos,” wrote,

Attention has already been drawn to the fact that, whereas the repressed was eventually described by Freud as consisting essentially of impulses, he found it necessary to fall back upon structural conceptions (the ego and the super-ego) when he came to seek an explanation of the agency of repression. Reduced to its simplest terms, Freud’s conception of repression is to the following effect:—(a) that the agency of repression is the ego, (b) that repression is instigated and maintained by the pressure of the super-ego (an internalized parent figure) upon the ego, (c) that the repressed consists essentially in libidinal
impulses, and (d) that repression arises as a means of defence against impulses involved in the Œdipus situation and treated by the ego as 'guilty' in terms of the pressure of the super-ego. That the agent and the instigator of repression should both be regarded as structures whilst the repressed is regarded as consisting or impulses involves a certain anomaly which so far appears to have escaped attention. The extent of this anomaly may perhaps best be appreciated in the light of the fact that the super-ego, which is described as the instigator of repression, is itself largely unconscious; for this raises the difficult question whether the super-ego itself is not also repressed. Freud himself was by no means oblivious to this problem; and he expressly envisions the possibility of the super-ego being in some measure subject to repression. Repression of the super-ego would, of course, represent the repression of a structure. It would then appear that the general possibility of the repression of a structure is recognized by Freud; and in the light of the considerations already advanced, it becomes reasonable to ask whether the repressed is not invariably and inherently a structural. In this event the anomaly to which I have referred would be avoided.

The anomaly referred to by Fairbairn was did not escape Dr. Low's attention, he wrote,

The author rejects the psychoanalytic doctrine both as philosophy and therapeutic technique. In point of philosophy, he cannot share the view that human conduct is the result of unconscious drives, sexual or otherwise. (Low, 1978, p. 12)

The model of AT is based on a concept of personality very much like that of Fairbairn; normal people have a multiplicity of states of self and this is essential for the variety of activities that make up ordinary daily living. At issue in AT is therefore, not whether the ego is "split" in Fairbairn's model, or whether people are "multiple," but whether one can live decently in one's community with self- and mutual-respect.

4.7 Temper

Except for the works of Dr. Low, already cited, there is no scientific literature on the phenomenon of temper as defined in the Recovery method and in AT which I was able to locate with an extensive search effort. There is some literature on Recovery, Inc., as a self-help group which is listed in Schmitt (1991b). Kaplan and Saddock (1995), for example, only describe temper tantrums, quite a different phenomenon.
The model of Affirmation Therapy described in this thesis is based on the discovery, by the author, of The Fundamental Error of Social Reality and the method of Recovery, Inc., developed by Dr. Abraham A. Low. The work of many other researchers in the fields of mental illness, personality, and society were influential in shaping the form of Affirmation Therapy as it has been developed to date. This thesis is meant as a beginning in the steps of scientifically exploring the utility of Affirmation Therapy as an enhancement to the currently established methods of psychotherapy. Only methods which contradict the finding that no mistake made could or should have been avoided are inherently incompatible with AT.

Until someone can demonstrate an achievable method for avoiding a mistake which was made, it appears that the finding that there are no mistakes made which could or should have been avoided is objectively true. The strength of this argument is found in the fact that it takes only one mistake made that could have been avoided in the whole of history to refute the validity of the idea of The Fundamental Error of Social Reality. Should the existence of such a mistake be demonstrated, the usefulness of AT is still worth evaluating further, I believe, based on the preliminary results garnered thus far in my life and, as I have observed, in the lives of people with whom I have shared my work.

I began the formal study of bioengineering in 1966, shortly after the Bioengineering Program at the University of Illinois at Chicago (then known as the University of Illinois at Chicago Circle) was started. I recall discussions with my fellow students as to exactly what bioengineering was and would become. One view was that it would be electronic and mechanical engineering of medical instrumentation, as the medical electronic equipment of the mid 1960's tended to be, as I saw it, either very "user-friendly" for medical personnel but very poorly engineered in other ways, or resembled the kind of equipment that belonged in an electronics laboratory and was so complex that one needed to have a strong background in electronics to understand how to use it and this equipment tended to be very well designed from the standpoint of its circuitry. For people of that view, the benefit of bioengineering would be well-designed medical electronics which would be easy for medical personnel to use and would be designed according to good engineering practice. This field today is often called biomedical engineering.
The second view, which was prevalent in bioengineering at the University of Illinois, and one that I favored, was that the whole realm of biology and medicine would be "fair game" for a suitably trained bioengineer. While my fields of concentration were (1) in Hospital Instrumentation and (2) in Prosthetic Devices and Artificial Organs in my graduate studies, which are of the biomedical side of bioengineering, I thought that the future of bioengineering might well include an engineering approach to systems of diagnosis. This thesis is an exploration of the possibilities of an engineering based approach to problems which initially seemed to me to be outside the purview of engineering. I had to invent many of the methods I used in the work of this research, it was to me as though I was straying into uncharted territory as an engineer. I have designed and built many items of electronic equipment "from scratch;" I did the marketing, the circuit design, the mechanical design, the component selection and procurement, the metal fabrication, machine shop work and assembly, the artwork, the writing or the instructions, the final testing, the delivery to the customer, the after-sale on-site support. For a time, in the late 1970's and early 1980's, I designed and built custom electronic test equipment used by a government contractor to demonstrate to the government agency for whom this contractor was building electronic apparatus that their equipment met the government specifications. I work at present as a broadcast contract engineer for radio stations. The point of this is that I have done and can do the traditional form of engineering. I did not do a "far out" thesis for lack of ability to do the "standard stuff." Because this thesis is about personhood, psychotherapy, and engineering, an uncommon combination according to my reading in scientific and engineering publications, I believe it wise to make it clear that I am able to do ordinary engineering.

In designing electronic apparatus, I have the tools of Ohm's law, Norton's theorem, partial differential equations, and many more well established tools of engineering. In taking bioengineering into the areas of psychology and psychotherapy, there are no such standard tools to be found as best I can tell. I have known people with engineering backgrounds who went into the field of psychology. From knowing these people, I am of the opinion that they changed fields because "they weren't very good" at engineering. There may be many people whom I never met who were very successful at engineering and then went into psychology, I have no evidence either way about this. For me, "floundering around" in research into psychology and psychotherapy methods as a bioengineer was a sharp contrast to any other engineering I have ever done. I did a lot of floundering before I recognized the idea of The Fundamental Error of Social Reality. As I did the test equipment I built for the aforementioned government contractor, I set out to test it carefully. As an engineer, I can find no flaw, no weakness of design in the Fundamental Error.
I wondered why Dr. A treated my wife and myself so terribly. Dr. A was a decent person, who, except for the colossal blunder (I find that to be an accurate description) of deceiving my wife and myself about the purpose of the meeting in which my wife and I “were ambushed,” and ambushing us despite my protestations that I was psychotic and needed my concerns to be confidential. I set out to find what, besides a dreadful, accidental misunderstanding could have caused that disaster. In retrospect, in part after reading the discharge summary for my first psychiatric hospitalization, I conclude that Dr. A most likely thought I had performed an autocastration. There is a literature about this, it has happened. (Lowy and Kolvakis, 1971; Money and De Priest, 1976; Haberman and Michael, 1979; Pabis, et al., 1981) The people described in those case reports and in others I read do not resemble me; they were all people of low achievement, none were identified as being at exceptional risk of cancer, none were reported as having a testicular growth. I finally conclude, based on all the evidence I have, that Dr. A was unable to accept my being multiple to such a degree that he decided that my being some sort of transsexual was the more likely explanation. Dr. A did bring this view up in therapy sessions after the confrontation, it never quite made sense to me, but I outwardly used it to try to get medication, as best the issue was understood ten years ago, (premarin and provera) to minimize both the risk I saw of prostate cancer and osteoporosis. Dr. A seemed certain that I should be taking testosterone unless I was transsexual, he never accepted the risk I saw from my dad’s history.

For a year or so, I joined a gender issue support group, some of whose members were transsexual or were transvestites. I found their views of life to be very different than mine, and realized that I do not have the beliefs or attitudes of either a transsexual or transvestite. But when I was very psychotic, I discussed the gender question with Dr. B at length, hoping that he would come to understand the problems I was having with dissociation. In 1993, six years after I first began seeing Dr. B, he told me that he finally accepted the diagnosis I had brought to his attention in 1987.

Dr. A and Dr. B made choices that had disastrous effects on my life. In my opinion, they made awful mistakes. With the model of AT, I know that they could not have done better, given their training and my illness. The method of AT solves the issue of their mistakes very simply. If I were to hold them accountable for their mistakes in some way that finds fault with them as people, why would I not find even more fault with myself for becoming mentally ill and coming under their treatment because I became ill? With AT, blaming is without merit, it would only disrupt and degrade the quality of my life. With AT, I do not set standards I cannot meet, I do not set standards others cannot meet.
As in the Recovery method, effort is among the most important factors in AT. In AT, effort is the tool whereby one reaches goals. After using the method of the AT model in my own life, I reach some conclusions about goals. All goals which cannot be reached with certainty if reasonable effort is made toward them are inappropriate goals. All goals need to be clear and detailed enough that it is possible to tell whether progress is being made in reaching them. All goals need to be capable of being tested, so it is possible to tell whether the goal has been achieved. If a goal is set which does not meet these criteria, there is no way to tell whether the effort one makes is worthwhile. Let me give an example, to show the method of AT at work in a real world example.

I recognized the possibility of doing a doctoral thesis about The Fundamental Error of Social Reality shortly after I discovered it. I realized that I would be doing research in the fields of psychology and psychiatry, in which I had no formal training. It occurred to me that I faced formidable obstacles which would have to be overcome were I to do an acceptable thesis about the discovery. When I set out to study psychology, psychotherapy, and psychiatric treatment methods in 1988, I knew that having a goal of doing such a thesis was an inappropriate goal, for I had no way to tell if it was achievable. So, I set an achievable goal instead. That goal was to find out what it would be necessary to do this thesis and find out if it was possible to do it. I realized almost immediately that I would need an eclectic and quite thorough understanding of the essentials of psychology, and set out to read books to determine whether I could attain adequate competence in psychology for the needs of the thesis. I realized I would need to be able to talk with people in depth and about sensitive topics, and began to talk with other patients to find out whether I had or could develop adequate skills in talking with other people. I realized the need to see if there was a flaw in the idea of The Fundamental Error of Social Reality, and if so, how I might find it. I realized the need to find a thesis committee. Around 1993, I tried to explain the work I had done to a psychologist who was recommended as a possible committee member. He was of the relativist persuasion and early into the conversation, told me that he was too busy to make the effort to understand what I had done. I said to him, offhandedly, “I was hoping to find someone who could understand my research besides myself.” His response, “Are you delusional, or are you on the cutting edge?” I answered, “Perhaps both.”

In the model of AT, virtually everyone, if not everyone, suffers some psychological abuse, and such abuse tends to generate mistaken beliefs. Specifically, in AT, the belief, “I could have, should have, but didn’t,” is a delusion. But, in the model of AT, the question is not whether one is delusional; the assumption is almost certainly that one is. But that question,
by itself, is unimportant. What is important is whether one has authentic self-love, self-respect, and a suitable will to appropriate effort such that one’s intrapersonal life and interpersonal life is genuinely satisfactory, taking into account the prevailing circumstances of one’s life in a kind an decent manner.

I am aware of several rules that have been proposed for the determining of appropriate conduct. The first may be called “The Iron Rule,” it is simple. It is the preemptive first strike, “Get them before they have even the slightest chance of getting you.” The second may be called “The Brazen Rule,” it is also simple; but not as simple as The Iron Rule. Get them as soon as you see real evidence that you are at risk, “Do not hesitate if you notice a threat.” The third may be called “The Silver Rule,” it is not so simple. Wait until you cannot stand it any longer and then get them, “Be nice as long as you can, then retaliate with everything you’ve got.” The fourth is “The Golden Rule,” it is often impossible in today’s world. Do unto others as you would have them do unto you, “If you’re in a good mood and want to be treated well, treat others well; but, if you are in a bad mood and are seeking punishment, trash others as much as you want them to trash you.” (The problem with the golden rule as it is commonly stated, I think, is that people who seek to be abused can justify their abusiveness by it.) The fifth I have called, “The Platinum Rule,” it is impossible (at least such is my opinion) without some form of the method of AT, and simple with it; simpler by far, in my experience than even the iron rule. Forgive without limit, for no mistake made could or should have been avoided, “Build, proactively, a better world for the future of humanity.”

Whether the discovery of The Fundamental Error of Social Reality and the invention of Affirmation Therapy develop according to the degree of promise I believe they hold will only become known in the future, after they have been shared with other people in sufficient numbers that their effects can be determined. This thesis is but one step in the process.

I have tested the method of AT carefully over the past ten years, under at-times very trying circumstances. For myself, I know that Affirmation Therapy works; indeed, works superbly. The mental health professional with whom I used “full-blown, no-holds-barred” Affirmation Therapy in the fall of 1996 has told me recently he finds the same result. There are two of us, now. I believe there will soon be more; in due time, many more. That is my considered understanding as a person well trained in engineering.
GLOSSARY

ABSOLUTISM—The philosophically based belief that there are aspects of reality which are independent of the believer.

ABUSE—In the model of AT, the subjective experience of harm of a theoretically preventable nature. Although abuse, when it occurs, is not preventable, learning what is abusive may allow preventing it in the future. Whether or not a particular event is abusive depends entirely upon what the person who experienced the event believes about it. Granted that there is a need for statutes governing abuse and its consequences, nonetheless, such statutes need to have sufficient flexibility that the harm suffered by someone who experienced abuse is no less respected than the person’s needs to deal with the harm. The following examples are intended to clarify what does and does not constitute abuse.

Consider that someone is feeling angry and is in a state of temper. Consider that this person throws a golf-ball-size rock at you, and you are struck in the head and injured. The fact that the throwing of the rock was deliberate and the thrower’s intention was to cause you bodily harm is not relevant to the presence or absence of abuse. Whether abuse occurred depends on your beliefs about the incident. Suppose you were an assailant and the rock was thrown in self-defense, and you knew and accepted this; you respected your intended victim’s right to self-defense, and might well not believe you suffered abuse.

Same as above, except the thrower was an assailant and you did not see the rock coming. You would most likely believe you had been abused.

Consider that you are on vacation in an unfamiliar area riding your bicycle in a wooded area in the country. You come around a bend in the road, and there is a golf course spanning the road. You are struck in the head by a golf-ball and are injured. Suppose that the ball had been struck before you rode around the bend and the golfer had no way to know you were coming. You might interpret this as abusive if you have a hatred for golf, but might not find it abusive if golf was your favorite sport.

Same as above, except the golfer could see you before hitting the ball. This situation is more likely to be experienced as abusive, especially if you believe that the golfer “should have known what would happen.”

Consider that you are going to your automobile to go to the store for something urgently needed, as storm is just beginning, and the first water to reach the ground is a golf-ball-size hailstone which strikes you on the head and you are injured. You may believe you suffered abuse if your spouse was supposed to get the urgently needed item on the way home and did not feel like bothering to do so.

Same as above, except that your spouse did bring the item, but you dropped it and it broke. You took responsibility for replacing it and had no idea that there would be hail. Most likely you would interpret your injury as “one of those things” that just happens from time to time, unfortunate, but hardly abusive.

In Affirmation Therapy, abuse includes maltreatment and neglect, and is a subjective experience. As the technical definition of punishment includes positive punishment and negative punishment, so there is positive and negative abuse in the model of AT. As positive punishment involves acting toward the person whose behavior is being punished and negative punishment involves acting away from the person whose behavior is punished, so positive abuse includes what is commonly called maltreatment and negative abuse includes what is commonly called neglect. In AT, the presence or absence of abuse is always determined by the subjective experience of the “abuser,” the intention of the “abuser” is not a factor in the question of whether abuse occurs. See the glossary remarks about punishment for clarification of this point.

Positive abuse includes such things as spanking a child for failing to understand the directives of an adult when the adult holds the child to an impossible standard of behavior, or scolding a child when the child does something the “scolder” does not want or does not do something the “scolder” does want, and child cannot do as the scolder wants. Negative abuse includes such things as failure to comfort a child who is feeling afraid, or inadequate food or education.

See also PSYCHOLOGICAL ABUSE.

ADULT ROLE—The psychosocial role a mature person plays in interpersonal relationships which is at peer level with other mature people. See Berne (1964).

AFFECTIVE—Concerning moods, emotions, and such. In this thesis, for simplicity of understanding the idea of brain hemisphere specialization, affective thinking is treated as a “right-brain” activity.

AFFECTIVE ADULT ROLE—The “feeling” role (right brain thinking) of a mature adult who is relating to another mature adult as a peer.
AFFECTIVE CHILD ROLE—The right brain thinking role of a person who is being instructed in how to grow into a mature adult.

AFFECTIVE PARENT ROLE—The right brain thinking role of a person who is instructing a person who is in the child role.

AFFIRMATION THERAPY (AT) is an iterative psychotherapy process in which discomfort is used to recognize mistaken beliefs and The Fundamental Error of Social Reality is employed to correct such beliefs through the objectivity of forgiveness. AT uses both analysis (non-Freudian) and synthesis in its method of psychotherapy.

AGGRESSIVE—Using power to prevail over other people in social situations.

ALL-OR-NONE LAW OF SYNAPTIC TRANSMISSION—the principle in biology that transmission of a nervous impulse across a synapse is a binary process, not an analog one, because the post-synaptic membrane either becomes depolarized or it does not.

ANARCHY—the condition of a society which has no laws, no rules, no folkways, nor mores, no traditions, and no culture. The model of AT presumes that the human species and/or its predecessors lived in a state which was essentially anarchistic prior to the invention of spoken language.

ANGER—in AT, anger is the belief that something happened that should not have happened. This belief, if not spotted, tends to turn into the behavior of angry temper.

ARGUMENTUM AD VERICUNDIAM A fallacy in formal logic stemming from inattention to the subject matter, in which an appeal is made to supposed authority instead of to objective evidence.

ASSERTIVE—A pattern of social behavior, in the pursuit of wants or needs, which is directed toward cooperation and peace, based on self- and mutual-respect. It takes the following general form, as an example, if someone has done something that you dislike and you want it to not happen again.

"When you..." "I feel..." 'I want..." "If what I want does not happen, then..."

The "...then..." is not an aggressive statement in an assertive process. Consider the following as an illustration. (In AT, feelings are thoughts)

"When you don’t close the garage door after you take your bicycle out for a ride, I am concerned that someone may take things from the garage. I think this would be bad for us because there are some expensive lawn tools in the garage. I know you get forgetful at times, everyone does, but I want you to think about what you are doing more carefully when you ‘tune out’ what is around you because you are concentrating on only one thing. If you don’t practice being more careful, I am afraid that you may get hurt or may hurt others in ways you might feel bad about."

ASSOCIATION—The process in the brain whereby thoughts are linked to each other.

THE ASSOCIATION—The Association of Nervous and Former Mental Patients, an early name of Recovery, Inc.

BASIC—Having to do with the typical average nature of something, in contrast to PHASIC, which is relatively unusual. Dr. Low gave as an example, Lake Michigan, which is basically a lake suitable for pleasure boating, but which phasically, in a severe storm, is not.

BIOENGINEERING—Engineering applied to the fields of biology and medicine.

BLINDSPOTTING—A mental technique to temporarily ignore some environmental factor, an important aspect of the Recovery method, based on the imagery of the blind spot of the retina of the eye. Something that is blindspotted is still there, its presence is not denied; it merely is given no attention.
CHANCE CORRELATION—The accidental appearance evidence suggestive of a relationship or association between two (or more) phenomena when there is no mechanism or process which produces the evidence except the accidents of chance or chaos.

CHILD ROLE—The role of a person who is being instructed into the ways to live. See Berne (1964).

CHOICE—The property of the mind which allows deciding between alternatives.

CO-CONSCIOUSNESS—The ability for various aspects of self (subpersonalities, personalities, “id” (in Freud’s model), ego (in Freud’s model), superego (in Freud’s model), memories, hopes, desires, and whatever else constitutes “self” to communicate with each other freely and spontaneously, while retaining their identities.

COGNITIVE—Having to do with the phenomenon of knowing. For simplicity in the model of AT, cognitive processes are predominantly left-brain intellectual activities, in contrast to affective processes which are defined as predominantly right-brain.

COGNITIVE ADULT ROLE—The intellectual role (left brain thinking) of a mature adult who is relating to another mature adult as a peer.

COGNITIVE CHILD ROLE—The left brain thinking role of a person who is being instructed into how to grow into a mature adult.

COGNITIVE PARENT ROLE—The left brain thinking role of a person who is instructing a person who is in the child role.

CORRELATION—In this thesis, the word “correlation” is used in the most general sense. The concept of linear correlation coefficients is only a tiny subset of the phenomenon of correlation as used here. Consider the following illustration.

An automobile is being driven on an urban expressway in heavy stop-and-go traffic. Consider the height above the pavement of point which is at the center of mass of the valve stem of the front right tire. At a constant speed and on smooth pavement, this point would trace a essentially sinusoidal curve if plotted against time. That sinusoid would be a correlation, though hardly linear. However, in the heavy traffic, with stopping and starting, the plot of the valve stem height against time will be a far more complicated function, but there will still be a correlation between the time and the height.

In terms of mental illness, a person may have biochemical imbalances as an aspect of a mental illness, and the symptoms may be palliated or alleviated or cured by medications which correct the imbalances. The correlation between symptoms and medication does necessarily not mean that medication resolved the problem of the mental illness. Even if a medication is site-specific in its action, and the site unambiguously is the area of the brain involved in the particular mental illness, and the symptoms of the illness are absent as a result of the medication, this does not necessarily mean that the medication corrected a chemical imbalance which caused the illness.

Consider, as an illustration, a person who has suffered from severe, chronic depression, and has an irrefutable biochemical imbalance associated with the depression. Suppose, further, that this person has been taking medication the effect of which is freedom from symptoms of depression. Suppose that the objective fact is that the depression and chemical imbalance corrected by medication are both caused by a disordered thinking habit. If the habit is corrected to an ordered habit, one in solid contact with objective reality, and thereby the process which caused the chemical imbalance is removed, both the symptoms of depression and the chemical imbalance would be cured.

Correlations of the sort in which medication seems to resolve such a state of depression as describe in the above illustration, are considered to be intuitive correlations in this thesis, even if they can be put into mathematical form. An intuitive correlation is one in which the mechanism relating the seemingly correlated phenomena is not known in precise detail. The notion of “precise detail is important in the model of AT.

As an illustration, consider a person suffering from paranoid schizophrenia, whose symptoms are controlled by a neuroleptic medication. To know in precise detail the mechanism of the person’s schizophrenia, one would have to show how the detailed content of the person’s ideation was determined by the chemical imbalance corrected by the medication.

The model of AT does not presume that biochemical imbalances of genetic origin are not causal factors in the etiology of mental illness. Rather it presumes that, until the full meaning of The Fundamental Error of Social
Reality is incorporated into social reality, there is no way to tell with certainty what are physical/genetic/biochemical/infections causes and what causes are psychosocial.

DECEPTION—For the purpose of this thesis, deception is the planned and intentional use of factually incorrect information in psychological experiments with human subjects, to see how people behave in such situations. In the design and the model of AT, deception was and is to be avoided to the greatest achievable extent.

DENIAL—Holding to a mistaken subjective belief in the presence of clear and obvious objective evidence to the contrary.

DETERMINISM—The belief that causality operates in this world with such preciseness that choice is an illusion of deterministic origin.

DIRECTLY OBSERVABLE—Phenomena which can be recognized and noted (Werkmiester, 1957) with a minimum of interpretation.

DISHONESTY—Intentionally stating as fact that which is not. It does not matter whether one is sincere, sincerity is not the same as truthfulness. In a matter of importance, an honest person makes a reasonable and diligent effort to determine the objectivity of the facts at hand, a dishonest person tends not to make this effort.

DISORDERED THINKING—Thinking which is at variance with objectivity. The most important example, for the purposes of this thesis, is the belief that a mistake actually made could have been avoided through an achievable process.

DISSOCIATION—The process the mind/brain whereby thoughts and experiences are kept separated.

DISSOCIATIVE IDENTITY DISORDER—The new name in the DSM-IV for what was previously called multiple personality disorder.

DSM-III-R See CITED LITERATURE

DSM-IV See CITED LITERATURE

ENGINEERING—Using scientific principles in the solving of problems of practical importance with efficiency and economy. The principle methods of engineering, in which scientific principles are used, are analysis and synthesis.

ERROR—The degree of difference between the actual results of a process and the intended (design) results.

FACT—Information which is independently and objectively verifiable.

FEAR—The belief that something may happen which shouldn't; it is properly understood to be an alerting to the need to be careful and not careless. Fear, as a belief, stirs emotional responses, but the emotions are not fear, rather a sign of it.

FEELING—A belief structure which is based on subjective opinion and not objective fact.

FORGIVENESS—The process whereby the pain of past harmful experiences is resolved so that the experiences can be readily remembered and the pain associated with them is clearly of the past and so is of no present danger. Shame and similar beliefs identify the presence of harm; Guilt identifies who was harmed and by whose actions; and Forgiveness allows repairing the damage.

FREEDOM—The state of mind in which it is acknowledged that mistakes made are unavoidable, that some things are deterministic, others are matters of will and choice, and the acceptance of this in a way that optimally facilitates learning.

FREE WILL—A will that is untrained or undisciplined. A person guided by free will tends to suffer from tyranny of that will, only when the will is trained (Recovery lingo) or disciplined, can a person know real freedom.
GUIDED-FREE-ASSOCIATION—An insight directed method of free association in which feelings of discomfort or such are intentionally used to steer the otherwise free process of allowing associations to come to consciousness spontaneously.

GUILT—The belief that someone did something that harmed someone in some way.

HONESTY—The intentional stating of a belief as a fact, having met the standard of diligent objective scrutiny in establishing that the belief is a fact.

INDIVIDUAL EDUCATIONAL PLAN—A plan made to guide the education of student in a special education program.

INTEGRATION—The fusion of various aspects of self (see co-consciousness) into a single entity in which the identity of the individual aspects is lost.

INTERNALIZATION is the mind/brain process whereby events external to a particular person become incorporated into the person’s personality and sense of selfhood.

KINDNESS—An approach to dealing with self and others based on respect, taking into account both abilities and limitations, and which is based on objective reality

LEARNING occurs when someone does something and what happens as a result is not, exactly, in every detail, precisely what was anticipated.

MALTREATMENT is treating a person in a way that causes objectively identifiable harm; such harm may be subtle and not evident only with casual observation.

MEDICAL MODEL See MEDICAL MODEL OF MENTAL ILLNESS.

MEDICAL MODEL OF MENTAL ILLNESS—A model of mental illness in which the illness is caused by a genetic condition, an infection or injury or such. The medical model of mental illness is, for the purpose of this thesis, a dichotomous alternative to the psychosocial-biological model of AT in that the medical model denies the observation of AT that, for the present, the preventable etiology of mental illness is psychosocial.

MENTAL HEALTH is a condition of the mind in which there is freedom from psychological pain and therefore life is basically pleasant, productive and enjoyable.

MENTAL ILLNESS is a condition of the mind in which psychological pain impairs to a significant degree the ability of a person to have mental health

MERE EXPOSURE EFFECT—The following is an operational definition from Alan Weintraub: “If you are told something often enough, you will come to believe it, no matter what it is.” The Fundamental Error of Social Reality has survived as long as it has only because it is told so often that mere exposure to it has made it believable.

MISTAKE—A mistake is made when someone does something and what happens as a result is not, exactly, in every detail, precisely what was anticipated.

MORAL DILEMMA—A moral dilemma is the result of setting unrealistic standards in such a way that every available identifiable alternative is clearly wrong from some standpoint which is in accord with the standards.

MULTIPLE PERSONALITY—A mind-brain condition in which the self is divided into separate entities. It is not a disorder if the entities have good cooperative communication, and do not compete for executive control of the person.

MULTIPLE PERSONALITY DISORDER—A mind-brain condition in which the self is divided into separate entities which have poor communication with each other and alternate in taking executive control of the person.

NEGLECT is a form of abuse in which things wisely done to meet the needs of a person are not done
NEGATIVE ABUSE See neglect

NEGATIVE PUNISHMENT is the removal of a stimulus following a behavior such that the likelihood of the behavior is reduced.

NEGATIVE REINFORCEMENT is the removal of a stimulus following a behavior such that the likelihood of the behavior is increased.

OBJECT RELATIONS—A theory of personality in which personality elements are comprised of internalized aspects of external entities. It is a derivative of psychoanalysis.

OBJECTIVE See objective reality

OBJECTIVE REALITY—Verifiable, confirmable facts; in contrast to the subjective reality of opinion, consensus, or tradition.

PARENT ROLE—The role a person plays in instructing a person in the proper ways to live (Berne, 1964).

PASSIVE—Not making an effort.

PETITO PRINCIPII II—Something true in a specific situation is inferred from a supposedly universal premise which is derived from the specific situation.

PHASIC See basic.

POSITIVE ABUSE See maltreatment.

POSITIVE PUNISHMENT is the presentation of a stimulus following a behavior such that the likelihood of the behavior is reduced.

POSITIVE REINFORCEMENT is the presentation of a stimulus following a behavior such that the likelihood of the behavior is increased.

PROACTIVE is the state of mind/brain in which effort toward desired goals is maximized, it contrasts with PASSIVE.

PSYCHOANALYTIC—Any method which uses analysis of any form to understand the mind. Freudian psychoanalysis is only one form of psychoanalysis; the basic method of AT in using The Fundamental Error of Social Reality to probe for, and forgiveness to rectify, disordered thinking, employs a very non-Freudian psychoanalytic-psychotherapeutic method.

PSYCHODYNAMIC—A way to understand the mind/brain in terms of active, ongoing internal thought processes.

PSYCHOLOGICAL ABUSE occurs when a person is required to do what is actually impossible and is punished (in the ordinary sense) for the inevitable failure. What is actually possible cannot be known in advance with certainty; this is why "You should have..." statements are inherently abusive.

PSYCHOSOCIAL—The combined aspects of personality and society.

PSYCHOSTATIC—A way to understand the mind/brain that does not involve the active ongoing internal thought processes.

The medical model of mental illness, as defined in this thesis, is psychostatic.

PSYCHOLOGICAL ABUSE is the internalization of any communication which results in a subjective understanding that the person who experiences abuse did something which he or she should have done or did not do something which he or she should have done. There is no boundary to the subtleness of psychological abuse, indeed, it is psychological abuse which is too subtle to be recognized when it occurs which has the greatest potential for harm.
in the model of AT because subtleness facilitates secrecy about the subjectively experienced abuse; secrets kept from oneself have the greatest potential for real harm.

**PSYCHOLOGICAL PAIN**—Feelings of discomfort and distress which prevent pleasure, serenity, and inner peace of mind.

**PUNISHMENT (ORDINARY SENSE)** is inherently abusive in the model of AT, for it is based on unrealistic standards. Punishment in the ordinary sense is the attempt to teach a person not to make certain mistakes by harming the person. This is paradoxical if the intent is to punish a harmful behavior; it is basically saying to the person being harmed, “I will teach you not to do harmful things, that is why I am doing a harmful thing to you.”

**PUNISHMENT (TECHNICAL SENSE)** reduces the likelihood of a behavior. It is a concept of operant conditioning. If the behavior which is intended as the object of punishment is not reduced, then punishment did not occur, regardless of the intentions of the “punisher.” This is a technical definition which contrasts strongly with ordinary dictionary definitions, in which punishment is typically the act of doing something unpleasant to a person’s body or mind in the attempt to force a behavioral change. There are two types of punishment, positive and negative. Positive punishment involves delivering an aversive stimulus in response to the behavior of which reduction is sought. Negative punishment involves, in response to the behavior the reduction of which is sought, removing a pleasant stimulus. Consider a child who has few chores and detests taking out the garbage. Positive punishment could involve requiring that this child take out the garbage as an aversive stimulus. Consider another child who has a number of chores and who is generally cooperative, but has the chore of taking out the garbage, also detests doing so, but who finds pleasure in receiving an allowance which is conditional on doing the chores. Negative punishment for this child could involve temporary cancellation of the allowance while the child has to continue doing all the chores. Consider a child who does something “naughty” and is spanked. If the “naughty” behavior is reduced, punishment occurred, if the behavior is not reduced, punishment did not occur, if the child is held to a standard of behavior which is, as determined by subsequent events, impossible to meet, abuse occurred regardless of whether the behavior was punished. Note that the word “child” is here used in the sense of “child role” as described in this glossary. If the targeted behavior is not reduced in likelihood, then, regardless of intent, punishment did not occur. Wade and Tavris (1990, Chapter 6) discuss punishment in the technical sense in detail.

**REALITY, CONSENSUS**—The beliefs, regarding facts, to which most if not all people in a society accept as real as a matter of social convention and convenience. The idea that a mistake made should have been avoided is an example of consensus reality.

**REALITY, OBJECTIVE**—The facts which are established through the means or scientific scrutiny, and are found thereby to be true. Objective reality is not the same as physical reality, because of the limitations of the field of science at any particular time.

**REALITY, SUBJECTIVE**—The beliefs a particular person holds about what is factual. Subjective reality depends upon a particular person’s experiences and abilities.

**RECOVERY, INC.**—A self-help group with headquarters at 802 N. Dearborn St., Chicago, IL, founded by Dr. Abraham A. Low while he was a member of the faculty of the University of Illinois at Chicago.

**RECOVERY LINGO** is the specialized adaptation of the American English language developed by Dr. Low and described in his books (see CITED LITERATURE).

**REINFORCEMENT** increases the likelihood of a behavior. See NEGATIVE REINFORCEMENT and POSITIVE REINFORCEMENT.

**RELATIVISM** is the belief that there is no objective truth, that “If you believe it, then it is true.” Pure relativism is incompatible with AT. But the approach of relativism is useful in dealing with TRIVIALITIES, in which there is no right or wrong to be found from the standpoint of objectivity in the model of AT.

**REPRESSION** is a form of dissociation in the model of AT, a way to not know about important aspects of one’s past. Repression is a form of disordered thinking in AT.
SCIENTIFIC PRINCIPLES are the tools used to identify objective reality. Because the tools of science change over time, objective reality is subject to change. Objective reality is the closest model to actual physical reality that the mind/brain can achieve.

SENSATION is the process by which the mind/brain becomes aware of external reality of whatever form.

SERENITY is a proactive state of the mind/brain in which focus on a task is optimal and productivity maximized because the person is reasonably free of inner conflict.

SHAME is the belief that one has done something which has put oneself into a dangerous condition. Typically, shame is a response to the fear (belief) that what one has done will result in separation from acceptance by one's community.

STIGMA is an intense form of shame in which some aspect of self is interpreted as being outside the boundaries of social acceptability and is of such great magnitude that one faces grave risk if the aspect becomes known, or, if is known, then one is presumably unacceptable in some manner as a member of society. Stigma is a property of the individual, the internalization of stigmatization by society; stigma results from social norms and cultural values which establish the boundaries of acceptability when a person finds himself or herself outside those boundaries.

STOCKHOLM EFFECT—Named after a report of a woman who, after being abducted in Sweden, became her accused abductor's strongest defender at his trial. It is considered to be a form of denial of the severity of inflicted abuse through identification with the abuser.

SPOTTING—Recovery lingo for bringing the attention of the mind to a task typically temper. It is based on an analogy with a spotlight.

SYMPTOMS are the inner experience of a patient, for the purposes of this thesis, one with mental illness. Symptoms are therefore not what is used in psychiatric diagnosis, clinically manifest signs are; such signs are the expression, as interpreted by the clinician, of symptoms. This distinction was important in the early development of AT because the symptoms I was having, when converted into signs, resulted in my receiving what was, in retrospect, very inappropriate medication. Further, when I protested my observations of this, my protest became yet another sign that the medication was appropriate.

TEMPER, ANGRY—Also called aggressive temper. Judgment, harsh criticism, retaliation, and such are typical ways in which angry temper may be expressed. Temper is not a feeling, it is not an emotion, it is a habit of behavior which, in its angry form, tends to give rise to conflict.

TEMPER, FEARFUL—Also called retreating temper. Shame, self-doubt, low self-esteem, depression, and such are typical ways in which fearful temper may be expressed. Temper is not a feeling, it is a complex pattern of behavior, a habit. Numerous examples can be found in the APPENDIX containing excerpts from Dr. Low's work.

TENSENESS is a sense of heightened alertness and activity which, in the absence of real danger, tends to generate temper.

TRAINED WILL—The state of mind/brain in which a person realizes how to properly direct effort in a way that enhances the quality of life.

TRIVIALITY—A matter of relative unimportance, yet a meaningful aspect of life. Trivialities have the property, in both Recovery and AT that they are not of the realm of right and wrong.

TRUTH is, for the purpose of AT, that which objectivity allows the models of the mind/brain to approach using the methods of science and scientific principles.

UNDESIRABLE EXCEPTIONALITY is Recovery lingo for ways some people whose disordered thinking leads them to inadequate self-respect attempt to compensate with some degree of grandiosity.
APPENDIX

Fairbairn's Object Relations Theory of the Personality (Fairbairn, 1963)

In response to many requests I have prepared the following brief synopsis of the theoretical views I have expounded over the last twenty years (see References; Fairbairn 1952a, 1952b, 1954, 1955, 1956a, 1956b, 1957, 1958, Guntrip 1961).

1. An ego is present from birth.

2. Libido is a function of the ego.

3. There is no death instinct; and aggression is a reaction to frustration or deprivation.

4. Since libido is a function of the ego and aggression is a reaction to frustration or deprivation, there is no such thing as an 'id'.

5. The ego, and therefore libido, is fundamentally object-seeking.

6. The earliest and original form of anxiety, as experienced by the child, is separation-anxiety.

7. Internalization of the object is a defensive measure originally adopted by the child to deal with his original object (the mother and her breast) in so far as it is unsatisfying.

8. Internalization of the object is not just a product of a phantasy of incorporating the object orally, but is a distinct psychological process.

9. Two aspects of the internalized object, viz. its exciting and its frustrating aspects, are split off from the main core of the object and repressed by the ego.

10. Thus there come to be constituted two repressed internal objects, viz. the exciting (or libidinal) object and the rejecting (or antilibidinal) object.

11. The main core of the internalized object, which is not repressed, is described as the ideal object or ego-ideal.

12. Owing to the fact that the exciting (libidinal) and rejecting (antilibidinal) objects are both cathected by the original ego, these objects carry into repression with them parts of the ego by which they are cathected, leaving the central core of the ego (central ego) unrepressed, but acting as the agent of repression.

13. The resulting internal situation is one in which the original ego is split into three egos—a central (conscious) ego attached to the ideal object (ego-ideal), a repressed libidinal ego attached to the exciting (or libidinal) object, and a repressed antilibidinal ego attached to the rejecting (or antilibidinal) object.

14. This internal situation represents a basic schizoid position which is more fundamental than the depressive position described by Melanie Klein.

15. The antilibidinal ego, in virtue of its attachment to the rejecting (antilibidinal) object, adopts an uncompromisingly hostile attitude to the libidinal ego, and thus has the effect of powerfully reinforcing the repression of the libidinal ego by the central ego.

16. What Freud described as the 'superego' is really a complex structure comprising (a) the ideal object or ego-ideal, (b) the antilibidinal ego, and (c) the rejecting (or antilibidinal) object.

17. These considerations form the basis of a theory of the personality conceived in terms of object-relations, in contrast to one conceived in terms of instincts and their vicissitudes.
APPENDIX (Continued)

EXCERPTS FROM DR. LOW'S PUBLICATIONS

Introductory Remarks

The method of psychotherapy developed by Dr. Abraham A. Low which has become Recovery, Inc. depends on understanding certain words in context. Recovery Inc. is a method of changing thinking patterns, for Dr. Low noted that “The reason for our almost fanatical preoccupation with the subject of beliefs is that it is they which either order or disorder the lives of mature human beings.” (Low, 1966, pp. 69-70) Beliefs are thoughts, they may have both cognitive and emotional aspects, but they are thoughts nonetheless. I find Dr. Low’s method to be primarily cognitive, it uses language to restructure thinking processes, and does so largely by re-defining commonplace words. I think this strategy is the central genius of Dr. Low’s work.

Dr. Low defined words through examples, for it is not sufficient to reach only intellect in redefining commonplace words, the emotional components of language are no less important than the intellectual. I find it is when the emotional components and the intellectual components of a person’s life are in cooperative harmony that life is truly good and even wonderful. I have been as unable as Dr. Low was to define some of the essential words of the Recovery method in a simple dictionary manner. Therefore, I have used, with permission, extensive excerpts to show the kind of “cognitive re-framing” that is part of the Recovery method.

However, Recovery is not a matter of printed words, it is a group process. It is not possible to understand the Recovery method well merely by reading what Dr. Low wrote. To have a good grasp of the Recovery method requires attending Recovery meetings. Fortunately, Recovery Inc., is not an anonymous group, although it respects confidences. Anyone who behaves appropriately is welcome at a Recovery meeting. Mental health professionals are welcome along with members of the community. The only restriction on mental health professionals is that they are not allowed to be leaders of groups, with, perhaps a very few exceptions for a short time when a professional may be instrumental in starting a new group, stepping aside at the earliest practical moment so a non-professional can successfully take over.

A newcomer to Recovery is expected to observe what happens for the first few meetings during the panel and discussion parts, but is free to interact during the mutual aid section at the end of the meeting. The design of the Recovery meetings is intended to make the meetings safe for those present, there are certain topics which are not legitimately part of Recovery, these include religious and political issues. Recovery focuses on trivialities, as Dr. Low defined them, for he found that the difficulties his patients had stemmed from treating trivial events as though they were very significant and very significant events (such as temperamental outbursts) as trivial. Correcting this type of mis-classification is one key to the success of the Recovery method.

The excerpts are included in this appendix to facilitate understanding the method Dr. Low developed as it is essential background for my research. There are many key ideas which are not included in these excerpts, what is here is just a sample. To understand the Recovery method well, it is necessary to read his works in full, to attend some contemporary Recovery meetings, for, while the basic structure described by Dr. Low has been retained, the meeting structures described in these excerpts prevailed when Dr. Low was alive, and there have been some modifications since his death.

Dr. Low was trained as a medical doctor, his training predisposed him to see his patients from the perspective of a medical model. He presumed that his patients suffered from a “weak nervous system,” which could be strengthened with Will training, and, indeed, his method works for many people. Why it does not seem to work for everyone is one of the concerns I have for future research. At issue, for me, is the experience a person brings to new situations, some people, I find, have been so traumatized against new ways of thinking by what I observe to be past abuse that they are truly terrified of change. Yet, without change, those trapped in dysfunctional patterns of thinking have no escape. For this reason, I think prevention of such thinking patterns is a much wiser strategy, if it is possible, than trying to change them after they have become well entrenched as enduring habits.

It took me several readings of Dr. Low’s writings and many Recovery meetings before I was able to develop new habits based on recognizing the escalating tendency of temper very early in a temperamental vicious cycle, and so, to be able to largely avoid them. It was, for me, personally, time and effort which was very wisely invested. In a speech in 1952 before the Chicago Dental Society, Dr. Low said, “In conclusion, let me revert to the subjects of disposition and predisposition which I discussed above. The average person is not critical, that is, he is not disposed to fatigue himself with the exacting task of spotting. Should he wish to be trained in this difficult art he would have to acquire not only temporary dispositions to exercise it but a lasting predisposition for continuous spotting. This would call for persistent application and laborious practice. An enduring predisposition for correct spotting would save a person from becoming the dupe of his own personal prejudices or the fertile soil for appealing ideologies or a soft touch for persuasive sharers. Should this spotting ideal ever materialize, millennium would be at hand, and I for one cannot be duped into the belief that millennium is around the corner or even a likely prospect for a far distant future.”
For me, for those with whom I have thus far shared my research findings, the "continuous spotting," or a reasonable approximation to it, is not all that laborious, indeed, I find it far less laborious than what I did before I learned the Recovery method. Dr. Low remarked in at least one audio-taped lecture that the Recovery method is simple but not easy. Perhaps that was true when he said it, but, with the knowledge I have that no mistake made should or could have been avoided, the Recovery method may well turn out to be easier, in the final analysis, than just about anything else. Training my mind to understand Dr. Low's language was not simple nor easy at first, but I find this was so because I cherished false and mistaken beliefs which were contrary to fact, I find I did this because I was taught to do so by people who were sincere but mistaken. The Recovery method became easy for me once I decided to forgive anyone and everyone who ever hurt or harmed me, and this became easy once I realized that no such hurt or harm should or could have been avoided.

Incidentally, there are some typographical errors in the original publications of Dr. Low, such errors were commonplace in the days before computer word processing. The excerpts from Dr. Low's writings were scanned into a computer and have been spell-checked, so some of the errors have been corrected in the excerpts herewith. At the same time, there is some chance that the scanning and optical character recognition processing substituted one correctly spelled word for another, I found several examples of this in the proofreading of the excerpts, but may have missed others. I apologize for any missed word substitution errors.

In this dissertation, this appendix of excerpts from Dr. Low's work has two versions. In the version submitted to the University of Illinois, the excerpts are printed in full as I received permission to quote from Dr. Low's publications as needed to clarify his work and the way it is a large part of the basis for my dissertation. However, I did not receive permission to include these excerpts in the version submitted to University Microfilms, Inc., and therefore only the references are included in the microfilm version of this thesis. At the time of this writing, Dr. Low's books are available from the headquarters office of Recovery, Inc., 802 North Dearborn Street, Chicago, IL 60610.

After the excerpts were transcribed into this thesis, a new edition of Mental Health Through Will-Training was published, there are some changes in punctuation and paragraph breaks, and the chapters are consecutively numbered. Page references to Mental Health Through Will-Training are given for both the 1978 and 1997 editions.
Excerpts from Mental Health Through Will Training (Low, 1978, 1997)

Preface (Low, 1978, pp. 11-14; 1997, pp. 419-423)

The present volume is meant to give an account of the psychotherapy methods evolved in the past fifteen years by Recovery, Inc., a non-profit group whose purpose is to train post-psychotic and psychoneurotic persons in the practice of psychiatric self-help. An extensive report on the association’s history, scope of activity and mode of operation was offered in 1943. A concise but fairly comprehensive description was published in 1949.

The contents of the book are in the main reproductions of panel discussions conducted by the ex-patients and group psychotherapy interviews held by the author with his private patients in the years 1944 to 1949. Several essays on “sabotage” have been added, describing the manner in which patients offer resistance to the physician’s instructions. The bulk of the material was previously published in the “Recovery Journal” and “Recovery News,” issued by Recovery, Inc., and edited by the author. It deals with a system of group psychotherapy evolved by the writer since 1933.

Psychotherapy, individual or group, is invariably based (1) on a philosophy, (2) on techniques. In years past, the field was dominated by three main philosophies and techniques: Freud’s psychoanalysis, Adler’s individual psychology, and Jung’s approach which, because of its vagueness and mysticism, defies precise classification. More recently, the psychoanalytic doctrine has taken the lead and all but crowded out its erstwhile rivals. It established its hegemony in universities and philanthropic foundations and gained unquestioned prominence in the province of psychotherapy. The doctrine appears to be in firm control in the official psychiatric organizations, in the mental hygiene activities of the national government, in the veterans administration, presumably also in the hospitals of the armed forces. Official psychotherapy, in the United States today, is essentially psychoanalysis.

The author rejects the psychoanalytic doctrine both as a philosophy and therapeutic technique. In point of philosophy, he cannot share the view that human conduct is the result of unconscious drives, sexual or otherwise. To his way of thinking, adult life is not driven by instincts but guided by Will. In emphasizing the priority of Will over Drives he is merely echoing the principles and teachings of the late Professor Emil Kraepelin, founder of modern psychiatry, and those of the late Wilhelm Wundt, father of modern psychology. Quite proudly he claims also to echo the voice of common experience and common sense. Whatever may be meant by drives, be they instinctual cravings (the favorite psychoanalytic term) or emotional trends, desires, wishes, yearnings and leanings, they all eventuate in impulses, acting or ready for action. To the author it is inconceivable that adult human life can be ordered without a Will holding down impulses. What precisely is meant by the term Will is amply demonstrated in the text.

In point of psychotherapeutic techniques, psychoanalysis must be accounted a failure on the evidence of its own testimony. The most startling defect is the insignificant number of patients which can be reached by the method. The Chicago Institute for Psychoanalysis, for instance, has been able to report no more that 319 patients treated six months or longer during a ten year period. The Menninger Clinic or Topeka, Kansas, tops this record of poor productivity with a report of 100 patients similarly treated for six months or longer in the course of ten years, 1932-1941. In order to fully appreciate the story told by these astonishing figures one must remember that the two institutions are generously staffed and richly financed. Knight, tabulating the results of treatment as published by the psychoanalytic institutes of Berlin, London, Topeka (ten year surveys) and Chicago (five years) was unable to quote more than 660 cases treated for upward of six months in the four clinics during a ten year period (five years in Chicago). Of this total, 363 patients were treated in Berlin, 114 in Chicago, 100 in Topeka, 74 in London. Stating it otherwise, the productivity of the psychoanalytic techniques, as reported from four


5Low, Abraham A., Recovery, Inc., A Project for Rehabilitating Post-Psychotic and Long-Term Psychoneurotic Patients, published in “Rehabilitation of the Handicapped,” page 213, New York, 1949, the Ronald Press Company. The latter article has been incorporated, with the publisher’s permission, as a revised reprint in the present volume, page 16.

6Institute for Psychoanalysis, Ten Year Report, 1932-1942, Chicago.

leading clinics, ranged in point of the number of patients carried per year, from 7.4 (London) to 36.33 Berlin). Figures of this kind admit of one conclusion only: The psychoanalytic techniques are available for a small fraction only of the multitude of post-psychotic and psychoneurotic patients. The reason for its restricted availability of the treatment, is the egregious amount of time needed for the administration of the treatment, an overall average of hundreds of hours being required for each individual patient. For patients cared for in private practice there is the added handicap that the time-consuming process involves a necessarily exorbitant expense. Whether the emphasis be on the time factor or the cost element, in either case, the method is all but unavailable for the masses of patients.

Aside from its limited availability for numerically significant groups of patients, psychoanalysis is also, again on the evidence of its own testimony, therapeutically ineffective. Knight, assaying the therapeutic results obtained in 660 analyses conducted for six months or longer in the institutes of Berlin, London, Chicago, and Topeka, tells us that 183 patients (27.7 percent) were considered "apparently cured"; 186 (28.2 percent) were "much improved"; 291 (44.1 percent) were either somewhat improved, or worse, or showed no change. Needless to say, a 27.7 percent yield of "apparently cured" patients, even adding the 28.2 percent of the "much improved" contingent, constitutes a serious indictment for any psychotherapeutic method. Oberndorf is authority for the statement that 40 percent of the "psychotic cases treated by psychoanalysis plus institutional regime at the Menninger Clinic" were discharged as cured. He comments that this is also the percentage of those "discharged as cured from mental hospitals in the United States." It is well known, however, that the forty percent figure for cures of state hospital patients represents the spontaneous recovery rate. Is it permissible, then, to draw the inference that, for psychotic patients at any rate, the results of psychoanalytic treatment are identical with their spontaneous chances of "outgrowing" their psychosis? Taking either the hint offered by Oberndorf or the disappointing figures supplied by the above mentioned statistics, the conclusion seems inescapable that psychoanalysis has failed as a therapeutic technique.

It is not intended here to criticize psychoanalysis with a view to extolling the work of Recovery, Inc. But inasmuch as the psychoanalytic method has well nigh monopolized the field of psychotherapy it is incumbent on a diverging approach to measure its record of accomplishment against that of the recognized procedure. A few simple figures culled from the files of the author will demonstrate that the combination of office treatment with the group methods practiced in Recovery, Inc. achieves a range of availability which dwarfs that of psychoanalysis.

Between January 1, 1946 and December, 31, 1947, in a representative two year period, the author was able to examine in his office a total of 425 new patients. Deducting from this figure those patients who did not return after the initial examination (140) and those who suffered from somatic or neurological conditions (24), there remained 261 subjects who were available for psychotherapy. Of this final group, 156 were given treatment for six months or longer. In other words, employing the method described in this book, one man was enabled to give active psychiatric care to a considerable multiple of the patients serviced in a comparable period by large staffs of psychiatric institutions. Clearly, the Recovery method is vastly superior to psychoanalysis in the matter of availability to the masses of patients seeking psychiatric care.

As concerns the therapeutic effectiveness of Recovery techniques, as distinguished from mere availability, it is sufficient to point to the basic character of the organization: the members know one another; they meet frequently and regularly in classes and at parties; they get together in family gatherings and consort socially; they form sewing clubs, bowling parties and dancing teams; many of them spend evenings or Sundays together, dining or visiting theaters and amusement places. One can readily surmise what would happen if no more than a negligible 28 percent of the lot would finally reach the status of "apparently cured." The organization would explode in no time. Instead, the association, staffed by one physician, financed without outside assistance, shunning though not completely escaping publicity, has prospered close to fifteen years. This record speaks for itself. It needs no statistics to support its claims.

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Recovery, Inc. was founded, November 7, 1937, by thirty ex-patients who regained their health after receiving shock treatments and/or other therapies at the Psychiatric Institute of the University of Illinois medical school, the predecessor of the present Psychiatry Department of the Illinois Neuropsychiatric Institute. The author was at the time the assistant director of the Institute. Between 1937 and 1940 the organization limited its services to the patients admitted to the wards of the Psychiatric Institute. In fall of 1940 it expanded its work to include the psychoneurotic patients of the out-patient department. In September 1941 the group severed its connection with the University of Illinois medical school and established headquarters of its own in the Chicago Loop District where it is now located at 116 South Michigan Avenue. In the years since 1942 the bulk of its membership was recruited from the authors private practice. As is evident from this brief description, Recovery, Inc. has had the opportunity to try out its techniques (1) with an intramural patient population, (2) with an out-patient group, (3) with private patients. The object of the organization, apart from its tendency to save time for the physician and money for the patients, is to help prevent recurrences in mental diseases and to forestall chronicity in psychoneurotic conditions. Its techniques place the emphasis on self-help.

THE "RESIDUAL SYMPTOM" OF THE RECOVERED MENTAL PATIENT

After leaving the hospital the mental patient is supposed to be restored to health. This is true in most instances if by mental health is meant the absence of delusions and hallucinations, of violent impulsiveness and indifference to group standards. But returning home the patient still suffers from restlessness, tenseness and preoccupation. His inability to relax is aggravated by the sense of being stigmatized. Many returned patients are so suspicious of being watched or mistrusted that even simple inquiries like "how do you feel?" or "how are you today?" are likely to cause irritation. These innocent questions may suggest to the patient that the reality of his recovery is doubted. Feeling stigmatized, the patient becomes self-conscious and introspective. On a given night he might have difficulty falling asleep. This is apt to alarm him. The alarm increases the difficulty of sleeping. Then more alarm, more sleeplessness and more alarm yet. A vicious cycle is thus set going which may keep the patient from properly resting night after night. Other vicious cycles may soon establish themselves. The patient notices a sense of fatigue which in itself may be as insignificant as any sensation of fatigue experienced by the average person. But feeling stigmatized he correlates his tiredness with the possibility of a relapse, and the more he dreads the relapse the more intense becomes his fatigue; the heavier the fatigue the more haunting the fear of the relapse. One patient had a nocturnal itch after returning home, another complained of a twitch in one arm, a third felt a hair on the tongue. Experiences of this kind are distressing enough to conjure up the vision of an impending relapse. The experiences become far more terrifying when the patient observes, in fact, that the arm suddenly begins to shake in automatic motion or when "awful flashes" shoot across the eye. Patients reported an "electric buzz running through the muscles," that "the tongue lay stiff in the mouth," that "my own voice sounded strange," that "the ear felt pushed in," that "I can't seem to hear myself when I speak." Palpitations, numbness, head or chest pressures, dizziness, difficulty of concentration, dimness of vision, air hunger, headaches, nausea and scores of other disturbances were reported by numerous patients. Observations of this sort may give rise to the vicious cycle which has the familiar character of the symptom increasing the fear and the fear intensifying and perpetuating the symptom. While there are no statistics to substantiate the claim it is fair to assume that many recurrences of mental ailments are the direct result of these "residual symptoms" which, fanned by the fury of the vicious cycle, produce anxieties and panics which finally necessitate the much dreaded recommitment. Recovery, Inc. insists that the patient, prior to leaving the hospital, attend group psychotherapy classes in which he is given adequate instruction how to face the threat of the residual symptom and the pressure of stigmatization. At the time, the members of the family are urged to attend discussion courses in which similar instruction is offered. In this manner the pre-discharge care prepares for the after-care effort.

THE DEFEATISM OF THE CHRONIC PSYCHONEUROTIC PATIENT

Most residual symptoms from which the returned mental patient is likely to suffer are similar to or identical with the common complaints voiced by psychoneurotic patients. Hence, the possibility of treating both groups by the same method. The psychoneurotic patients admitted to Recovery, Inc. belong in the category of chronic, protracted cases mainly. Patients with symptoms of a few months' duration are rarities in the ranks of the group. Most members have a record of from two to twenty years of suffering. These "experienced sufferers" have made the rounds of physicians and clinics and were assured on numerous occasions, explicitly or by implication that some therapeutic measure will cure them. The assurance never materialized with the result that they no longer believe a cure possible. They know, however, that some or most of the past theories had a transient, palliative effect. The palpitations were milder after a reassuring talk; the dizziness yielded to a sedative. Hence, they treasure the "pep-talk" or the prescription. In order to secure these elusive aids they must complain; they must convince the physician that they "really" suffer, that their pains are not imaginary, that they can "positively not stand" their fatigue. To get a hearing from the doctor is all the more important because at home their complaints are likely to be met with impatience or ridicule. Complaining, then becomes a vital part of their daily routine. In the course of years, they develop the consummate art of the "expert complainer." What these long term patients crave is a sympathetic ear which, after years of griping, they can no longer secure from their relatives and friends. They delight in a lengthy discussion of their fears and frustrations. Their ideal is to be explored, analyzed, sounded and probed. Essentially they have decided that their case is beyond repair. What they expect is a hearing, perhaps some temporary relief, but not a final cure. The "chronicity" of this group has little to do with the nature of the symptoms, with diagnosis or etiology; it is self-appointed defeatism.

Since Recovery places the emphasis on the self-help action of the patients, it must ignore investigations and explorations which are not within the province of inexperienced lay persons. Complexes, childhood memories, dream experiences and subconscious thought play little part in the class interviews conducted by the physician and are entirely eliminated from the self-help effort carried on by the patients. The psychoneurotic individual is considered a person who for some reason developed disturbing symptoms leading to ill-controlled behavior. The symptoms are in the nature of threatening sensations, "intolerable" feelings "uncontrollable" impulses and obsessive "unbearable" thoughts. The very vocabulary with its frenzied emphasis on the "killing" headache, the dizziness that "drives me frantic," the fatigue that "is beyond human endurance" is ominously expressive of defeatism. The first step in the psychotherapeutic management of these "chronic" patients must be to convince them that the sensation can be endured, the impulse controlled, the obsession checked. Unfortunately, the physician is far from convincing. His attempt to "sell" the idea of mental health arouses the "sales resistance" of the patient. "The physician doesn't dare tell me the truth," muses the patient. "It would be against his ethics to declare me incurable." The resistance is easily overcome in the group interview. The fellow sufferer who explains how he "licked" his frightful palpitations after years of invalidism cannot possibly be suspected of trying to sell something. That "colleague" is convincing. He convinces the novice that he "really" suffers, that their pains are not imaginary, that they can "positively not stand" their fatigue. To get a hearing from the doctor is all the more important because at home their complaints are likely to be met with impatience or ridicule. Complaining, then becomes a vital part of their daily routine. In the course of years, they develop the consummate art of the "expert complainer." What these long term patients crave is a sympathetic ear which, after years of griping, they can no longer secure from their relatives and friends. They delight in a lengthy discussion of their fears and frustrations. Their ideal is to be explored, analyzed, sounded and probed. Essentially they have decided that their case is beyond repair. What they expect is a hearing, perhaps some temporary relief, but not a final cure. The "chronicity" of this group has little to do with the nature of the symptoms, with diagnosis or etiology; it is self-appointed defeatism.

THE PATIENTS MEET ON THREE DAYS EVERY WEEK

On three separate days each week the patients take part in group discussions, either as panel members or listeners. On Wednesday, family gatherings are held in private homes in the various neighborhoods of Chicago. The patients are subdivided into seven neighborhood groups, each comprising from ten to twenty families. Three such family groups function on the Northside, two on the Southside, one on the Westside of the city; one serves the West suburbs. On the occasion of the family meetings panels of three or four experienced members discuss a chapter of the author's three volumes on self-directed after-care or an article from the now discontinued Recovery Journal or from its successor, the Recovery News. The theme is centered on the topic of symptoms and the proper means of conquering them. The physician is not present at the family gatherings although he reserves the right to attend occasionally to check on the effectiveness of the procedure. Reports are currently conveyed to him by the panel leaders. Tuesday evening is devoted to a group psychotherapy class, conducted by the physician. Saturday afternoon, a public meeting takes place at Recovery headquarters, 116 South Michigan Avenue. It is attended by the patients, their relatives and friends. The first half hour is given over to a panel discussion similar to that held at the Wednesday home gatherings. In the second half the physician delivers an address in which he sums up the conclusions reached by the panel, approving or correcting their statements. The panel members are led by a panel leader.

TREATING THE "SETBACK"

Patients are required to attend classes and meetings for at least six months. The average patient experiences a considerable improvement in the first or second week of participation in the program. But the improvement is, as a rule, as short-lived as was the relief which the patient used to gain from the visits to clinics and doctors' offices. No meetings are held on the first four days of the week. During these days the novice is apt to suffer a "setback." He is again tortured by "that awful
fatigue” or has been “unable to sleep a wink for three nights in succession,” or the fear of doing harm to the baby reappears after it was gone for a short while. Every patient is warned to be on guard against the unavoidable setback. He is cautioned to contact a veteran Recovery member immediately after the symptom has reappeared. The assurance offered by the veteran is in accord with the language used by the physician, and the interpretations given to the novice coincide with those used in the physician’s classes and in his writings. New members are assigned to veterans whom they may call in distress. The veteran functions in the capacity of the physician’s “aide.” The contact is generally made by telephone but may be done in a personal visit to the aide’s home. If the result is not satisfactory the novice is permitted to call on the leader of his local panel. If this is ineffective he may contact the chairman of the organization who serves as deputy to the physician. Finally he may call the physician. The effectiveness of the scheme is evidenced by the fact that few instances are recorded in which the physician was called by novices.

THE SYMPTOMATIC IDIOM

If the patients are to help and reach one another they must be instructed to use a language which is not confusing. This is particularly important because language, if used glibly, tends to be alarmist and defeatist. By dint of its defeatist insinuations, language frequently engenders tenseness which reinforces and perpetuates symptoms. To avoid the fatalistic implications of the language used by the patient the physician must supply a terminology of his own in matters of health. There are many languages. Features and gestures speak. So do symptoms. Their language is a one word idiom: DANGER. This is called the “symptomatic idiom.” Accepting the suggestions of the symptomatic idiom the patient considers the violent palpitations as presaging sudden death. The pressure in the head is viewed as due to a brain tumor. The tenseness is experienced as, so “terrific” that the patient fears he is going to “burst.” His fatigue does not let up “one single minute,” and “how long can the body stand it?” In these instances, the implications of the symptomatic idiom are those of an impending physical collapse. If phobias, compulsions and obsessions dominate the symptomatic scene the resulting fear is that of the mental collapse. After months and years of sustained suffering the twin fears of physical and mental collapse may recede, giving way to apprehensions about the impossibility of a final cure. This is the fear of the permanent handicap. The three basic fears of the physical collapse, mental collapse and permanent handicap are variations of the danger theme suggested by the symptomatic idiom.

THE TEMPERAMENTAL LINGO

Another source of defeatism is temper. The patients are taught that temper has two divisions. The one comes into play when I persuade myself that a person has done me wrong. As a result I become angry. This is called the angry or aggressive temper, which appears in many shades and nuances: resentment, impatience, indignation, disgust, hatred, etc. The other variety of temper is brought into action whenever I feel that I am wrong. This gives rise to moral, ethical and esthetic fears or to the fear of being a failure in pragmatic pursuits. I am afraid that I sinned, failed, blundered, in short, that I defaulted on a moral, ethical or esthetic standard or on the standard of average efficiency. This is called the fearful or retreating temper which may express itself in many different qualities and intensities: discouragement, preoccupation, embarrassment, worry, sense of shame, feeling of inadequacy, hopelessness, despair, etc. The fearful temper is likely to lead either to a feeling of personal inferiority or to the sentiment of group stigmatization. Whether it be of the angry or fearful description, temper reinforces and intensifies the symptom which, in its turn, increases the temperamental reaction. In this manner, a vicious cycle is established between temper and symptom. The temperamental reaction is kept alive mainly by the unsympathetic and unthinking attitude of the relatives. By means of coarse statements or subtle innuendo they provoke loud explosions or silent agonies on the part of the patient. They tell him to use his will power, implying that he makes no effort to get well. With this, they indict him as a weakling, worse yet, as purposely shamming disease. They urge him to “snap out of it,” indicating that the symptoms are so easy to deal with that a mere snap would shake them out of existence. Other insinuations frequently leveled against the psychoneurotic or former mental patient are equally disconcerting. Complaining of fatigue he is told not to be lazy; mentioning his “awful palpitations,” he is admonished to be a man. The net result of this concerted environmental assault is that the patient is continually angry at his detractors and gradually accepting their insinuations, becomes ashamed and fearful of himself.

In telling the patient that wrong was done to him or that he is wrong his temper speaks to him. The language which it uses is called the temperamental lingo. Its vocabulary is limited to the terms “right” and “wrong.” Unless the patient learns to ignore the threats, warnings and incitements of the temperamental lingo, he will be the victim or angry outbursts and fearful anticipations. His tenseness will be maintained and intensified; new symptoms will be precipitated and old ones fortified. Temper is most dangerous when it plays on the symptom itself. By labeling sensations as “intolerable,” feelings as “terrible,” impulses as “uncontrollable” the lingo discourages the patient from facing, tolerating and controlling the reaction. The very sound of the labels (“intolerable,” etc.) is apt to rouse fear and defeatism. All a patient has to do is to call a crying reaction
by the name of "crying spell," and no effort will be made to check the burst of tears. The word "spell" suggests uncontrollability. Make the patient substitute "crying habit" for "crying spell," and the impossibility of stemming the flood at least will not be taken for granted. Similarly, if the patient raves about the "splitting" headache, the dizziness that "drives me mad," the pressure that "I can't stand any longer," the fatalism of diction is bound to breed a despondency of mood. In order to prevent the temperamental response the patient must be trained to ignore the whisperings of his temperamental lingo.

THE "RECOVERY LANGUAGE"

The combined effects of symptomatic idiom and temperamental lingo are checkmated if the patient is made to use the physician's language only. The members of the Association call it proudly the "Recovery language." The most important parts of its vocabulary are the words: "sabotage" and "authority." The authority of the physician is sabotaged if the patient presumes to make a diagnostic, therapeutic or prognostic statement. The verbiage of the temperamental lingo ("unbearable," "intolerable," "uncontrollable") constitutes sabotage because of the assumption that the condition is of a serious nature which is a prognosis. It is a case example of sabotage if the claim is advanced that, "my headache is there the very minute I wake up. I didn't have time to think about it. It came before I even had a chance to become emotional. How can that be nervous?"

A statement of this kind throws a serious doubt on the validity of the physician's diagnosis and sabotages his authority. Likewise, it is a case of self-diagnosing and consequently sabotage to view palpitations as a sign of a heart ailment, of head pressure as meaning brain tumor, of sustained fatigue as leading to physical exhaustion. Once the physician has made the diagnosis of a psychoneurotic or postpsychotic condition the patient is no longer permitted to indulge in the pastime of self-diagnosing. If he does he is practicing sabotage. Patients are expected to lose their major symptoms after two months of Recovery membership and class attendance. If after the two month period the handicap persists in its original intensity the indication is that sabotage is still in action. The patient still listens to the suggestions of the symptomatic idiom fearing impending collapse and permanent handicap. Or, he gives ear to the verbal vagaries of the temperamental lingo, feeling helpless in the face of suffering. Clinging to his own mode of thinking he sabotages the physician's effort.

Contrary to expectation, it is comforting to the patient to be called a saboteur. Considering himself as such he knows that he has "not yet" learned to avoid resisting the physician. The "not yet" is reassuring. It suggests that in time he will learn. The patients encourage one another to wait until they get well. They warn one another against impatience. The most effective slogan handed down from veteran to novice is, "Wait till you will learn to give up sabotaging."

THE "SPOTTING TECHNIQUE"

If the patient is to check his sabotaging propensities he must be trained to "spot" the inconsistencies and fallacies of his own language whether it is merely conceived in silent thought or given formulation in vocal speech. To this end, a system of "spotting techniques" was evolved by means of which the members learn to reject the suggestions of the symptomatic idiom and the temperamental lingo whenever a symptom or a temperamental reaction occur. An extensive though necessarily incomplete description of the spotting techniques is furnished in part 3 of this book.

SOCIAL ACTIVITIES

The social calendar of the organization is remarkably crowded. The activities are largely spontaneous, little supervised. Practically all events, be they group psychotherapy classes, public meetings or family gatherings, are somehow linked to sociability. After a group psychotherapy class the patients form small groups heading for the nearest drug store or restaurant where they rehash the theme discussed in class or chat about private affairs. The most stimulating social event is the "kaffeeklatsch" following immediately upon the Saturday afternoon public meeting. After the panel and the physician have finished their discussions the assembly hall is speedily converted into a sort of lounge. The patients, relatives and friends seat themselves around small tables and are treated to coffee and cake. Mothers and fathers exchange views about the progress of their still suffering or already recovering offspring. The patients join the chat, and the atmosphere is one of mutual encouragement, gratitude and hopefulness. The "kaffeeklatsch" may last an hour or longer. The physician moves from group to group, engaging in brief conversations or listening to the stories and views presented by members and guests. This informal mingling with patients and relatives provides the physician with information which he could hardly obtain otherwise. The men and women speaking to him are spontaneous, divorced from the official and cramping situation of the interview carried on in the ordinary examining room. Mrs. Jones reports an incident which she observed in Mrs. Smith's home on the occasion
of the last family gathering. The account is unreflective, reportorial, descriptive. These casual chats with the members are an invaluable means of acquainting the physician with the personal details of the patients' home life.

The family gatherings are similarly patterned. A panel discussion of about thirty minutes is followed by a modest repast furnished by the family in whose home the meeting is held. The physician does not attend family panels, but is currently kept informed by the panel leaders about what transpires about adjustment or maladjustment of the patients and about the quality of home life prevailing in the particular family. The panel leaders meet with the physician once a month to receive special training in the matter of conducting the panels. This is again an occasion when a vast mass of information is conveyed to the physician about the home life of the patients. It need hardly be stressed that the type and quality of information which the physician is thus enabled to collect is vastly superior to that obtained in his examining room while interviewing the questioning parents and relatives.

The members seem to have an almost unquenchable thirst for social contacts. They visit one another in their homes; they go together to shows and concerts, meet for lunches, for short trips, for joint visits to museums or parks or for plain walks. Some groups have regular schedules for bowling, barn dancing, hiking and swimming. The families of one Northside and one Southside group formed sewing circles. Consciously or unconsciously, the trend is to break through the dismal isolation and loneliness which have always been the blight of neurotic and post-psychotic existence. The patients state it explicitly that formerly they merely existed, now they live again. Formerly they were lonely individuals, now they are thoroughly integrated with the rich, pulsating life of a closely knit group.

A happy outlet for this burning desire for sociability is afforded by the informal afternoon gatherings which take place at Recovery headquarters, 116 South Michigan Avenue. A number of veterans, housewives mainly, volunteer each to spend one afternoon a week in the Recovery office, supervising the activities of that afternoon. Patients or relatives working in the Loop district drop in, partake of simple refreshments and spend time chatting or asking advice or seeking reassurance for disturbing symptoms. The physician's office is two blocks distant. New patients are asked to visit the Recovery office immediately after the termination of the initial examination. There they are met by the other patients and given information about the work of the organization. Panics, anxieties and apprehensions are easily soothed by the calming influence of meeting other patients who have suffered similar disturbances are now presenting the picture of good health.

MEMBERSHIP, FINANCES, ADMINISTRATION

Membership, at three dollars per year, is open to any psychoneurotic or former mental patient. At this writing (January 1950) the membership stands at 376. About 75 percent of the total is secured from the author's private clientele. The organization is financed by membership fees, donations, proceeds from the sale of Recovery literature, collections at meetings. The organization is almost but not quite self-sustaining. The yearly deficit is met by the author.

April 1948 the organization moved to its present larger quarters. With a considerably increased rental and the necessity for new furniture and office equipment it was deemed wise to create a guarantee fund. The members responded promptly and generously to an appeal for contributions. The goal was 5,000 dollars and close to 4,400 were collected.

The affairs of the organization are conducted by a board of three directors, all ex-patients. Mrs. Annette Brocken, ex-patient and assistant principal of a Chicago public school, is president of the organization and chairman of the board of directors. Serving with her are a vice-president, a secretary, a treasurer and six councilors. The author does not hold office, but functions as the medical director. An ex-patient is the editor of the “Recovery News.” Another ex-patient holds the position of the executive secretary doing all the routine work including dictation and typing. This is the only salaried employee. The monthly compensation is almost nominal.

RECOVERY LITERATURE

Between 1938 and 1941 the organization published a bimonthly magazine, “Lost and Found.” The author was the editor contributing the bulk of articles. The pages of the magazine were devoted mainly to a thorough discussion of the influence of domestic temper on the fortunes of the patients. In 1943 this material was issued in book form in three volumes entitled, “The Techniques of Self-Help in Psychiatric After-Care.” The issue is now exhausted after a total sale of close to 1,000 copies.

June 1946 to June 1947 the “Recovery Journal” was published. In consequence of rising cost of printing it was discontinued after the eleventh issue. It was succeeded by a phototyped news sheet, the “Recovery News,” which appeared eight times a year. Each issue contains a contribution by the author. Subscription is included in the membership fee and 2.00 dollars per year for non-members. A second edition of the “Self-Help Techniques” is in preparation.
Frank (Panel leader): The panel is ready to start and we are taking our material from the lecture entitled “The Wrong-Peering Temperament.” What we are going to discuss is the dilemma which means a difficulty of making decisions. Has anybody an example of having trouble making up his mind?

Tillie: Some time ago I went to Field's and wanted to get a dress for my little daughter Doris. I couldn't make up my mind between two dresses. I looked at both dresses and felt confused. And when I can't make up my mind I get a tightness in my left side and when I get this I feel like letting everything go. But this time I just took one and felt comfortable. Then I went to the socks department and I thought I would get size nine. But I thought they were too big and I was in confusion again. The tightness came back and I got flushed and felt I couldn't breathe. I was on the point of throwing the socks down and leaving the store but Doris said if they didn't have size eight and a half she was going to take size nine. So she made the decision for me. Then the tightness stopped immediately and I felt comfortable. Six months ago once the tightness had started all kinds of other symptoms would have come on and I would have been in an panic all day and maybe for several days. Today my panics last a short while, and they aren't a bit as severe as they used to be.

Maurice: I used to make conflicts and dilemmas out of things the average person wouldn't think to make an issue of, for instance, going to a movie or getting a hair-cut. I would make a start, then I'd think should I really go? Then I might pick up a book and read. After a few minutes I would feel I should go to the barber's. Then I would put it off again and so it would take me hours to make a simple decision. Months ago I remember I went to the library and I would be in a conflict about what books to take out, and for days I looked over books and never took one out. That made me tense and disgusted because I couldn't make up my mind. Today I can decide in a few minutes.

Carol: My two children have been sick the past two weeks. I thought it would be nice if my husband would suggest eating out tonight. A year ago I wouldn't have the nerve to make the suggestion. I would have been sore at my husband if he didn't make the suggestion himself. This time I said, “How about it,” and he was agreeable. But even now I don't know whether it was right to ask him. I get so tense when I have to ask for things.

Frank: All this tenseness derives from the fact that we don't want to make up our mind. We are afraid we'll have to blame ourselves. We'd rather pass the buck. But we have to learn to make decisions and to take chances that we may be wrong. You know the doctor tells us we must have the courage to be wrong in the trivialities of every day life.

Carol: I have another example. I have to take my wash to the laundry to have it ironed. Several months ago I used to be tense on the way home because I had to rush back to prepare lunch for the children and I was afraid I wouldn't make it in time. So I used to put off making the trip to the laundry and let it go day after day till we were most out of laundry. Today I just do it and if I feel tense on the way back I say to myself, “What of it?” The tenseness isn't so bad anymore anyhow.

Frank: These are examples of trivial conflicts and the very fact that they are so numerous keeps us in constant tension and the tension, of course, produces symptoms. I will give you an example of my own. As you know I am the editor of the Recovery News10 and there is an article I am planning on writing but I keep putting it off. Monday night I was home and I thought I would start on the article but didn't feel like doing it. Suddenly it became important for me to read the daily paper. Ordinarily I don't read it more than twice a week. But now it seemed I had to read it immediately. And so I got myself the Tribune, and read it thoroughly. After I was through with it I noticed the Sunday Tribune was still on the table from the day before. I got a hold of that and read it, again very thoroughly. Ordinarily I hardly throw a look at it. This you can call procrastination. But the point is I didn't make up my mind to do something that I didn't feel like doing. I haven't been able to lick this procrastination of mine as thoroughly as I would like to.

But I am gradually getting it under control, and on that Monday evening when I kept putting off writing I finally made up my mind and wrote and finished the article.

Don: I used to buy medicine from a drug store in the neighborhood. The clerk there knows about my condition because I told him. Now I am sorry that I told him because I feel uncomfortable when I have to go there to buy medicine. Of course, it is the stigma. When I need the medicine I put off going to the drug store. On several occasions I was pretty sick with my asthma but rather than talk to the clerk I endured sickness. Finally I needed the medicine badly and my first thought was again to put it off. But then I said to myself, “No sir, you know you will be tense all day if you don't make up your mind to face that clerk.” And if I am tense I get all kinds of symptoms, fatigue, sleeplessness and tremors. So I went and got the medicine and after that I felt I had done something worth while. Otherwise I would have suffered all day.

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10 The “Recovery News” was a mimeographed sheet which was edited by Frank Rochford in 1945 and early 1946. It was the predecessor of the “Recovery Journal.”
The central theme of today's panel was fear, more particularly, the fear of making a decision. Tillie feared deciding between two pairs of socks, Maurice feared taking a book from the library, and Carol, Frank and Don quoted similar fears of deciding, choosing, taking a stand and reaching a conclusion. Frank surmised that all the issues and problems, conflicts and dilemmas listed by the panel members were sheer trivialities. But the fact is that Tillie, while grappling with her difficulty, developed panics and confusions and all manner of frightening symptoms. To her the danger of making a wrong decision did not appear at all trivial. It loomed in her mind as a matter of momentous importance. She thought of serious consequences and grave responsibilities; she anticipated failure and disaster. In other words, her imagination was on fire.

If there were no imagination there would be few panics and anxieties. And without panics and anxieties nervous symptoms would die away. No nervous patient would ever fear collapse unless his imagination told him that palpitations, air hunger and chest pressure spell the danger of imminent death. Nobody would ever shiver at the thought of "another sleepless night" except that imagination paints a lurid picture of the fatal results that a mythical sleeplessness has on health. I may mention the fanciful notions which patients entertain about the dreadful effects of "nervous fatigue," and you will realize that the idea of danger created by your imagination can easily disrupt any of your functions. If this is true it is clear that the nervous patient is served by an imagination which is out of bounds, rampant, unbalanced. If the balance is to be restored the patient will have to acquire a working knowledge of how his imagination functions. Clearly, all I can offer in a brief address is a sketchy account of its mode of operation.

Imagination is either busy or idle. If idle it is bored, if busy it is interested and either stimulated or frustrated. Its business is to notice, observe and interpret events. Once the event is noticed imagination is aroused or stirred. It may then evince rising concern or stirring excitement. The concern will lead to further investigation and deepened interest, finally yielding some important or trivial discovery. The excitement will give rise to feelings, sentiments and emotions. Note here that concern, excitement, interest, feelings are intimately associated with the function of imagination.

What imagination notices, observes and interprets are events, facts and situations occurring outside or inside the body. Those taking place outside the body, in external environment, "strike" the senses of vision, hearing or touch and are "grasped" by them. This is the "sensory grasp" of outer experience. The events occurring inside the body, in internal environment, "affect" our deep sensibility and are noticed by intuition. This is the "intuitive grasp" of inner experience. We may then say that imagination is busy interpreting the facts of outer and inner experience. In the one sphere it makes use of sense perception, in the other of intuitive understanding.

In interpreting the meaning of events imagination classes them as either indifferent or significant to our welfare. The significant events are felt or thought of, that is, imagined as endangering or securing our welfare. In this manner imagination produces the sense of security or insecurity. If behavior is to be adjusted imagination must interpret events in such a fashion that the sense of security materially overbalances the sense of insecurity. Once this is accomplished an imaginative balance establishes itself.

After interpreting an event imagination renders an opinion which is in the nature of a tentative suggestion or a first guess. It suggests, for instance, or guesses that the person approaching you is a friend. The opinion is, then, that the situation is one of security. Under such simple circumstances, imagination is hardly likely to go astray. The situation is such that it calls for little or no imaginative appraisal. The sensory grasp is sufficient for proper identification. After the friend reaches you his features may strike your eye as being changed. You imagine they express anxiety. This is another imaginative guess. If you accept it you may be inclined to offer sympathy or aid. Suppose now that your guess was wrong. The offer of sympathy was then misplaced and may be resented. The tentative opinion rendered by imagination misled you to an incorrect conclusion and an equally unwise decision to act. In order to avoid premature conclusions, decisions and acts of this kind the opinion, suggestion or guess offered by the imagination must be verified. I may mention briefly that verification makes use of logic, past experience and of that singular capacity of the mature human mind to observe elements which contradict or support an opinion after it has been formed.

It is the tragedy of the nervous patient that after years of suffering he develops an unbalanced imagination the first guesses of which tend distressingly and consistently to interpret inner and outer experiences in terms of insecurity. The greater tragedy is that the first guesses are accepted sight unseen without an attempt at verification. Unable to resist its suggestions the patient becomes the victim of the imagination. An incessant stream of insecurity suggestions is poured forth with rapid-fire velocity leading to a continuous succession of wrong opinions, conclusions and decisions. The final result is that the patient, realizing that his first guesses tend to be either wrong or harmful comes to fear forming an opinion, reaching a conclusion, making a decision. In a sense, his fears are based on good logic. In most instances, imagination has misled and deceived him. On a hundred or thousand occasions it told him that his sensations will lead to collapse. The suggestion never materialized. How can that imagination be trusted? Whenever a symptom made its appearance, whether palpitations or numbness or dizziness, imagination suggested invariably that this was the last gasp, that an emergency was on. The patient went into a
panic, clamored for instant help, insisted that the doctor be summoned without delay. When the relatives, aware of the "nervous" nature of the spell, hesitated to call the physician, perhaps in the dead of the night, the patient passed into a violent burst of temper, and the wish had to be granted. But the moment the physician arrived his mere presence or calm manner dispelled frequently both symptom and temper in a trice. The deceitfulness of his imagination was here clearly demonstrated to the patient. It lied to him, led him to wrong conclusions, to hasty decisions. It produced temper, caused unnecessary expense, created domestic friction. Worst of all, it undermined his self-respect and made him look ridiculous. Trusting an imagination of this kind, it would seem, is impossible.

There were other experiences that made for distrust. Neighbors mentioned a remedy, or the patient read about it in the daily paper or heard of it over the radio. No sooner was the drug called to his attention than his imagination was absurdly fired with hope and enthusiasm. In the course of years he spent more money on pills and capsules than his meager finances warranted. Trusting the suggestions passed on by his ever lively imagination he consulted numerous physicians, wandered from clinic to clinic. He made costly trips because a change in climate was supposed to be beneficial. He went to sanitariums, watering places. He even had himself "checked at Mayo Brothers." His record of inept conclusions and ludicrous decisions is impressive, indeed. That record was inspired by his imagination, whose erratic and capricious counsel has been the ruin of the patient's reputation. How can he ever base a decision on its dubious recommendations?

It happened at times that he was free from symptoms for a few days, sometimes for a week, rarely a longer period. Then this imagination spoke the language of security. It suggested that he was cured, that the symptoms were gone for good. On these occasions he concluded he was well and decided to "do things." He resumed his social life, visited friends, played cards with them, went fishing and automobilizing. Occasionally, he ventured to return to work. The result of these efforts was dismal disappointment. Without any warning, "out of a blue sky," the palpitations recurred "worse than ever," right while he was engaged in a "grand game of poker." Or, he suddenly fainted while he worked on the bench. There was no escape from these dreadful symptoms. His imagination, even when it preached security, invariably led him straight into insecurity. How can he ever trust it? How can he depend on its first guesses or final conclusions? And without dependence how can there be deciding or acting? His life is doomed to be a stark tragedy, a bleak and barren existence, mechanical, tedious, lifeless.

We shall revert to the experience Tillie had in the store. When she was unable to make up her mind whether to buy a smaller size sock daughter Doris came to her assistance and made the decision for her. "Then the tightness stopped, and immediately I felt comfortable," Tillie said. But if a little child can guide the nervous patient out of confusion and bafflement the solution for his difficulties seems to be close enough at hand. Every patient has either children or mothers or friends. It should be easy or at least feasible to assign to them the task of making decisions and reaching conclusions. Unfortunately, the device does not work. Men and women have pride, and that pride is readily shaken, wounded and challenged. The fact that Doris had to make the decision for her was a severe blow to the mother's self-respect. It served to emphasize her tragic inability to act, to decide, to be self-sufficient. It accentuated the helplessness and wretchedness of her existence. Doris' intervention, it is true, relieved the symptoms of tightness and discomfort. Now Tillie's physical person felt secure for the brief period of a few minutes. But her moral and intellectual personality was made to feel more insecure than before. The next decision to be made was certain to reveal an increased distrust of herself and of her imagination.

To trust imagination means to let it perform its functions of dreaming, hoping, anticipating. If Tillie had given free play to her fancy she would have planned the purchase of Doris' dress days or weeks in advance. She would have pictured in her mind, that is, in her imagination how beautiful the child would look in a dress of a certain style, cut or color. She would have anticipated flattering compliments from neighbors and friends. She would have beamed with joy at the thought of Doris' delight when finally presented with the garb. On an evening walk with her husband she would have strolled along the show windows, viewing patterns, tentatively accepting some, with delight when finally presented with the garb. On an eveniog walk with her husband she would have strolled along the show windows, viewing patterns, tentatively accepting some, rejecting others. All along her thought would have dwelled fondly and proudly on the details of the situation when, a week or two ahead, she would arrive at home with the garment neatly wrapped in a box. The surprise, the breathless suspense, the ceremonial of unwrapping, the gasp of astonishment ringiog from the child's lips, the kiss of gratitude, the eagerness to slip into the dress immediately and eye it in the mirror. All of this and many other dreams, hopes and anticipations would have currently crowded Tillie's brain, continually feeding and occupying her imagination. This is precisely the point I meant to make. The acts of planning, dreaming, hoping and anticipating keep imagination busy and occupied, interested and stimulated. They prevent idleness and boredom. And if imagination is properly kept from being idle or bored there is no or little occasion for restlessness or irritability. And without restlessness and irritability symptoms do not stand much of a chance of being maintained or precipitated. Had Tillie permitted her imagination to be occupied with dreams and hopes her chest would have currently swelled with pride and her heart would have habitually expanded with joy. Instead her chest became the seat of agonizing pressure and her heart was rocked by wild palpitations because her imagination was allowed to busy itself with fears and anxieties mainly or solely. What prevented her from keeping her imagination fruitfully occupied was her preoccupation with terrors and panics, with symptoms and distress, in short, with the idea of insecurity. And if an imagination is more or less constantly preoccupied with ideas of insecurity it will be deprived of the opportunity to occupy itself with those dreams, hopes and visions from which ideas of security originate. If this happens the imaginative balance will be disturbed, the thoughts of insecurity will drown out the ideas of security, and
anxious preoccupation will cancel out the pleasurable occupations. The result will be a paralyzing fear of deciding, planning, initiating and acting. But without decisions, plans, action and initiative there is no possibility of developing pride, self-reliance and self-sufficiency. It was the sustained preoccupation with ideas of insecurity that prevented Tillie from acquiring even that modicum of self-trust that prompts the trivial decisions of daily existence.

You will understand now that if the nervous patient is to regain his lost imaginative balance his preoccupations with ideas of insecurity will have to give way to occupations with thoughts of security, that is, with hopes, dreams and pleasurable anticipations. You will also understand that hopes, dreams and joyful anticipations are the very warp and woof of decisions, plans and conclusions. And if you ask how you can manage to rout your preoccupations my answer will be of the simplest kind: Stop listening to the threat of the symptomatic idiom and the imbecilities of the temperamental lingo and your imagination will again be able to indulge in its stimulating occupations and you will be in a position to make decisions, draw conclusions, formulate plans without fearing the dreadful consequences suggested to you by temper and symptom. Learn to use the Recovery language of self-confidence and fearlessness and your imagination will be freed of the deadweight of panics and anxieties. Thus delivered it will once again occupy itself with thoughts of security and ideas of self-sufficiency.
Annette (Panel leader): The subject for today's panel is taken from the article entitled "Temper as Craving for Symbolic Victories." Has anyone an example?

Tillie: I was in the subway last Saturday and sat down pretty close to the corner and after I was seated a woman entered the coach and wanted to squeeze in right between me and the TV corner. She persisted and made me move. I was provoked but I moved although there was plenty of room in the coach. I felt my temper going up and I would have liked to tell the person a thing or two. But then I began to get tense and I knew that I bad to stop working myself up. So I thought, after all, this is a public conveyance and anybody can sit where he wants to. So when I thought of that my tenseness left and I stopped working myself up.

Annette: What was it that made you stop your temperamental reaction?

Tillie: I noticed the tightness in my side. When I get that I feel choked. Then I can't stay in a closed room. That Saturday in the subway if the tightness and choked feeling had kept up a few more minutes I would have wanted to get off the train. So I stopped working myself up, and the sensations left.

Sophie: Before I had my Recovery training, when I called my children from the outside to come and eat they usually didn't respond to the first or second call. Then I would get this tightening in my throat or a pressure in my head and my temper would rise and the symptoms would get more severe. After I got into Recovery I learned I had to control my temper in order to check this irritation. Now I call the children a half dozen times and I can call in the same level of voice and my temper doesn't rise any more. In the past when I used to work myself up I always feared that something would burst in my head for sure.

Annette: I will quote an example of my own. An elderly aunt of mine, we shall call her Aunt Jane, was the type of person who enjoyed temper tangles. She had never lived with anyone, but during the depression we had to take her into our home. When she came I decided I'd make an effort to get along with her. I felt I could do that because she confessed to be fond of me. But what I actually did was to try to convince her that she was wrong and that of course ended up in pretty terrific temperamental outbursts on both our sides. One time, after a rather heated argument, I awoke in the middle of the night with a very odd sensation in my abdomen. I felt as though something awful had happened and I was going to burst. I was frightened but did not know at that time that these were nervous symptoms. But the sensations followed so regularly on temperamental spats I couldn't help realizing that they were closely associated with my temper. Several years later after I had undergone a good deal of Recovery training I had occasion to get in contact with Aunt Jane again. A friend of mine let me use her car and I invited Aunt Jane to join us on an automobile ride. This time I had a good opportunity to notice how I had changed while my aunt had not. Whenever I found myself wanting to prove her wrong and myself right I knew at that very moment that all I was out to accomplish was a symbolic victory. I stopped short instantly and instead of getting provoked myself or getting her worked up I merely answered her remarks with "maybe" or "is that so?" The argument didn't even get started. On leaving the car my aunt was obviously irritated and said, "I am just worn out. I never spent such a boring day in my life." And if that remark didn't provoke me into a sharper answer I realized that I must have learned the technique of giving up the battle for trivial symbolic victories.

Carol: About this temper. I think it is grand that we have been drilled to get rid of it. In my case it is when I am with Pete, my husband, and I start to blow off steam. Pete, who knows Recovery, then says, "Temper!" and that puts me on the
right track again. A year ago or so I would be provoked with him when he would say, “Temper!” and I would snap back, “What of it if I have a temper.” After that I would usually let off a honey of temper. But now I know he helps me check it. And when I feel my temper rising I cut the feeling down and it doesn’t have a chance at all.

Annette: In conclusion I would like to say that the panel members meant to bring out that we all got into temperamental situations. In former days before we had our Recovery training we would have exploded or fretted with a long-drawn-out after-effect. During the explosion we would have had the momentary satisfaction of letting off steam. That would give us a momentary sense of relief. Besides that we would have had the pleasure of feeling ourselves in the right and the other person in the wrong. It is these two pleasures—letting off steam and feeling in the right—that our physician calls the “dual premium placed on temper.” The trouble is that this “dual premium” is short-lived, lasting only a few moments. But then it is followed by an after-effect which may last hours or even days. In that period of the after-effect we suffer many distressing symptoms. I know that I for one learned that the few moments of pleasure enjoyed during the immediate effects are not worth the hours and days of suffering I endured during the after-effect.

TEMPER, SOVEREIGNTY AND FELLOWSHIP
Phyiscian’s Comment on a Panel Discussion

A letter was to be mailed and, as a result, an ugly street scene developed and a family group took their evening meal in the dead silence of a sullen mood. Tears were shed and feelings were crushed. And all the commotion, confusion and agony were caused by—a letter to be mailed. But a letter is a sheet of paper and as such utterly incapable of rousing tempers and offending feelings. No issue was involved. The contents of the letter were not challenged; the propriety, wisdom, advisability of its being mailed were not questioned. It was simply a fight about nothing, a struggle for a scrap of paper, a fight without an issue, a fight for the sake of fighting. How is it that men and women of mature age engage in fights “for nothing?” Obviously, mature years do not necessarily mean mature thinking or adult acting.

A fight is centered around an object and rooted in a motive. In the case of Frank and his mother the object was the letter. What was the motive? A motive is a force that makes muscles move. Suppose the letter which the lady wanted to mail was addressed to a friend. Then the thought of the friend, the desire to communicate with her, the intention to please her supplied the motive that made Frank’s mother walk into the street and move toward the mailbox. If Frank and his wife Harriette had not entered upon the scene the letter would have been mailed without ado and we would have no difficulty understanding the object of the walk, its motive and its successful execution. We would say that an act of behavior was manipulated correctly, or that its purpose aimed correctly at its proper goal. After Frank and Harriette made their appearance the muscles of the letter carrying lady suddenly deviated from the goal of the mailbox, the purpose of mailing was forgotten or neglected and aiming was directed toward something that had essentially nothing to do with the original purpose. A new purpose intervened, changed the goal and redirected the aiming.

The original purpose was to communicate with another person, to give pleasure, to show consideration. The motive here was service. And service serves the end of peace; it creates good will and promotes the welfare of the group. This motive of service and group welfare was suddenly shelved after the arrival of Frank. A fight ensued, and its motive was hostility, competition, domination. What prompted that change in attitude? What is it that makes a person abruptly shift from a disposition to serve to a disposition to dominate?

Whenever you are alone in the privacy of your own home you are master of your dispositions. You may do as you please and may release whatever disposition you wish to express provided you keep within the bounds of law, morals and ethics. If your present disposition is to display a temper and other person in the wrong.

APPENDIX (Continued)
Groups are either loose assemblages, for instance, a crowd in the street, or a close knit organization like the family. The closer a group is organized the more is it pervaded by the spirit of fellowship. There is hardly a trace of fellowship in the street crowd; there should be a maximum of it in the family. All kinds of groups could be ranged between the street crowd and the family with varying degrees of fellowship governing their mutual relations. On this scale, a group of friends ought to be held together by a far greater measure of fellowship than, let me say, a group of co-workers in a shop, and the group of co-workers should score a higher rating in fellowship than a group of voters attending a political meeting. The point that I wish to make is that the family ought to rank highest in point of fellowship among all closely organized groups. In a family fellowship ought to be at its maximum, sovereignty at its lowest possible minimum. That this is not so is clearly evidenced by the almost universal prevalence of domestic temper.

When Frank met his mother he offered to mail the letter. Behind this offer was a desire or determination to be helpful or courteous or considerate. The act expressed the motive of service, that is, the spirit of fellowship. Frank has frequently stated in panel discussions that he and his mother do not get along well together. They live in a more or less continuous temperamental deadlock, in an atmosphere of strife, spite and bitterness. You may conclude, therefore, that Frank’s offer was a polite gesture rather than a genuine eagerness to be of help. But in group life an insincere gesture of generosity and fellowship is far more valuable than an outspoken expression of enmity and a brutal assertion of one’s sovereignty. No doubt, the rebuff offered by Frank’s mother was sincere. It was based on sincere bitterness and sincere hostility. Sincerity of this kind is anything but an asset. A group is interested in peace and order. And peace and order are destroyed or disrupted by the temperamental expressions of anger, vindictiveness and bitterness. A temperamental outburst is sincere, of course. So are murder and burglary. They are based on genuine and sincere desires to kill and rob. That the mother was sincere in her rude reaction to Frank’s offer of fellowship was no credit to her. That reaction was dictated by the mother’s will to have her own way, by her insistence on domination and her determination to assert her sovereign rights. As such it served the ends of unrestricted individualism, not those of rule-bound group life. It was based on the principle of sovereignty, not of fellowship.

This is not an attempt to exonerate our friend Frank. He practiced his share of rudeness and sovereignty when in a temperamental act of brusqueness he “grabbed Harriette and said, let’s go.” Both mother and son are currently disposed to display excesses of domestic temper exercising their disposition to assert their sovereign rights and ignoring the needs for fellowship, mutuality and toleration. What interests us here is the close relation that exists between the workings of an aggressive temper, on the one hand, and the spirit of sovereignty and fellowship, on the other. The members of the panel spoke of symbols and symbolic victories. One of the most pernicious symbols is that of sovereignty. Frank’s mother imagined, perhaps unknown to herself, that she represented or symbolized sovereignty in her dealings with the members of her family. Her will to assert her sovereignty provoked the resistance of her son with the result that family life was turned into a battlefield of temperamental dispositions in which both mother and son craved the glory of symbolic victories and both effectively frustrated one another’s ludicrous ambitions. In the end, a cruel, implacable deadlock developed in which feelings and sensibilities were ruthlessly slaughtered and fellowship was made a shambles. The realistic objects of the incessant fights were invariably such trivialities as a letter to be mailed or a sugar bowl to be filled. The symbolic goal was the craving to assert sovereign rights. The inevitable results were tears, crushed feelings and refusals to eat or otherwise to share and to practice fellowship.

The deadlock between Frank and his mother is undoubtedly extreme. It is characterized by an extreme insistence on the exercise of unrestricted sovereignty and an equally extreme refusal to practice fellowship. Deadlocks of more moderate intensity were mentioned by the other members of the panel. Annette was in deadlock with her sour-dispositioned aunt, Sophie with her boisterous youngsters, Carol with her soft-spoken and well-intentioned husband. All of them were in one way or another embroiled in the tug-of-war of domestic temper, all of them had in previous years indulged in the cruel game of craving symbolic victories in the battle for their sovereign rights, and all of them had an unenvious record of tears shed, feelings crushed and meals taken in the dead silence of sullen moods. But all of them told you in unmistakable language that for them the concept of sovereignty has been finally exposed as an empty, silly and childish symbol and fellowship has become a living, mature and concrete reality. Even Frank, the helpless party to a relentless and apparently incurable deadlock, was able to state that before he had his Recovery training “the deadlock led to endless quarrels because neither of us would give in. Now I keep quiet and while the deadlock persists there is no argument.” In his home, fellowship is not reestablished, but the peace destroying symbolism of sovereignty has been routed and with it Frank’s symptoms of fatigue and sleeplessness. And if it is true that Recovery training is capable of laying the ghost of sovereignty, then, we may be pardoned for claiming that our system of self-help is the sovereign means for promoting fellowship.
MUSCLES AND MENTAL HEALTH (Low, 1978, pp. 52-59; 1997, pp. 61-70)

A Panel Discussion conducted by Patients

Frank (panel leader): I will start off with an example. When I first came to Recovery I had so many symptoms I did not know where to start first. My symptoms were all pretty strong and I did not know which was the weakest. My main symptom was nervous fatigue. Today I know it is not muscular fatigue but merely a sense of being tired. At that time I had difficulty sleeping. It took me anywhere from an hour to three hours to get to sleep, and after I got to sleep I would wake up every hour or so, and this went on practically every night. I also had practically no appetite and had to force myself to eat. I also had blurring of vision, numbness in the arms and legs and pressure in the head. A noise in the ears bothered me a lot. On top of it I had difficulty making up my mind, and the simplest decision gave me trouble. Finally I had to give up my job and did not work for four years before I joined Recovery. Even after I came to Recovery it looked like a pretty hopeless job. Then I remember our doctor once saying in class that it is the minor symptoms that must be worked on first. But I couldn’t tell a minor symptom when I saw one. Today I know that it is not so much the weakest symptom that must be handled but the simplest method that must be used. And the simplest method is control of muscles. Ever since I used my muscles to walk on, fatigue or no fatigue, I am no longer troubled with that awful tiredness. And since I have been using my muscles not to toss in bed I have no trouble sleeping.

Harriette: Every now and then when I am talking with new patients they are surprised when I tell them that I was pretty sick for over fifteen years and am now well. They say maybe you were not as sick as I am. Of course everyone thinks they were the sickest person in the world but I think I was very sick all the time before I came to Recovery. I can remember in high school I got my famous headaches and nausea and fatigue and dizzy spells and weak spells and palpitations and my ears ached and my eyes blurred and my throat choked. And I would go to a doctor and he would prescribe a tonic or say I needed a rest and then maybe I’d be feeling better for a short while and then another series of symptoms would come along. Each time the new series would come they would be intensified until about six years ago they got so bad I decided to quit work. For the next two years I went around to doctors and clinics and had all sorts of x-rays taken and all kinds of medicine prescribed. But the trouble kept getting worse. So after I had gone all round to every place and even went to consult a doctor in Montana I talked again to the family physician and he recommended I should go to Chicago and consult our doctor who, my family physician said, treated his patients with a new method. He meant the classes and Recovery. Well, three weeks after I came to Chicago I was working part time. After four months I worked full time and have been working ever since, that is, over four years. I can say I feel better than I ever felt in my life and no amount of money could ever pay for what I learned in Recovery.

Frank: Can you say that you attacked your symptoms at their weakest point?

Harriette: I don’t know that. But the doctor told me to use my muscles. So I forced myself to eat when I felt nauseated and forced myself to walk when I felt exhausted. It wasn’t easy but what helped me was that I accepted the authoritative knowledge of our doctor. I know our doctor would not ask me to do these things if they could do harm.

Christine: My main trouble was a terrific feeling of depression and fatigue which I thought was the hardest thing to overcome. When I got up in the morning I thought I could hardly move and needed rest. But soon I learned that muscles could be commanded to move but that didn’t work the first few times. I had to practice a number of mornings and what helped me most was the example of other patients when they were interviewed in classes. I thought what they can do I should be able to do, too. And so I said to myself in the morning you certainly can make your hands and feet work. What helped me was, like with Harriette, that I accepted the doctor’s authoritative knowledge that my fatigue was in the mind and not in the muscles. My mildest symptom, I think, was that I had to force myself to eat. When I felt my throat was dry and I couldn’t swallow a bite I remembered that muscles can be commanded to work and kept on eating. so I think I probably worked on the mildest symptom by the method which to me was the easiest to use.

In the further course of the panel Phil recounted how he suffered from a lack of self-confidence after leaving the hospital, how he was afraid he made too many mistakes. "If I would get a wrong number on the telephone or forget to pick up a pencil I thought I was going back to the Psychopathic Hospital.” As a consequence he kept out of the way of people and experienced great hesitancy doing simple jobs. Finally he learned he could always "command the muscles no matter how weak the mind is.” He then reported a recent experience. He was driving his car and on stopping threw the door shut leaving the ignition key inside. When some time later he reached into his pocket he missed the key and knew he had left it in the car. He felt embarrassed. He knew he would have to phone his brother to ask for the reserve key. But then he would have to admit I made a mistake and would have to look foolish.” In former days he would have thought of calling a towing service to have the car pulled in or would have considered some other foolish move, trying by every desperate means to cover up his inadequacy. This time he simply forced himself to use his muscles, called his brother, got the reserve key and didn’t feel embarrassed at all.
When Harriette told recent members of Recovery that she recovered her health after fifteen years of futile search for a remedy she met with skepticism. Had she told the doubters that her main means of recapturing health was the use of her muscles their skepticism would have turned into outright cynicism. That the mind governs muscles is a truism accepted even by the most sophisticated mentality. But that muscles can be made to mold and influence mental activity sounds incredible to the skeptic and laughable to the cynic. Fortunately, our patients do not belong to the group of “advanced thinkers,” and to their plain common sense and unpolished way of viewing things the humble muscle commands as much dignity as the pretentious brain cell. They know that if in a nervous ailment central management breaks down the peripheral rank and file may be ready or can be trained to “take over.” And so, when in the lives of Harriette, Frank, Christine, Phil and many hundreds of Recovery members the machinery of central management was thrown out of gear, the muscles were trained to hold the line until management could be reorganized and revitalized. After the muscles had demonstrated their ability to keep the concern going the self-confidence of the brain was restored and the body regained its capacity for concerted action and balanced adjustment. To the skeptic such “pinch-hitting” of the muscles for the brain may sound incredible, and to the cynic it may appear laughable. But skepticism and cynicism are off-shoots of intellectualism, and Recovery stands for realism, plain common sense and an unspoiled way of viewing life.

At the time when Harriette joined Recovery she suffered from a condition in which her brain had almost ceased giving directions to the muscles. If any guidance was supplied it was in the form of fearful anticipations, gloomy misgivings and dismal threats. The brain had retreated from active management of the body. It cowered away in abject defeatism, shivered at the thought of giving orders and trembled at the prospect of having to take the initiative and to shoulder responsibility. There were tasks to be finished, decisions to be made and actions to be planned but the brain, paralyzed by fear, stressed the muscles into helpless inactivity and the inner organs into chaotic functioning. Harriette was tortured by “headaches and nausea and fatigue and dizzy spells, by weak spells and palpitations.” Her ears ached and her eyes blurred and her throat choked, and for solid years her brain warned her not to walk when she felt dizzy, not to work when she was fatigued, not to eat when she experienced her nausea. The sense of hopelessness in the brain created an attitude of helplessness in the muscles. Action was held in abeyance, life was suspended.

After fifteen years of unrelieved agony Harriette learned in Recovery that if the brain defaulted on its managerial duties the muscles can be made to “take over” and to “pinch-hit” for the cringing cerebral manager. At first she had her doubts. The method seemed too simple. When her nervous fatigue made her feel exhausted and her brain threatened that the next step meant unfailing collapse how was she to force her muscles to venture into that next step that might lead to destruction? But then she heard a patient recite in a class interview how she had routed her fears by “commanding the muscles” to do what they dreaded to do. That patient had developed the habit of growing panicky at the mere sight of a knife, fearing to do harm to the baby. During the interview I urged the patient to practice touching knives and assured her that the mere act of contacting or handling the “dangerous” object was certain to convince the jittery brain that there was no reason for jitters. The resoluteness of the muscles would conquer the defeatism of the brain. The patient accepted my suggestion, practiced touching knives and purged the brain of its fears. “I would have never believed,” the patient exclaimed, “that such a simple method could cure my fears. But it did.” Other patients reported similar experiences. One of them was afraid of crossing the street. Stepping out of the house meant to set going a chain of frightening symptoms, palpitations, sweats, dizziness, muscular weakness and dimness of vision. The brain sounded the customary alarm, warning of a dire emergency. After due instruction the patient learned to brave the empty threat of the sensations and the defeatist babble of the brain. He compelled his muscles to walk on, and convinced his cowardly cerebral manager that no danger existed and that the warning signals flashed by the brain cells were false alarms not to be taken seriously. After Harriette witnessed several class demonstrations of this kind she decided to give the method a fair trial with the result that she worked part time after three weeks of practicing muscle control and engaged in full-time activity after another four months. The brain had been convinced by the muscles that all that was required to shake off nervous fears was to make the muscles do what the brain feared to do.

That the brain receives the greater part of its knowledge from the muscles ought to be plain to anyone who is not blinded by the glamor of fanciful theories. Knowledge means experience, and the bulk of our experience stems from our actions, and our actions are carried out by our muscles mainly. I do not wish to deny that a great deal of experience is gathered from vision and hearing, touch, smell and taste. But the type of knowledge secured from these sources is chiefly informative. Practical knowledge, the knowledge of how to behave, of what to do at a certain time in a given situation comes to you from acting and practicing, that is, from the activity of your muscles. With regard to that variety of knowledge and experience that tells you what to do and what not to do there can be hardly any doubt that the muscles are pre-eminently the teachers and educators of the brain. It is true that after the brain has received from the muscles its education about things practical it stores, analyzes and codifies the items of knowledge which it has acquired. It sorts them according to their importance and value, their harmfulness and innocence, their promise of success and threat of failure. It formulates rules and standards and
elaborates an imposing system of logic and wisdom for the sound guidance of conduct. But the fundamental teaching and educating are done by the muscles. That a flame causes a burning pain the child learns after the muscles have touched the burning object. Once the pain and burn have been experienced through muscular action the brain forms the rule that the finger must be kept at a safe distance from flames. The relationship is clear: Muscles teach the brain, and the brain, enriched by knowledge, guides the muscles.

Before Harriette fell victim to a nervous ailment her brain had acquired a generous store of useful knowledge from the countless muscular acts of behavior which she had practiced in a busy childhood and active adolescence. From these endless series of muscular reactions her brain derived a set of rules, principles and policies which regulated her daily activities. One rule was that headaches, nausea, dizziness, palpitations and symptoms of a similar kind are average happenings not calling for emergency reactions. Another rule was that if doubts arose as to whether any of the symptoms were of an average or emergency character a physician possessed of authoritative knowledge should be consulted. A third rule, we may assume, was that the dictum of the freely chosen physician was to be accepted as sound guide for thinking about and acting on the inner experience. These rules had served Harriette well. They told her what to worry about and what to ignore, and they settled her opinions, beliefs and convictions about health. But after she developed her nervous incapacity she forgot the previously well established rules, indulged in self-diagnosing and produced sustained fears, panics and vicious cycles. Eating, sleeping, walking, conversing were now considered as acts fraught with danger. The brain was crammed with ideas of threatening collapse and impending disaster. All her opinions, beliefs and convictions gained from previous muscular behavior were drenched in a flood of defeatism. Fear ideas and emergency impulses poured forth from an intimidated brain down to the leaderless muscles, and action turned into inactivity, initiative into paralysis of will, self-confidence into helplessness and hopelessness. When after fifteen years of an agonizing existence Harriette decided to consult me, my problem was to convince her brain that eating could be done in spite of the threat of nausea, that nocturnal restlessness and brain storms were no bar to normal sleep performance, that brisk walking was perfectly compatible with "nervous exhaustion" and that a lump in the throat was no impediment to well articulated speech or to resolute swallowing. It was at that time that "commanding the muscles" was prescribed as the proper remedy. As was mentioned Harriette was at first skeptical. But when in classes and at Recovery meetings her skepticism melted she commanded her muscles to lie quietly in bed when she was tense and restless, to walk on when she felt exhausted, to eat when the mere sight of food produced nausea, and to speak forcefully when the throat felt choked. And after the muscles swung into action, disregarding the "symptomatic idiom" of the organs, Harriette’s brain was instantly convinced that exhausted muscles can do a fine piece of walking, that a weary body can lie motionless in bed until sleep supervenes, that a stomach harried by the prospect of nausea can be made to take in food without sending it back, and that a throat, drained of its moisture and contracted to a pin-point, could be induced to voice a well-modulated speech. With continued practice of systematic muscle training the brain finally was rid of its defeatism and invigorated by a newly gained conviction, mustered the courage to resume leadership and to reinstate the ancient set of rules, policies and principles for healthy conduct. Harriette’s muscles had re-educated her brain.

Had Harriette retained her skepticism she would have refrained from practicing muscle control, and defeatism would have nullified or retarded her cure. Unfortunately, too many patients persist in their skepticism, scorning the use of a method which appears “too simple” to promise results. One such patient recently tried to challenge my statements about the role of muscles in shaping conduct with the question, “But, doctor, I don’t suffer from palpitations or dizziness or fatigue. My trouble is an obsession. How can muscles cure an obsession?” The obsession from which the lady suffered was one of jealousy. The patient knew that her husband was a model of matrimonial loyalty, but could not shake off the thought that he was unfaithful. She was told: “I grant that yours is what is called an obsession. But if you ponder the meaning of the word you will realize that what obsesses your brain is an idea. You know from experience that ideas come and go. How is it if you cannot get rid of your idea? How is it that it ‘obsesses’ you and occupies your attention all the time? The reason is that the actions of your muscles feed this idea and reinforce it incessantly preventing it from leaving the brain as ideas ordinarily do. Command your muscles not to act on the obsession, and it will die of inanition. What you do is to keep the thought of jealousy alive by means of your muscular action. You rummage in the pockets of your husband’s clothes to find evidence of his philandering. When you arrive home you search rooms, garret and basement to discover tell-tale objects left by an unwelcome visitor. You spy on your husband’s activities, telephone his office numbers of times to check on his whereabouts, scrutinize his mail and notebooks and keep a close watch on every one of his movements. When he arrives in the evening, you subject him to a relentless bombardment of quizzes, questions and suspicions. All of this is done by your muscles. Every search, every act of watching, every sequence of questioning intensifies your tenseness and keeps your attention forcefully riveted on the obsessive idea. That idea would die a natural death within a short time, as ideas commonly do, if you permitted it to expire. But the action of your muscles keeps it alive, prolonging your suffering and refusing to let your brain find its normal equilibrium. The surest way to make the obsession depart from your brain is to command your muscles not to ask questions, not to telephone your husband’s office, not to launch into endless searches of rooms, pockets, drawers and notebooks. In your case, the muscles, if properly restrained, would not only re-educate the brain, they would also give it the much-needed
breathing spell and would relieve it of the well nigh intolerable tenseness under which it is placed through the action of your muscles."

I could quote numerous other examples illustrating the many uses to which the method of muscle control lends itself in its task of either convincing the brain that defiance of symptoms is possible and harmless, or relieving it of pressures caused by morbid preoccupation with disturbing ideas and impulses. But my time is up and I shall close with the assurance that what Harriette did can be done by every nervous patient and that the simplicity of the method which she used ought to be no occasion for skeptical shrugs and cynical sneers. Precisely because the method is simple, it is prompt, effective and—convincing.
FEELINGS ARE NOT FACTS (Low, 1978, pp. 92-98; 1997, pp. 111-119)

A Panel Discussion Conducted by Patients

Annette (panel leader): I remember a distressing sensation which gave me no end of alarm. It was a severe cramping or pain in the side of my abdomen. It was so severe that when it hit me I felt I could not walk. I had the same sensation on numerous occasions and was always afraid it would return. I know now that anticipating its return made matters worse. I was alarmed when I had the sensation and was perhaps more alarmed when I didn't have it but anticipated its return. After six years of almost constant suffering I finally went to the hospital but the doctor couldn't find anything wrong with me physically and sent me to the Illinois Research Hospital. It was then that I came under our physician's care and joined Recovery. It was only then that I realized that it was not the sensation that caused all the discomfort but the panicky feeling that something terrible was about to happen.

At the time I felt like something would burst in my side. I was sure I wouldn't be able to stand it, that I would go to pieces. When the doctor told me, "Your sensation is distressing but not dangerous," it took me quite a while before I understood what he meant. I had to take his word for it but I continued to feel something awful was going to happen. Today the sensation comes back occasionally. I have a slight twinge in my side every right now. In former days I would have been concerned. Today I know and know for sure that the sensation is merely distressing and not at all dangerous. I no longer anticipate trouble. Any other example?

Margaret: Recently I had company from out of town. I hadn't seen them for two years so I asked them to dinner. The cooking and the preparations were too much for me, and I got quite excited. I had again that pressure in my chest, and the palpitations were just awful. And I got a terrible pain in my head and my eyes smarted, and every time I turned my head it cracked. A year ago I would have become panicly and my husband would have called the family physician, and I would have fussed and stewed for days. This time I knew they were symptoms and they were distressing but not dangerous.

Annette: Did you go ahead with what you had to do?

Margaret: I felt like giving up but I didn't. I know there was no danger.

Mary: Yesterday I was invited to spend the afternoon with a friend. I took my little nephew along and had no trouble at all making the trip. I didn't feel nauseated as I used to feel on street car rides. By seven o'clock I got ready to leave the party. As soon as I reached the street my legs started to give in and my heart pounded and my stomach flew around and I looked at my nephew and didn't know what to do. My first thought was to rush back to my friend's house and ask somebody to bring me home. But I knew these were symptoms and the sensations were not dangerous and I just stood there waiting till the symptoms would disappear. But I couldn't even wait because my nephew looked up at me and asked, "Aunt Mary, aren't we ever going home?" I was still very uncomfortable. But I took the next street car and we got home without trouble.

Annette: This is a beautiful example how you can be very uncomfortable and can manage to stand the discomfort if you keep in mind the physician's authoritative knowledge that you are not in danger. Any other example?

Caroline: I had a very gratifying experience this morning after my husband and I got up. He said, "What's the matter, don't you feel good today?" I asked, "Why?" He said, "You are very quiet today." Usually I am very talkative in the morning and, for that matter, all day. I have always a desire to talk about my symptoms and I guess I drive people nuts. This constant talk about my symptoms is sabotage. I know that but I haven't been able to check it so far. This morning I decided to stop talking and complaining and kept quiet. So I said, "I have a pain in my head but I know it will go away." We then talked of something else and I couldn't help but realize how different it was than a year ago. A year ago I would have said I have a terrible pain and I would have been sure I had a brain tumor and the doctor just won't tell me and I don't know what to do and if Recovery and our physician can't help, who can? But this morning I stopped that.

Before I came to Recovery when I had this particular pain in my head I would give in and go back to bed and my husband would bring me a hot water bottle and it seemed that made the pain worse and then he would bring me an ice bag and in the meantime I would work myself up and he would suggest I take an aspirin but that did not help. After I came to Recovery regularly and talked to the other members of the group I learned to handle this symptom. This morning my husband offered to go to the store for me as he always does when I complain of my headache. Usually I become dramatic and say that my pain is so severe that I can't even think what I want from the store. This time I merely said, "Give me a few minutes and I will write the list."

Annette: Here we see Recovery training at its best. Not because Carline did so much better this time and is improving, but because Caroline has learned to make fun of herself and her symptoms. She has gained insight and knows now that she dramatizes her symptoms. She knows she plays a game and plays for attention. She has learned not to take herself and her symptoms seriously. This is a great advance. Any other examples?

Gertrude: As most of you know, my husband has been discharged from the service. Before he went in I was quite sick and one of my difficulties was getting his breakfast. I would have a terrible feeling of helplessness when I would make it and I would say I can't do it. I would then get a feeling of tightness in my throat and feel like crying. On these mornings I used to have a feeling of unreality. I would feel alone and things looked changed and distant and I felt I was changing. When
my husband was discharged and came home. I made up my mind that I was going to do my job and he gets up at five-thirty. I anticipated this feeling of helplessness but even so I got up and I just felt fine. I discovered I was just looking for things but they didn’t happen. Really I was only anticipating a danger but there wasn’t any if I didn’t anticipate it.

Annette: I had similar experiences with the feeling of unreality and with anticipating. You know our physician tells us that anticipation is nothing harmful but it must be calm and not fearful. You may anticipate a palpitation. But don’t think of it as dangerous. I remember one day I had to take some responsibility about a social function being given by Recovery and I was the social chairman and had to arrange for a picnic grove. I didn’t like being on the job but I knew it was good for me. About a day before the picnic was scheduled I became very uneasy. I thought I had to appear at my best at the picnic and what will happen if I get some extremely distressing sensations? I may get this dizzy feeling and a sense of unreality. With me this is a feeling as though I couldn’t really feel things. I would handle them and although I knew I touched them I had the feeling I didn’t touch them. I realized I had a fearful anticipation and knew I was not supposed to anticipate in fear. But I had difficulty shaking off that fearful anticipation so I called another member of Recovery. I said I know I shouldn’t anticipate danger and maybe I was merely tense as anybody might be preparing a picnic. This member then said, “You think you are merely tense but I can tell by your tone of voice you are quite anxious about that symptom and the fact it may return.” Then she said, “Why, you can handle that. You have handled it before.” Then she told me how she used to be fearful and she learned not to anticipate danger. I realized then how the older members of Recovery did things and I was not experienced yet and didn’t know yet how to handle that anticipating. But with months of practice I soon learned how to anticipate calmly. What helped me most to overcome this anticipating was the thought that I was average and not supposed to do a job. You know the doctor always tells you the average people you meet are not critical. If you make a mistake they will know that people on an average do make mistakes. They will not condemn you. We must always keep in mind how we judge other people. If they commit a blunder we think nothing of it. We do not think they are imbeciles. We simply notice the fact that somebody made a mistake and know that people do make mistakes. As the doctor says, “People are tolerant with others but they may be intolerant with their own mistakes.” We nervous and former mental patients must learn to become tolerant toward our own mistakes. We must not want to be exceptional. It is time now to bring the panel to a close.

FEELINGS ARE NOT FACTS

Physician’s Comment on a Panel Discussion

As I listened to the panel and heard one patient after another repeat that sensations are distressing but not dangerous, it occurred to me that nothing could symbolize more beautifully the close union that exists in Recovery between patient and physician than this fundamental Recovery principle that sensations are merely distressing but not dangerous. The patient alone knows how distressing is his sensation; the physician alone knows how harmless and devoid of danger it is. The patient knows his feelings, the physician knows the diagnosis.

Annette suffered cramps, Margaret had chest pressure and palpitations, Mary, Caroline and Gertrude were stricken with headaches, vomiting, tightness in the throat and feelings of unreality. Each had their own assortment of symptoms, and it would be absurd to assume that Annette felt Margaret’s palpitations or Margaret experienced Annette’s cramps. You see, sensations and feelings are intensely personal and subjective and are known to him only who happens to experience them. You may say that a feeling is known to the person only who feels it. To the outsider it is unknown unless he is told about it. His knowledge of other people’s feelings is hearsay knowledge. With regard to the patient’s feelings the physician is an outsider who cannot attain anything but hearsay knowledge of what the sufferer experiences. Without being told he would not know that the patient has palpitations unless he counted the pulse. He could certainly not know how intense, threatening or tormenting they are.

Contrast now this highly personal and subjective quality which we call feeling with its celebrated counterpart—thought. If Margaret had the thought that the sun was shining or spring was in the air she would have no difficulty communicating her idea to Annette. If Annette agreed to and accepted Margaret’s idea the two would share it, and there could be no doubt that both knew exactly what they meant by sunshine and spring and air. But suppose the two spoke of cramps. To the one the word may convey the experience of a wild panic, to the other that of a mild twinge. You see the difference: thoughts can be exchanged, accepted or rejected like an objective commodity. Feelings are strictly personal and singular, incapable of being exchanged or shared.

The basic distinction between feelings and thoughts is the physician’s dilemma and the patient’s calamity. It is the main reason why patient and physician have so much difficulty understanding one another. The physician speaks the language of thought, and the patient replies in the language of feeling. How can they meet? Take, for instance, the matter of sleep and sleeplessness. I know that patients who complain of insomnia get their due share of sleep. But after the patient awakens he feels for certain he has “not slept a wink.” My thought about sleeplessness is founded on expert studies and thorough knowledge and can be communicated to any patient. But will he accept it? Will he consent to share it with me? I tell him he slept, but being fagged out and listless he is told by his feelings that he has not slept. Will he listen to the language of the
physician or to that of his feelings? You know the answer given in Recovery. If the patient is inclined to cooperate he will be guided by the physician's thought. If he is ready to sabotage he will consult his feelings. Whether he does the one or the other means all the difference between health and suffering.

Another example of the clash between the patient's feelings and the physician's thoughts: My thoughts about "nervous fatigue" and "nervous exhaustion" are known to you. The patient merely feels fatigued but is not. His "fatigue" is a psychological feeling and not a physiological condition. Being discouraged and "having nothing to live for" or to "look forward to" he arises in the morning with the dreadful anticipation of one of those drab and depressing days in which he will have to perform a deadly routine without zest or inspiration. The monotony and lifelessness of that day stares him in the face. Being discouraged and "sick and tired of it all" he cannot relax; his muscles feel heavy and limp. The physician knows it is discouragement and self-disgust but the feelings of the patient speak forcibly and persuasively of a real, physiological fatigue. Who will the patient listen to? To his physician or to his feelings? The answer is the same as with sleep: the patient is inclined to accept the verdict of his feelings and to sabotage the physician's authority.

I want you to know that your feelings are not facts. They merely pretend to reveal facts. Your feelings deceive you. They tell you of danger when there is no hazard, of wakefulness when sleep was adequate, of exhaustion when the body is merely weary and the mind discouraged. In speaking of your symptoms your feelings lie to you. If you trust them you are certain to be betrayed into panics and vicious cycles.

I said that your feelings lie to you, that they deceive and betray you. How can that be? How can feelings be true or false? If you are sad what has that to do with truth, deception or treachery? Feelings are either experienced or they are not. They are present or absent but never true or false. Thoughts alone possess the quality of truth and falseness. And if the patient's feelings tell lies they do so because an incorrect and deceptive thought is attached to them. The deception is accomplished by the thought, not by the feeling. The panel members expressed this relation between thought and feeling with convincing plainness. One after another they stated that before joining Recovery they thought of their panics as dangerous, but now they think of them as merely distressing. You see, a panic is a feeling of extreme distress which annexes either the thought of danger or that of harmlessness. The panics experienced by patients are not pure feelings, they are overlaid and modified and taken captive by a thought. If the annexed thought is that of danger a vicious cycle will develop and the panic will be prolonged. If the thought is that of security the panic will be stopped abruptly. It all depends on whether the patient will accept the physician's thought of security or his own thought of danger. If this be so, then, it is no longer a question whether the physician's thought ought to prevail or the patient's feelings. It is no longer the problem of thought versus feeling but of one thought versus the other. The patient is not asked to change his feelings or to discard them or to disavow them. He is merely asked to substitute the physician's thought for his own. You will now understand the meaning of my introductory statement that the Recovery slogan "Sensations are distressing but not dangerous" symbolizes the close union between patient and physician. If it is assumed that the physician approaches the patient with an objective thought and the patient reciprocates with a subjective feeling the two could never meet. Feelings cannot be exchanged or shared. If the patient were nothing but distressed or sad or despondent, the physician's thought could hardly reach him. Communication and mutual understanding would be blocked effectively. But if the feeling experienced by the patient is reduced to a "quarter-feeling" of despair, associated with a "three-quarter-thought" of danger, then, the physician's thought of security can easily meet the patient's thought of danger. It can modify or eliminate it. In Recovery this has been done with singular success. As the panel members quoted themselves: In former years they entertained their own thoughts that the panic was dangerous. Now they accept the physician's thought that it is merely distressing.
THE WILL TO BEAR DISCOMFORT (Low, 1978, pp. 120-123; 1997, pp. 145-149)

In a recent panel discussion Phil stated: “All my life I have had difficulty with my handwriting. When I had to write anything or sign a paper I became tense and the strain made it impossible for me to write clearly. I always thought I just couldn’t help it. I get nervous and can’t write, that’s all.... In Recovery I have learned that everybody can command his muscles to move. And now when my hand tenses up while I am writing I know I can make the muscles of my hand to move calmly instead of racing ahead with the scribbling and then the tenseness will pass....”

Phil, in his pre-Recovery days, had the conviction he could not write and the certainty he could not help it. His credo was “I can’t do it, that’s all.” After joining Recovery he discovered that convictions and certainties can be discarded and credos can be changed. When he changed his belief and dropped his conviction which method did he employ?

Phil’s fingers were never paralyzed. Hence, he was able to write. But for some reason he developed a sense of embarrassment and self-consciousness about the act of writing. The self-consciousness produced tenseness which caused the fingers to go into a mild spasm whenever they were made to wield the pen. The spasm may have given rise to some sort of a cramping sensation. That created discomfort. In order to avoid discomfort he avoided writing. He feared to write because he dreaded the discomfort it entailed. But the more he feared it the more annoying grew the discomfort; the greater the discomfort the more intense the fear. In the end, the vicious cycle, relentlessly fanning both fear and discomfort into extremes of agonies, made Phil believe that smooth, effective and painless writing was impossible.

What seemed impossible to Phil was not the act of writing but rather the necessity to face, tolerate and endure the discomfort connected with it. This is an important conclusion because it describes the pattern which applies to every nervous fear. Some of my patients go to bed with the fear of not sleeping. They think they fear sleeplessness because it ruins health. But what actually frightens them is the torture, that is, the discomfort of lying awake in the dreadful stillness of the night. Or, a patient becomes panicky on entering a street car. He thinks his fear is that of threatening collapse. But what actually scares him is the prospect of being tormented during the ride by palpitations, choking sensations, dizziness and sweats. Again, it is the anticipation of discomfort and nothing else that causes the apprehension. I could easily quote hundreds of situations in which nervous patients are convinced that what they fear are certain acts or certain occurrences while, in point of fact, the only fear they experience is that of a discomfort which they conceive of as “unendurable” or “intolerable” or “unbearable.”

To put it bluntly: nervous fear is the fear of discomfort.

Phil disposed of his fear of writing by commanding the muscles to carry out the requisite movements. In Recovery, he said, he learned that everybody can do that. But a command is not a method. I shall ask: How did Phil learn to make his muscles obey his command? Long before he knew of Recovery, long before Recovery existed he had issued commands to his muscles to write but they balked. On a thousand occasions he had made his fingers pick up the pen and run it across the paper but the order miscarried. The fingers shook and the pen tottered. The product of his painful effort was an illegible scribble, not a clear script. Why did his muscles defy his command in pre-Recovery days and heeded it promptly after he passed through Recovery training? Which is the Recovery method of making muscles obey directions?

In his pre-Recovery days Phil issued orders to his muscles to perform the act of writing. Had he done nothing else there can be no doubt that the writing would have been accomplished. But while giving directions to his fingers his mind was obsessed with the thought that writing was an “unendurable” torture and that he could not go through with the task. Your muscles will not move, of course, if you suggest to them the fear that the movement will lead to disaster. The very thought of disaster (“unendurable” torture) will block motion. Fear even if mild makes muscles tremble and the trepidation thwarts proper execution. If you want your muscles to carry out your commands you must not scare them into anxiety and hesitation. To strike the muscles with fear and then to ask them to act with precision is absurd. My patients are guilty of this absurdity. Gripped with a grotesque fear of discomfort they first tell the muscles that the contemplated action is impossible or fraught with danger and then command them to act. The muscles, with a better logic, release a tremor and bungle the job. Whenever that happened to Phil in his pre-Recovery days he felt hopeless and concluded “I cannot write. That’s all.” But that is not all by any means. The “I cannot” ought to read more correctly “I care not.” Phil could write very well but did not care to bear the discomfort of a painful and difficult writing with fingers scared into fumbling and trembling. In Recovery he was trained to face, tolerate and endure discomfort and once he learned to be uncomfortable without winning he gained confidence and passed on to his muscles the assurance that writing was possible though uncomfortable. The muscles, then, swung into action without tremor or delay. The method which was here at work was plainly and simply THE WILL TO BEAR DISCOMFORT. It is the only and authentic Recovery method of making recalcitrant muscles obey directions.

If the nervous patient is to rid himself of his disturbing symptoms he will have to cultivate the Will to bear discomfort. Time was when bearing discomfort was considered part of life, a part accepted by everybody and practiced everywhere. Children were reared with an eye to making them stand up under hardship. Heavy labor, sustained exertion, privations and drudgery were regarded as incidental to the sweat and toil of daily existence and were borne with patience, resignation and humility. But in our days comfort is hailed as something in the nature of a supreme achievement. It is cherished, worshiped, idolized. When we catalogue the accomplishments of our age the first item we are likely to point to...
with mounting pride is the fact that our modern technique has eliminated drudgery from the daily routine. We boast self-complacently of the labor saving devices which a busy industry rolls off its assembly lines in bewildering profusion. The housewife is daily assailed by the advertiser's exhortations to escape the "backbreaking" drudgery of homework. Billboards flatter you that "electricity is your servant." Your kitchen and bathroom are choked with gadgets meant to do away with the discomfort of effort and exertion. Educators rack their weary brains to ease the "uncomfortable" task of acquiring school knowledge. Mothers and fathers have learned to shun the discomfort of staying home with their babies. Youngsters resenting the discomfort of rules and conventions are in feverish haste to cast off age-old restraints. I shall ignore the fact that automobiles have abolished the effort of walking, that typewriters have disposed of the inconvenience of writing and that an elaborate push-button system prevents us effectively from working off our unspent energies on household chores and office jobs. All of this may be rated as an unavoidable development, perhaps even desirable in a limited sense. What is more important is that this process of removing effort and creating mechanical comforts is being acclaimed as a value and cultural achievement. We take a childish pride in our "modern progress," extol with boyish conceit our "high standard of living." We class as "backward" and "unprogressive" countries which lack the mechanical comforts which we enjoy. In all of this, the cult of comfort is recommended as the royal road to superior culture. The pursuit of comfort is glorified and the facing of discomfort discouraged. In this modern scheme of life the Will to bear discomfort has no place. If comfort is raised to the level of a value or ideal discomfort is necessarily looked upon as something not to be tolerated and endured, as something that is definitely not part of life, certainly no necessary part of our "modern life."

I do not wish to convey the impression that I am opposed to the use of such mechanical conveniences as refrigeration, electricity and gasoline. If anyone wishes to introduce these or kindred comforts into home or shop he has my blessing. But he will have to know that this type of legitimate comfort is merely useful and not at all valuable. In those departments of life which are governed by valuations the cult of comfort is decidedly misplaced. If you want to maintain the values of health and self-respect, of initiative and determination, of character and self-discipline, what you will have to learn is to bear the discomfort of controlling your impulses, of steeling your Will, of curbing your temper. This calls for an attitude which far from exalting the virtues of comfort places the emphasis where it belongs: on THE WILL TO BEAR DISCOMFORT. When Phil embraced the Recovery doctrine that discomfort, even in our "advanced" days, is a thing to be patiently borne, bravely faced and humbly tolerated he discovered forthwith that his "I cannot" write was nothing but an "I care not" to be uncomfortable. He then revised his distorted valuations, braced himself against that part of life which means discomfort and realized to his amazement that with the emphasis properly shifted things were done more efficiently and life was quite comfortable again.
APPENDIX (Continued)

TEMPERAMENT AND TEMPER (Low, 1978, pp. 139-143; 1997, pp. 168-173)

Betty, on the Saturday afternoon panel, reported that several weeks ago she had an appointment to see Dr. Low at his office. "I had to wait from 2:30 to 4:00 P.M. Then I had to go shopping for a belt and a pair of shoes. After that I had to go to the insurance office and to be there before closing time. At the department store I had to spend time picking the merchandise I wanted. Then it took more time yet before the saleslady took care of the purchase. I got to the insurance office just five minutes before closing time. By now I had a severe headache, and when I was on the street it occurred to me that I had to get a few things for supper and that after supper I had to attend the monthly Recovery meeting of the panel members in the evening. The head pressure became worse and I felt exhausted. Finally I arrived home, trembling and sweating and palpitating. Then I noticed that my husband had not returned from work although it was past his usual time. My first thought was that something had happened to him. My symptoms became worse. Then I remembered my Recovery training and thought I shouldn't anticipate danger. Instantly I felt better...."

Betty, in an emotional upheaval, summoned forth a slogan she had learned in Recovery and obtained instant relief. Experiences of this kind are now commonplace among our members. They know that all they have to do to stop emerging symptoms is to spot their emotionalisms and to refuse to accept the suggestions of doom and disaster offered by their temperamental lingo. And if Betty managed to secure instant relief from her spotting the conclusion seems inevitable that she spotted correctly and applied the appropriate technique taught her in Recovery. But Recovery techniques and Recovery maxims stem from me, your physician, and if it is true that I ever taught Betty or anyone else not to anticipate danger I must have been dreaming or utterly careless in the choice of my words. How can anybody be alive and avoid anticipating danger? To be heedless of danger is a sure prescription for running straight into it. Just cross streets and turn corners unmindful of the dangers of a busy traffic and I will not want to be responsible for what might happen to you some day. Clearly, Betty applied a Recovery slogan correctly but in quoting it distorted its phrasing.

No wife worth the name can avoid uneasy thoughts and anxious anticipations if her husband is unduly late in arriving at the customary time. The image of an accident, of collapse and even misgivings about foul play must of necessity arise in her brain if she is possessed of affection and imagination. In a situation of this kind the thought of possible danger is the unavoidable and proper response. No teaching of any kind, Recovery or otherwise, will ever be able to eliminate this response which is necessary for life and desirable for human relations. The question is how a person experiencing the response of apprehension will react to the experience. Will he worry with reflective calm? Or, will he work himself up to a burst of emotional hysteria? If he permits himself to become emotional and hysterical, then, the original response of plain worry has been "worked up" or "processed" into a temper reaction. What patients are taught in Recovery is to curb their tempers and to leave the original responses to run their course, that is, to let them rise and fall, come and go. Temper keeps them rising and coming and prevents them from falling and going.

What I here call "Original Responses" are the ordinary run of thoughts, feelings, sensations and impulses which, in the average individual, come and go, rise and fall. They are inherited and constitutional. A dog jumps at you unexpectedly. You are startled, and the startle is an original response which everybody is likely to experience in an event of this kind. It would be absurd to tell you not to get startled. The response is rooted in your racial inheritance, embedded in your constitution. It is original, natural, hardly changeable. Another example: your ear is assailed by a harsh word or your eye by a disdainful gesture. If you are at all responsive you will feel hurt or insulted or shocked. That is again your original response, just as constitutional and refractory to change as is the startle occasioned by the dog's jump. Original responses of this kind are without number. The pity aroused by suffering, the joy and warmth produced by a smiling infant, the enthusiasm created by a stirring speech, the delight felt at the sight of a friend, the anger provoked by an affront, the impulse to run in the face of danger—these and a multitude of others are all original responses. The sum total of original responses which a person is possessed or capable of are called his temperament. Temperament means that a person is sensitive, receptive, impressionable to events inside and outside him. If your temperament is receptive and impressionable your original responses will be many and varied; if it is dull they will be few and static. It is temperament which responds to events with readiness or sluggishness, warmth or coolness, sympathy or aversion, interest or indifference, thrill or chill.

When Betty, arriving home, found her husband missing the thought struck her that something might have happened to him. Every wife would or should have experienced the same response provided her temperament was endowed with the average qualities of warmth, affection and tenderness. If Betty's temperament was of this description she had to feel concern, worry or misgivings. You see here that when temperament stirs feelings are apt to rise. In the present instance, the feeling was that of worry. Betty might have acted on this natural and original response of worry. She might have telephoned to the husband's place of employment or to any locality at which she could have reasonably expected him to stop on his way home. Had she done that her original response would have guided her to a rational, sane, well adjusted reaction. Or, she might have analyzed the situation in the light of previous experience and reflected that her husband's arrival had been delayed frequently in the past by overtime work, by a traffic jam or by a decision to have his hair trimmed before setting out on his homebound trip. This again would have led to a rational and sane reaction. Betty would have simply waited, calmly and patiently. But
Betty's temperament was not disposed to release the responses of calm and patience. She is or was a nervous patient, and if the temperament of a nervous patient sits it is likely to develop—temper. And you know that temper is incompatible with calm and patience. Temperament raises mild and moderate fears, worries, angers and joys. But temper acts differently. Its responses are always vehement, immoderate, excessive and even explosive. In her pre-Recovery days, Betty responded to disappointments with temper. After she had gone through her Recovery training her responses became again those of her native temperament, calm, even, sane. In former days her temperament led her straightway into hysterical emotionalism. Now it produces feelings of average intensity. Formerly, when disappointed, her temper suggested a grave emergency. Now her temperament merely hints at a possible average danger. To think of danger—calmly—is undoubtedly wholesome and necessary in life in general but particularly so in the hustle and bustle of our metropolitan life. Why, then, did Betty think she "shouldn't anticipate danger?" Obviously, she confused two types of anticipation, those generated by a wild temper and those inspired by a mild temperament. In Recovery she was taught not to entertain hysterical anticipations in response to average dangers which merely call for gentle and moderate worry. When she met with the average situation mentioned in her panel example her temperament produced the original response of concern. But unwittingly and following a year-long tendency she thought of a dire emergency and developed temper. The result was that her "symptoms became worse." Now she remembered her Recovery training, spotted her temper and felt instant relief. She acted correctly but when she reported the event she used a wrong phrasing. She claimed she spotted and stopped her temperament when, in actual fact, she put a stop to her temper. She applied properly the Recovery techniques for curbing temper but misquoted the implied principle when she presumed to have checked her temperament.

My patients will do well to ponder the lesson of this clear-cut distinction between temperament and temper. Afflicted with nervous ailments they are extremely sensitive and the original responses of their native temperament are aroused by actions, statements and events which other people, less impressionable, would overlook and ignore. Somebody maintains silence in their presence. Instantly my patients are likely to construe the reaction as slur or indifference or neglect. Or, they commit a minor blunder or sustain minor losses, failures or defeats. The average person would take these insignificant mishaps in his stride and not a ripple of excitement might cross his temperament. But my patients are apt to respond with self-blame, embarrassment or a sense of inefficiency. This is in itself no calamity and merely indicates that my patients are unfortunately blessed with temperaments which pour forth endless streams of original responses. The responses as such are no wise different from those experienced by men and women not the victims of nervous trouble. Everybody may at any time feel slurred or neglected and may on occasion indulge in self-blame and a sense of embarrassment. With the average person such common inner disturbances are readily forgotten or dismissed. But with my patients there are no minor or common disturbances. Every disturbance has to them the major aspect of an urgent emergency. And if an emergency is thought of emotion is mobilized and temper released. Minor apprehensions are then fanned into major explosions, into panics and tantrums. These dramatic or dramatized developments can be checked if the patient is trained to regard his worries, embarrassments, misgivings and forebodings as what they really are: the innocent outpouring of a temperament which has been sensitized by an endless career of suffering and has acquired the habit of producing an unbroken succession of harmless original responses. The nervous patient will have to learn to be tolerant of his responses and to refrain from processing temperament into temper.
Florence, on the Saturday panel, spoke with surprising candor about her marital life. "I was always jealous of my husband," she said. "All he had to do was to invite some girl to ride home with us from church and I became jealous and felt very insecure. Before I joined Recovery I did not know that this was temper. I felt I had a right to ask my husband not to pay attention to any woman but me. But when I got my Recovery training I learned that I was not the judge to decide who was wrong and who right. Today I know that when the jealousy gets a hold of me I feel irritated but nobody is wrong. I have learned to let the irritation run its course, and it does that in a few minutes. And after my jealousy is gone I feel good and feel proud that I am able to control it. In this manner I endorse myself and that makes me feel better yet. In former days when the jealousy came over me it produced a blurring of my eyes and gave me a headache that would last for days and my married life was a mess all the time. Today I have very few of the symptoms and both I and my husband lead a much happier life than we ever did before I joined Recovery."

Florence suffered from jealousy for many years but did not know it was temper. That was before her Recovery training and at that time she merely "felt" insecure. She also "felt she had a right to be jealous. I shall ask: Who or what did Florence "feel" for? The answer is: She felt for her own security and for her own rights. She showed little if any feeling for the husband's security which was gravely threatened by her jealousy, and for his rights which were ruthlessly ignored when he was forbidden to extend simple courtesies to a fellow church member. And my conclusion is: Florence, in her pre-Recovery days, had feelings for her own dear Self only whenever the jealousy took hold of her. The feelings for the husband were either absent or feebly operating. Yet, the couple had formed a life partnership. They were united in mutiny, and the marital union, assuredly, called for mutual feelings, for sharing, communicating and exchanging. Instead, whenever she was in the throes of jealousy, Florence made her feelings flow out toward her own Self only; the partner's Self was denied its legitimate share of consideration and affection. If the concern about security and rights was at all the outcome of feelings they were certainly self-centered and not group-centered. And self-centered feelings (self-pity, self-blame, self-disgust, self-importance) are temper, of course. For you, the members of Recovery, this is commonplace and needs no explanation.

Florence aimed her jealousy at her husband. Since he was her partner in their marital group the feeling was group-oriented although in a superficial sense only. But it declared the other person as wrong and oneself as right, and that quality stamped it as unquestionably temperamental. Her jealous temper led Florence to be resentful, sullen, suspicious, indifferent, perhaps also hostile and vengeful. All these feelings tie in with jealousy, their main characteristic being that they adjudge the other person as wrong and oneself as right. Though they must be classed among the group-directed responses, nevertheless, they are tempers.

Many of you remember the time, some eighteen months ago, when Florence first joined Recovery. None of you realized that she was of a jealous disposition. How could you know? She never showed temper when she was with us. She was unfailingly sweet, considerate, patient, forever willing to be helpful. As a member of our group, she displayed a vast capacity for joy and enthusiasm, affection and forebearance, devotion and selflessness, fellowship and compassion. Needless to say, these were feelings, group-centered with regard to their aim, genuine in intent, sincere in application. As such, they were emphatically not temperamental. Her affection had, of course, no implication of somebody being branded as wrong and herself exalted as right. Feelings of this kind whose exclusive tendency is to benefit and serve the group go by the name of sympathetic responses. They may properly be called the feelings of sympathy. By their very nature they cannot be suspected as furnishing the material out of which temper is woven.

You will also remember that at times Florence appeared in our midst with drawn features and a worn look. Her mood was depressed, and her depression, we know now, was largely the result of her physical ailment. In these periods of depression her countenance reflected silent grief, a soft resignation, a touching sadness. But there was no wailing and complaining, no self-pity or self-blame. Nobody was assessed as wrong, nobody as right. She just suffered in placid resignation. Feelings of this kind signify a lowering of the feeling tone, from joy to grief, from sympathy to apathy. They are known as the apathetic responses and may be fittingly called the feelings of apathy.

My opportunities for observing Florence were limited to office, classes and meetings. I had no occasion to study her behavior in such casual situations as encounters with sales persons and elevator operators, in chats with neighbors and friends, at card games and on visits to theatres. What was the nature of her responses in these contacts? We know that Florence is a warm person, easily stimulated and eagerly responding. So we may take it for granted that in most instances her reaction was mainly that of sympathy. Occasionally, more particularly when her severe physical ailment dulled and lowered her receptiveness, her attitude might have been that of apathy. But when an idle sales girl, busy with her make-up, kept her waiting impatiently at the counter; when a neighbor was sharp and a friend neglectful; when her bridge partner spoke in a sarcastic vein, or when an unamannered person, with tactless remarks and distasteful noises, prevented her from enjoying a show, we may safely assume that she was a prey to irritation, annoyance or outright anger. Under circumstances of this sort it was more than likely that she was chilled in her sympathy, roused from her apathy and seized with antipathy. Was this a feeling? Or, was it temper? The answer is plain: if she was merely irritated and annoyed it was a more or less unadulterated
feeling; if she proceeded to condemn the offender as wrong and to exalt herself as right it was temper. You will now understand that feelings are of three kinds: sympathy, apathy, antipathy, either toward oneself or others. Temper is of one kind only: antipathy, against oneself or the other person, plus the judgment of right and wrong. On the basis of these formulations we may sum up the meanings of the various reactions displayed by Florence. When she was moved by jealousy she was resentful, sullen, suspicious, indignant, perhaps hostile and vengeful. This was antipathy plus judgment of right and wrong, hence, temper. When she was free from jealousy she responded with genuine or tolerably genuine feelings of either sympathy, apathy or antipathy with no judgment of right and wrong marring the relative purity of the responses. This was feeling without admixture of temper. As everybody does, Florence expressed both feeling and temper.

Feelings should be expressed. This does not mean they ought to be acted on or acted out. It merely means they should be communicated to or shared with somebody who can be trusted to understand them. If the feelings are those of sympathy their expression will create good-will and, thus, further the interests of the group. If they are those of apathy or antipathy their expression will give relief to the person oppressed by them. Obtaining relief, the oppressed person will be purged of antisocial trends, and the ends of the group will thereby be promoted. This is different with temper. Feelings can be reported. They lend themselves to matter-of-fact discussion and calm appraisal. But temper, involving a claim to being right, cannot be reported objectively, calmly and matter-of-factly. It invariably leads to arguments, debates and rebuttals. Even close relatives and intimate friends, asked to pass a verdict on the justification of a temper outburst, may and frequently do voice disapproval, criticising the uselessness or harmfulness of the explosion. If the temperamental person resents the rebuff a new temper reaction is released, this time involving the relatives and friends. The result is that the temperamental hothead obtains no relief from his tension and group life is disturbed. Temper should be checked and controlled. It should not be given any expression at all. It should merely be avoided or, once it has occurred, it should be prevented from recurring. Feelings call for expression, temper for suppression.

Florence needed training in Recovery to learn that temper is different from feeling. Why did she fail to make the distinction herself? She has a keen intelligence and a refreshing willingness to learn by experience. Her intelligence could have told her that most feelings are noble, that even those that lack the attribute of nobility are not likely to injure the group. By the same token, she could have discovered, by sheer use of her native intellect, that temper, far from being identical with feeling, is its very opposite. It is positively ignoble and disrupting group life. And should she have consulted her past experience she could have easily learned the fact which I mentioned, that feelings, when communicated, give relief while temper has no such effect. How is it her intellect and experience failed her? The answer is that men and women derive their views not merely from their own observations but mainly from public opinion. And contemporary public opinion has fostered a type of thought which glamorizes temper by the clever trick of identifying it with feeling. The trick is of an engaging simplicity. Temper and feeling, in the present-day psychological jargon, are deftly lumped together under the common name of emotion, and emotion is nimbly interpreted as feeling. The next step in the argument, assiduously promoted by modern psychologies, is that emotions, being the driving power in the human economy, are infinitely more important than intellect. With this, emotion is not only glorified but also raised to the rank of dignity and nobility. This view, given wide currency by recognized professions, leading universities and philanthropic foundations, has found its way into the channels of communication with the result that dailies, weeklies and monthlies, radio, film and television fairly vie with one another in the gentle art of catering to unbridled tempers carefully avoiding the odious word and slyly substituting the terms “emotion” or “emotional experience.” Antisocial impulses, born from dark temperamental dispositions, are then portrayed as “just emotions,” as “plainly human,” indeed, as of valuable “human interest.” True, these emotions (read: tempers) may also be troublesome; they may cause tenseness, maladjustment and symptoms. But the newer psychologies have wisely anticipated this unfortunate inconvenience and provided a suitable remedy by spreading the gospel of “free expression” of “emotional” frustrations and aggressions. That this vicious doctrine of free expression has had a prominent share in the spread of both individual and social tenseness and of all kinds of antisocial trends is plain but will not be elaborated here. What interests me at this point is the deplorable fact that my patients have been exposed to the sinister influence of this modern dogma of the identity of temper and feeling and have been reached by the insidious propaganda carried on by textbooks, by the stage and the press to the effect that ungoverned emotions (read: aggressive tempers) can be cured by the expedient of “free expression.” Well, Florence, under the influence of an utterly irresponsible public opinion, gave formerly “free expression” to her temper and almost wrecked her marriage. Today, when through old-fashioned Recovery teaching she has recovered her mental balance, she expresses her feelings but suppresses her temper and with temper curbed, her feelings, properly communicated and shared, spread their warmth and glow over a happy marital scene.
Mildred reported on the Saturday panel that all her life she had a perfectionist attitude. "I set a standard for myself that an Olympic champion could not approach. I worked at top speed and tried to do everything at once and drive myself to finish my job in half the time it would take an expert to accomplish it. But then I get tremors, pressure in the head, a feeling of falling apart as though my arms and legs don't belong to me and some sort of sensation in which space has become a solid wall and I must push my way through it every time I move. When this happens I become panicky and feel sure I am losing my mind. The other day I was in the basement washing clothes. I had meat cooking upstairs on the first floor, the vacuum connected on the second floor ready to use, and the washing machine in the basement. As if this were not enough I went out into the yard starting to untangle a hopelessly gnarled clothesline, blaming myself all the time for messing up my work and accomplishing nothing. I had hardly untangled the clothesline when it began to rain. I became confused and frightened and felt I couldn't move across the yard because the solid wall was there instead of space. Suddenly I remembered my Recovery training and spotted my frustration as an attitude of perfectionism. I realized that my rushing from one job to another was the desire to do more than an average person can do and that my confusion was a sense of disappointment at not being able to do the exceptional job. So I stopped the rush, calmed down deliberately and made up my mind to do one job after the other. In an instant the confusion went and the fear of losing my mind stopped. Before my Recovery training I would have kept on working fast and would have gotten into the vicious cycle of fear, self-blame and the depression that went with it. The vicious cycle used to last for months and at one time lasted three years."

Mildred, in a confusion which threatened to unhinge her mind, "calmed down deliberately" and decided to give up her ambition to do the perfect job. "In an instant," she says, "the confusion went and the fear of losing my mind stopped." But if a mere decision is sufficient to put an abrupt end to a long-standing confusion my patients ought to have no difficulty getting rid of their perplexities, vicious cycles and tortures. What Mildred did all of them ought to be able to do.

What was it that troubled and confused Mildred? There was cooling to be done on one floor, cleaning on another floor and washing in the basement. A fourth job was waiting to be finished in the yard: tending to the "hopelessly gnarled clothesline." The issue was: should all four jobs be carried out at once or one after another? If the tasks were done coincidently Mildred would have the sense of pride, of outstanding accomplishment, of perfection and excellence. If they were done singly and successively the job would be of average quality, lacking the glamour of top performance and peak achievement. Reduced to these simple terms the choice and decision which Mildred was to make was between two discrete philosophies: to be average or exceptional.

I spoke to you about philosophies on several occasions. It is precisely your philosophy (of life) which tells you which decisions are correct and which acts are acceptable. You will remember I mentioned three main philosophies which are current among human beings: realism, intellectualism and romanticism. The intellectualist claims superior powers of reasoning while the romanticist boasts of his exquisite capacity for vigorous feelings, interesting sensations and strong impulses. The one strives to be recognized as being distinct from the "ignorant mob"; the other as being apart from the "vulgar crowd." Their philosophy is decidedly that of exceptionality. They fear or hate to be rated as "just average." The realist, on the other hand, does not view the members of his group as mob or crowd. To him they are average persons, not perfect by any means, not exceptional on any count, but worthy people of average efficiency and average solidity. Their averageness may be of good, plain or poor quality but essentially they are average in the entire sweep of their daily existence. And so is he, the realist. He is average in thought, feeling and action. He claims no glory or glamour, no excellence or exceptionality.

Mildred subscribed to the philosophy of exceptionality. This is nothing uncommon. There are very few people who do not think of themselves as being of a superior breed, as ranking above the "common herd," that is, as being exceptional. With most of them it is merely a dream, an ambition and aspiration. They hope to be exceptional but now they are "nothing but average." In their dreams and fancies they are romanto-intellectuals but in actual practice they behave as realists. Their sense of exceptionality is properly controlled by their knowledge of being average. If you keep this in mind you will realize that most if not all people embrace both the philosophy of exceptionality and that of averageness. The average person adjusts and balances the two philosophies in such a manner that the one (averageness) is leading and controlling, the other (exceptionality) is led and controlled. If this is done, then, decisions and actions are balanced and adjusted on a practical level while dreams and fancies are given free play on an imaginative level. Mildred had no leading philosophy of realistic averageness to tell her which of her decisions were correct, which of her actions were feasible. In her mind, the two philosophies were not held apart, they were not properly distinguished the one from the other; they were permitted to merge and fuse. The free fusion of the two philosophies produced a confusion of the mind. What directed her behavior were her dreams and hopes, her wild aspirations and vague ambitions. With these unrealistic leads to guide her reactions her decisions became fantastic (to act at one and the same time on four separate jobs in four separate places). As a result, her actions became tangled, involved and as "hopelessly gnarled" as was her clothesline. In the end, she despaired of ever reaching the correct decision and became lost in a sea of confusion.
The daily round of the average individual consists in the main of such trivial performances as reading, conversing, working on a job, cooking, washing, cleaning, telephoning, shopping. The person with a settled sense of averageness does these routine chores with hardly any thought wasted on them, without hurry, without anxiety, without the harrowing fear of possible failure. Considering them as routine he knows they involve no danger and is happily at ease, poised and spontaneous while engaged in his work. It is only on those relatively rare occasions when highly important or emergency reactions must be faced that the person possessed of a sense of averageness may become tense and may suffer a decrease in his spontaneity. Spontaneity means that you are not self-conscious, that you are not on your guard for fear of making mistakes. Spontaneity means the COURAGE TO MAKE MISTAKES. In trivial or routine activities no calamity arises if perchance a mistake occurs. This is the reason why realists, that is, men and women of average aspirations go about their daily tasks with due caution and circumspection, it is true, but without any marked fear of making a mistake. Mistakes made in trivial performances are trivial themselves and their possible consequences are just as trivial and not to be feared. With the fear of mistakes largely removed from the mind of the realist his decisions are reached with ease and his actions initiated without undue hesitation. All of this is the result of spontaneity and, in turn, favors its development.

This is altogether different in the instance of the perfectionist or the person consumed with the desire to achieve exceptionality. To him every puny endeavor, each trivial enterprise is a challenge to prove and to maintain his exceptional stature. His life is a perennial test of his singularity and distinction. For him there are no trivialities, no routine performances. He is forever on trial, before his own inner seat of judgement, for his excellence and exceptional ability. He cannot achieve poise, relaxation, spontaneity. He cannot afford to have the COURAGE TO MAKE MISTAKES. A mistake might wipe out his pretense of being superior, important, exceptional. With no margin left for mistakes he is perpetually haunted by the fear of making them. The fear paralyzes decision, hampers actions and confounds plans. Striving for indiscriminate peak performance and confronted with his pitiful record of jobs undone, unfinished and hopelessly bungled he is horrified by his cumulative inefficiency and becomes confused.

Mildred, a confirmed exceptionalist, turns realist embracing averageness as her leading philosophy. She did that after she joined Recovery. There she learned that romantico-intellectualist dreams and fancies must not be permitted to express themselves recklessly but must be fed and controlled by an average and humble attitude. She also learned that this must be done through a system of persistent spotting, thorough self-control and relentless self-discipline. It was not easy for Mildred to accept and absorb the idea of control and discipline. She is a product of our modern age and as such was subjected all her life to the contemporary doctrine of unrestrained expression of feelings and impulses. Impulses and feelings are precisely those elements in our experience which baffle at being rated as average. They are singularly private and intimate and personal and exceptional. With nervous patients this tendency to set themselves off from the others is apt to assume ridiculous proportions. If you emphasize your feelings, their importance, and intensity; if you are forever suspicious that they are not properly understood; if you constantly fear and complain that they are deliberately ignored and cruelly hurt; if you pamper and coddle them and, thereby, work yourself up to a hysterical pitch, then, your emotionalism and impulsiveness may easily reach such a fury that they impress you as exceptional, indeed. You will now understand that our modern tendency to favor unrestrained expression of feelings and impulses overemphasizes individual differences and personal distinctions and thus promotes the sense of exceptionality.

Modern education is only one of the factors which promote the philosophy of exceptionality. Another factor is modern machine technique. A machine leaves little or no room for average performance. A machine loses its usefulness if it fails to work at top speed and record efficiency. It must be perfect within the sphere of its application. The numerous gadgets introduced these days in kitchen, shop and office are worthless unless they conform to the "highest standard" of performance. Their work must be faultlessly smooth, perfectly safe and of top flight productivity. In our mechanized existence the machine has become the symbol of perfection. Mistakes are no longer tolerated in this modern scheme of mechanical excellence. If mistakes happen as, for instance, in an airplane or railroad accident the engineering tribe loses no time shifting the blame from the "flawless" machine and placing it where it "properly" belongs: the "human element." The machine can do no wrong. It is always "perfect." It is man, that miserable, as yet unmechanized, backward and bungling creature who is at fault. Man and human nature have become an anachronism, a relic of that unspeakably imperfect "horse and buggy age" which to the modern mind is the epitome of clumsiness and ineptitude. In spite of the "marvelous" advance of technique man and machine-regulated existence. If our mortal state of imperfection can only be redeemed through the "faultless operation" of lifeless machines, well, we are old-fashioned enough to renounce the machine and enjoy our averageness and spontaneity. Mildred, trained in the philosophy of Recovery, learned to scorn faultless operations and perfect performances. In the process, she acquired poise and relaxation and is now in the happy position of doing jobs efficiently (not perfectly, not faultlessly) by the simple procedure of practicing the COURAGE TO MAKE MISTAKES in the trivial affairs of her daily round.

\textit{Literalness}

The concept of sabotage is basic to the philosophy of Recovery. The nervous patient sabotages his own health, his social adjustment, his efficiency and equilibrium and—most pernicious form of sabotage—the physician’s authority. The trouble is that the patient, engaged in a systematic effort of obstruction, plies his trade in such a subtle and almost underhanded manner that he is not aware of his own plotting and machinations. In former days the author believed that the patient weaves his obstructionist plots from the depths of subconscious motivations. This absorbed him of all suspicion of deliberate conspiracy. Gradually, however, it became increasingly obvious that a good deal of conscious contrivance was at work. The patient asks the innocent-sounding question, “Don’t you think my condition could be the result of a glandular trouble?” That this is a diagnostic statement and therefore an attempt at sabotage is clear to the physician. But is it equally clear to the patient? Is he conscious of the fact that his question challenged the physician’s diagnosis? It is safe to say that at the precise moment when the inquiry is made the thought of antagonism or obstruction may be absent from the questioner’s mind. But if we survey the patient’s mental activities beyond the immediate scene and trace his meditations no farther back than to the bus trip which he successful. But Drs. J. and F. were no numskulls, either, and the one diagnosed a mild anemic condition, and the other blamed the fatigue on a low blood level. To the doctor’s office the picture changes radically. While on the bus he was preoccupied with the diagnosis given him on the occasion of his previous visit. He was told then that his condition was of a nervous nature, that it implied no danger, that the combination of office treatment and group management would eliminate his complaints. Now, on the bus, he views the physician’s pronouncements with a critical eye. It seems preposterous to him that his “unbearable” fatigue should be labeled “just nervous,” i.e., innocent and harmless.

Why then was he asked by other physicians to take a rest, to stop working? True enough, his present physician is competent, highly recommended and undoubtedly pressure. And the doctor who writes the health column in the morning paper suggested yesterday that fatigue states are frequently caused by a lowered metabolism which, in many instances, can be traced to a glandular deficiency. Why should all these possibilities be ignored? The ruminations continue in this vein until the train of thought is interrupted by some incident that diverts the patient’s attention. The sabotaging activity is no longer pursued. Leaving the bus, the patient enters a restaurant to take his lunch. He reads the paper, gives some fleeting thought to all kinds of topics and observations, and the subjects of complaints and diagnosis sink to a lower level of consciousness. When he faces the physician his diagnostic doubts may still be removed from the upper strata of his conscious awareness. But are they buried in the subconscious? They were mulled over and rehearsed just half an hour ago and are quite fresh in memory although not in the forefront of conscious meditation. They wait merely for the proper occasion to be revived. When the physician opens up with the introductory question, “How are you today?” the patient’s shivering antagonism is quickly aroused, and the thoughts recently rehearsed during the bus ride are promptly sprung on the physician. That antagonism may not at the present moment be glaringly conscious. But it was in the limelight of awareness a short while ago. It did not have the time to sink down to the subconscious level. We may safely call it half-conscious or quasi-conscious.

Clearly, if sabotage is to be controlled and eliminated it must be stopped at its source and origin. It originates at times and in places outside the physician’s office, in the bus, at home, on the street, in the workshop. In the presence of the physician the sabotaging thoughts burst forth spontaneously with little reflection and hardly any deliberation. But in the absence of the physician the sabotaging is done reflectively and deliberately. If a person is spontaneous, his utterances are burst out and poured forth impulsively. Usually there is neither time nor incentive to revise the spontaneous performance. On the other hand, when the patient sabotages in clear reflection he has the time and occasion for correction provided he has also the incentive to correct. Recovery, with its untiring insistence on a total effort, supplies the patient with the needed incentive. But the patient’s endeavor is bound to be vague, groping and ineffectual unless he is supplied with adequate insight into the devious ways in which his own sabotaging tricks operate. Armed with both incentive and insight he will be properly equipped for the long-drawn-out and gruelling battle against his sabotaging propensities, the ENEMY NUMBER ONE of mental health. Of the many disguises behind which sabotage hides the most important ones will be mentioned in the present volume. As may be expected, the most common form is one which is frequently encountered in ordinary conversation:

\textit{Literalness.} Essentially, this device makes use of the technique of rejecting a statement made by the speaker without opposing it openly.

Example 1. The patient reported that at a card game his mother corrected him every few minutes. He was provoked, threw the cards on the table and precipitated a violent argument. He slept poorly that night and awoke in the morning all exhausted. He was told to avoid drawing the temperamental conclusion that he is right and mother wrong. His reply was “I think that mother is wrong but not that I am right.” It was not easy to make the patient see the obvious truth that the question raised in an argument is who is right and who is wrong; that if the one party to the controversy is declared to be in the wrong it follows inevitably that the other party must be right; that if he thought the mother was wrong it was obvious that he felt he was right. “Can’t I think the one thought and not the other?” the disputant continued. “Not any more,” he was told, “than you can think of light without darkness, good without bad, love without hate. Once the one pair of the team of opposites is thought
of the other pair is called up automatically." The patient was then shown that he could have used his own common sense to realize that he was literal and listened to the letter instead of to the meaning of the physician's statements. If he had done that he would have demonstrated a will to conquer his temper. Instead, he distorted common sense and debauched logic and sabotaged the will to get well.

Example 2. A lady exclaimed in utter frustration, "I can't plan. I get flustered when I begin and then I do not know what to do next." The physician remarked, "Of course, if you say you cannot plan ... but was unable to continue because the lady interrupted him sharply, "I don't mean to say that I cannot plan. It is merely difficult for me to make a decision because I have no determination." She was told bluntly that her manner of reasoning was devoid of logic; that the sharp distinction which she chose to make between planning, making decisions, and having determination was superficial sophistry, a literal differentiation meant to confuse the issue instead of clarifying it. Being a college graduate and possessed of such keen logic as to be an artist at word juggling, she ought to employ her logical capacities to analyze her own statements in terms of sabotage. Her aim ought to be to get well, not to stage a senseless and futile debate with her physician. The result was that she produced a new literalistic perversion of logic. She shouted, "I do not mean to debate with you, I merely wish to make you understand my point of view." Whereupon she was told politely but firmly, "Whether I understand or misunderstand you is of no significance. The thing that counts is that you make every effort to understand me."

Example 3. A patient turned in an urgent message of distress over the telephone. He complained in a voice quivering with excitement that his tenseness was "simply unbearable." "What can you suggest for my relief?" he inquired. He was asked to come to the office that same evening. "But I don't see how I can stand it that long," he replied. He was assured that there was not the slightest danger in a tenseness of this kind and there was no reason for being alarmed. "I am not alarmed, doctor," he shouted, "but I feel something is going to happen if I don't get help. Can't you let me come to the office right now?" The man is a government official of considerable rank and could easily see the identity of meaning between "alarm" and "feeling that something is going to happen." He had been given a number of private interviews but resented being considered a psychoneurotic person. He protested forever that his distress was physical in origin and was annoyed by the physician's insistence that it was emotional in nature. The words "fear" and "alarm" were taboo to him. Taking them in their literal sense he wiped them out of existence by using a phrase with a slightly different connotation.

Example 4. A patient suffered from an itch on the scalp for over five years. In the course of time he developed a marked self-consciousness and tenseness which interfered with his general well-being and his occupation as a drummer in an orchestra. For the past two yearS drumming had become an obsession with him. He was compelled to drum incessantly on the table at which he sat, on the outer aspect of his legs when he stood, and on the walls of houses when he passed them. The members of his family claimed they "went almost crazy" because of the perpetual drumming. After several months of private and class treatment the itch was under good control, and the tenseness and self-consciousness had given way to a satisfactory measure of relaxation. But the drumming persisted. The patient was asked, "Why don't you stop that drumming? You got rid of the itch by learning to ignore the discomfort and by controlling the muscles of the hands when they 'itched' to scratch. You can control the drumming by exactly the same procedure. Whenever you feel the 'overwhelming' impulse to drum you can check the impulse and can command your muscles not to carry out the drumming movements." The patient replied, "Drumming is music to me, and I like music." He was promptly reprimanded for his literalistic misunderstanding of this sort. "You know as well as I do," the physician said, "that you do not maintain the drumming for its musical value. You know, it is nothing but noise." "It is rhythm, though," the patient replied. After some sparring he finally admitted that his attempt to identify compulsory finger movements with music and rhythm was nothing more than sabotage made possible by a literal misinterpretation of the physician's words.

Example 5. A patient who had lost many of her symptoms continued to complain of blurred vision which had been declared frequently by the physician to be of nervous origin. "The blur still bothers me," the patient said, "I don't see things clearly." The physician renewed his assurance that the symptom was of a nervous nature and nothing to worry about. "I don't worry," insisted the patient. "I merely thought you might want to examine me again." The eyes were re-examined and the patient told that there was no evidence of any defect. The patient persisted, "Don't you think an oculist ought to look at them?" "I do not object to examinations," the physician replied, "but your solicitude indicates that you worry about your vision." The patient then exclaimed with obvious irritation, "But doctor, I assure you I don't worry about my eyes. But, of course, I wouldn't like them to get worse. After all, a person may go blind." The literalistic quality and sabotaging character of this kind of word juggling requires no comment.

Brief examples: A woman patient reported in astonishing frankness about her wild temper outbursts. She related a series of uncalled-for acts of spite and vengefulness, interlarding the recital with comments as, "Of course, I know it's my fault ... I am just a nag ... What I need is a good licking, I guess." When the examiner warned her not to indulge in an orgy of self-blame she burst forth, "I don't blame myself; I am just telling my story."

A patient was told not to get sore at herself because that was her main form of temper. She replied, "Doctor, I don't get sore at myself. I am just disgusted with myself." Another patient was warned not to be irritable whereupon she rejoined, "I am not irritable. I am just upset by what my daughter says."
A patient remarked, “I have been coming here several weeks, and I don’t see any results.” Examiner: “You must not be discouraged.” Patient: “I am not discouraged. But of course if one does not see progress ....” This patient could have easily told himself that “not seeing results” and “not seeing progress” is identical or synonymous with “being discouraged.”

Patient: “When I go shopping I wait and wait and have trouble making the purchase.” Examiner: “So, you are still having difficulty making a decision?” Patient: “No, I merely cannot get myself to pick the merchandise I want to.” The identical meaning of the phrases “having trouble making the purchase,” “having difficulty making a decision,” and inability to pick the merchandise I want” ought to be obvious, but nothing is obvious to a person bent on perverting meanings through literal distortion.

Examiner: “I hope I did not hurt your feelings when I said that.” Patient: “No, I just don’t agree with you, and, frankly, I don’t think you have a right to tell me that. It just makes me mad if everybody jumps at me.”

The patient developed a mild depression consequent on the mother’s death. Examiner: “You must avoid guilt feelings.” Patient: “I don’t feel guilty. I didn’t do anything wrong.” Examiner: “You blame yourself for not having done enough for your mother.” Patient: “This I do.” Examiner: “Doesn’t this mean feeling guilty?” Patient: “I thought guilt is crime.” This literalism is rather naive but variations of the theme are frequently encountered with patients steeped in the practice of sabotage.

Patient: “Yesterday I had something like a daze.” Examiner: “You don’t have to be afraid of that.” Patient: “I am not afraid. The only thing, I wouldn’t like to have to go to the hospital again.” She feared “to have to go to the hospital again” but was not “afraid!”

In all the situations quoted in the examples the patients display a tendency to block the physician’s effort, to combat his views, to reject his suggestions by means of a literal misinterpretation of the words he uses. Once the patient’s attention has been called to his favorite methods of sabotaging he is in a position to correct his habits. In Recovery, corrections of this kind are made frequently and effectively.
Goals are of two kinds: short range and long range. The process of bringing up and educating children extends over twenty to twenty-five years. It takes the greater part of a man's adult life to establish a reputation, to acquire unquestioned mastery of a profession, to build up a smooth-running business enterprise. Such long range goals, requiring prodigious amounts of time for their development and ripening, tax the patience, endurance and determination of the individual. Short range goals are less or not at all exacting. The purchase of a garment, the writing of a letter, the trimming of the lawn or the visit to a friends' home are goals of this description. They call for a minimum of patience, endurance and determination. They are usually accomplished in little time, with scant effort and with negligible risk of failure.

Long range goals, as a rule, carry considerable responsibilities. If you neglect the cutting of your lawn you will not be likely to suffer the tortures of self-reproach. But let the thought obsess you that you neglected the education of your children, and your peace of mind will be gravely affected. You will suffer pangs of conscience and bitter despair. Short range goals permit leisurely, relaxed aiming. But long range goals demand steady concentration and strained attention. They leave little room for relaxation and diversion.

If your goal is of the short range variety you will be able to aim at it correctly if you make use of the proper tool and command the requisite skill and technique for using it. You will do a good job at cutting the grass in front of your home if you employ a suitable lawnmower with moderate skill and a smattering of knowledge about its technical construction. This is entirely different if your aim is directed at a long range goal. Tools, skills and techniques alone will be of little significance if your ambition is to secure a good education for your children. A goal of this kind demands patient application, sustained effort, unflagging determination, and above all an unshakeable sense of duty and responsibility. To be brief: short range goals must be aimed at with skills and techniques; long range goals with character and will power.

The fact that you set yourself a given long range goal indicates that you prefer that goal to another. You might have chosen a business career but you decided on a medical education in preference to trading or manufacturing. The preference placed a valuation on your choice. You value your activities as student or practitioner of medicine. Your aim is now directed at a value.

A physician may value a multitude of things and activities. Hunting, traveling and golfing may be valuable for his recreation. Card games, radio and movies may be of value to him in point of relaxation and diversion. To be expansively dressed, to own a high priced automobile and to acquire membership in an exclusive club may be of value to his reputation or to his vanity. He may, of course, value material possessions, and if in the pursuit of wealth he engages in stock market or real estate speculation be certain that the thrill or the mere prospect of amassing a fortune will be valuable to him. But clearly, the faithful devotion to a noble profession and the greedy scramble for money cannot possibly have the same value. Obviously, valuations must be of two kinds. How are they to be differentiated?

An overcoat is of value as protection against rain and cold. If keeping dry and warm is your present goal the overcoat will be a suitable means with which to aim at the goal. Generally speaking, every means or tool which enables you to aim at your goal is of value for this particular goal. If your goal right now is to escape the summer heat a swim will be of value. If your goal is to still your hunger a hamburger or frankfurter will be objects of value. Since everything may at times become the suitable means of aiming at a goal the possible range of values is limitless. The question is not, however, whether a given means or tool is of value to a given goal. The more important question is whether the goal itself is one of value.

A goal may be of value to the individual or to the group. Whether an overcoat satisfies your desire for protection against the weather and whether a dish of meat relieves your hunger is of no direct interest to the group. These goals serve your personal comfort and are individualistic in nature. They are individualistic values. On the other hand, if you bend your energies to educating your children the group will recognize your endeavor as being valuable to the community and will class it as a group value. Needless to say that when we speak of values we mean group values only.

In order to guide the conduct of the individuals belonging to it the group has set up a table of valuations. All group values, that is, all valued or preferred group goals are there ranged in proportion to the importance they bear to the group purpose. The individualistic goals of personal comfort, vanity, emotional and temperamental dispositions and competitive ambitions are reasonably tolerated within the framework of the table of valuations but are not included in it. To put it otherwise, the group permits a moderate degree of indulgence in gambling, drinking, frolicking. It sanctions certain emotional drives and temperamental leanings. It may even grant a modicum of license to greed, unwise speculation and sharp competition. But all these activities are strictly classed as individualistic and are denied a rating in terms of valuations.

A group strives for stability first and foremost. Short range goals could never guarantee stability. They are pursued for a short time until mood, caprice, disposition suggest other more convenient goals. If stability is to be maintained the group must insist on reserving its table of valuations for long range goals only. As was mentioned, aiming at long range goals calls for steadfastness, determination, patience and sustained effort. In other words, it calls for character. Character is opposed or indifferent to mood, caprice, disposition. Everything that is purely individualistic and personal is outside the sphere of character.
A person endowed with character aims at his long range group goals (values) either with rigid, unyielding principles or with elastic but firm policies. Principles admit of no exception, policies do. It is unprincipled behavior to steal or cheat even once. But it may be a good policy to relax discipline frequently in dealing with children or employees. Principles call for relentless, severity, perhaps even for fanaticism; policies call for a flexible strategy, for maneuver and careful adjustment to the requirements of the just prevailing situation. But no matter how fundamentally different they are with regard to rigidity and flexibility both principle and policy defeat their purpose unless they are acted on with steadfastness, determination, patience and sustained effort.

Health, it would seem, does not figure in the average table of valuations. The group holds its members responsible for their character and, for instance, frowns on dishonesty and lack of responsibility. But it does not set up a code that obliges the individual to tend to his health. There are other important functions which though they represent undoubtedly long range group goals are not included in the table of valuations. Parenthood is one of them, sociability another. The group unquestionably values them but refrains from regulating or supervising them. The reason presumably is that the vast majority of people can be depended on to take adequate care of health, children and social contacts without any prompting on the part of the group. Be that as it may, the fact is that health does not seem to be considered a value in its own right. The other fact, however, is that without health there can be no proper aiming at long range goals and their corresponding values. The functions of loyal service, religious devotion, patriotic duty, parenthood, friendship, sociability, civic-mindedness cannot be accomplished if the individual is crippled, bed ridden or otherwise seriously handicapped. That functions of this order cannot be properly discharged if they are continuously frustrated by frightening sensations, panics, and anxieties needs no comment. Mental health particularly is not only a value. It is a necessary prerequisite for the unhampered functioning of all the values represented in the table of valuations.
Nancy had been apprehensive and self-conscious all her life. After she married and had children the responsibilities of caring for the family weighed heavily on her tender conscience. One day, about twelve years ago, she became panicky, with palpitations, dizziness, dry throat, and body tremor dominating the picture. She was so scared that she feared she was losing her mind. She recovered from the first scare but the fear of mental collapse persisted. Her sleep was poor. She watched herself continuously magnifying minor observations. When she discovered that her memory or concentration failed her on some occasion she considered this as incontrovertible evidence that her mind was slipping. In time she developed other well defined fears. The main fear was to be confined in a closed space. She suffered agonies of dizziness, sweats, churning of the stomach, sinking feelings, faints and palpitations whenever she ventured to take a ride in an automobile, street car, elevated or railroad train. Rides in an elevator were less disturbing if they were short stops but if the point of destination was a high upper floor the performance was a nightmare. Since the physician’s suite was situated on the 17th floor of a downtown building a visit his office was looked forward to with great apprehension and required a companion to reassure her. As the years past Nancy’s fears expanded. She grew to fear her impulses. She dreaded the thought of being alone with her daughters or with her husband for fear she might do harm to those she loved. “My impulses,” she said, “become confused. I feel the urge to be helpful, but once I have done a good turn I instantly resent it and feel a hatred against the person to whom I was friendly a minute ago. Isn’t that proof that I am going insane?” She attended classes and Recovery meetings and begged to be interviewed after merely four weeks of participation in the self-help program before she had a reasonable opportunity to stage an initial improvement. Such early requests for class interviews are generally considered a good sign of cooperation.

**E—Examiner**

**P—Patient**

E: You have been in classes for only four weeks and I do not expect you to have improved a great deal. Are you still afraid of closed rooms and high places?

P: Right now I feel awfully weak and exhausted after a thirty minute ride on the L. C. (Illinois Central).

E: If that is so I presume that your other fears have not improved, either, and that you are still obsessed with the thought that you will lose your mind and that you might do harm to the members of your family.

P: I have not noticed any change, except that I am now more hopeful.

E: Let me ask you, Nancy, what precisely do you fear when you enter an automobile or train coach or an elevator? Are you afraid of an accident?

P: I was in three major accidents and was not a bit scared. As a matter of fact, I was the calmest person in the crowd, perhaps because I don’t care if I die. Another thing: I am afraid to be in an automobile even if it stands in the garage.

E: I understand, Nancy, that if you notice a weakness of memory and attention you think of a possible mental ailment. I also understand that if you have frightening impulses you fear you might some day carry them out. These fears are exaggerated but they are not absurd or ridiculous. But if you state that you fear being in an automobile even when it is not moving, well, that is absurd. You cannot possibly think of danger under these circumstances, and your fear is without rhyme or reason. Can’t you tell me what makes you quiver with fear in situations that neither you nor anybody else considers dangerous?

P: I get so worked up when I step into a car or an elevator that I fear I am going to collapse the next minute.

E: People get “worked up” on many occasions but do not fear they will collapse. Why do you?

P: I get those awful palpitations and the sinking feeling in my stomach, and I go into a cold sweat and I feel so faint that I think that’s my last moment. Right now when I merely speak of these things I have my palpitations.

E: Now I know what you are afraid of. You don’t fear cars and elevators or closed spaces and high places. What you fear is your sensations that are called forth by these closed or high localities.

P: You may be right but it does not matter to me whether it is the sensations or the places that frighten me. I simply feel that I am going to pass out.

E: The distinction which I made may matter little to you. But to me it is a fundamental difference whether your fears are caused by sensations within you or by objects without. If your fears are the result of frightening sensations and overpowering impulses I ought to be able to teach you how to control them, but I am unable to give you directions how to exercise control over automobiles and elevators. I do not mean to be facetious if I mention in the same breath such disparate things as automobiles and sensations, elevators and impulses. But it is about time that patients should know that the only things they are afraid of are their own inner experiences, their thoughts, feelings, sensations and impulses. I do not deny, of course, that some fears stem from objects outside you. There are holdups and burglaries and drownings and killings. But these objective dangers, as a general rule, hold little terror for nervous patients. What they are mostly afraid of are terrifying sensations, threatening impulses, obsessing thoughts and depressing feelings, that is, their own inner experiences. You gave
an excellent example of your indifference to realistic, objective dangers when you stated that in three separate automobile accidents you were "the calmest person in the crowd." This is a common rule with nervous patients. In situations of grave realistic and objective danger they may be calm and fearless. But let them be confronted with disturbing inner experiences and they become panicky and hysterical. Do you realize now that what you fear is not automobiles, street cars and elevators but your own inner storms and excitements that are aroused when you approach or enter these objects?

P: I understand. But will that stop my palpitations and sinking feelings?

E: Why do you question that? Common sense ought to tell you that you cannot conquer a fear unless you first know what it is that you are afraid of. And if I succeeded in demonstrating to you the true object of your fears you ought to have gained some relief already. You ought to feel more confident now because at last you know what it is that scares you. The fact that you do not feel relief proves that you did not accept my explanation. You still doubt and question it. If this is so I shall have to give you other and perhaps more convincing examples. You know, Nancy, that many people hesitate to admit trivial misdemeanors, for instance, children to their parents. They hesitate even if the parents have seldom inflicted bodily punishment on them. What they are afraid of is that after confessing they will have the tortured feelings of shame, embarrassment and loss of face. They do not fear anything realistic like being spanked; what they fear is their own inner feelings. You have also heard of mature men who fear asking their employer for an increase in salary. They fear to advance their request even if they know for certain that the boss is a kindly person and by no means bossy. In most instances, this fear of approaching another person with an otherwise well justified request is due to the fact that on previous occasions the making of requests was followed by a sense of embarrassment and sensations of tenseness, stammering, flushing and perhaps palpitations and faintness. That man who trembles at the thought of approaching his superior may try to analyze the nature of his fear. In all likelihood, he will then advance inconsequential reasons. He will say that what he fears is that his "boldness" may cost him the job or that, after all, his services are not worth more than he earns. In all of this he will ignore or evade the real explanation that what he fears is the possibility of arousing unpleasant inner experiences. Do you think you understand better now what I am driving at?

P: You mean to say that I am afraid of my sensations when I fear rides in automobiles and elevators. I think I know that now. But will the knowledge help me get rid of the fears?

E: Knowledge alone will not help. But once you know what you are afraid of you can devise plans for eliminating fear. You will agree that if you fear something you think of that something as a danger. You will also admit that in order to fear a danger you must believe it is real and not imaginary. In other words, you must take the danger seriously and be convinced of its reality. All you have to do is to dispose of a fear is to refuse to believe that there is danger. Then you will ignore it or laugh it out of existence. If you laugh at a thing and ridicule it you cannot possibly fear it. That is the reason why a sense of humor is such a strong antidote against fear. You see, Nancy, if at the moment you are gripped with the fear of your sensations, if at that moment you could reach the conviction that the danger is unreal, imaginary or not serious you could laugh at it and make it disappear in an instant. Unfortunately the many scares you have gone through in the past ten or twelve years have cowed you into such an abysmal fright that you have lost every trace of a sense of humor with reference to that fear. Your only salvation is to gain the unquestioned conviction that the danger you think of is not existent. I have tried to convince you of that; I pointed out to you the reasons why a fear of this kind cannot possibly be based on a realistic danger. But it seems you are not convinced yet. Why do you still listen to the language of your body instead of accepting what your physician tells you?

P: I have tried my best to accept what you told me. I have read many times what you said about the symptomatic idiom and the temperamental lingo. I have listened to what the patients told me and I have studied the interview with Ruth on the "Vicious Cycle of Panic." I know all of that. But when I enter an automobile my knowledge is gone. What can I do about that?

E: What you can do is to gain conviction. You have acquired knowledge but you do not possess conviction. You say that your conviction fades the moment you enter an automobile. What happens is that the moment you reach the car your heart begins to palpitate, your stomach churns, your throat contracts. To put it otherwise, your inner organs are "scared." That scare communicates itself to the muscles of your arms and legs. They feel tense and heavy and refuse to move. In a sense, they feel paralyzed. Having read the interview with Ruth you will know that this is the proper setting for a vicious cycle. The panic "marches," as it were, from the inner organs to the outer muscles and to the brain. The greater the commotion of the organs the more intense is the "paralysis" of the muscles, and the more threatening the paralysis of the muscles the more terrifying is the fear in the brain. You ask what you can do. Well, you cannot dictate to the heart to stop palpitations, or to the stomach to cease churning. But you can command your muscles to move, paralysis or no paralysis. And once you make

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The interview with Ruth on the "Vicious Cycle of Panic" was published in volume 2 of the "Techniques of Self-Help," page 31.
the muscles move in spite of their apparent paralysis the brain will instantly be convinced that at least one of the dread dangers it feared is without foundation and nothing to be taken seriously. That may not do away with the commotion of the inner organs. The palpitations and other sensations may continue. But a breach has been made in the solid rampart of the panic, and the implicit belief in the reality of the danger is shaken. When on the next occasion you enter the car the organs may again be thrown into a violent turmoil but you will no longer be scared by the “paralysis” of the muscles. Assurance and conviction will now be more assuring and more convincing with the result that the brain will be more calm, and with a calm brain there is no possibility of a sustained panic. With the panic petering out in consequence of reassurance the organs will soon quiet down, and this time conviction will be strengthened. On the occasion of a third or fourth or a dozen other trials you are certain to cut short the panic in its very beginning. Then conviction will score the final triumph and you will be cured of your fear and incapacity. Do you realize that the way to shed your fears is to give the proper directions to your muscles?

P: Frankly, that sounds a bit too easy. It doesn’t just seem possible that I should cure my fears by moving my muscles. It should take more than that.

E: It will be difficult for you to convince me that it is “a bit too easy” for persons to command their muscles to move if they feel paralyzed by the fear of making another step. You did not mean to say that my suggestion sounds too easy; you thought it sounds too simple. I shall not enter into a detailed discussion of this very important distinction. I shall merely tell you that I do not want my patients to believe that cures and remedies must necessarily be complex, involved and time-consuming. It is easy to sit in a chair and to be given lengthy and interesting explanations about how fears arise and develop. That is complex but easy. But if a boy is afraid of swimming or diving it is not at all easy to make him move his muscles for the purpose of a resolute jump. That jump is simple but difficult. Do you realize that you expect to be cured of your fears by means of complex but easy and sometimes glib explanations instead of by means of simple but exacting directions? You want to be studied and analyzed and discussed but you do not want to be told what to do and how to act. What will the most lucid explanations profit you if you are seized with a deep anxiety or a paralyzing panic? In a condition of this kind you are utterly unable to make use of the ingenious and fascinating explanations you may have been given. If in a panic you try to remember what you learned and to reason out what is the sensible thing to do your mind will fail you disastrously. The panic weakens your memory and blots out your reasoning power. All you will be able to do in a commotion of this sort is to apply simple rules. Their very simplicity renders them capable of being employed in a situation in which complex thought is impossible.

P: I do not mean to be contrary, doctor. But it seems to me that when I get into a panic I will not be able to carry out even simple rules.

E: That may be correct for the first and second trial. But if you continue to practice you become ever more proficient in the application of these simple rules. Moreover, you have ample opportunity to practice in situations that are less disturbing or threatening. You mentioned that you are obsessed by the fear of doing harm to your husband and your daughters. This fear does not throw you into a panic. It is with you all the time and being strung out over endless hours and days it is milder, less vehement, less acute. This fear can be handled with a method that is not only simple but also easy. You know that in consequence of the fear you avoid touching knives or any sharp objects. Well, should you practice the simple method of deliberately touching sharp objects in the presence of those that you fear to harm you would have no difficulty convincing yourself that your impulse to do harm is not dangerous. You would soon refuse to take that impulse seriously and would learn thereby that at least some of your fears are ridiculous and can be laughed at. Once you have succeeded in discarding one of your fears by the simple method of commanding your muscles to act against them you will have learned the general principle that fears can be checked by a command to the muscles to counteract the suggestions of danger. The lesson that you have learned with minor fears will then carry over to the region of the major fears. As with most patients, your fears are many in numbers. Some of them are strong, some are mild. You may say that the fears form a chain with strong and weak links. If you wish to break a chain you must attempt to pry it open at its weakest spot, not where the links are strongest. This is the Method of Attack on the Weakest Point which I have mentioned in interviews repeatedly.

P: I have tried so often to touch knives. I wish I could, but I can’t.

E: What happened when you stretched out your arm toward the knife?

P: Well, I felt I couldn’t do it.

E: Don’t tell me that you couldn’t do it. Tell me what happened. Tell me whether you had a panic when you advanced your arm in the direction of the knife. Did you feel like fainting? Did you have violent palpitations, sweats and weakness and churning?

P: No, I simply couldn’t move my arm.

E: Do you see the difference between entering the car and picking up a knife? In both instances you are afraid, that means, you have the idea of danger in your brain. But in the case of the automobile the idea of danger is attended by threatening sensations, while in the case of the knife it is nothing but a thought. You will now understand why I call this fear of touching a knife a weak link in the chain of your fears. All you have to do to get rid of your fear of the knife is to convince yourself that your thought of danger is absurd. And the best means of reducing an idea of danger to its absurdity is to act against it. The moment you touch the knife and notice that nothing happens, not even a palpitation, certainly no fainting or
any other sign of a panic, once you notice that the thought of danger is immediately proved absurd. Although you are a newcomer to this group, nevertheless, I am certain you heard the members of Recovery mention in their panel discussions how they learned to conquer their fears through their muscles. Many of my patients were afraid to be on their feet because they thought their muscles were exhausted by nervous fatigue. When they decided to walk on in defiance of their fears they became convinced in an instant that their idea of danger was absurd. With some, success came on the first or second trial, with others after a period of extended trials. But whether success comes quickly or slowly the underlying principle is the same: attack the chain of your fears at their weakest point and convince your brain through your muscles that its ideas of danger are absurd.
Virginia's health broke when she was 20. Her previous history was that of an average girl with a good record of school, job and social adjustment. But after she passed her twentieth year she suffered an attack of depression. She lost weight, ate and slept poorly. Her interests weakened. She neglected her job and her appearance. She felt tired all the time and had to make an extreme effort to perform the trifling tasks of her daily routine. Dressing, speaking, walking required an excessive amount of energy. Her mood was down. She experienced the desire "to make an end of it" but lacked the courage to do so. Due to her dejected spirit she blamed herself for past mistakes and petty misdemeanors. Finally she had to be taken to the hospital. She returned after six months and felt well for four years. Then she drifted again into a mood of depression. This time she received a course of electro-shock treatment and regained her health after only five weeks of hospitalization. She resumed her activities, secured a position with a real estate firm but continued to be tired, restless and irritable. It was at this point that her mother heard of Recovery. Virginia joined the organization practicing the system of self-help and conquering fatigue, irritability and restlessness. But in spite of her patient application she was unable to shake off a sense of shyness which made her feel miserable and helpless when she was to meet people singly or in social groups. She volunteered for a class interview in the spring of 1947 stating that a previous interview two years ago had given her much relief.

E—Examiner
P—Patient

E: How are you, Virginia?
P: I feel all right. But I am so self-conscious. I shut up like a clam when I am among people. When I want to say something I can't find a thought. It seems my brain freezes and I can't think. It is all a fog and blank. If somebody asks a question my throat tightens and I can't speak a word.

E: Have you been working all the time?
P: I have worked continuously since shortly after I left the hospital.
E: That makes it close to four years of continuous work. Did you change jobs during this time?
P: No, I am still holding the same job that I got four years ago.
E: Do you think your employer is satisfied with your work?
P: I got three raises and my boss leaves the running of the office practically to me.
E: I consider this a neat accomplishment and a very creditable comeback after what you went through. You ought to be proud of yourself. Instead, you shrink and almost swoon when you are asked to do nothing more than open your mouth and formulate a simple sentence. You say your brain freezes and you cannot think, your throat tightens and you cannot speak. How is it you do a good piece of speaking and thinking right now? How is it your brain thaws up and your throat unlocks during this interview? You are certainly among people here. More than that, this is an audience and you the star performer tonight. You are in the limelight, watched by everybody in this hall. Many people with strong nerves and no record of a past breakdown will when they are asked to make a speech before a public gathering of this size. And, remember, what you say here is a tale of weakness, a recital of your shortcomings, a confession of personal inadequacy, while in a social setting where courtesy and etiquette banish all possibility of being exposed. Can you explain this strange behavior?
P: I am relaxed here. But when I meet people on the outside I am tense.
E: I am frequently tense myself. But that does not cause my brain to freeze and my throat to tighten. No matter how tense I sometimes am I get my brain to think and my speech muscles to produce words and sentences. How is it you cannot think and speak when you are tense?
P: I don't know how to explain it. I simply don't get thoughts and the words don't come.

E: I shall try to give the explanation. You will grant, Virginia, that to speak means to produce movements of the muscles of speech. To put it differently: speaking is a muscular act. I take it you know that muscles will act only if they are stimulated and will refuse action if they are frustrated. From this you may conclude that your muscles of speech are stimulated here tonight but would be frustrated if you were to repeat this performance elsewhere. What stimulates muscles is courage and self-confidence, that means, the sense of security. What frustrates them is fear and self-distrust, that is, the sense of insecurity. Do you understand now, Virginia, that when you have the thought of insecurity in your brain it will frustrate and tighten your muscles and keep them from acting and speaking?
P: It seems to me I have no views or thoughts in my brain when my speech stops. My head feels like a blank and no thoughts come, not even the thought of insecurity.
E: If you say you have no thoughts in your brain you seem to believe you know how your brain works. In this, you presume a trifle too much. Right now you sit on this chair. Moreover, you keep sitting. You do not jump up or run away. How...
could you maintain your seat unless you were certain that the chair is solid and you are in no danger of falling? Yet, you may insist the thought of security was not in your brain while you kept up your sitting activity. Do you realize that you could never sit down or continue sitting unless your brain told you that the act of sitting is safe and secure? The same consideration holds good for every variety of acting, for eating, standing, walking, speaking. You would never dare voice a sentence unless your brain told you that the statement you are about to release will not endanger your social, moral or ethical security; that the remark you intend to make is neither offensive nor compromising. This rule applies to every act, no matter how simple or how insignificant. You could never make a step unless you were sure you would not fall and fracture your leg. You could never ask even the most innocent question unless you were reasonably certain it would not be resented. These examples which could be multiplied indefinitely will tell you that ordinarily no act of yours will be released unless the brain first takes the view that no danger is involved. After the brain has, in the flash of a momentary decision, reached the conclusion that the situation is one of security it stimulates the muscles to release the appropriate act. The conclusion that the planned act is safe is formed without your conscious knowledge. We say it is arrived at intuitively and not discursively. When you came here tonight you had already formed the conclusion in your brain that the situation of this interview is one of security. Hence, your thoughts did not freeze and your throat did not lock. Why is there freezing and locking when you attend a social gathering?

P: I guess because there my brain forms the conclusion of insecurity.

E: That is correct if you specify what kind of vicious cycle you have in mind. The most common varieties of vicious cycles are those of fear and anger. But fear and anger are part of life, indeed, a most significant part of life; and if they run in vicious cycles their action represents a very stormy, an almost tempestuous sort of life. However, when your thoughts freeze and go blank they can hardly be said to be stirring with life. In a sense, they are dead. Their life pulse has gone out of them. If you speak of freezing, of fogs and blanks, of shutting up like a clam, that means that you pass into something like a state of lifelessness. Your vicious cycle affects the pulse of your responses and reactions. You know what a pulse means. It means something that rises and falls, something that begins, matures and finally fades away. This is true of muscular movement, of glandular activity, of nerve impulses, of thoughts, sensations and feelings. All of them have their life history of being born, of maturing into full action and of passing out of activity. For the sake of simplicity I shall limit the discussion and consider the pulse cycle of thought only. You know that if you now happen to think of the weather that thought will not show life and vigor during this interview and loses its vitality in other groups?

P: I don't know exactly but the nearest I can think of as an explanation is that I don't feel cramped here as I feel in

E: That does not explain a great deal. It seems to me I shall have to do the explaining. We spoke of a vicious cycle.

P: I think I know what you have in mind. I produce a vicious cycle.

E: Correct. But how is it that this conclusion of insecurity keeps occupying your brain all the time you attend the gathering? Why is there no letup, no change of conclusions?

P: I still think it is the vicious cycle that does that.
your destination it has deepened into what you call a blank. The brain feels lifeless and dispatches impulses to the muscles not to stir, not to move. In this manner, the helplessness of the brain communicates itself to the muscles and the vicious cycle is set afoot. I told you that brain and muscles influence one another in this cycle or circular movement. Since they interact or act on one another it ought to be clear to you that if you cause the one to move the other will follow suit. To state it differently: make the one move and the other will perforce join the movement. You may not be able to get the brain moving. But you certainly can do that with muscles. Command your speech muscles to act, and the brain will instantly realize that its theory of helplessness is a myth, a fiction, an untruth. The more vigorously your muscles will move, the less will the brain be able to believe that it is helpless. That this can be done you demonstrated here with your perfect speech performance during the present interview. You remember the first occasion when you were interviewed about two years ago. You stammered, hemmed and hawed and had extreme difficulty squeezing a few words out of your throat. The first sentences leaped out of your mouth explosively. I had to proceed slowly and cautiously, giving you ample time to warm up to the task until finally you took heart and gained courage and gave an excellent account of yourself. At that time you experienced a vicious cycle of helplessness at the beginning of the interview. During this cycle your brain was devitalized and deprived your speech muscles of their vitality. But once you commanded your speech muscles to move the very action of the muscles had a vitalizing effect on the brain. The movement of the muscles convinced the brain that speaking is possible. And when the brain witnessed the living, vital performance of the muscles it acquired a new vitality itself and lost its lifelessness. The more forceful was the action of the muscles the more vitalized became the brain; the more vital the brain the more forceful the muscles. By commanding your muscles to move you had thus transformed the vicious cycle of helplessness into the vitalizing cycle of self-confidence.

As the interview drew to its close it was explained to Virginia that her energetic performance during the interview could be duplicated and multiplied on numerous other occasions inside Recovery and outside. What she had to do was to practice commanding her speech muscles to initiate the vitalizing cycle of self-confidence whenever she had an opportunity to do so. It developed that Virginia had neglected this practice by refraining from joining the panel discussions at family gatherings. She realized that this was her golden opportunity and felt that having gained revealing information about the nature and operation of the vitalizing cycle she was now in a position to practice with understanding. Reports reaching the writer indicate that Virginia is making a good effort at participating in panel discussions and is ready to transfer to social engagements outside Recovery the experience she is gaining in the family gatherings of the ex-patients.
Symptoms must be attacked where they are weakest (Low, 1978, pp. 304-311; 1997, pp. 376-384)

Roy was 35 years of age when he was first seen in the physician's office. He was married, had two children, loved his home and was well liked by friends and neighbors. His employment record was good. He had held his present position for fifteen consecutive years advancing to the rank of a foreman. All in all he had done well until three years ago when suddenly, "out of a blue sky," his right arm and right leg went numb. The numbness had come on at the moment when he entered the plant to start on the afternoon shift. It disappeared as fast as it had come lasting a few minutes only. But Roy was frightened into a senseless fear that he was headed for a stroke. Ordinarily stolid and unemotional, he was now pale, trembling, restless. His fellow workers noticed the change and drove him home. The family physician ordered Roy to stay home for a week and to rest. The following week an electrocardiogram was taken and the doctor was heard to say that something in the graph was "flat instead of round." After that Roy developed violent palpitations, headaches, dizziness, fatigue, air-hunger, difficulty of sleeping, fears of physical collapse and mental breakdown. He saw specks floating in front of his eyes and once "nearly went blind" for a couple of minutes. Some of his sensations were bizarre and intensified his fear of a mental breakdown. Looking at his hands he saw them in a yellow tinge. He felt pains which settled in narrowly confined places, in the left wrist or in the space above the right knee. His teeth began to hurt. There was a pain around the heart. He lifted his little son and instantly felt a pain around his right ear. He lay on the left side and something clicked in the right flank. The fingers of the right hand might hurt and suddenly the pain shifted to the back of the head. He felt pressure of the throat, had night sweats which roused the fear of tuberculosis, pain in the chest, difficulty of sleeping, trouble in concentration and "confusion all the time." A combined course of office and group treatment produced a good improvement. He returned to work and was able to attend to his job in spite of the fact that some of his sensations persisted as weak "reminders." He had learned in Recovery to ignore the threat of symptoms and turned his new knowledge to good account. There were minor setbacks but he handled them well until after about six months of successful self-management a major setback occurred which he was unable to shake off. When he was interviewed in class he stated that the present setback had lasted upward of four weeks already.

B—Examiner
P—Patient

B: What is it that has troubled you most in these past four weeks?
P: My eyes feel blurry, my memory is poor, and I have an awful fatigue and the legs feel heavy and numb. And I have these headaches again and the pain around the heart.
B: You have been ill for three years before I saw you. Is that correct?
P: It was not quite three years but almost that long.
B: And during these three years your trouble got worse and worse?
P: Well, I had some good days.
B: Your symptoms changed. They kept coming and going.
P: I can't say that. Some stayed on.
B: Some of your pains shifted from one part of the body to the other?
P: No, I didn't have that.
B: So far you have denied or corrected or rejected about every statement which I made. When I mentioned that I saw you for three years you set me right by stating that "it was not quite three years but almost that long." You will understand that the difference between "three years" and "almost three years" is so insignificant that you could safely ignore it. Instead you stress and emphasize this trifling distinction, underscore it pointedly and make an issue of things that have no importance. You pick flaws in my argument and turn this interview into an occasion for verbal fencing, sparring and skirmishing. This proves that you came here tonight in a fighting mood which is merely another way of saying that you are in the grip of tenseness. You say that the tenseness has been in evidence for fully four weeks without letup. Does that mean that it was with you all day and every day during these four weeks?
P: It was easier the first few days and the first week. I could relax at a card game or at a show. I guess my mind was taken off my troubles when I had some diversion. But in the past three weeks it got worse and worse. Even a show or a card game didn't help me. I got so tense that everything irritated me, even my little girl and my wife at home. Maybe you are right, I am in a fighting mood. It makes me mad because I like to get along with people. I simply cannot understand it.
B: Perhaps I can make you understand it. Look here, Roy, tenseness is a sensation. Having attended classes for close to a year you heard me state repeatedly that sensations rise and fall. How is it that your tenseness has risen but did not fall?
P: I think I know what you mean. I attached the idea of danger to the sensation.
B: Correct. But what does it mean to attach an idea to a sensation? Can ideas be made to change places, to wander from one spot to another? In other words, can ideas be shifted and shoved and pushed around just as you may please?
There are feelings and impulses. You know that when your eyes blur, when your head aches and the legs are numb you do not merely experience these sensations; you also feel alarm about them. They depress your mood, they strike you with despair, with discouragement and the sense of helplessness. Think of the anguish and anxiety that go with the listlessness and fatigue that descends upon you in the morning. Think of the anger and resentment that you feel rising within you when you notice your pains and aches and work yourself up to a pitch of excitement. All of these are feelings added to the sensations. Do you think you can cut them short or bid them to disappear and make place for other more comfortable feelings? Of course, you cannot do that. Feelings cannot be redirected or rearranged at the bidding of your will. Neither can impulses. When you are in agony over your disturbing sensations instantly there is the impulse to call off an engagement or to summon the physician or to turn with fury upon your wife or child because of some innocent remark they may make. These impulses are just as spontaneous and passive as your sensations and feelings. They appear and you know of their presence only after they have emerged. You cannot manage them as you can your thoughts. You cannot command them to come or to go. They come upon the scene spontaneously and passively. If they are to depart the process is again passive and spontaneous. Do you understand now that thoughts are active and deliberate while sensations, feelings and impulses are passive and spontaneous? Do you also understand then that while you cannot drop your sensations, feelings and impulses by a command of will you can do that with your thoughts?

P: I understand that and I know you are right. But somehow I haven't been able to get rid of the thought of danger. I've tried many times to think of what you tell us about sabotage and that we are not permitted to make our own diagnosis. I know that when you say there is no danger there isn't any. But the idea sticks to me and I cannot get rid of it.

E: Several months ago it was just as difficult for you to shake off the idea of danger. But you did it and got well. There is no earthly reason why you should not be able to repeat that performance. But in order to succeed you will have to practice as hard as you did months ago. That practice calls for a method. Do you remember which method you were asked to use at that time?

P: I came to classes and meetings and I accepted your authoritative knowledge.

E: Of course, you have to accept my authority and must attend classes and meetings. But that is not what I meant by method. What you mention is the person who taught you the method and the occasions and places where you were supposed to learn it. You may have some opportunity to practice that method in classes and in my office. But the bulk of practicing will have to be done at home, in the shop, on the street and in all kinds of places and situations where there is no physician and no Recovery to help you along. What you did was to learn theoretically how the method works. But you failed to apply it systematically. You do not even seem to know which method I refer to. What I want you to learn is to throw out or bid them to disappear and make place for other more comfortable feelings. Of course, you cannot do that. Feelings and work yourself up to a pitch of excitement. All of these are feelings added to the sensations. Do you think you can cut them short or bid them to disappear and make place for other more comfortable feelings? Of course, you cannot do that. Feelings cannot be redirected or rearranged at the bidding of your will. Neither can impulses. When you are in agony over your disturbing sensations instantly there is the impulse to call off an engagement or to summon the physician or to turn with fury upon your wife or child because of some innocent remark they may make. These impulses are just as spontaneous and passive as your sensations and feelings. They appear and you know of their presence only after they have emerged. You cannot manage them as you can your thoughts. You cannot command them to come or to go. They come upon the scene spontaneously and passively. If they are to depart the process is again passive and spontaneous. Do you understand now that thoughts are active and deliberate while sensations, feelings and impulses are passive and spontaneous? Do you also understand then that while you cannot drop your sensations, feelings and impulses by a command of will you can do that with your thoughts?

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practice to his wife, then to his friends and lastly to his boss who represents the strongest link in the chain. You may be inclined to doubt whether a method which works well with temper will also be effective with symptoms. Well, if you have read my books you will know that temper, exactly like symptoms, is initiated by an irritation or annoyance, that is, by sensations. To these sensations the temperamental person adds the ideas of either, "he is wrong" (angry temper) or the thought of "I am wrong" (fearful temper). You see here that in temper as in symptoms a thought is always linked to a sensation. Clearly the same method can be applied to both situations.

I shall give another example. You know that many of my patients suffer agonies because of their self-consciousness. They hesitate to address people, to offer opinions or to take part in conversations because they fear they might say the wrong thing or they may display a clumsy and awkward manner in speech, movement or carriage. Most of them are haunted by suspicions of being misunderstood or of being considered below par. Obviously there is here again a linkage between disturbing sensations and thoughts of insecurity. The sensations are those of discomfort on meeting people, and the thought is that of the danger of compromising oneself. In order to check the idea of insecurity the first step to be taken by the self-conscious person will have to be to practice in an environment in which the chances of being misunderstood or underrated are at their lowest. This is one of the reasons, as you know, why I insist that my patients associate with their fellow-sufferers in Recovery. There they have an opportunity to attack their fears and suspicions where they are weakest. I hope you realize now that if you wish to get rid of your troubles you will have to adopt this well tried method which means that you will have to attack those of your symptoms first which form the weakest links in the chain of your ill-balanced sensations, feelings and impulses.

P: It seems to me my symptoms are all pretty strong. It would be quite a job to find weak sensations among them.

E: I cannot agree with you on this point. You said your main difficulties are now (1) blurring of vision, (2) poor memory, (3) headaches, (4) pain around the heart, (5) fatigue with heaviness and numbness in the legs. It might be difficult for you to persuade yourself that the first four symptoms are without danger. The moment you experience the pain in the region of the heart the thought of a stroke or sudden collapse shoots into your brain, and it will not be easy to shut it out by means of a simple procedure or formula. You may also find it difficult to believe that your blurred vision, your poor memory and your headaches are harmless and devoid of danger. But this is altogether different with your fatigue. You think that your muscles are in danger of exhaustion should you continue to tax their fading strength. This thought of danger can be thrown out of your brain instantly if, accepting my authoritative knowledge, you conclude that yours is a psychological feeling of tiredness and not a physiological condition of exhaustion. If you do that you can decide to step out vigorously and to walk on for dozens of blocks. The sheer act of brisk and steadfast walking will give you the conviction that your muscles can easily perform a good sized piece of labor without withering or caving in. If you continue the walking practice day after day the conviction will gain strength and become unshakeable. The thought of muscular weakness and physical infirmity will give way to the idea of health, vigor and resistance; or the thought of security will replace the idea of insecurity. After you will have broken the link of fatigue in the chain of your symptoms you will know that when your body spoke of danger in connection with the fatigue it lied to you. Why should you believe the other symptoms if they voice threats and sound alarms? It seems to me that if the one symptom has been exposed as a liar the other symptoms can no longer escape the same kind of exposure.

I shall make one more point: what you call nervous fatigue is a condition that has its highest intensity in the morning, dwindling in strength in the afternoon and disappearing in the evening. You know that this is the case with your own so-called fatigue. Now if your muscles were weak to the point of exhaustion why should they regain their strength after a day’s exertion? This alone ought to convince you that your fatigue is a feeling and nothing else. Moreover, this feature of the afternoon decline gives you an added opportunity to practice replacing the thought of insecurity with the idea of security. If after a day’s work you set out on an energetic evening walk of about one or two miles you can easily persuade yourself that fatigued muscles which are capable of doing strenuous exercise after a day’s hard labor cannot possibly have been exhausted in the morning and early afternoon. If you carry on your practice in the evening your performance will not only be convincing but it will have the additional advantage of being easy of execution.
Peter told the story of his seven years of suffering. It began when one night he awoke and could not catch his breath. He rushed to the window, tried to draw in the fresh winter air but the "air-hunger" persisted for what appeared to him hours of never-ending torture. He felt nauseated again but in the morning belched incessantly. Although the breath-holding spell did not recur he still shuddered when he remembered the ghastly experience of the preceding night. He was certain he had a heart ailment. His physician reassured him with the result that except for recurring belching reactions he managed to maintain a precarious adjustment for five years. Then the belching increased in intensity and became associated with a pain about the heart region. This time the physician's assurance that his condition was harmless failed to convince Peter. One day, while working in his shop, he jumped up and "couldn't breathe." Now he was sure he was in danger of a physical collapse. He became panicky and intractable and was taken to the hospital. He was given electro-shock treatment which added the suggestion of mental ailment to the fear of physical collapse. After discharge from the hospital he returned to work. He was now obsessed with all kinds of fears and tormented with suddenly rising violent impulses. The fears centered about lungs and heart, and the impulses were in the nature of indiscriminate aggressions, for instance, "to punch somebody in the face." The impulses were controlled but the fears spread. He became afraid of swallowing because eating might lead to belching. If he occasionally exploded in a temper outburst he felt wretched. If he controlled temper he "felt like a rat." Trigger symptoms made their appearance. He thought of getting a spell of air-hunger, "and presto I got it." His concentration suffered. At time he stammered. All of this made him feel confused, self-conscious, miserable. It was at this stage that he was seen in the office and assigned to classes. He made a fair improvement, got the belching, air-hunger and fear of swallowing under tolerable control but what disturbed him most was his lack of self-confidence and the inability to check his temper.

E—Examiner
P—Patient

E: From what I know about you it seems to me that this example is representative. It represents your customary habit of reacting to minor frustrations. You asked a question, and the boss returned a gruff answer. Instantly you became irritated to the point of "burning up." The next link in the chain of events was that you came back with a "saucy" remark. The boss, refusing to become temperamental, laughed and made your blood "boil." The final result was that you belched for hours. You will realize that what "burned" and "boiled" was your temper. You know, however, that temper will neither burn nor boil unless you form the idea that you have been wronged. From this we conclude that prior to releasing your temper you thought...
or decided that the boss was wrong and you were right. It was this temperamental thought in your brain that touched off the temperamental commotion in your body. This again led to the “saucy” remark and ultimately to the sustained fit of belching. Let me repeat: there was (1) the temperamental thought, (2) the temperamental commotion, (3) the “saucy” remark, (4) the belching. You will understand that the thought “he is wrong and I am right” can be rejected, suppressed or dropped. You will also understand that your “saucy” remark could have been checked. In other words in this fourfold series of incidents, two lent themselves readily for control. You could have rejected the thought of being wronged by the boss and could have prevented your muscles of speech from voicing the “saucy” remark. Do we agree on this point?

P: Of course. I heard you say that many times and I know that ideas can be rejected and that muscles can be commanded not to move. I know that but it doesn’t seem to help me. That thing gets me and I explode.

E: What you say means that control of thought and muscles is theoretically possible as a general principle but practically impossible in your particular case. Which means that you are an exception. But I do not recognize exceptions, and what one patient can do another can likewise. We shall take it for granted then that you could have controlled the temperamental thought in your brain and the temperamental utterance of your speech muscles. How about the temperamental commotion (“boiling”) and the belching? Do you think you could have stopped that?

P: I can only say what you told us in previous interviews. Temper runs its course and symptoms do the same.

E: Correct. Both temper and symptom run their course, and you cannot stop them by an effort of the will as you can do with thoughts and muscular action. And if you say that temper and symptoms run on of their own momentum that means that once they are set going they continue on, rising and falling passively without any possibility of arresting their progress until they exhaust themselves. For this reason they have been termed the passive responses of the body to a disturbing event. They are called passive because they cannot be actively influenced by the intervention of will. This is different with thought and muscular action. Your will can play on them as it chooses. If you now think that your boss emitted a “dirty laugh’ you can in a second change your view and admit that the laugh was perhaps not so dirty after all. If the thought strikes you that his remark about the tools was provocative and offensive there is nothing to prevent you from surmising that a more sympathetic explanation may be just as acceptable. And as concerns your muscles, well, that muscles can be restrained from moving is a commonplace fact that need not be stressed. And when you had the impulse to “let loose” and “tell the boss a mouthful” you could have decided to hold your tongue and to prevent your speech muscles from moving. Muscles and thoughts can be manipulated actively and for this reason are called the active reactions in contradistinction to the passive responses of temper and symptoms. If you really wanted to get rid of the belching all you had to do was to stop your speech muscles from voicing the “saucy” remark and to reject the absurd idea that you are the judge as to who is right and who is wrong. Had you done that your temper would have been reduced to a flicker of an inner stir and the belching would have been aborted. Do you understand now that your belching cannot be cured unless you control your temper and that the latter can only be checked if the brakes are applied to thought and muscles?

P: I understand that when I listen to you. But at the moment my temper gets me I forget what you told me.

E: Which means that in your opinion your temper is an overwhelming power that has you in its grip and leaves you helpless when it seizes you. But the grip is so tight only because you do not make the proper effort to loosen it. The time to make this effort is not when you are face to face with the boss. There a deadlock has developed between you and him, and the mere sight of the boss makes your temper flare. In order to get a hold on your temper you must practice control under circumstances which do not produce the situation of the deadlock. You must practice at home with your mother and wife and child. There is no deadlock at home, or if there is one it is mild and can be handled with ease. With the members of your family your temper rises slowly and perhaps never reaches excessive heights. There ought to be no difficulty rejecting the thought of “I am right and she is wrong” when your little girl irritates you with her childish pestering or when mother and wife ask annoying questions. These trifling impositions give you an opportunity for practicing temper control dozens of times each day. From your own account and from reports that come to me from other sources I know that you "let yourself go" in the morning before you leave for work and in the evening after you return from the shop. You permit yourself the expensive luxury of releasing wild thought and speech reactions. Once these active reactions are set off the passive responses of temper and symptom follow promptly in their wake. When you arrive at the shop in the morning you are already primed for the responses of temper and symptom because you failed to practice control of thought and speech reactions the evening before. On entering the shop you are disposed to explode and belch because you pre-disposed yourself to flare-ups in the paltry domestic squabbles of the previous day. Your temperamental disposition at the shop in the morning is the result of the temperamental predisposition cultivated in the evening at home. If you wish to get rid of your belching you will have to realize that the place to practice temper control is at home and not in the shop, and that the elements which have to be controlled are the active reactions of thought and muscles, not the passive responses of explosion and symptom.

E—Examiner
P—Patient

E: How are you, Helen?
P: I have been well for more than six weeks but last week I had a setback. It was during a card game. I didn’t get my paralysis, but it was bad enough. I had a panic and couldn’t shake it off for two days. Today I am much better, but I am still shaky.

E: You speak of paralysis. Can you tell the class what you mean by that? You are a young woman, and why should you have a paralysis at your age? Tell your story briefly and try to explain what you mean by “paralysis.”
P: I have always been restless. After I got married I couldn’t stand being alone at home in the evening, not even with my husband. We had to be in the company of people all the time. We either had people visit at our home, or we went out visiting. Usually we played cards. One day, three years ago, while playing a game of bridge, my hands suddenly went limp. I tried to move them and couldn’t. Of course, that scared the wits out of me. I pretended to have a headache and excused myself. The moment I left the table my arms moved again. That was the first time I had that paralysis.

E: Did the condition return?
P: It did not for about three weeks. In between I played cards repeatedly and had no trouble moving the arms. I actually forgot the whole thing. But one evening I played again and the arms gave out. This time, I was so scared I didn’t have the presence of mind to fish for an excuse but just ran out of the room. My husband called a doctor who said he couldn’t find anything wrong with me. But I felt like in a daze, although I knew I could move the arms again. After that I could not get myself to play cards when I was out of the house. I was in terror when I thought that the arms would stop moving again.

E: Were you able to play cards at home?
P: Yes. I played without trouble at home, even when visitors were present. I was also able to visit people but I did not touch a card when I visited. I gave excuses, said I had a headache or felt dizzy and couldn’t concentrate. That helped for a while but one evening the hostess was insistent and wouldn’t take an excuse. I gave in and, sure enough, there was the paralysis. After that, I refused to accept invitations. I still had visitors at my home but they gradually petered out because I did not reciprocate.

E: Did the “paralysis” ever appear when you played cards at home, with only relatives present?
P: This didn’t happen for a long time until, one evening, it finally happened. After that, there was no more card playing with anybody except my husband and my parents. With them, I never had the paralysis.

E: Did you have any other trouble aside from this “paralysis?”
P: For many months the paralysis was the only trouble. But then all kinds of other trouble came. The greatest trouble was meeting people. I hated their questioning me about my condition. I had to explain why I kept away from them, and it wasn’t easy to find excuses. Finally I kept out of everybody’s way, that means, I avoided going out as far as I could.

E: Did you continue seeing your relatives?
P: I did. But they became bothersome, too. When they came to the house the first thing they told me was, “Why, you are not sick! You just look the picture of health. You must be feeling fine.” When I told them I still had my fears they said, “Oh, it’s all in your mind.” Or they told me to snap out of it, to use my will power. I knew they were right and the doctors had told me the same thing. But I hated their way of talking, perhaps because they were right.

E: That was an excellent description. I need not tell you, Helen, that what you just described was a very severe nervous condition. Had you continued avoiding people and shutting yourself up in your home your life would have been that of a helpless cripple, doomed to lead a useless and miserable existence. If this is so why don’t you make an effort to get well?
P: If I had a setback does that mean I don’t make an effort to get well? You told us so many times that setbacks are unavoidable.

E: That is correct. But I also told you that you must learn how to handle the setback. Do you think you handled it in accordance with my instructions?
P: I got over it in two days. Is that so bad?

E: It is bad enough. You said you were panicky and couldn’t shake off the panic for two days. Then you added that you are still shaky today. Had you done what I asked you to do the setback would not have developed into a panic and would have lasted minutes or hours and not days. What did you do when you noticed the setback?
P: I remembered what you told me. I knew that sensations are distressing but not dangerous. Wasn’t that what I was supposed to do?

E: You did very little. You merely “remembered” and “knew” something that I said. That’s not what I call “doing.” I shall ask you: Did you attend the Recovery meetings? Did you go to family gatherings?
P: No, I didn't. I was so fine the past six weeks that I was sure I was well and didn't need the meetings.

E: You spent three years in utter agony. Then you got well but were warned that the condition was likely to return unless you took part in classes and Recovery activities for at least six months. You attended my classes but neglected going to Recovery meetings. That means you made a half-effort. Why did you not make a total effort?

P: I did what I could. I had to come to your office twice a week. That took up two afternoons. The class took up an evening. Then I had to take care of the house and the children, and my husband is entitled to some of my time, I think. And you told me I should go and visit people which I did. All of this took plenty of my time.

E: You mentioned the home and the children and social activities. They are all very important. I do not deny that. You may call them the domestic, social and marital purposes. You took care of them and deserve all the credit that is due for the accomplishing of purposes, especially if they are as worthy as the ones you mentioned. You might have added that you had to attend a church meeting or meetings of a civic club. These would be the purposes of citizenship, community and church interest. All worthy and commendable purposes. But when you are ill your main and all-absorbing purpose must be the will to get well. All other purposes, no matter how inspiring and exalted, must be subordinated to the one leading and supreme purpose of getting well and keeping well. Unless you regain and maintain your mental health all other purposes will be frustrated. Only if you keep well will you be able to discharge your duties as mother, wife, friend, church and club member. I do not mean to say that health is more important than motherhood or religion. I merely say that motherhood, religion, citizenship and fellowship cannot function unless health is made to function first. To a patient his health must have unquestioned priority over all other purposes. Health must be the supreme aim to him all other aims must be subordinated to the demands of health. You spent your effort on subordinated purposes and neglected that aim that ought to be supreme now. Instead of concentrating all your strength on the main issue, you frittered away your energies on a number of side issues. Why are you so careless of your welfare? Don't you want to keep well?

P: Of course, I want to keep well. I just shudder if I think of my suffering in the past.

E: You say you want to keep well. In a sense you are right. You would like nothing better than to have done with the "paralysis" and the awful difficulties into which it got you. That merely means that you wish to have your health. It does not mean that you have the will to health. I shall not enter into a comprehensive discussion of what is the difference between a loose wish and a determined will. This much I will say: A wish does not commit you to exercise all your energies toward attaining it. You wish to make a trip to a distant country. You may say you want the trip. But you don't want it hard enough to sacrifice other aims in its favor. You will not sacrifice your life savings or the welfare of your family for the sake of that wish. That wish is not directed toward a supreme aim. You do not give it priority over the family purpose. Should you for some foolish reason make that trip a supreme aim you might perhaps sacrifice all other purposes to it. Then you would pursue your aim with the force of a total effort. The trip would no longer be backed by a loose wish but would be insisted on with the vigor of a determined will. I hope that you understand now the difference between a supreme and subordinate purpose. Health was to you a subordinate aim, a loose wish, something that you thought you might be able to attain at the cost of a half-effort. You know better now. You know that health must take precedence over all other purposes and must be attended to with the energy of a total effort. If you keep that in mind you will not have to worry about your setbacks. You will be prepared for them and will shake them off in minutes instead of hours or days.

The examiner then pointed out that the real reason for Helen's failure to attend Recovery meetings was her sense of shame. Helen, he commented, is still harassed by the idea that her nervous ailment is a disgrace to her and her family. She still suffers from the pressure of stigmatization. To feel stigmatized means to be tense. The tenseness creates pressure on the nervous system and may produce or revive symptoms. As long as Helen continues to feel stigmatized she will be in danger of becoming "paralyzed" again. If she wants to prevent a return of the symptoms she will have to learn how to shake off embarrassment and stigmatization. One of the purposes of Recovery gatherings is to rid the patient of his feeling of being stigmatized. If Helen continues to shy away from the meetings she will have demonstrated that her will to avoid embarrassment is stronger than her will to get well. That will is a mere wish, not a solid determination.
Irene, a woman of 30 and mother of two children, developed a depression of mood which persisted for five years with only brief intervals of fair health. When she was first seen by the examiner she complained of a "complete absence of interest," difficulty of sleeping, lack of appetite, fatigue. She claimed she had no zest, pep or initiative. She could not plan, make up her mind, decide to get things started. In the morning it took her literally hours to get dressed, to choose the proper attire, to get started with cooking, dusting and cleaning. When she finally began to do her work she had to drag herself. Everything was done with extreme effort. Even such simple acts as turning on the faucet or lighting the gas range required her to use all of her strength. She could only do things if she forced herself to do them. A simple conversation was "hard labor," walking was an ordeal. On the other hand, sitting or lying was intolerable because it made her restless. Because speaking and walking called for extreme effort she avoided going out and meeting people. After several weeks of combined office and group treatment she recovered her health and staged a comeback that surprised both her and the members of the family. When interviewed in class she reported that all her symptoms were gone and that she was as well "as anyone might wish to be."

E—Examiner
P—Patient

E: I have observed you closely for the past two months, and there can be no doubt that you have regained your health. But tell me, Irene, what do you plan to do for the purpose of maintaining your health?
P: I shall attend classes and Recovery meetings and I will study your books and the Recovery Journal. Isn't that what you want me to do?
E: Of course, I want you to do that. But the maintenance of health is a lifelong task and I do not expect you to attend classes all your life. And whether you will continue membership in Recovery forever is questionable. So, what is your program for keeping well aside from your present activities in classes and meetings?
P: I certainly intend to take part in Recovery for good. I know that many members feel the way I do. They think they are in Recovery for keeps.

E: I like your spirit. But you cannot depend on Recovery exclusively. Suppose your husband will be transferred to an out of town branch of his concern. Then you will be separated from Recovery and will be thrown on your own resources. Are you prepared for a development of this kind? Are you ready to practice self-help?
P: I never thought of that. But it seems I'll be able to manage.

E: Look here, Irene, you have suffered for almost five years and have only been well some two months. In these two months you have heard me state repeatedly that every patient must be prepared for setbacks. You have listened to several interviews in which patients reported that they drifted into setbacks after months and years of good health. Last week you had an opportunity to listen to the interview with Emily who had enjoyed good health for three years in succession and then developed a severe spell that landed her in the hospital. You remember that when I criticized Emily for neglecting her participation in our after-care project she gave the excuse that three years ago she felt sure she was able to manage herself without the aid of classes or meetings. Emily paid dearly for her false sense of security. Now you also say you think you'll be "able to manage." Are you going to repeat Emily's mistake?
P: I don't know what more I can do than come to classes and work in Recovery.
E: Be certain I appreciate your loyalty to Recovery. But I must repeat what I mentioned before. Suppose some day you will be deprived of Recovery support. Are you prepared to practice self-help? Do you know how to go about it? Do you know which method to employ? You wish to keep well. That means you want to prevent a recurrence of your ailment. But prevention must be practiced correctly, methodically and systematically. Do you think you know the method which will help you maintain your health?
P: I don't know what to say.

E: You see, Irene, you told me that when you were ill you had no interest, zest or initiative. You could not plan or decide. Making up your mind and getting things started was difficult or impossible. Simple tasks which are ordinarily done without hesitation, required extreme effort. All of this can be summed up in the statement that you lost your spontaneity. Do you understand now that if you are to keep well you will have to know (1) what is the nature of spontaneity, (2) what you can do to strengthen and preserve it? I shall try to tell you something about that. While I am speaking here before the class I have in mind a plan or intention. My intention is to express certain ideas and to make this class accept them. This intention must be carried out by my muscles. The muscles of my lips, tongue and cheeks must pronounce my sentences, the muscles of the throat must provide the proper intonation. The face muscles will have to mold and fashion my features in such a manner that they give adequate expression to everything voiced by my lips. Add the gestures of my arms, the carriage of my frame, all of them must fall in line with the central intention conveyed by my word. In the space of one hour I shall have to

APPENDIX (Continued)
set in motion hundreds of muscles in thousands of combinations and all the movements they will perform will be required to give expression to one intention, one plan, one idea. Let me tell you that what I described here is the pattern for every act of every description no matter what may be its meaning. You may say that every act expresses one single intention through a multiplicity of muscular movements. Suppose now that when I arrived tonight I felt tired, discouraged and dispirited, the reason perhaps being that I experienced a grave disappointment in the afternoon. If this is so, then, my intention may still be to plant certain ideas in your brains. But that intention will now be coupled with another intention: to go home and rest, to get this class out of the way, to be finished with it in record time. My mind will no longer be "made up" or determined by one single intention. Instead it will be torn between two intentions. The intention to continue this address will grapple with the opposite intention to go home and relax. The result will be that two sets of antagonistic impulses will reach my muscles of speech, intonation, facial expression and gestures, and the muscles will sometimes express the one group of impulses (to make a good and effective speech) and sometimes the other group (to be done with that speech that keeps me from taking a rest). The dual intention will distract your attention and will involve me in contradictions. Before long I will notice that I stray from the theme and that I do not hold the interest of the audience. The observation will scare me. I will lose my assurance and will be self-conscious. And once I become self-conscious I am not spontaneous. You will understand now that spontaneity is interfered with or destroyed by self-consciousness. You will also realize that self-consciousness is produced by the fact that two contradictory intentions endeavor to make the muscles express two different ideas at the same time. The muscles are thrown into disorder expressing portions of the one idea and fragments of the other with the result that the speech loses clarity and gives the impression of confusion. Do you understand, Irene, that when you lacked spontaneity your mind was the seat of two contradictory basic intentions and was not "made up" in favor of one single plan?

P: I know I was always self-conscious when I was ill. But when you speak of contradictory intentions I don't know whether that was so. I know I wanted to do something and felt I couldn't. I had to drag myself and when I forced myself to cook or clean I did it with great effort.

E: You say you wanted to cook but had to force yourself to do it. That means your intention or plan to cook met with resistance. You know that at present if you intend to cook you simply send an impulse down to your muscles and they perform the act. They do that with ease, without effort. You no longer drag yourself which means that strain is eliminated; you hardly think of and certainly do not reflect strenuously on what your muscles are doing which means that you are no longer self-conscious about your actions. Since your cooking proceeds without effort and without self-consciousness you can say that you are now spontaneous. Your spontaneity has reestablished itself because your impulse to cook is no longer resisted and thwarted by the contrary impulse not to cook. You will understand this situation better if you consider another example in which resistance hampers prompt and effortless action. I shall quote the act of buying necessities or conveniences. Should you want to buy a loaf of bread all you would have to do would be to have the proper intention and to impart the corresponding impulse to your muscles to walk out of the home, to cross the street, to enter the bakery shop, to pick up the bread and to pay for it. All these actions would be executed promptly, and without effort and without self-conscious hesitation. You would act spontaneously. In the afternoon of the same day you might want to purchase a coat. The question will be: cloth or fur? Now you will no longer just dispatch an impulse to your muscles, fetch a seal coat, pay for it and stroll home. Now there will be stalling, hesitation, plenty of thought and an abundance of reflection. You may want that sealskin instead of the cloth coat but it was not sufficiently dressy. Then the seal caught your eye and now you were uncertain whether you could afford it. The impulse to buy engaged in a running fight with the impulse not to buy, and the result was a sense of insecurity, strain and tenseness (effort) and stalling and hesitation (self-consciousness). In the end, you were left without spontaneity. You will now be in a better position to understand the factors which tend to do away with your spontaneity: (1) there is a conflict of intentions and impulses, (2) a sense of insecurity, (3) effort and self-consciousness, (4) inability to decide, plan and act. The inability to decide, plan and act is the outward expression of your defect in spontaneity; the conflict of impulses, the sense of insecurity and the self-consciousness are its inner causes.

In the subsequent portions of the interview it was explained that if Irene meant to preserve and strengthen her spontaneity she had to cultivate ideas of security and to reduce as far as possible her thoughts of insecurity. The examiner then demonstrated with suitable examples that patients can weaken their sense of insecurity if they learn to adopt the philosophy of averageness in preference to thinking in terms of exceptionality. Irene had been brought up as a perfectionist. Her ambition was to keep her home "perfectly clean"; to do a perfect job in the education of her children; to attain excellence as hostess, wife, friend, neighbor. Trivial errors, trifling mistakes and insignificant failures caused her to sweat and fret, to wear herself out with vexation and self-reproach. She worried, felt provoked at her fancied inefficiency, was perpetually...
flustered and confused. The confusion multiplied her record of bungled trivialities and botched irrelevancies. A vicious cycle developed: The more she was confused the more she bungled; the more persistently she bungled the more disturbing became her confusion. In the end, she lost confidence in her ability to do things "correctly," developed an exaggerated self-consciousness and lost her spontaneity. After joining Recovery she learned to be human and average, to permit herself to be "like others," to bungle as much or as little as people bungle "on an average." She rejected the grotesque idea of the "perfect job" and the "flawless performance," and imbibed the now familiar Recovery doctrine to "have the courage to make mistakes in the trivialities of everyday life." If Irene continued to practice these Recovery doctrines in her everyday activities, if she practiced methodically to laugh at the paltry consequences of her trivial mistakes, she was certain to develop self-assurance and to rout her self-consciousness. Then her muscles will not be wedged in between two sets of antagonistic impulses, her spontaneity will be established on the firm ground of self-confidence, and her solid habits of thinking in terms of averageness will prevent her from becoming discouraged, despondent and depressed.
INTRODUCTION (Low, 1967, pp. 11-12)

Psychiatric after-care has for its objective the prevention of relapses. It may be assumed with reasonable safety that the same set of circumstances which caused the original breakdown is also responsible for the subsequent relapse. To prevent relapses then means to gain adequate control of these circumstances.

Chief among the disturbing circumstances is the emotional situation in the domestic scene. When the patient returns from the hospital he is received into an atmosphere which is charged with anxious expectation. The relatives, wife, husband, father, mother are eager, solicitous, protective. But their eagerness is overdone, and the solicitude and protectiveness assume all too easily the mark of apprehensive fitfulness. The ex-patient is watched, cautioned, superintended, directed and interfered with. The unceasing supervision suggests to him that the reality of his recovery is not trusted—once mentally ill, always mentally ill. The stigma of mental disease rears its ugly head and stares him in his perplexed face.

If the ex-patient rebels, insisting on a measure of free movement and self-directed action, he is likely to be reminded that he has to “take it easy,” that he is still “nervous and in need of lots of rest.” With subtle reminders of this kind the fact is painfully accentuated that although discharged he is still on probation; once mentally ill, always mentally ill. The home situation is now heavy with the spirit of the stigma.

The ex-patient may continue his rebellion. He rejects insinuations and provokes arguments. The more he resists the “well meant” advice the more rigid becomes the supervision. A vicious cycle ensues. The determined resistance offered by the patient—the "parolee"—causes the relatives to intensify their pressure, and the increased pressure provokes more determined resistance. Tempers explode and nerves snap. In the end, a violent outburst occurs, and the patient is hustled back to the hospital. There the face of a relapse is entered upon the record and the time-honored dictum of “once mentally ill, always mentally ill” is confirmed, verified and perpetuated.

This is not an attempt to incriminate domestic discord as the sole source of relapses. Nor is the author sufficiently naive to consider all relapses as preventable. There can be no doubt, however, that the temperamental explosions of an ill-balanced domestic scene are currently producing readmissions which could be avoided if tempers were adequately curbed. To express it otherwise: unbridled tempers are closely correlated with the mounting rate of recurrences. Conversely, an effective curb on domestic temper can be expected to reduce the incidence of relapses.

The explanatory remarks appended to most of the lectures are primarily meant to serve as guides to physicians.
Edna's behavior was civilized but not cultured. As such we characterized it as of poor average quality and concluded that for behavior to be plain or good average it must be cultured and not merely civilized.

Service and Domination Are the Principal Motives

Behavior, if it is not reflex, is guided by intentions or motives. There are two main varieties of motives: service and domination. Love, friendship, admiration, neighborliness, civic-mindedness, patriotism, honesty in business dealings, ethical conduce in professional affairs, loyalty to men and causes, plain courtesy and civility, are all prompted by the motive of service. Hatred, enmity, contempt, dissension, rascality, hypocrisy, jealousy, envy, discourtesy and incivility are the product of the motive of domination.

In average life, neither the motive of service nor that of domination exist in their pure state. A person inspired by the spirit of service exclusively would be a saint; one inspired by the sole urge for domination would be a monster. Neither fits into the scheme of average life. Both are exceptional and extreme in their motivations.

The average person is activated by both major motives and tends both to serve and to dominate. This existence, side by side, of two mutually contradictory motives cannot be overemphasized if the problems of the recovered patient are to be discussed properly. When your son or daughter, husband or wife is returned to you, you will, at the same time, try to serve and to dominate them. You would not be human if you did not do so.

The Two Major Motives Require a Healthy Balance

How can two opposite trends of behavior be enacted coincidently? The answer is: by means of a healthy balance. A healthy balance of the two major motives makes for healthy group life. Group life turns into endless strife if those sharing it insist on domination exclusively. It is monotonous, colorless, and "lifeless" if nothing but service prevails.

You know the game called "tug of war." One set of people tug at the one end of a rope, another at the other end. If the pulling strength of the two groups is equally balanced there will be no action. On the other hand, if the distribution of forces is too unequally balanced, there will be no contest. One of the groups will have a "walkaway." A healthy contest will ensue only if the pull of the one team just over-balances that of the other. This example will show you what is meant by a healthy balance. A balance is healthy if the opposing forces are neither equally nor too unequally matched. In the field of motives, a healthy balance is maintained if service over balances domination without overwhelming or eliminating it.

Rude Behavior Is More Common at Home Than on the Outside

It is a popular belief contrary to actual experience that the spirit of service is generously displayed in the home sphere and that the spirit of domination increases the more the sphere of action includes strangers. According to this theory, relatives are generally approached in the spirit of service, strangers in that of domination. If this were so, irritation and annoyance would be rare at home and abundantly experienced in the company of strangers. However, if you consult your own past record you will realize that the bulk of your irritations stem from your close relatives and friends, that a smaller but considerable portion of annoyance can be traced back to your coworkers and card game partners, and that the strangers whom you meet in the department store or in the street car are seldom a source of irritation or provocation. In other words, the average individual tries his best to be friendly and courteous with the stranger but loses his temper frequently with those familiar to him and is likely to be rude and impatient with his intimates. The reason for this discriminating behavior is clear; you risk nothing or little if you are harsh and brusque with your son, father, or mother. They are helpless in the face of your rudeness. What disciplinary measure can a mother resort to if her son is intractable? She cannot very well eject him and deny him his share of family life. Her love renders her a victim of the son's incivility. Let the same son display his rudeness in the presence of strangers, and he will not be permitted to victimize any of them. They will not hesitate to pay him back in kind.

You all know of the husband who frequently, and without compunction, is late for dinner at home and practically always ahead of time when expected at the house of a friend or stranger. Should it happen that, through some unforeseen circumstance, he is prevented from being punctual for the outside engagement, he is certain to telephone and to offer profuse apologies. No apology is even thought of if the delay merely concerns the dinner arrangement at home. In this instance, the punctuality and the apology to the hostess are the expression of a spirit of service and the lack of courtesy displayed to the wife an exhibit of domination.
APPENDIX (Continued)

The Problem Adult Displays "Devil-at-Home-Angel-Abroad" Attitude

In this husband's pattern of behavior, domination has a "walkaway" at home and service abroad. There is no healthy balance between the two sets of motives. The two forces are altogether too unequally distributed over the divergent spheres of life. Behavior of this kind goes by the name of the "devil-at-home-angel-abroad" attitude. It is a common pattern among children, and a child practising it to excess may be called a "problem child." It has struck me that I am frequently told of problem children but seldom of problem husbands and wives, mothers and fathers. True enough, the average wife and husband, mother and father, do not in the fashion of problem children throw tantrums or break china. However, if problem behavior at least in one of its manifestations is characterized by domination at home and service abroad, the terms "problem husband," "problem wife," "problem father," and "problem mother" ought to have equal rank with the term "problem child." They ought to be considered its most common adult equivalent.

Edna was a problem wife, i.e., a problem adult. In her contacts with outsiders she was a model of gentleness and civility. She was known as a charming hostess and delightful guest. She went out of her way to please friends and acquaintances and was careful not to be overbearing or imposing. Her smile was winning and her manner engaging. In contrast to this graceful conduct in social settings her behavior at home was marked by impatience and irritability. True, she was not violent, vituperative or profane. But her charming ways simply evaporated the moment she crossed the threshold of her home. On the outside she was cultured and refined, at home merely civilized and—not exactly coarse.

I do not wish to be too critical but cannot help stating it as my opinion that too many of you relatives of patients are problem adults. Too many of you, although well behaved in social contacts, tend to display a relentless trend toward domination when dealing with members of your own family. If this is true the recovered patient, on returning home, will face an atmosphere of harshness and impatience that is likely to break again his restored health. If this calamity is to be avoided, those of you who conduct yourselves as problem adults will have to learn how to acquire the manners and attitudes of normally balanced individuals.

Temperaments and Dispositions Can Be Changed Through Determination and Insight

Both domination and service are based on what is called disposition, or temperament. The spirit of domination gives rise to or stems from the competitive or domineering temperament, that of service has a similar relation to the cooperative or submissive temperament. The implication is that if the relative of a patient is advised to mend his domineering ways he is asked to change a disposition or a temperament. Is this possible? The answer is: it has been done frequently, hence, it can be done. Indeed, if tempers and dispositions could not be changed what would be the rationale of trying to influence men by means of religious, educational and artistic endeavors?

There is much talk these days about adult education. As a psychiatrist I claim practical experience in this field. For many years I made an effort to re-educate adult persons and secured a measure of success. But I never obtained satisfactory results unless I was able to give the patient insight into his failings. It is an axiom of psychotherapy that a set of dynamic habits (dispositions or temperaments) cannot be changed unless (1) the patient is determined to effect a change, (2) the psychiatrist gives him insight into them.

Edna had no insight into her shortcomings. She was simply not aware of their existence. She was convinced that her actions were animated by the very noblest intentions and that her conduct was dictated solely by the sense of responsibility and the spirit of devotion. In her mind there was no question she was right and her husband wrong. This assurance of oneself is a common pattern among problem adults. Too many of you relatives of patients are problem adults. In this husband's pattern of behavior, domination has a "walkaway" at home and service abroad. There is no healthy balance between the two sets of motives.

Temperaments Are Concealed in Words and Acts and Revealed in Tones, Gestures and Features

It is a comparatively rare occurrence among relatives or friends of average breeding that one person takes offense at the words or acts of the other. However, it is a common experience that relatives and friends hurt and irritate one another by means of tone, gesture and feature. Every civilized person has learned to control words and motor acts. Even if his temperament is competitive and domineering he will take care not to give it verbal and motor expression. The calamity is that unless a person is a supreme actor he has little practice in the control of tones, gestures and features. It may be stated as a fact that if a person is possessed of a domineering temper he will conceal it in words and acts but reveal it in tone, gesture and feature.

Like so many "temperamental" persons, Edna was too impetuous to be sufficiently on guard in choosing her words. A good deal of her domineering disposition was, therefore, revealed even in her address. You remember I told you that in her eagerness to superintend George's daily life she passed on numerous occasions remarks like, "Why do you make it so difficult for me? Didn't I suffer enough when you were sick? Do you want me to go through all this again? If you don't mind
your own health, can’t you at least have some consideration for me and the children?” (See page 44) (this reference to page 44 refers to Lecture 3, The "Conditional" Standard of Behavior, Low, 1967, pp. 36-46, which is not included in the excerpts chosen for my doctoral dissertation—jhb) These questions contained no verbal or motor indication of rudeness or hostility. Edna did not swear or yell. On the face of it, her harangue was in the form of a plea or request and devoid of threats or invective. However, when she asked, “Why do you make it so difficult for me?” the implication was that George contrived to make difficulties for her. When she continued, “Do you want me to go through all this again?” the implication was again a damaging indictment of George’s good intentions. The insinuation was unmistakable that George might want her to “go through all this again.” The climax of innuendo was reached when she wound up her wild exclamation with the outcry, “If you don’t mind your own health, can’t you at least have some consideration for me and the children?” This last sentence contained the unavoidable suggestion that George was careless of his own health and indifferent to the welfare of wife and children.

You may suspect here that I read into Edna’s verbal barrage meanings and thoughts which are not hers. However, this is beside the point. The question is not what Edna’s statements may mean to me. The more important question is how a husband with average sensitivity, acted on by his wife, will interpret the meaning of her words and actions.

The Meaning of an Act May Be Grasped, Understood, or Comprehended

The meaning of an act can be secured through (1) superficial grasp, (2) deep understanding, (3) broad comprehension. If I see a man approaching his neighbor, shaking his hand and saying, “How are you?” the man’s motor behavior was perceived by my eyes and his speech behavior by my ears. The meaning of the act was then grasped in its superficial sensory aspects only. My eyes and ears merely registered the fact that a man greeted his neighbor and shook hands with him. Whether the handshake was prompted by friendship or mere courtesy; whether it was offered joyously or grudgingly, whether the greeting expressed genuine interest, politeness or wily hypocrisy, cannot be distinguished by means of sensory perception. Friendship and courtesy, genuine interest and hypocritical wile are motives, and motives cannot be seen or heard. Instead, they must be inferred, either by solid judgment or by vague intuition.

After the surface of the act has been explored by the senses, judgment or intuition penetrate underneath the superficial appearance and, thus, understand the motive. Understanding, therefore, goes deeper than mere sensory grasp. Whether understanding be based on solid judgment or vague intuition, in either case, it takes its cue from intonation, gestures and features. From these it infers the motives which are underneath or back of the act.

Articulate Behavior Is Grasped, Inarticulate Behavior Is Understood, Together They Are Comprehended

Motion and speech can be easily observed and measured in their details and, thereby, analyzed as to their precise meaning. A friendly handshake and a violent blow may be executed, at different times, by the same right arm of the same man. But the direction in which the arm swings, the force with which it is advanced, and the velocity with which it moves can be conveniently measured and shown to be different in the handshake from what they are in the blow. Moreover, the manner in which the muscles bend and stretch, pull and push, raised and lowered the fingers and hands, forearm and upper arm in the various joints can again be measured and analyzed. Similarly with speech behavior. Words, sentences and paragraphs can be easily interpreted and analyzed in accordance with the rules of grammar, syntax and logic. This is different with intonations, gestures and features. Their analysis is either impossible or, at any rate, beyond the grasp of the average person. For some reason which it would be too difficult to explain here, behavior which is easily analyzed is called articulate, while behavior which defies analysis is termed inarticulate. We conclude that an act of behavior can be given articulate expression in motor and varied reactions, and inarticulate expression in tones, gestures and features. Articulate behavior is grasped by the senses, inarticulate behavior through judgment and intuition.

When the man whom I observed approaching his neighbor extended his right arm and asked, “How are you?” his handshake and inquiry were expressions of articulate behavior, motor and verbal. Its meaning could be analyzed through the senses as a greeting between two neighbors. In the ensuing conversation, I noticed a shadow of resentment in the knit brows and a strange tenseness in the taut checks. The man’s look was staring and his smile wry and forced. While speaking his fingers fidgeted nervously about his coat and the arms executed gestures of impatience. His utterances had sharp undertones and shrill emphasis. All of this was inarticulate behavior. From it I inferred that the motive which prompted the encounter was not sheer joy of seeing the neighbor nor friendly interest. The precise motive of the act was not yet fully understood, but some motivational possibilities were already ruled out. After I had, thus, grasped the articulate portion of his reaction through my senses and its inarticulate portion through my intuitive judgment, I felt I had comprehended the total behavior through a synthesis of grasp and understanding.
We shall now return to Edna. She gave articulate expression to her concern and devotion in verbal and motor reactions. This George grasped as a tendency toward marital service. At the same time, however, she gave inarticulate expression to her impatience and annoyance in tones, gestures, and features. This George understood as a disposition to marital domination. What George grasped in one portion of Edna's behavior clashed with what he understood in the other portion, and the result was that he failed to comprehend the meaning of her total behavior.

If a person notices that the articulate reactions of his friend, wife, father or mother clash with their inarticulate responses, he is likely to conclude that the clash is the result of hypocrisy and duplicity. He is then irritated, disappointed or repelled. This is the reason why it is so important for you relatives of patients to avoid a discrepancy between the articulate and inarticulate portions of your behavior. You must make every effort to regulate your conduct in such a manner that the returned patient will not be shocked by the observation that what he grasps in your motor and verbal reactions is contradicted by what he is made to understand in your intonations, gestures and features. If you do not avoid this duplicity of expression your son or husband will be unable to comprehend your total attitude and will become distrustful, perplexed and unhappy. The unhappiness will result from the realization that there is no common ground of understanding between him and his family. It is the sad lot of many of our patients that, after their return, they meet with a lack of understanding which they are unable to comprehend.

The Disease Mobilized the Patient's Sensitiveness to Inarticulate Behavior

There are sensitive and dull people. The dull react mainly to articulate behavior. Since the average individual is civil and courteous in matters of articulate speech and action, the dull have no difficulty escaping hurts and injuries. The sensitive are in a more precarious plight. They pay little attention to that portion of conduct which is expressed in words and motor action. Their attention is mainly focused on inarticulate responses. Raucous tones and hard features are apt to upset their countenance no matter how sweet the words and smooth the movements. And it is worth remembering that the patient who returns after months of agonizing loneliness is by no means dull. The disease has mobilized his sensibilities, and the anticipation of a stigmatized existence has sharpened his idiosyncrasies. This returned patient is particularly likely to listen to intonations, to scan features and to be hurt or even crushed if they are severe, reprimanding and disdainful. In my forthcoming lectures I shall make an effort to show how inarticulate intonations, gestures and features can be controlled to the point of harmonizing them with the words and motions of articulate behavior. Unless you produce this harmony between the two portions of your conduct, you will not be equal to the task of giving the proper after-care to your returned relative.

The lecture on the "major motives of behavior" is undoubtedly in theme and language above the educational level of the average ex-patient and his relatives. It treats the listener to such semi-technical terms as "dynamic habits," "extreme motivations," "sensory perception" and "inarticulate expression." In other words, the physician spoke up to the public, not down to it. Moreover, it must not be forgotten that the printed text is the result of marked revision in style and composition, differing considerably from the original spoken address. What is here compressed into one lecture was delivered in four separate installments spread over four consecutive biweekly meetings, each lasting from thirty to forty minutes. With so much time at his disposal the speaker had ample opportunity to enter into detail, to define terms and to explain meanings. In presenting a list of lectures the author does not intend to offer a course in the art of public speaking of which he is by no means a master. At present it is merely intended to present themes and concepts. That the physician who wishes to become acquainted with the principles of group therapy must be able to address a group ought to be understood. If he is, he will have no difficulty making use of the ideas and formulations contained in each lecture no matter how compact and concentrated they may be. Nevertheless, the author does not wish to underestimate the gravity of the task. Group therapy is by no means an easy undertaking, and even the most careful study of this volume will hardly be likely to transform the reader into an expert. The writer has spent many years in assiduous practice before he acquired his present facility.

It is the writer's opinion that if the subjects of temper control and will training are to be emphasized in group procedures the discussions must move on as high a level of relevance and pertinence as possible. The listener must be made to realize that the meaning of his actions is "concealed in words and acts but revealed in tone, gesture and feature." He must be given adequate insight into what is direct expression and indirect implication of his daily performance. The topics of intentions, suggestions, insinuations and innuendo must be brought to his attention. He must be taught to watch and inspect his own inarticulate behavior which must be understood in contrast with his articulate utterance which must merely be grasped. Such instruction may seem difficult of formulation but the author found that it is feasible and attainable. Group therapy is a necessity. That it is also a difficulty is a credit to the method and a challenge to the physician.
LECTURE 5 (Low, 1967, pp. 59-72)

THE TEMPERAMENTAL DEADLOCK

In one of my lectures I told you that behavior in a group is determined by two major motives, domination and service. I also told you that both motives are powerfully operative in every person and added that if they are to remain in a "healthy balance" the motive of service must have the edge over that of domination.12

Motives Move Muscles

A motive moves, and what it moves are muscles. This is a fundamental truth no matter how commonplace it sounds. Mark this statement: men act on one another through muscles mainly. And whether their actions be motivated by the spirit of service or that of domination the motive is carried out by muscular movement. Another thing must be kept in mind: what is irritating and annoying, insulting and agonizing is again behavior expressed in muscular action. Behavior, expressed through glands (sweating) or through blood vessels (blushing, blanching) will hardly ever have an irritating or offending effect.

Take a simple example, one that plays on the trivial plane of everyday existence. After a strenuous day's work a husband returns home. Previous to leaving the office he telephoned to tell his wife that he expected to arrive in about half an hour, adding that having an important evening engagement he wished to have an early dinner. On entering the dining room he notices the table is not set. He is piqued, disappointed, provoked. "What's the use of my telephoning?" he blurts out. "If that's the way I am treated I may as well eat outside." The wife apologizes meekly, protesting that the meal would have been ready in time had the husband called just a trifle earlier; even so, why fuss about a few minutes' delay? There is an angry reply, thundering and fuming on the part of the irate husband, mute resentment on the part of the flustered wife; the one indignant, the other crushed, both upset. The meal is finally taken in a tense atmosphere of strain, discomfort and irritation.

In this instance the husband's temper was aroused. What had actually happened was that his tendency to dominate was frustrated. The frustration mobilized hostile impulses which were given expression in muscular movements of the speech organs. Could the temper have been checked, the impulse restrained, the muscular expression prevented?

That muscular movements can be restrained, checked and stopped at will goes without saying. This ought to be sufficient to establish it as a principle that domineering behavior must never reach the state of muscular violence, either in speech (profanity) or in motion (blows). That tempers can be checked and dispositions changed was discussed on a previous occasion. I told you that the problem adult does precisely this checking and changing when, meeting strangers, he puts forward his best behavior. This observation alone ought to dispose of the time-worn argument that "after all you can't change a man's nature. In a phrase of this kind, temperament is thought of as identical with nature. I grant that it would be difficult to change a person's nature. But a man's temper is by no means his nature. At any rate, the average man's temper is not necessarily derived from natural inheritance. It is a far safer assumption that it is acquired through a process of mis-education.

"Nature" Can Be Changed Through Enforcement of Conditional Standard

Time was when it was considered "natural" that a father caned and strapped his children. In those days the father who lost his temper was perhaps not commended for his rash actions but his cruelty was excused as being ordained "by nature." When later public opinion turned against mistreatment of children fathers changed their "nature." How was it possible to change paternal "nature?" The answer is: by a change in public opinion.

Few persons dare give way to their "nature" if it runs counter to public opinion. You remember what I told you about the conditional standard. I said that it "determines which acts of behavior are called-for or uncalled-for by the requirements of time, place and circumstances of a given situation." I may add that public opinion determines which tenets of the conditional standard must be enforced, and which can be flouted.

In days bygone, public opinion tolerated wife beating and cruelty to children and animals. The result was that husbands, fathers and drivers who were so disposed yielded to their "nature" and indulged in orgies of cruelty. Today, when

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12The writer is well aware of the existence of motives that have little or no relation to either of these "major motives." Behavior may be motivated by such essentially asocial urges as hunger, joy of recreation, curiosity, or interest in one's own health. These motives re largely individualistic and may be practiced apart fro group aims. However, should they attain the status of group motives they would instantly assume the character of either service or domination of the group, or any combination of the two trends. If recreation consists of a lonely swim it will hardly touch on group life. If the swimming is done in connection with a group it will be performed in the spirit of co-operative service or of competitive domination.
Domestic Cruelty Can Be Outlawed by Determined Public Opinion

The husband who, in our example, did not refrain from bullying his wife when dinner was delayed a few minutes, did so because that portion of the conditional standard which declares bullying as uncalled-for is not enforced by present day public opinion. That same husband is expert in restraining his domineering "nature" where public opinion interposes its unequivocal disapproval. Public opinion condemns temper outbursts at social functions or in the presence of strangers anywhere. The consequence is that the average bully shelves his "nature" when he appears in public. This is a common observation which demonstrates that "nature" cannot only be changed but discarded if it runs the danger of unqualified public condemnation.

There is a surprisingly large number of domestic bullies in the list of the parents, husbands and wives of our patients. Some display their temper in free explosion, others are more subtle and conceal it behind transparent invective or crafty innuendo. The present lectures are intended to teach you how to control your tempers, how to avoid invective and innuendo. But there ought to be little need for teaching. Anyone of you who is possessed of a propensity for bullying knows how to control the tendency, for instance, when you attend a party. Should public opinion decide to outlaw domestic cruelty everyone of you would instantly drop your bullying and domineering ways for fear of social ostracism. There would be no necessity for teaching you how to do it. You would change your disposition with the same ease with which you change your attitude when you enter the room of your hostess.

Lax Enforcement of Conditional Standard Encourages Domestic Bully

How can public opinion be changed? How can the public be induced to ostracize parental domination, marital bullying and any other kind of domestic cruelty?

The task seems super-human. Yet, at the risk of being ridiculed as a visionary I am ready to state that it is easy to accomplish. Of course, it would be difficult, although by no means impossible to change the views and standards of the general population. The millions of inhabitants of this country will hardly be inclined to accept your or my dictates. But don't forget that your public is not that of the United States. Your public consists of the relatively small circle of friends and associates with whom you entertain close contact. When you meet me I am your present public. At that moment you are subject to my scrutiny and my judgment. On meeting me you try to avoid creating a poor impression, and initiate a vigorous attempt to gain my approval for what you say or do. For the moment I am your public opinion. The question is whether I, as the present representative of public opinion, am pledged to a rigid enforcement of the conditional standard. If I am you will make every effort to conform with that standard, not only in words and acts, but also in implications. The calamity is that my method of enforcing the conditional standard may be lax. Then you may, for instance, tell me how yesterday you lose your temper with your wife and conclude your account with the casual statement, "It's too bad that I have to act that way. But I can't help it. I am a hard-working man, and when I come home from the shop I think I am entitled to an hour's rest." When you told me your story and added the concluding question I should have replied in the negative. You were not right. Indeed, you were very wrong. What happened was that, on arriving home, you found two neighbor women chatting with your wife. You were tired and in a mood to screech out on the sofa and were prevented from doing so by the presence of the neighbors. After they left you made a scene and precipitated a violent argument. Whether you are right or wrong is an irrelevant question. Even if you were right in claiming an hour's rest you were utterly wrong in permitting yourself to lose your temper. This is what I ought to have told you. If I had done so you would have been rebuked for your rude behavior. Public opinion, as represented by me, would have condemned your bullying tendency. Had I been a true defender of or contender for the conditional standard I would not even have dignified you by an explicit rebuff. I would have simply stated, "Whether you are right or wrong is immaterial. Temper is a matter of breeding, not of right and wrong." If you were possessed of even a modicum of finesse, the implied refutation would not have escaped you.

Recovery, Inc. Could Create Its Own Public Opinion

It is my sad duty to admit that I am a poor representative of public opinion. Under the present circumstances, I cannot get myself to express or indicate my disapproval of people who fail to control their tempers because they think they have a right to release them. Most likely my failure to rebuff domestic bullies is due to my fear of offending too many of my friends. However, I am determined to change tactics in my dealing with your relatives of our patients. I think it is about time to create within our group the type of public opinion that will set its face solidly against bullying and domineering no matter how skillful its disguise. It seems to me we should not hesitate to cultivate in our midst an attitude that will condemn all varieties of domestic cruelty and at the same time be the support and comfort of the weak and the wrong.

Recovery, Inc. could create its own public opinion. It is a temptation to use the bullies themselves as agents of change. But it is much wiser to use the patients themselves, who are already on the road to recovery. The first step is to create a group of patients who are determined to change the views and standards of the general population. The second step is to create a group of patients who are determined to change the views and standards of the general population.
of domestic cruelty with uncompromising severity. Then we will be the first group of numerical importance that will do away with that lethal blight of human relations: the dual conditional standard which prohibits rudeness outside the family circle and sanctions or at least tolerates it inside the home. We, the members of the Recovery, Inc. group, have pioneered in so many ways. Why not pioneer in matters of domestic adjustment? Why should we not try to create our own brand of public opinion? The average person cannot withstand the pressure of public opinion within the group to which he belongs. Of course, there are the hobos and Bohemians. They seem to do as they please and fail to conform to a set standard. But then, they do not belong to a settled group. The average man and woman belong to a well-ordered group and depend on its public opinion, provided it is enforced. When years ago public opinion could not be enlisted for the support of the Volstead Act the latter was unenforceable; at the same time, the Harrison narcotic law was successfully enforced because it had the endorsement of public opinion. Let public opinion be unequivocally opposed to the divorce evil and it will be reduced to its unavoidable minimum. Let it set its face unqualifiedly against criminal tendencies and crime will be relegated to the outer fringe of society instead of permeating it close to its core.

**Argumentative Temper Is Common Among Relatives of Patients**

I quoted the example of the husband who returned home and fumed because dinner was not ready. I added the story of the man who went into a rage because his wife had the "effrontery" to chat with neighbors at an inopportune time. Obviously, the two temperamental persons had hardly any excuse for exploding. You may now contrast the reactions of these gentlemen with the behavior of our prototype of a domestic temper—Edna.

Edna was subtle. She did not explode. She did not raise her voice to the pitch of yelling, nor did she bang doors or pound her fist on the table. As I said, Edna was civilized, and her method of matrimonial domination made use of approved means. Her chief weapons were: argument and criticism. Compare her behavior with that of the two explosive men, and you will realize that they used vocal and verbal violence while Edna used vocal and verbal strategy. The two men tried to outshout their wives, Edna made an effort to convince her husband that she was right and he was wrong, that she knew how to do things and he did not.

I know that some of you relatives of patients are given to violent explosions. However, it is merely your voice and your vocabulary that explode. I have yet to hear of the husband, father or mother of a returned patient who exploded to the point of using muscular violence in their temper outbursts. Most of you, it seems to me, are of the Edna type. You scorn brutality and make use of strategy—the strategy of the argument. Be this as it may, my estimate is that the violent temper is practically nonexistent, the explosive temper relatively rare, and the argumentative temper quite common among the relatives of our patients.

**Edna’s Argumentative Temper Led to “Temperamental Deadlock”**

Edna had an argumentative temper which grated on George’s sensitive ears. She made a show of superiority whenever an opportunity offered. She was, of course, a consummate "back seat driver" and reprimanded George for driving too slowly or too fast, for passing a light or not passing it in time. More irritating was her invertebrate habit of correcting George when he made an innocent statement. He might be reading the paper and venture a comment on some news item. Instantly she interrupted him with the exclamation, "How can you say that? That’s the way you always talk. Can’t you ever use your brain?" In such verbal scrimmages it was the subtle use of the words "always" and "ever" that conveyed the hidden implication of a wholesale condemnation of George’s intellectual capacity. George was just a child and "always" wrong; Edna had a mature mind and was "ever" right. She was most agonizing when she criticized and corrected him in the presence of visitors. He offered an opinion and was rebuked by her shrill outcry, "But honey, that is not so. I don’t understand how it is her nature." But occasionally, especially when the argument developed in the privacy of the home, he could not contain himself and flung back a sharp answer. Then Edna let loose and poured forth an endless stream of criticisms and accusations. A major contest was on and disturbed domestic peace in an ugly torrent of recriminations and countercharges.

You may be inclined to dismiss my account of Edna’s and George’s squabbles as just so many trivialities. But then, don’t forget that we are engaged in a discussion of average everyday adjustment. And keep in mind that everyday adjustment means adjustment to trivialities. Domestic life, at any rate, consists of hardly anything but trivial occurrences. Whenever you find irreparable rifts and unabridged dissension among close relatives be certain they took their inception, in nine cases out of ten, from just those trivial irritations which I described as the source of Edna’s and George’s daily struggle. Remember what I told you weeks ago: “What taxes the adjustive capacity of the average individual are the more or less continuous, repetitious and habitual irritations of common everyday life. Calamities and disasters are hardly ever habitual; small irritations frequently are.” (page 40) (this reference to page 40 refers to Lecture 3, The “Conditional” Standard of Behavior, Low, 1967, pp. 36-46, which is not included in the excerpts chosen for my doctoral dissertation—jbh) Edna’s tendency to criticize, correct
A "Healthy Balance" Is Established If the "Intellectual Appraisal" Predominates Over the "Emotional Expectation"

To experience an event is to interpret its meaning. This is certainly true of consciously experienced events. Suppose a drop of rain falls on my cheek. I shall then interpret its meaning as being rain and not snow, as being the result of a drizzle and not of a cloudburst. If my interpretation is not carried any further the event stands analyzed by a process of intellectual appraisal. However, I may be inclined to add another interpretive step. I may surmise that the rain is likely to bring relief from a suffocating heat wave. Then I interpret the event as welcome and desirable. To the intellectual appraisal has now been added the emotional expectation.

The conditional standard demands that, in interpreting the meaning of a neutral event the intellectual appraisal takes the lead over the emotional expectation. Intellect and emotion are, then, in a state of "healthy balance." The balance is disturbed if in a neutral situation emotion is permitted to take the lead. We then speak of an "emotional imbalance." It told you that, after the development of the "temperamental deadlock," Edna expected George to be stubborn and anticipated opposition and refusals. Emotional expectation took the lead over intellectual appraisal in interpreting the meaning of neutral events, the condition of "emotional imbalance."
events which were then habitually experienced as irritating. The result was that hostile impulses were aroused and hostile acts released almost uninterruptedly.

A Healthy Balance of Experience Is Largely Dependent on Public Opinion

It ought to be clear now that adjustment depends on the manner in which events are experienced that is, interpreted. Interpretation will be correct if intellect and emotion are in a state of "healthy balance." This sounds simple enough. However, a "healthy balance" can be obtained only through persistent cultivation. What must be cultivated is the predominance, in neutral events, of intellectual appraisal over emotional expectation. A person who succeeds in cultivating this predominance establishes cultural methods of experiencing and interpreting events. It will now be easy for you to grasp a distinction which I made in a previous lecture when I called Edna merely civilized but not cultured. Culture refers to balancing of experiences, civilization to muscular control of impulses. Edna controlled her impulses but failed to balance her experiences. After the development of the "temperamental deadlock" she even had difficulty controlling her impulses.

The maintenance of balanced experiences depends to a large extent on the influence of public opinion. The precise nature of this interdependence will be discussed in subsequent lectures. For the present I merely mention that contemporary public opinion does little to discourage the "temperamental tangle" or to encourage the "healthy balance" in the management of domestic relations.

The indictment of present day public opinion is by no means a fortuitous utterance in the context of Lecture 5. On the contrary, it is a constituent part of Recovery, Inc. teaching. The public at large considers temper the legitimate offspring of "human nature" and thus declares it as unalterable and inaccessible to education as "nature itself." Recovery, Inc. rejects with vigor the claim to unalterability and brands uncontrolled temper as the illegitimate offspring of a public opinion oblivious to its duties and responsibilities. The vicious doctrine of the "irresistible impulse" the validity of which is under grave suspicion even in forensic cases, is part and parcel of the concept of temper as "natural" inheritance. To Recovery, Inc. heredity is no brief for an unrestrained laissez-faire attitude, and "nature" no carte blanche for domestic cruelty. Both patients and relatives are made to realize that the "nature" which they inherited is subject to the influence of training and self-discipline. In emphasizing the necessity for self-discipline the author does not intend to assume the function of a moralist or uplift crusader but to perform the plain duty of the physician whose pursuit is to cure effects by removing their causes. And many relapses have their undoubted cause in uncontrolled domestic temper. And many tempers can be traced back to the unfortunate doctrine of the "irresistible impulse." And the doctrine of irresistibility is sanctioned by a public opinion which is irresponsibly tolerant of temperamental misconduct.
Suppose you speak of a certain couple and state, “They have been marrying twenty years.” You will instantly stop short and add apologetically, “I beg your pardon; what I meant to say was that they have been married twenty years.” In this instance you made a mistake and immediately noticed the slip. How is it you made the discovery so quickly? Do you keep an incessant watch over your speech performance? Are you so self-conscious and introspective that you are continually on guard against errors?

**Insight Is Acquired Through Perpetual Self-Scrutiny**

You may be a reasonably relaxed person and fairly free from the habit of morbid introspection; however, there is no doubt that, unbeknown to yourself, you are forever on the alert lest your reactions of speech, thought, and action fall short of accepted standards. If, for some reason, you exclaim inadvertently, “I am positively I am right,” not a second will pass before you will be painfully aware of the mistake which you made when you used the adverb “positively” in place of the adjective “positive.” The correction will follow automatically. Why do you hasten to correct the misstatement? The person who listened to you knew what you intended to express. The meaning of your sentence was clear even if your grammar was faulty. Why, then, the correction? The answer is: the average individual has a passion for being right and for avoiding being wrong.

The fact that people have the capacity for instant correction of errors and slips proves that they are continually watching their performances. This process of perpetual self-scrutiny and self-inspection makes it possible for them to gain and maintain insight into the propriety, adequacy, and pertinency of their acts of behavior.

When you made the mistake about a couple “marrying” twenty years you offended against the standard of logic; when you used “positively” instead of “positive” your mistake was one of grammar. An individual with average intelligence and average school knowledge masters these standards to such an extent that he hardly ever violates them. If violation occurs correction follows instantaneously. Insight or, as we may now say, the knowledge of having made a mistake, works here with an almost 100 percent exactness.15

**Insight Gives Knowledge of Having Offended Against a Standard**

I told you repeatedly that when the recovered patient returns home he is likely to suffer from the misbehavior of his relatives. I also told you that misbehavior of the kind that is likely to confront him is due to the common disregard for the rules of the so-called “conditional standard.” In one of my lectures I said that the conditional standard “refers to behavior which while ordinarily not regulated by standards may, ‘under certain conditions,’ become subject to regulation.” I added the following examples: “When at home I am permitted to dress or undress as I choose. But ‘conditions’ change when I leave the home. Then I must be dressed. Similarly at home I may smoke; at a concert I must not. At home I may whistle, sing, hum, and yawn but when interviewed by my prospective employer the whistling, singing, humming, and yawning would inevitably be interpreted as improper conduct.” (See page 37) (this reference to page 37 refers to Lecture 3. The “Conditional” Standard of Behavior, Low, 1967, pp. 36-46, which is not included in the excerpts chosen for my doctoral dissertation—jhb) At present I wish to resume the discussion of the conditional standard from the viewpoint of insight, i.e., the knowledge of having offended against a standard.

If you walk on the street it is immaterial whether you move close to or at a distance from the curb. There is no standard which regulates this portion of your street behavior. However, if you are in the company of a lady “conditions” change, and the “conditional standard” directs you to take your place between the curb and the lady. The rule has become so deeply grooved in your consciousness that you hardly ever fail to take your “correct” position. The conditional standard works here almost as automatically as do the standards of grammar and logic when you choose your words in a common conversation or your arguments in an ordinary discussion. Should it happen that, for some reason, you find yourself in the wrong position you will instantly step to the other side and perhaps apologize to your companion. Insight into your mistake will operate with promptness.

Let us now assume that the lady in question is not a stranger or friend but your wife. Will you now also immediately act on your insight if your position is contrary to the requirements of the standard? Will you then also hasten to change your position after discovering the mistake? I gave you the answer to this question when I discussed the behavior of the “problem

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15 Only that variety of insight is here considered which comes into operation after a mistake was made. Essentially, this is what is commonly called “hind-sight.” The other variety of insight which goes by the name of “foresight” is here not discussed.
adult" who is meticulous in his observance of the conditional standard in outside contacts but utterly remiss in his domestic conduct.

The "Problem Adult" Chooses Not to Exercise Insight at Home

The "problem adult" hardly ever bangs doors in the home of friends but may do that habitually in his own. When invited he is eager to converse with his table partner, but at home he frequently maintains a stony silence toward his wife. Moreover, should he accidentally slam a door in the home of his friend or feel indisposed to carry on a conversation at his hostess' table he would instantly realize (or have insight into) the unseemliness of his conduct and offer an apology. Do you think his insight is keener abroad than at home? Is it logic to assume that one and the same person has excellent insight in one locality and almost none in another? This would be an absurd supposition, and the only possible conclusion is that the problem adult has good insight into his missteps both outside and inside the home but makes use of it in one of the spheres only. In his outside contacts he chooses to exercise his insight; in his domestic contacts he chooses not to exercise it.

If a husband has currently the poor taste to read the paper while he is sitting with his wife at the table his insight into the impropriety of the act is beyond reasonable doubt. He knows that his behavior is discourteous and excuses himself on the score of having the right to practice the discourtesy because the pressure of work leaves him no other time for reading the news. And, after all, a man must keep himself informed! You will instantly recall my statement that, in conflict-torn individuals, the "sense of being wrong" leads to the "claim to be right." (See page 78) (This reference to page 78 refers to Lecture 3, The "Wrong-Fearing" Temperament, Low, 1967, pp. 73-85, which is not included in the excerpts chosen for my doctoral dissertation—jbh) That the claim is a flimsy excuse rather than a valid explanation is plain from the fact that, on numerous occasions, the "overworked" husband prefers to spend his precious time on a dime novel instead of on table conversation although the dime novel is hardly likely to quench his thirst for information. Obviously, that husband chooses to be discourteous. His misbehavior is not due to a lack of insight but to a failure or even refusal to practice it.

Premium of Pleasure Blocks Insight Into Temperamental Misconduct

You have heard the remark that the temper of a given person is inborn and ingrained, that it is as unchangeable as are the proverbial leopard's spots. The husband who bangs doors or reads at supper time does so from temperamental leanings. Is it true that the inclination to make noise or to maintain an icy silence is as unchangeable as the leopard's spots? Of course, if a man thinks he has the right to indulge his inclinations the sense of being right adds relish to the reaction and places the premium of pleasure on it. And if a man secures from an act the pleasurable feeling of being right he will refuse to abandon it and choose to continue. But for the premium of pleasure that rests on temperamental behavior a change of temper would be as easy as a change in clothing. The obvious inference is that in order to make men control their tempers they must be made to realize that the claim to be right is no justification for the will to be rude.

After you finish dressing or eating you do not protest that you had a right to dress or eat. Under ordinary circumstances the propriety and justification of the act is not contested by any person or standard. You are not called upon to offer apologies or excuses for innocent behavior of this kind. Should, however, a person after consuming a meal, exclaim, "Don't you think I had a right to eat?" you would instantly know that the eater himself thought the propriety of his act might be challenged and had to be justified. Mark it: whenever a person insists on being right he either was or felt he was challenged. Or, whenever anybody insists on being right it is obvious he thought he was or might have been wrong. If you are convinced of the innocence of your behavior you do not apologize for it; you may draw the conclusion that the emphasis on one's being right indicates a sense of being wrong. In other words: whenever you claim to be right you display insight into being or thinking of being wrong. Self justification is a sequel either to self accusation or to the fear of outside challenge. If it will be well for you relatives of former patients to realize that your persistent claims to be right are a clear indication of your perpetual sense of being wrong.

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14This formation about the claim to be right pointing to a sense of being wrong applies, of course, to trivial, everyday grievances only. It may also but does not have to hold in disputes about realistic rights, privileges, and possessions.
Edna's Insight Into Being Wrong Was Blocked by Determination to "Stand on Her Rights"

After the "temperamental deadlock" developed between Edna and George home life was a bedlam of squabbles and recriminations. The question of right and wrong was uppermost in the minds of both marital contestants. When one of them asked a harmless question the partner might retort temperamentally, "Why do you ask me that?" and provoke the tart counter question, "Haven't I a right to ask questions any more?" Domestic peace was gone, and resentment and bitterness took its place. In due time, both Edna and George became obsessed with the idea that they had to "stand on their rights" and must not permit "the other side" to neglect or infringe on them. Edna's motto was, "I'll force him to do his part." And with this program in mind she set out on a systematic campaign to make demands just in order to show George that he "can't get away with it." She had always done her shopping without assistance from her husband. Now she currently discovered that she had no time to visit the downtown stores and frequently telephoned George to do an errand or two for her after leaving his office. Gradually, the telephone requests became routine. To the shopping assignments were added other commissions. "Honey, couldn't you drop in at Elsa's on the way home and pick up a package she has for me?" As the demands increased George suspected a scheme and balked. He first offered excuses for not complying; finally, he bluntly refused. Edna was furious. Didn't she have a right to get cooperation? Her demands became more numerous and more insistent and George's refusals more abrupt and outspoken. The battle for rights raged along the entire length of the marital front. Differences of opinion and taste were no longer adjusted amicably but fought over ferociously.

Both Edna and George were what you would unhesitatingly call "nice people." Both subscribed to the standard of clean living and fair dealing; both had the capacity for kind feeling and sympathetic understanding. Nor were they grossly deficient in common sense and judgment. When Edna evolved her newly devised program of not "letting George get away with it" she had a clear understanding that the principle meant spite and vindictiveness and was likely to undermine domestic peace. There was no doubt in her mind that this "fight to the finish" might easily lead to the "finish." What she did was done with full insight into the undesirable and reprehensible nature of her conduct. But when the idea assailed her that her procedure might wreck her home she discarded it with the consideration that it would be wrong to let George "walk over her." You see, her insight into being wrong was sideswiped by her determination to "stand on her rights."

This is the crux of domestic discord in practically all its manifestations: one partner bullies the other and has the unobscured insight that bullying is indefensible. But the insight is without effect because it is swept aside by the self-deception that the bullying is done "by right." Do you see the involved tragedy? Humans are so constituted that they relish a "fight for rights." If they manage to convince themselves that their fight is one for "rights" the prospects are they will be reluctant to cease fighting and will choose to continue. The result will be the "temperamental deadlock."

Domestic Fights Center Around Imaginary Issue of Being Right

There are occasions—rare in civilized groups—when men fight for objective realities. There are occasions when they are really and objectively assaulted and insulted. There are other occasions when vicious, scheming, unscrupulous persons attempt to gain an unfair advantage over them. Occasions of this kind call for fight. But that fight is, as a rule, fought coolly, deliberately, with slow moves and well-calculated measures. The impulsive outburst, the rise of temper, and sudden attack are, as a rule foreign to such realistic struggles. When parents conduct their temperamental domestic warfare against their sons, husbands against their wives, brothers against their sisters the fight is for something that has no reality except in the mind and imagination of the fighter. That something is the imaginary "sense of being right." I wish you would grasp this fundamental distinction: fights for realities are rare in the daily round of average life, and the fights encountered in domestic discord are almost invariably centered around the imaginary issue of "being right."

If a mother cooks a meal she does so because there is an objective need for feeding the members of the household. Incidentally, she may also like to cook. If so, she may cook even if there is no pressing need for a meal, just for the pleasure of exercising the fond function. The cooking is then done from a subjective feeling rather than an objective need. Presumably, every act has this double motivation. If, as a physician, I treat a patient, I satisfy an objective need for practicing my profession but also a subjective feeling of doing something worth accomplishing. The feeling which I speak of may be either painful or pleasurable. For the present, I shall consider those situations only in which action is accompanied by a sense of pleasure exclusively or predominantly.

Temperamental Behavior Feeds on Two Pleasurable Subjective Feelings

In temperamental behavior, there can hardly be an objective need for the tantrum. Here, everything is subjective feeling. In releasing a temper outburst, you give off steam and experience the pleasurable sense of relief. After you have given free rein to your temper the clear insight into the rashness and rudeness of your action prompts you to hunt for an excuse and to rationalize your conduct on the grounds of your being right. To the pleasure of having gained relief from tension is added...
the further pleasure of “being right.” In this manner, each temperamental act feeds on two pleasurable subjective feelings. How can you ever expect to give up a habit voluntarily if it attracts you with the almost irresistible lure of one pleasure topping the other?

I told you that Edna and George were what you would call “nice people." If you scan the list of your friends you will observe that most persons with an explosive temper belong to the class of “nice people." This seems to be a contradiction. What you expect of “nice people” is precisely that they keep a vigilant eye on their behavior and correct it whenever their insight tells them that their action offends against a standard. The temperamental person, I said, has insight into the inexcusable nature of his explosions. If he belongs to the class of “nice people,” why does the insight fail to curb his temper? The answer ought to be plain: the man with a temper has insight into the ugliness of his conduct but the double pleasure of securing relief from tension and adding the sense of “being right” blocks his customary intention to be “nice.” The double premium of pleasure placed on temper behavior prevents insight from asserting itself. Indeed, the temperamental person is vitally interested in silencing the voice of insight. Should he heed it, it would deprive him of the coveted relief from tension and of the stimulating sense of being right. Temperament is the enemy of insight. In order to blot it out it invents the excuse of “being right.” Again I remind you of my statement that the “sense of being wrong” leads to the “claim to be right.” I shall now add that the insight into being wrong calls imperatively for the claim to be right.

_Business Is Governed by Impersonal Rights, Family Relations by Personal Sentiments_

“Rights” is a term borrowed from the business field of competition and domination and ought to have no place in the home which is the domain of service and cooperation. It would be absurd to say that a baby is given the bottle because it is “by right” entitled to it. All the mother has in mind while feeding the baby is its needs for the milk, or her own needs for tending her offspring. Whether the food is merited, deserved, or earned is, of course, not considered. If the tot cries through the night the parents, although deprived of their comfort, do not think of questioning the baby’s right to cause the disturbance. The same holds true of other relationships between parents and children. A father provides for needs and comforts, not because the children have vested rights but because of affection, interest, love, pride, and other sentiments which have nothing or little to do with consideration of rights.

In business, “rights” reign supreme. A laborer receives just as much compensation for his work as he has a right to demand. Business transactions are, as a rule, drawn up in the form of contracts. If one of the contracting parties fails to live up to his obligations he forfeits his contractual rights. In the family no rights are forfeited because of default. If a wayward son absconds with the father’s money, in nine cases out of ten he is certain of indulgence and forgiveness. Business activities are governed by impersonal rights, family relations by highly personal sentiments.

However, it is well known that enlightened self-interest taught business men to use tact and courtesy in dealing with employees. Moreover, if a clerk is discharged, the average employer has full insight into the fact that hardship is inflicted and misery created. He is not likely to obscure or block the insight by insisting that he is right and the employee wrong. He does not moralize or rationalize but advances the realistic reason that business necessities call for economy and retrenchment.

_Mother’s Determination to Be Right Causes Relapse of Recovered Daughter_

Agnes, a girl of 22, recovered and was sent home. During the last weeks of hospital residence she had enjoyed the ordinary privileges of a recovering patient. She was permitted to take walks on the hospital grounds and to go on the street without supervision. When Agnes arrived in the parents’ home the mother lost no time taking matters in hand and superintending every step of her daughter. The “darling” had to take it easy, to get her proper rest, and to leave everything to the care of the solicitous mother. When the patient protested that she felt relaxed and had not the slightest trace of fatigue the mother countered with the subtle remark, “Are we going to have these arguments again? You ought to know by now that it was the arguments that broke your health.” The daughter meekly suggested, “I didn’t have arguments in the hospital,” whereupon the mother terminated the discussion by the peremptory statement, “I guess I can’t help it if you don’t listen. But you’ll have to blame yourself if something happens again.” All protests were in vain and Agnes had to lie on the couch, provoked, outraged, and—not at all resting.

In the afternoon the patient wished to telephone a friend. The mother objected. “Take your time. What’s the rush? Why are you so restless?” The minutest details of daily routine were blocked and interfered with as if the mother dealt with a baby that “got into everything.” When Agnes spent more time in the bathroom than the mother thought necessary there was a knock at the door and an anxious inquiry, “Don’t you feel well, dear?” At meal times the injunctions, warnings, and prohibitions followed one another with rapid fire speed. “Why don’t you start? ... You better take this tender piece, this one potato is enough; you better take more cauliflower . . .” After three days of continuous harangue of this kind the daughter began to assert herself. The mother’s insistence provoked resentment; resentment turned into spite. Finally the very voice of the mother was a source of irritation. The atmosphere was charged with mutual
antagonism. In the evening of the eighth day the mother insisted again on the daughter's taking a rest. There was a sudden flare-up and violent argument. Agnes felt a choking sensation, became frantic with rage and flung herself at the mother ready to strike her. The father pulled the two apart but was unable to control the hysterical outburst. The daughter went on railing, sobbing, and yelling. In the end it was decided to return her to the hospital. When the mother gave to the physician her account of the events preceding the readmission she punctuated her narrative with the ever-recurring inquiry, "Don't you think I was right?... Wasn't that the right thing to do?... Wouldn't it have been wrong on my part to let her do as she pleased?" Again, the sense of being wrong leading to the incessant claim to be right. And at the end of the path to righteousness lies the helpless victim that recovered her mental health only to have it sacrificed to the mother's determination to be right.

**Insight Is Dimmest If Domination Hides Behind Disguise of Service**

Agnes' mother also belonged in the class of "nice people." She was a conscientious mother, a loyal wife, a generous friend. The tragedy was that she "stood on her rights," and was ready to defend them though it might mean a fight to the finish. Even after the daughter had plunged back into the darkness of mental derangement the question uppermost in the mother's mind was whether or not she had acted right. Instead of adjusting to the daughter's objective needs for a modicum of privacy and self-management she acted on her own subjective urge to enforce maternal supervision. On the face of it she was anxious and concerned about Agnes' welfare and seemed actuated by a spirit of service. In one of my next lectures I shall dwell at length on this deadly bane of domestic life domination disguised in the cloak of service. For the present, I shall give you in conclusion the following distinction, from the viewpoint of insight, between the three different patterns of domination which I described. First, there was the employer who discharged a worker. He exercised domination with good insight into the oppressive nature of his act. The insight was unobscured by pretense or excuse. Second, the husband who ignored or tyrannized over his wife. He had adequate insight into the objectionable and domineering quality of his behavior but the insight was clouded and blocked by his claim to be right. Third, Agnes' mother who harassed her daughter to the point of distraction. Her domineering attitude was so thoroughly overlaid with a deceptive appearance of service that insight, if at all operative, was at its dimmest. The dimming was successfully effected by the cloak of service that was spread over the acts of domination. It will be easy for you relatives to realize that this type of behavior which uses service as disguise for domination is the most dangerous for the peace and health of the returned patient.

It is hardly necessary to add a comment to Lecture 7. The theme is in direct succession to the topic discussed in the preceding chapters and integrates well with the total pattern. In the following chapters the subjects of temper control and will training will be resumed in their various implications with the theme merely continued and the pattern preserved. Comments will be added only when called for by special considerations.
Emotions Are Either Elemental or Incidental

Some emotions arise spontaneously without anything in the environment apparently being responsible for their emergence. For some unknown reason a person is suddenly thrown into a fit of moroseness or sadness; another person, for equally unknown reasons, suddenly experiences a wave of joy and well being. No explanation can be given for the unexpected shift in feelings. The thing simply happens and cannot be accounted for on the basis of present circumstances or preceding events. Emotions of this kind assail and overwhelm the individual with the abruptness of a change in the elements (cloudburst, snowstorm). They may therefore be called elemental emotions. On the other hand, there are emotions which are directly traceable to external events. A familiar example is the reaction of the inexperienced mother who witnesses a tantrum thrown by her little son. There is a sudden stoppage of breathing—an innocent breath-holding spell. No special manipulation is required to terminate the youngster’s antics. If left to himself the spell will spend itself and normal breathing will be quickly resumed; or, a few drops of cold water will revive respiration with the promptness of magic. But to the mother it looks like dreadful danger and impending disaster. Her frightened screams make the neighbor hurry to the scene who, more experienced, restores the child’s breathing with a jet of cold water. After that, the mother who had been mortally alarmed but a few seconds ago instantly dismisses the fear and is overjoyed with happiness. In an instance of this sort, one environmental event, the breath-holding of the child, produced fear, and another environmental event, the restoration of breathing, caused the fear to change to joy. The rise and fall of the emotions was here incidental to happenings in the environment and the reactions were, therefore, due to incidental emotions. That incidental emotions can hardly be unchangeable may safely be assumed. If a gunman points a loaded pistol at my head, the danger is realistic and my emotion called-for and justified by the gravity of the incident. However, if a man is afraid of riding in an elevator there is no realistic danger in the incident and the resulting emotion is unjustified and uncalled-for. The ride is merely thought to be dangerous and the elevator merely stands for or symbolizes the idea of danger. What the man fears is a symbolic rather than realistic danger.

Realistic Dangers Are Frequently Ignored

The average man is surprisingly indifferent to realistic dangers. Otherwise, how is it possible that men are ready to risk their lives daily and hourly for the sheer pleasure of racing their automobiles? In a city of moderate size death and crippledom threaten at every corner but hardly anybody troubles to take the necessary precaution. Think of the astounding equanimity with which the average person engages in hazardous occupations and in daring sports activities, and you will readily agree that realistic dangers are generally ignored or even flouted.

There are realistic dangers which are inevitably attended by violent fears. But even their frightening effect is soon neutralized by that miraculous capacity of the average human being which we call adjustment. If a child is seriously ill the mother is certainly alarmed, perhaps to the point of distraction. However, if the child dies it usually takes a few months before the parents are either sensibly resigned to the misfortune or comforted by the prospect of having or adopting another child. I could remind you of the well-known instances of disaster which we all witnessed during the early stages of the economic depression which burst upon us in 1929. Millions of persons went bankrupt and lost their positions and life savings, but most of them rearranged their affairs and were soon prepared to face the wreckage with sober resignation. You may draw the
APPENDIX (Continued)

Conclusion that realistic dangers are either generally ignored or easily adjusted to. You may draw the further inference that dangers which defy ready adjustment and give rise to sustained or chronic fears are suspect of being symbolic in nature.

I have frequently spoken to the adverse effect which the fear of being wrong exercises on domestic life. This fear is undoubtedly sustained and chronic, lasting a lifetime with most individuals. It defies adjustment with stubborn tenacity, and few are those who have learned to face it with composure and fewer yet those who know how to ignore it. This alone is sufficient to mark it off as the fear of a symbolic danger. It will now be my task to explain to you what precisely is meant by the terms "symbol" and "symbolic danger."

Realism Deals With Objective Measurement, Symbolism With Subjective Feelings

A woman dies. The physician, weary after a strenuous night's vigil, departs, leaving the afflicted husband and children to their grief and sorrow. Gradually, a group of sympathetic friends and neighbors foregather in the dimly lit room and are soon joined by relatives summoned from more distant sections. Finally, the clergyman arrives, and in the end the undertaker puts in his sombre appearance. To all of them the deceased woman meant or symbolized something. She was a wife, mother, sister, aunt, friend, neighbor, patient and parishioner. Even to the undertaker, for all his official imperturbability, she most likely meant or stood for or symbolized suffering mankind.

Then comes stark realism: the death certificate must be made out and signed by the attending physician. This document lists the dead body as belonging to one Jane Jones, 58 years of age, 5 feet 7 inches tall, having been a resident of Chicago, Cook County. It records, with cool and impersonal indifference, that the deceased had been ill from September 11 October 27, 1939 and that she expired at 8:34 A.M. in consequence of a myocardial degeneration, etc., etc.

The certificate spoke of height and age, of the time of death and the duration of the disease. It added a few remarks of a geographical nature (address and place of residence) and finally seated the name of the illness which terminated life. All of it was impersonal, unfelt and mathematical. Certainly, the fact that the patient measured several feet and inches, had lived a certain number of years and resided in a certain locality is no index to what the deceased meant or stood for or symbolized to the mourners. To them she symbolized motherhood and wifehood, humanity and friendship, loyalty and kindness. The children adored her, the husband loved her, the more distant relatives, friends and neighbors valued her qualities and treasured the memories of common joys and sufferings. You see the difference; realism deals with what can be objectively measured, symbolism with what must be personally felt.15

Symbolism, Emotions and Self-Valuation Are Closely Interrelated

To an adult person, an apple will hardly ever stand for or symbolize a personal feeling. Instead, it will be objectively measured as to whether it is red or yellow, sweet or sour, ripe or green, big or small, expensive or cheap. To a child, on the other hand, an apple may symbolize something that arouses keen personal feelings. For some reason he tries to take hold of it but discovers painfully that he is unable to reach it. He struggles, climbs laboriously on the chair, tugs at the tablecloth and if finally successful in grabbing it utters a triumphant yell. To secure the apple is to him a symbol of strength and success. On the other hand, if he fails in his effort there will be a wail or cry of disappointment. He will resent his inability to obtain the desired object and sense it as a symbol of weakness and failure. The success aroused in him the emotions of joy, happiness and delight, the failure those of anger, grief and resentment. In either case, the event was not merely objectively described and measured but subjectively valued. The boy was proud of his attainment or unhappy over the lack of it. His success enhanced the value of his ego, his failure reduced that value. Both gave rise to his primitive code of self-evaluation. You see here the intimate interrelation between emotion, symbol and valuation.

It has been said that the child discovers the symbolism of his self-value at an early stage of his development. This is supposed to happen when one day, in a moment of immature self-observation, he is struck by the face that when he wants to move his arm he can do so "at will." At this moment, the theory continues, he becomes aware of his ability and power, in other words, his self-value. Enjoying the movement which discloses his power he repeats the act and, overwhelmed with the exhilarating evidence of his self-value, keeps repeating the performance in endless sequences. Be this as it may, the fact is that children are fond of repeating their performances in uncounted series. Moreover, at a later age, they frequently accompany their repetitious manipulations with the self-confident comment, "Look what I do." At this stage it is a common observation that when a child is handed a cookie he may reply, "Put it back. I want to take it myself." Obviously, the child cherishes and values his power of self-management and self-direction.

15Impersonal symbols like mathematical signs, trade emblems, road markers, etc., are here neglected as having no bearing on personal adjustment.
Gradually the infantile table of valuation grows and extends its ever increasing score of symbolisms. As the months and years pass the child is no longer content with managing and directing his own self; he aspires to the direction of others. He sees an object on the table and could easily fetch it but delights in asking daddy to get it for him. Mother asks him to put on his shoes but he suggests, "You put them on for me." The maid prepares to dress him as she always does. But the youngster wants to be dressed by daddy. He rejoices in ordering his parents about, insists on being lifted and swung and otherwise played with. He makes the mother tell him stories and read to him, all of it in a peremptory, dictatorial manner. If he has already reached the state of mastery of language he reels off question after question, some of them revealing a genuine curiosity and interest, most of them, however, undoubtedly intended to make others speak and return answers. The others must do what he wants them to do. He manages and directs their activities. The valuatinal symbolism for primitive leadership has been created and leadership is conceived by the tot as meaning reckless use of power.

On goes the process of development. New symbols are formed and the childish table of valuation enlarged. After the child has learned to rejoice in the delights of self-management and leadership he is currently thwarted in the exercise of both values. He is just busy playing with his toys when mother calls him to the bathroom. He ignores the call and continues toying with his blocks. Mother calls again, and he still pays no attention. Finally he is briskly grabbed by the arm and dragged away from his favorite activity. The experience is decidedly one that he does not cherish or value. His primitive temper is aroused; he resents the interference, revolts against mother’s effort to manage him and offers opposition and resistance. Mother may be reasonably strict but frequently she weakens and gives in. Then the child experiences the thrill of triumph. In the course of time he has numerous occasions to enjoy the delight of forcing his will on the others, of resisting them, of denying their requests. The symbols of conquest, of victory and triumph are formed. The child has now created the valuational symbolism of primitive domination.

The Child as Enemy of the "Conditional Standard"

After the child develops domination as the leading feature of his primitive table of valuation his mind is increasingly focused on antagonism, opposition and resistance. His main aim is now to score victories and to subdue others. People and things assume a symbolic meaning. Heretofore, mother was a person with realistic functions; she gave help when he was in distress, provided entertainments when he desired them, put him to sleep when he was tired and fed him when he was hungry. Now she is reduced to the status of an empty figure in a strange world in which the son hunts for symbolic values. In this weird world of his the chief values attach to the symbol of victory. A prospective victor must have somebody to vanquish, to humble, to provoke and to irritate. Mother is assigned this role of the punching bag and whipping boy. As such she plays the symbolic part of a victim and the boy that of a victor. Symbolism becomes now the keynote of existence. Potatoes are no longer realistic food; they are merely a welcome opportunity to refuse to eat them. Mother will then humble herself and implore him to take "a tiny spoonful at least" and he will revel in the sight of a helpless victim of his domination. Before long he notices that when he is recalcitrant and resistive father and mother beg him to be nice and to act like a good boy. In some vague form he senses the distinction between good people and bad people and dimly realizes that objectionable manners are the surest means of antagonizing the parents and of scoring victories over them. He now embarks on a systematic campaign to initiate a naughty course of behavior. Mother cautions him not to climb on the window sill, and he does it with gusto. She wants him to be clean "like a good boy"; so he contrives to soil his clothes whenever he has an opportunity. He has perhaps not heard the words "standard of behavior" but knows how to offend it with uncanny mastery. His conduct degenerates into a riot against the standard of good manners. As his rebellious course continues he becomes a sworn enemy of everything regulated by the so-called "conditional standard."

Infantile Conflicts Result in Disguise of Domination Behind Pretense of Service

Occasionally the meek mother refuses to do his bidding. Then he resorts to screaming, whining and nagging. He soon notices that such conduct is particularly likely to antagonize and provoke mother. The screaming, whining and nagging are now practiced routinely. Somewhere he picks up a word of profanity. Mother is horrified and pleads with him not to use it. Henceforth he rejoices in repeating the few expletives he happens to know. In due course he develops a talent for choosing that type of behavior that is certain to scandalize the parents. Their horror is then skillfully utilized to make them yield to his wishes. You say he has an ugly temper, but essentially he is nothing but a radical devotee of his childhood philosophy which drives him to accumulate an imposing record of symbolic victories over helpless victims. It is this philosophy that impels him to develop an unruly temper and to adopt the manners of a ruthless bully.
At six he enters school. There he tries his bullying manner with the other children but is severely handled. In repeated encounters of this kind he learns that temperamental behavior is badly misplaced in the new environment. Forced by dire necessity he mends his ways. He practices a pleasing deportment and gradually acquires the habits of courtesy and consideration. A cooperative spirit is substituted for the bullying propensity. In his contact with outsiders his behavior becomes impeccable and carefully adjusted to the requirements of the conditional standard. But this change takes place on the outside only. At home he still indulges his craving for ruthless domination. However, his approach is modified. He has been exposed to the mellowing influence of religious education, has imbibed the philosophy of service and cooperation taught him by his teachers and has passed through the school of self-discipline and teamwork imposed on him by group games with classmates. He acquires a socially oriented table of valuation and its effect carries over into the home atmosphere. When he now loses his temper and releases a tantrum he is oppressed by a sense of shame and has a distressing insight into the obnoxiousness of his misbehavior. His present group values of service and his pristine infantile values of domination clash and throw him into a violent inner conflict. That conflict must be solved and the solution is found in a gradually maturing system of disguising domination behind the pretense of service.

Misbehavior Is Excused on the Flimsy Pretense of Duty and Obligation

His mother is busy tending the baby and requests him to make some purchases at the nearby grocery store. In his pre-school years he was in the habit of offering undisguised refusal on such occasions. Or, he might pretend not to hear even if the request was repeated several times. Or, he stalled and called back, “I have to go to the bathroom” and then spent endless time on the toilet seat doing nothing more urgent than playing with the faucet or tearing up the paper. This was ill-concealed obstruction and well-nigh frank disobedience. Such candid display of antagonism would now shock his new set of values and throw him into the throes of torturing compunctions. This must be avoided. He must devise a scheme which will permit him to give his domination the appearance of service. According to his new set of values it is his duty to obey mother. But there are other duties, for instance, the duty to do his homework. If the two duties cannot be performed at the same time one of them must be neglected in favor of the other. And so he adopts an ingenious method of blocking, repelling and resisting the parents’ wishes and pleas on the excuse that other duties and obligations have a prior call. He claims to be busy with home work if asked to do an errand, to have to prepare a report for the next Boy Scouts’ meeting when approached with some other request. The procedure permits him to be discourteous and uncooperative without causing a stir in his tender conscience.

The new formula works. It conceals conveniently his domineering temper behind the smoke screen of a dutiful disposition. He can now be impatient, demanding, and even abusive and charge it all to necessity, obligation and moral command. After arising he dawdles in the bathroom and when reprimanded for delaying the older sister’s morning toilet he counters with the snappy reply, “I have to be clean at school, haven’t I?” He shares his room with a younger brother and manages to disturb his activities or his sleep with some “must” or “have to” or “can I help it if . . . ?” Shortly after the brother has fallen asleep he reminds himself that he forgot to finish some chapter of required reading. He then jumps out of bed with studied noise, turns on all the lights and floods the room with a blazing brightness. His rummaging among books and papers is designedly loud, his steps on the floor unnecessarily heavy and his incessant pulling of drawers and moving of chairs annoyingly disturbing. When the brother remonstrates the reply is, “Can I help it if the teacher gives me too much work?” His ancient craving for scoring symbolic victories and beholding symbolic victims can now be easily satisfied on the flimsy pretense of a “must” or “have to.”

The new method of screening temperamental rudeness behind the pretense of moral compulsion is at first limited to the defense of his own wrongdoing; gradually, however, its field of application is extended to include savage attacks on the wrongfulness of others. He misses his fountain pen and turns with righteous fury against mother, “Can’t you be more careful? Must you always muss up my desk?” In the morning, he does not find the school book. This gives him the desired opportunity to let loose. “Where is my American History?” he keeps yelling through the house. “I had it on my dresser. Didn’t I tell you to leave my things alone? Can’t I ever have order in my room?” He is critical, argumentative and insulting, always basing his assaults on pious consideration for duty and responsibility.

The one thing that is in the way of his fully enjoying his new strategy is his normal capacity for introspection. As is the habit with the average individual, he scrutinizes the value of his actions and finds them wanting. In spite of his moral alibis he cannot avoid the realization that his conduct is rude. The fact that his mother suffers and that the peace of the home is disturbed by his pugnaciousness is so glaring that he cannot possibly ignore it. For all his bravado he is unable to escape a burning sense of guilt. The problem of right and wrong becomes an acute issue. He solves it in the manner which I outlined when I discussed the subject of conflict and insight. The sense of being wrong leads him to the incessant claim to be right. His incessant claims to be right give him a new impetus to initiate fights and to enjoy the sight of victims.

Introspection and Insight Disturb Workings of New Strategy
At 25 he marries and acts the role of the "problem adult." However, his wife is not his mother and what the latter condoned the former is determined not to tolerate. Gradually the marital situation degenerates into what I described as the "deadlock." In the end he is a failure from the viewpoint of adjustment. What wrecked his adjustive career was the system of disguising domination behind the cloak of service. In one of my forthcoming lectures I shall endeavor to show you that the best means of forestalling this adjustment-wrecking system is to cultivate insight to the point of making it impossible for individuals to practice this monstrous device of self-deception. But in order to dispel self-deception efficiently the current misconception that temper is unchangeable must be exploded. Keep in mind that the emotions which form the basis of temper are not elemental but incidental. Keep also in mind that temperamental persons fight for infantile symbols rather than adult realities. Incidental emotions can be controlled and infantile symbols can be shed by means of proper insight. The precise method of how this can be effected I shall attempt to demonstrate in the near future.
LECTURE 9 (Low, 1967, pp. 113-124)
SYMBOLS AND THEIR INTERPRETATIONS

In my last few lectures I described the manner in which temper arises from symbolisms developed in childhood. I demonstrated that children form infantile symbols of triumph and victory which provide the background for future temperamental dispositions. The object of the subsequent lectures is to continue with the analysis of temper in order to teach you how to dispose of infantile symbolisms for the purpose of paving the way for adult realistic conduct.

Objects and Actions Have Both Realistic and Symbolic Meanings

Every object which you possess, every act that you perform, every sentence that you speak has both a realistic and symbolic meaning. When you buy a coat you think that you are guided by realistic considerations for durability, monetary value and protection against rain and cold. No doubt you are. But a good part of your money is unquestionably spent with an eye to your social status. Color, style and pattern are so chosen that they represent or symbolize your relative importance in your social group. Or, you own a house and it serves the realistic function of a shelter, but it may also represent or symbolize such unrealistic qualities as community opinion, personal dignity and family tradition. To quote another example: your automobile is, realistically enough, a means of transportation. But will you deny that it also symbolizes your financial capacity? Morever, if you race along the road, you may actually pursue the realistic purpose of saving time. But you will admit that frequently you speed and pass other vehicles and beat the street car to the corner without being hard pressed for time. Is it realistic and sensible to risk your life for the pleasure of overtaking another driver, or for the glory of competing with street cars? Let me tell you that what secures pleasure in such instances is something purely symbolic: when you pass a driver you score a symbolic victory over another person; you enter into symbolic competition with the street car when you shoot ahead of it and you conquer—symbolically space and time when you can pile up a record of say—two hundred miles in three or four hours. These examples will demonstrate that even the most common objects and acts have a considerable symbolic content side by side with their realistic meaning.

If the pattern and style of your coat fittingly symbolize your social importance you like them and may even be proud of them. You certainly adore your home if you feel it represents symbolically beauty, dignity and family tradition. And that you may grow enthusiastic over the superior performance of your car is clearly evidenced by the fact that you are ready to boast of its “marvelous pickup” at the least provocation. You see, if an object of your possession symbolizes power of any kind you enjoy it, feel proud of it, speak of it in enthusiastic terms and boast of its excellence. What I am driving at here is that symbols evoke sentiments.

I spoke of symbols residing in objects and mentioned coats, houses and automobiles as symbolizing power. I could have selected any arbitrary assortment of things and events, and it would have been easy to prove that all of them have both a realistic and symbolic component. The cigar which you smoke has the realistic function of providing stimulation but also the symbolic connotation that it is relatively expensive and that you can afford the price. You may refrain from using a less expensive brand for the sole reason that it might not be the fitting symbol for your social status. Your tie and your gloves, your brief-case and wrist watch belong in the same category. They have a symbolic representation side by side with their realistic function and you like them and may even be proud of them as expressing symbolically your social or economic power.

A Mother Is Not Judged by Realistic Criteria

The most important symbols are those representing persons. Here is a woman, 48 years of age, five feet eight inches tall, her hair grayish, her eyes blue, her walk steady but cautious. I could add a description of the color and texture of her skin, of the shape of her nose, of the regularity or irregularity of her features, of the proportional size of trunk and limbs, and what I would furnish would be a factual account of her realistic appearance. But if I know that the woman is your mother my description is trite, banal and meaningless. You simply do not judge your mother by realistic criteria. Let her have a hunchback, and her symbolic value to you will not diminish one iota. Let her waste away and shrivel to ugly proportions; she will still be adored and loved by you as the symbol of motherhood, devotion, kindness and self-effacement. Even after death wipes out her realistic existence altogether she is still your cherished symbol of motherhood which you worship in loving remembrance.

What I said of the mother applies with equal or similar force to wife, daughter, son, father, indeed, to all persons who are close to you, either as relatives and friends, or as colleagues, partners and classmates. The closer they stand to your heart the stronger counts their symbolic value, the less significant is their realistic existence.
APPENDIX (Continued)

The Physical "Self" Is Symbolically Distinct From the Social "Self"

Nobody is perhaps inclined to think of himself in terms of symbolism. On the contrary, everybody seems to pride himself on being a realist. Yet, what is called the "self," is little more than an aggregate of symbols. However, the term "self" admits an ambiguity of interpretations, and in order to avoid confusion it will be advisable to define in as simple words as possible what precisely is meant by it.

In the morning, when you arise you throw your robe around your "self," then you shave and wash your "self." Judging from your smile and whistle, it is fair to assume that while performing these successive acts you enjoy your "self." After you finish washing and shaving you give your "self," the benefit of a refreshing shower. Finally, you terminate the morning toilet and remove your "self" to the dining room. There you treat your "self" to fruit, eggs, ham, toast, and coffee. Suddenly you throw a glance at the clock and notice to your dismay that today you will again be late at the office. The occurrence that you can't get your "self" to be on time for your work and your inability to discipline your "self," sufficiently to cease dawdling has always been a "self" humiliating experience to you. You know that nobody is to blame but your "self." Indeed, you are mortified by the fact that you do not have your "self" under sufficient control. In the past you made repeated efforts to overcome this handicap which was anything but a credit to your "self" but no matter how often you told your "self" that things had to change, you seemed to lack sufficient "self" mastery to remedy the situation. In the end, you decided that all you could do was to resign your "self" to the unfortunate situation and to let things take their course.

It will not be difficult for you to realize that the "self" which is washed, shaved, and removed to the dining room and there treated to a meal is significantly distinct from the "self" which is blamed for or credited with some act and finally feels humiliated and becomes resigned to the handicap of a situation. The one is the physical, the other the social "self." Using less familiar but more correct terms, one might call the one the physiological, the other the sociological "self." However, for reasons of simplicity. I shall use the words "physical" and "social."

Slurs to Social "Self" Arouse Tempers

The average adult person is hardly ever sufficiently naive or inane to take credit for the number or size of the eggs which he is capable of consuming; nor is he likely to boast of the artistry of wielding the razor or dressing a sandwich. These manipulations may disclose skill and dexterity but they do not represent or symbolize the value of the "self." At best they could only be symbolic of the accomplishments of the physical "self," and adult individuals are not in the habit of exalting the status of their physical "selves." What they are fond of emphasizing is the excellence of their social "self." This they conceive of, paradoxically enough, as representing or symbolizing their individual worth. In the average person's mind the physical "self" represents nothing but realistic functions while the social "self" is thought of as the jealously guarded repository of qualities which are the symbolic expressions of his personal value.

You may value and cherish the symbolism represented by your coat, automobile, and house. These values will hardly be challenged by anybody. The occasions will be rare when your coat will be insulted, your car slighted or your house ridiculed. And if you love your mother, wife, and daughter, hardly anybody will ever stand in the way of your tender sentiments for these exalted symbols of your inner life. But if you develop the symbolisms of your important, weighty and prominent social "self" the occasions for real or imagined slurs, piques and affronts will be innumerable. A contemptuous shrug on the part of the man you speak to, a quizzical raise of the eyebrow in the countenance of your neighbor with whom you chat, a critical intonation in the question asked by your employer, friend, wife or brother will be felt, on a thousand occasions, as a severe challenge to value of your social self, as an indictment of your moral, esthetic or intellectual integrity. A challenge of this kind is almost certain to cue you to the quick and to provoke your temper. You see here again the close interrelation between symbolism, self-valuation and temper.

The Symbolic Meaning of Social Contacts Is Subject to Interpretation

If two men meet at a party they establish both physical and social contacts. Obviously, the physical contact of sitting face to face or side by side is of no significance under the circumstances. What counts is their social contact. That contact is effected through speech and action. The two may chat, or the one man may offer a cigaret to the other, or both may raise their glasses and drink to one another's health. Whatever they do has the symbolic meaning of being officially polite or sincerely amicable or shrewdly calculating or may be representative of any number of symbolic attitudes. Suppose the one man is an elderly leader of the community, the other a young man who has not yet made his mark, either socially or economically. Then the older man's toast to the health of his younger companion may mean or represent or symbolize a desire to be condescending, and to display a democratic sense of benevolence. If the younger man, encouraged by his partner's friendly demeanor, deems the occasion propitious for clumsy familiarity his behavior may be conceived of as meaning or
symbolizing boldness or insolence. In either case, the symbolic meaning of the acts and words are subject to interpretation, correct or incorrect. The point I wish to emphasize here is that symbols must always be interpreted.

Temper is usually the result of misinterpretation of symbols. Your son, improved but not yet recovered, has just returned from the hospital for a brief week-end visit. After his arrival, you address the innocent question to him, "Why don't you take off your coat and make yourself comfortable?" This plain sentence which, in the main, spoke of such realistic subjects as a coat to be removed and of comfort to be secured, offers a wealth of opportunities for symbolic misinterpretations. Perhaps your remark was meant as a casual suggestion without any significant implication. But to your son, fresh from an environment where everything was strictly regulated and systematized, your statement may symbolize a tendency to superintend his activities, or an urge to criticize his ways, or concern about his state of health. Indeed, it may be taken to represent your fear that he is not visibly improved and still in need of solicitous care. If so, the likelihood is that your plain inquiry will be misinterpreted as unwarranted intrusion or intimation, and your son's temper will be aroused.

When George neglected conversation at the table Edna experienced the silence as a slur against her "self." In like manner, when Edna proposed a visit to the theater George experienced the approach as an imposition on his "self." In either case, what was felt as a disregard or imposed on was not the physical but the social "self." Clearly, to both of them, their social "selves" represented or symbolized something that was extremely delicate, easily agitated and readily wounded. The "self" of the average, common individual expects in its daily contacts nothing but an average, common measure of deference and consideration. If the average person is denied a request he takes it for granted, as a rule, that the denial was based on some lack of consideration and growled back acidly, "Didn't you see the pile of correspondence on my desk?

Of course your son is still sick and easily irritated. But what is at fault is his manner of misinterpreting the symbolic meaning of your approach. When you asked, "Why don't you take off your coat?" the question meant or symbolized to you an expression of legitimate fatherly interest; but to your son it meant or symbolized an intention to "boss" him. Your interpretation of your own intention differed from that of your son's. If a stranger had witnessed the scene he would have shared your opinion and disapproved of your son's misinterpretation. That stranger would have represented the views of the "common man" who gives things their "common interpretation" and acts on "common sense." His final verdict would have been that your interpretation was based on realistic common sense while your son's misinterpretation was the result of special personal sensibilities. Mark that temper is a misinterpretation of the symbolic meaning of behavior, based on special personal sensibilities. Such sensibilities go by the name of idiosyncrasies.

When Edna advanced the routine suggestion to go to a show he was likely to misinterpret her approach as lack of consideration and growled back acidly, "Didn't you see the pile of correspondence on my desk? It wouldn't do you any harm to consider my work once in a while. Must you always think of your pleasure?" Common sense was no longer used and the realistic needs for innocent entertainments or for occasional silence grated on special sensibilities; they were disposed to be oversensitive and personal and frequently resented Edna's inquiries and requests summarily as attempts to impose on him. When Edna advanced the routine suggestion to go to a show he was likely to misinterpret her approach as lack of consideration and growled back acidly, "Didn't you see the pile of correspondence on my desk? It wouldn't do you any harm to consider my work once in a while. Must you always think of your pleasure?" Common sense was no longer used and the realistic needs for innocent entertainments or for occasional silence grated on special sensibilities; they were misinterpreted as meaning or symbolizing a vicious attempt to interfere with the partner's comfort or to intrude on his or her legitimate pursuits. Domestic peace was wrecked through misinterpretation of common realistic wishes and needs as symbolizing personal and special impositions and animosities.

The Inflated "Self" Experiences Refusals or Denials as Insults and Rebuffs

When George neglected conversation at the table Edna experienced the silence as a slur against her "self." In like manner, when Edna proposed a visit to the theater George experienced the approach as an imposition on his "self." In either case, what was felt as a slurred or imposed on was not the physical but the social "self." Clearly, to both of them, their social "selves" represented or symbolized something that was extremely delicate, easily agitated and readily wounded. The "self" of the average, common individual expects in its daily contacts nothing but an average, common measure of deference and consideration. If the average person is denied a request he takes it for granted, as a rule, that the denial was based on some...
realistic inability or some justified indisposition, dictated by fatigue, lack of time or a well-reasoned dislike of the proposal. The denial does not symbolize to him a personal insult. His “self” is not sufficiently inflated to experience every refusal as affront and every grant as homage to his importance. But suppose you deal with your superior. He does not represent a common person; he symbolizes an exceptional, special individual. If he makes a request it is a business suggestion, hence, something in the nature of a command; if his request is refused the denial is justly experienced as rebellion against his authority. You see, if you are confronted with an important, exceptional and special person you are no longer permitted to use common procedure; instead, you will be wise to show special attention and special consideration. The important person symbolizes a “self” with special sensibilities which are extremely delicate, easily agitated and readily wounded. Requests are experienced as orders, denials as rebuffs.

In the situation of the temperamental deadlock the partners develop the conception of their “selves” as superior, important and brooking no resistance. Edna and George thought of their “selves” as average and common when they were with strangers or friends. But when dealing with one another they experienced their “selves” as specially privileged. To Edna, her own “self,” appeared as something superior, entitled to special consideration, and George’s “self” as inferior, is duty bound to display deferential behavior and not to balk at her wishes and commands. Since George entertained the same notion about the importance of his own and the insignificance of Edna’s “self” there was no common ground for friendly understanding and genial compromise. Marital adjustment ran aground on the reef of special demands and special refusals. Domestic peace was wrecked by the elaboration of a system of symbols which assigned special privileges to the one “self,” and denied them to the other.

*Mature Knowledge, Combined With Persistent Practice, Conquers Temper*

Recently one of our friends, a diligent visitor of our meetings, made the following comment: “I agree with everything you say; indeed, I know from personal experience that you are right. Moreover, when I listen to your lectures and read in *Lost and Found* your description of Edna and George, I cannot help feeling that you must have repeatedly witnessed the temper outbursts that pass between my wife and me. But doctor, are your explanations going to help me and my wife? I know that we are in a temperamental deadlock and that my impatience and sarcasm are utterly unjust and unreasonable. But no matter how intently I listen to your explanations, I am unable to control my temper. I know I am wrong but that knowledge does not seem to help me.”

The author of this comment is a man of fifty with a record of more than twenty years of conjugal temper, according to his own frank avowal. His attendance at Recovery, Inc. meetings dates back six months and his acquaintance with *Lost and Found* is of equally recent origin. Presumably, he began practicing temper control a few months ago and has already discovered that “knowledge does not seem to help him.” Obviously, our friend expected quick results to follow hastily acquired knowledge. This seems to be a common misunderstanding among our followers. They apparently entertain the belief that all that is needed to conquer temper is some knowledge—and by no means an excess of it—about its working mechanism.

In reply to this assumption I can merely repeat what I once said to you that “temper and dispositions can be changed provided the one displaying them (1) acquires insight and realizes the need for a change of manner, (2) is inspired with the determination to effect the necessary change.” (See page 51) I grant that our friend has acquired insight or knowledge, but I doubt whether he is inspired with the requisite determination to practice till the change in temper occurs. You, the relatives of our patients, must keep in mind that what we physicians are able to furnish is knowledge of the problems involved in the subject of domestic temper. The thing that you are required to supply is the determination to practice until control is accomplished. If after a few brief trials you decide that knowledge does not seem to help you, you limited yourself to the one part of our program (the acquisition of insight) but neglected to carry out the other part (the persistent practice based on the newly achieved insight). I am ready to grant our friendly critic one important concession. Thus far I merely endeavored to analyze the ravages inflicted by temper on domestic peace. I also urged you to practice what I tried to teach you. But to date I have not yet made the effort to suggest to you an effective method of practicing temper control. Be certain that relatively detailed instructions on this score will be forthcoming in the future.

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*Lost and Found* was a bimonthly magazine published by the Recovery Association. It was discontinued in 1941.
LECTURE 12 (Low, 1967, pp. 151-161)  
CULTIVATION AND REPUDIATION OF TEMPER

In my last lecture I discussed the temper outburst of the man whose corn was stepped on by another person in a crowded street car. We concluded that his temper was aroused by the fact that an innocent accident was misinterpreted as a deliberate offense. We further stated that the misinterpretation was not shared by the other passengers, including the wife of the temperamental hothead. They gave the correct interpretation to the meaning of the event and took the objective attitude that the incident was due to a chance happening rather than to an aggressive intention. On the other hand, the unfortunate victim of the collision failed to be objective and approached the occurrence with the subjective disposition to take revenge and to punish an offender.

In Trivial Mishaps the Onlooker Is Objective While the Sufferer Is Subjective

No doubt you often witnessed similar scenes in which toes were hurt and tempers exploded. The spectacle is always the same; the injured person acts on his subjective disposition while the onlookers take the objective attitude. Our sufferer—we shall call him Joe—was frequently an onlooker himself and as such invariably retained his objectivity. There was never a doubt in his mind on such occasions that the suffering inflicted on others was accidental. The thought of an offense did not occur to him and he always marveled at the temperamental agitation which people are likely to display when a "sore spot" of theirs was touched by a sheer accident. Other men's experiences he viewed objectively, his own subjectively.

Had any of the onlookers been in Joe's place be certain they would have acted Joe's part. Their objectivity would have wilted, their subjectivity would have soared to the heights of temperamental violence. You see, it is "human nature" to be calm and objective in the case of a trivial mishap which involves your fellow and to become emotional and subjective if the same trivial mishap affects your own "self." The other man's "self" is viewed objectively and rationally, your own "self" subjectively and irrationally.

Everybody Is a Dual Personality With a Dual Viewpoint

You do not have to wait for a shakeup in a street car in order to observe the dual character of "human nature." In the peaceful precinct of your own privacy you can make similar observations; if your daughter or maid breaks a dish you become enraged at their carelessness; if the breakage happens to you it is an accident which is instantly dismissed from your mind without comment. Your guest's late arrival is inexcusable and "just an outrage," while your own failure to be on time is unfortunate and unavoidable. If your fence is damaged by the neighbor's little son you burn with indignation at the atrocious manner in which "some people bring up their children." If the damage is done by your own boy to the neighbor's fence you excuse the act on the grounds that "Charlie is just a child and doesn't know what he is doing." In the case of an offense committed by another person, your subjective predisposition is always ready to condemn; in your case, your objective attitude is ready to condone. You are—and everybody seems to be—a dual personality with a dual viewpoint. At times you advance the subjective viewpoint and become emotional and temperamental; at other times the objective viewpoint is favored and emotion and temper are controlled. "It all depends on the way you look on things," and your temper will have free rein if you cultivate the subjective way of looking at things while it will be kept in reasonable control if the objective view of things is given the right of way.

The Average Person Is Unaware of Approving and Endorsing Temper

Your viewpoint is a set of habits and as such subject to the process of nursing, tending and cultivating which I described in a previous lecture. (See page 149) You remember I told you that a habit is cultivated by the approval and endorsement which it receives in anticipation, immediate effect and after effect. But you will immediately protest that your temper outbursts come upon you unheralded and unexpected. They are, you think, the response to a provocation which, as a rule, was not foreseen. And as to the approval and endorsement which you are supposed to confer on your temper you will enter a most strenuous denial. Why, you certainly do not brag about your fits nor do you boast of your rages. As far as you are concerned you are wholly unaware of your approving or endorsing.

The Temperamental Street Car Rider

In reply to your protest I shall remind you of a recent experience when the street car conductor "had the nerve" to challenge the validity of your transfer ticket. You insisted on continuing the trip without paying another fare and staged a violent argument. This was a temper outburst. But was it anticipated? There was undoubtedly the immediate effect of fury
and indignation. You do not deny that. And after you finally yielded and paid the additional fare you were certainly aflame with resentment over the “unheard-of outrage.” This was the after-effect, and you do not deny that either. But why speak of approval and endorsement? There was no time to think, judge or reflect. The thing overpowered you; you were thrown into a fit of anger and “could not help” exploding; it all happened spontaneously, was neither staged deliberately nor anticipated, approved or endorsed. What actually took place was an occurrence that is common enough. In the interim between transferring from one car to the other you entered the dime store to buy a toy for your child. The aisles were packed with people and you had to “worm” your way slowly to the counter. The salesgirl was busy and kept you waiting. In the end, you had spent fully twenty minutes on the purchase. On the way out you met a neighbor and “couldn’t just run out on her.” So you had a friendly chat and, in the process, rounded out a full half hour’s waiting time. You will remember that while hurrying back to the corner you worried about the conductor’s reaction. You feared to be challenged and armed yourself hastily with suitable excuses and explanations. Do you realize that you anticipated a fight and were primed for an explosion?

Mark that in this instance you knew you were wrong and the conductor was right. You knew that you had exceeded the allotted time and had forfeited the use of the ticket. You simply permitted yourself to commit one of those petty frauds which are thoroughly reprehensible and deplorable but somehow sanctioned by widespread usage. But in spite of the fact that you knew you were wrong you worked yourself up to a feverish pitch, assailed the conductor with heat and indignation and fought a ferocious battle for your rights, presumably for your “sacred rights.” Do you now understand that when you defended your rights you endorsed your emotion and approved of your temper? The mere fact that you insisted on being right gave approval to your procedure. You endorsed your own viewpoint and condemned that of the conductor.

**Endorsement and Approval Pervade Every Phase of Temperamental Reaction**

When you finally decided to pay the additional fare and took your seat inside the car you were still ablaze with excitement. A burning desire for revenge raged within you. You were going to write a letter to the company “the very first thing” you arrived home. And you were not going to mince words, either. You fairly reveled in the thought of “getting even” with that impossible conductor. And, in this stage of the after-effect, you not only endorsed and approved of your temper but anticipated another temperamental delight when you thought of the letter you were going to dispatch.

You see, endorsement and approval pervade and penetrate every phase of your temperamental reaction and give their distinctive coloring to anticipation, immediate effect and after-effect. In giving their sanction they nurse, tend and cultivate your temperamental disposition until, through unceasing cultivation, it hardens into a set predisposition which becomes firmly entrenched in your innermost organization.

If temper is cultivated and perpetuated by continuous endorsement it is obvious that in order to eliminate temper a way must be found to eliminate endorsement. What you endorse in a temperamental act of behavior is its justification, reasonableness and propriety. In your altercation with the street car conductor you endorsed and justified your expected bout during the stage of anticipation when you prepared your excuses and explanation. To explain means to justify, to excuse means to endorse. Your endorsement became vehement and impetuous when, during the stage of the immediate effect, you insisted with fervor that you were right and the conductor wrong. Endorsement almost climaxxed into a passion for righteousness when, during the after-effect, you fairly burst with indignation at the outrage of which you fancied yourself the innocent victim.

**Treating Temper Means Treating After-Effect**

Clearly, in order to check your temperamental disposition you will have to eliminate endorsement and justification. But it would be futile to concentrate your corrective effort on the immediate effect. During that stage your blood boils, your pulse hammers, and reasoning and reflection are all but wiped out. Every effort at control is here wasted. The stage of anticipation is similarly unfavorable for the practice of control. In our example with the street car conductor, anticipation was conscious, plain and palpable and might perhaps have lent itself to successful treatment. But ordinarily, anticipation is a subtle process, largely hidden from conscious perception and not easily analyzed. The only stage which offers itself as suitable occasion for the practice of control is the after-effect. If this is correct the problem of treating temper resolves itself into the question of how to deal with the after-effect.

**At Home Norma Nursed, Tended and Cultivated Temperamental Disposition**

You remember my description of the dual reaction of Norma, the salesgirl. (See page 125) When Norma was behind the counter she controlled her temper with consummate skill, but at home that same temper was released with the utmost lack of self discipline. With customers she practiced the objective attitude, with her mother she displayed the subjective disposition. The dual reaction appears baffling and mysterious but is easily explained on the basis of a dual treatment of the
after-effect. One day, on coming home in the evening, Norma found that the dress which she was eager to wear at a dinner engagement that night had not yet arrived from the cleaner. She turned on her mother with violent accusations, fumed and raged and made the home a scene of madness. After a while she left and took a bus to the place where she was to meet her boy friend Charles. During the ride she had ample time to go over in her mind every detail of the commotion she had caused at home. The picture of the mother crying and sobbing was before her. She could not forget the frightened and pleading look in the old lady’s eyes, her haggard features and the sad expression of helplessness and resignation. And Norma fell into a pensive mood. For the flier of a moment she sensed the unnecessary rudeness of her behavior and winced under the impact of a guilty conscience. But in another instant she shook off doubt and self-criticism and the softness which for a few seconds had stolen over her face gave way to a look of set determination. And forthwith, during the entire length of the bus trip, she indulged in an orgy of justification, approval and endorsement. True, she caused her mother a great deal of suffering, worry and sleeplessness. Perhaps she could be more lenient and less irritable. But good heavens, there was plenty of irritation with the customers at the store, and a girl coming home after a strenuous day cannot help being nervous and a mother ought to know that. After taking all the abuse from insulting customers was she not entitled to some consideration at home? And contributing a good part of her salary to the family budget had she no right to demand some service? That was nothing but fair exchange and if mother, in her old fashioned ways, didn’t grasp that simple fact, well, there will be more spats and more arguments and mother will have nobody to blame but herself. You see, during the stage of the after-effect Norma gave full endorsement and approval to her temper outburst when she mused that “if mother didn’t... well there will be more spats and more arguments and mother will have nobody to blame but herself.” She anticipated already renewed temper outbursts and gave them endorsement and approval in advance. And while thus piling endorsement and approval on renewed anticipation she nursed and tended and cultivated her temper and perpetuated her subjective predisposition.

At the Store Norma Repudiated and Condemned Temperamental Reactions

At times—even very rare occasions—Norma lost her temper with a customer. One instance stood out with particular force in her memory. A lady asked to be shown handbags. Norma was polite and sweet but her patience was put to an almost unbearable test. The woman, a shriveled spinster of notoriously mean disposition, was rude in the extreme and expressed her dissatisfaction in such insulting remarks as “I don’t see why you show me nothing but trash. Have they no experienced girls in this store? Why, a girl of your age ought to have better taste than that....” Finally, Norma could not contain herself and retorted, “You don’t have to buy, Madam, if you don’t like the bag.” Whereupon the acid remark, “I don’t need your advice, young lady, and it wouldn’t do you any harm to acquire better manners.” The atmosphere was tense, the lady growing more insulting, Norma more impatient. Finally, there was biting reference to “poor breeding,” “lack of common sense” and “girls without proper upbringing.” The last insinuation finally unnerved Norma who snapped back, “You don’t have to buy but I don’t have to stand for your insults.” The lady rushed to the floorman, registered a complaint against that “most unmannered person” and Norma was called before the manager and duly censured. All during that afternoon her cheeks burned with shame and rage and her body shook with indignation. In intervals between serving customers she had time to reflect on the incident. Oh, she could just kill that nasty hag. But, of course, it was a customer, and the manager was right in reprimanding her for the rash reply. Alas, a salesgirl had to know how to take it. And next time, be sure, she was going to be courteous no matter how ugly and sarcastic and insulting the customer may be. You see, in her role of a salesgirl, Norma did not give approval and endorsement to her explosions, and the after-effect was not utilized for the purpose of justifying the propriety and reasonableness of outbursts. Instead of endorsing her temperamental habits and viewpoints she repudiated and condemned them. She did that both in the after-effect and in the anticipation of the next occasion when a similar contingency should arise.

Endorsement of After-Effect Anticipates Renewed Outburst

The two illustrations which I offered ought to demonstrate clearly that it is during the stage of the after-effect that temper can be either cultivated or inhibited. If during that stage you endorse your preceding explosion your predisposition for other explosions is strengthened. The sense of “having been right” clothes your temper in a halo of righteousness and places a premium on the next outburst. Without being clearly aware of it you are already primed for the forthcoming opportunity when you might again experience that exhilarating feeling of “being right” or “having been right.” The endorsement of the after-effect and the subsequent anticipation of a renewed outburst combine to cultivate the temperamental habit and to make it well nigh ineradicable. On the other hand, if temper is repudiated in the after-effect there will be no anticipation of the next explosion except in horror—and cultivation of the habit will be avoided.

I have told you repeatedly that temper is practically no problem in social contacts. It hardly ever happens that you “forget yourself” when you are invited on the outside or when you have guests at home; nor do you ever dare “forget yourself” with your superiors or with important people anywhere. Of course, what the term “important” precisely means to you is difficult to state. But be certain that if keeping on good terms with the neighbors looms as an “important” task in your
mind your temper will not be permitted free explosions against them. And if your employees are more than mere "hired men"; if the quality and continuity of their service count as "important" items in the list of your business assets, you will never or seldom "forget yourself" in dealing with them. If this is true, what is needed for conquering temper is not to "forget" the "importance" of situations. Why, then, did I offer such complex rules for temper control as withholding approval and endorsement during and after the various states of the explosions? Would it not be a far simpler procedure to call to your mind the "importance" of domestic peace and to urge you not to "forget yourself" in the presence of wife, husband, father, mother, son and daughter?

The Returned Patient Must Be Protected From Continued Eruptions and Explosions

I do not have to tell you that domestic peace ought to occupy a most "important" place in the mind of every member of the family. However, the fact is that its "importance" is generally ignored or overlooked. You know the reason: if you "forget yourself" on the outside you incur the danger of ostracism and social isolation, while at home your forgetfulness carries no penalty. Present day public opinion sees to it that you exercise the utmost vigilance in your public and semi-public relations but is indifferent to your family relations. If public opinion insisted on your being as much on your guard with the members of your family as you are with strangers and friends domestic temper would no longer be the grave issue that it is today. You would simply refrain from staging temperamental scenes. None but the simplest rules would be sufficient to check your wild outbursts. You would merely have to keep in mind that not only customers, office clerks, union laborers and neighbors but also the members of your own family "are always right" in those trivialities which customarily arouse temper. If this rule were backed by the force of determined public opinion your home would be as perennially peaceful as are the average office, grocery store and bakery shop. But this would include the entire round of your daily activities and your temper would have no sphere left upon which to play. You would be an angel, freed of the last remnant of your "human nature." I am not sufficiently naive and visionary to anticipate the very possibility of such ideal circumstances and take it for granted that "human nature being what it is" you will continue exploding and "forgetting yourself" at home in spite of all the golden rules which I may be able to devise for you. Knowing the obstinacy and conservatism of "human nature" I do not for a moment think of asking you to eliminate your temperamental disposition. All I ask you is not to nurse, tend and cultivate it until it hardens into an inveterate predisposition. This you can do by withholding approval and endorsement during the stage of the temperamental after-effect. If you do that, the recovered patient, after leaving the hospital, will return to a home which, while not free from temperamental outbursts, will not be continually rocked by fierce eruptions and violent explosions.
When Margaret displayed a domineering disposition was she driven by emotion or guided by thought? If the answer be, as it should be, that both emotion and thought had their proportional share, the question arises: was the thought the preponderant influence or was emotion?

**Emotional Imbalance Versus Intellectual Instability**

Recently it has been the custom to explain behavior and misbehavior alike on the basis of emotion mainly or exclusively. Thought, reflection and intellectual processes in general are reduced to a secondary and rather evanescent role. Read, for instance, the average popular book on crime. The emphasis is almost exclusively on emotional conflicts as the primary cause of delinquency. You are told that the criminal is some sort of human machine that is driven on toward the anti-social career by a powerful wave of hatred, hostility and aggression. The wave is traced back by skillful interpretation to its feeble beginnings in early infancy when it was nothing but a trickle of immature antagonisms. The picture is that of lurid resentments lodging mysteriously in the tender organism of the child, fattening on environmental frustrations, gradually crowding to the surface and finally gaining expression in the criminal act. After reading this account you cannot help gaining the impression that the infantile resentments and grudges were never as much as touched by ideas, thoughts, teachings and principles.

The doctrine of the preponderance of emotion over intellect seems to pervade every province of modern thought. Juvenile problem behavior, adult “nervousness,” marital maladjustment and perhaps every variety of normal and abnormal conduct are credited these days to what is called “emotional instability,” “emotional imbalance” or “emotional conflicts.”

The general run of parents, teachers and preachers do not seem to share the view that human conduct is primarily dominated by emotion. In their effort to influence behavior they still use the intellectual methods of imparting thoughts, concepts, principles and standards to those they wish to educate and elevate. Who holds the correct view? Those who educate children in actual practice? Or those who write about them in theory?

**Emotion Drives Man, Intellect Guides Him**

In a familiar simile, emotion is likened to the fuel which furnishes the driving power of the automobile while intellect is portrayed as playing the role of the man at the steering wheel. The comparison is by no means apt but may serve the purpose of a rough illustration. Without fuel the car would not move; without proper steering it would lose direction and miss its goal. What is more important? Motion and speed, or goal and direction? Thus phrased, the question is beside the point. If you are a contestant in an automobile race, goal and direction are important but power and speed alone will win the race. Conversely, if without being particularly hurried, you wish to reach a certain destination, speed and power will avail you little if you take the wrong direction and miss the goal. In other words, what is more important in a given enterprise fuel or steering, emotion or intellect—depends entirely or largely on the purpose which drives or guides you. Emotion drives, intellect guides. Is it true that human behavior, normal or abnormal, is mainly the result of blind, irrational drives with guidance, goal and direction relegated to a rather insignificant, secondary role?

It is difficult to speak of emotion with anything approaching authority. The laws governing the operations of intellect are fairly well known, thanks to the discoveries made by students of logic, philosophy and grammar. Investigation into the field of emotion was less successful. Emotions do not lend themselves readily to rational analysis. Their very nature and essence is that they are irrational. A few things, however, are tolerably well known about their qualities and effects. Of these, I shall try to give you a brief account.

**Example of Feelings Maintained, Disturbed and Restored by Successively Changing Thoughts**

In the evening, after dinner, you are seated on the couch with your wife, chatting and planning. Bob and Lois, your son and daughter, are attending a party in the neighborhood. Bob, 22, is to be married soon; Lois, 18, will graduate in a few weeks. Fate has been kind to you. With a steady position, a cozy home, a loyal wife and two lovely children, there is hardly anything to wish for. Your income is by no means excessive; it is just comfortable. Nevertheless, you can afford to plan for the purchase of an automobile and to contemplate a vacation trip to the country. All in all, you have a right to feel satisfied, composed and self-confident.
While you are chatting with your wife, the telephone rings and you rise from the couch to answer the call. When you return your countenance has changed. You no longer look contented and relaxed. Instead, you seem to be apprehensive, worried, disconcerted. The reason for the change in your feelings is a message from a colleague who informed you that the firm by which you are employed is in financial difficulties. A host of upsetting thoughts float through your brain. Your plans will have to be readjusted, the automobile will have to wait, the vacation trip postponed, and the preparations for the son’s wedding and the daughter’s graduation will have to take a drastic cut in style and expense. It is a painful realization and your happiness is gone, your comfort disturbed and your confidence shaken. Prior to receiving the message you felt secure; now you are seized with a sense of insecurity.

You spend a hectic, sleepless night, tortured by visions of insecurity and poverty. In the morning you arise with your thoughts focused on a future of struggle and misfortune. When you arrive at work you are listless and despondent, oppressed by gloomy anticipations. Life seems futile, work meaningless.

In the afternoon notice arrives from the president of the corporation announcing that a reorganization has been effected guaranteeing the continued operation of the plant. The employees are given assurance that no layoff is planned. Instantly, your spires rise, your despair is swept aside. You feel secure again, resume your plans for automobile, vacation trip, wedding and graduation and feel once more satisfied, composed and self-confident.

Analysis of Example in Terms of Thought and Feeling

The example which I quoted at length seems to represent an unbroken sequence of dramatically changing feelings. However, on closer analysis, you will realize that your reactions cannot possibly be explained on feeling alone. You were with your wife and were happy. That the happiness was a feeling can hardly be doubted. But a thought was in some way connected with it. You felt happy and at the same time thought you were secure. The feeling of happiness was linked to the thought of security. Which was first and which second, which cause and which effect is difficult to state. You may have felt happy because you thought you were secure. In this case the thought of security would have caused the feeling of happiness. On the other hand, the happy feeling might have caused a sense of security. Whatever may be the relationship the fact is that thought (of security) and feeling (of happiness) were closely interwoven.

In the second phase of your experience the telephone message arrived. It conveyed the idea (thought) that your position was in danger, and turned happiness into unhappiness. Here, the causal relation is clear: the thought of insecurity produced the feeling of unhappiness.

Next came the second message, emanating from the office of the president and announcing that your position was safe. Cause and effect are here again clearly defined: the thought of security reestablished the feeling of happiness.

Perhaps it was unnecessary to choose an elaborate example for the purpose of demonstrating that feelings are frequently dependent on and caused by thoughts. Simple, everyday occurrences would have served the same purpose. Your baby is sick, and, thinking of danger, you feel despondent. After the physician assures you (makes you think) that it is nothing but a gastric upset you instantly feel relieved. Again, the thought of insecurity (concerning the baby’s condition) produced the feeling of depondency; the feeling disappeared when the physician changed your thought. Another example: you move along in a department store hemmed in by a milling crowd. Suddenly you notice that your little son is missing. Alarming thoughts race through your brain and cause the feeling of panicky fear. After a few minutes the youngster emerges by your side, and your panic is instantly dissolved. Again, a thought caused a feeling and another thought removed it.

“Pure” Feelings Have Little Influence on Average Adjustment

I do not wish to be misunderstood as suggesting that feelings are always irretrievably linked to thought. There are the well-known feelings of hunger, thirst and sex. That they may occur without being initiated, carried or even remotely influenced by thought processes can be safely assumed. The same is true of the situation in which one person falls in love with another. Even if you maintain that the lover has his thoughts about his idol and, for instance, thinks of her as charming, angelic and divine; nevertheless, his thoughts are obviously secondary to the feeling. The exalted feeling produces lofty thoughts, not the reverse.

I mentioned hunger, thirst, sex and love as examples of so-called “pure” feelings which have little or no admixture of thought. I could have added the fears and joys of the baby which must be “pure” feelings as the baby can hardly be credited with what we call thought. Finally, I could have referred to the “pure” emotions aroused by the beauty and majesty of nature, which, if genuine and not sentimental, are obviously not dictated by thought. The list is impressive but insignificant from the viewpoint of average daily adjustment. And what we are interested in are the daily and hourly reactions of father to son, mother to daughter, husband to wife. In the average home, hunger and thirst are hardly likely to determine behavior. The average husband and wife are not expected to carry their original infatuation into the daily marital scene. And as concerns sex the situation is clear: if, as some maintain, sex exercises a powerful influence on average daily existence the effect is due
to the *thought about sex* rather than to the sexual impulses as such. Aside from the exceptional instances of sex aberrations and sex delinquencies, sex life in itself is not likely to result in abnormal behavior. It produces maladjustment only or mainly if it is linked to such thoughts as sin, guilt, disgrace, self-blame and self-contempt, expectation of punishment and anticipation of dire consequence to health. Again, you see how even here thought dominates feeling.

*The Popular Explanation For Emotional Instability Is Lack Of Understanding*

After this lengthy exposition let me revert to my original question: was Margaret's behavior driven by emotion (feeling) or guided by intellect (thought)? On the face of it her life with Tom seems to have been an endless series of clashes, conflicts and upheavals. How could such a vast amount of friction and dissension be determined by anything but emotion! When Margaret threw a tantrum, what else but an easily aroused emotionality could have caused the commotion? Try as we may, it seems we cannot escape the conclusion that her maladjustment was produced by what is called emotional instability. Yet, had you asked any of her friends or any of Tom's associates and employees, their dictum would have been tersely and simply that the two did not understand one another. The emotional turmoil would have been reduced to an intellectual element: lack of mutual understanding.

What precisely was it that Margaret failed to understand? When she harassed Tom she certainly knew (understood) that she caused him suffering. When she staged a tantrum she did not have to be told that her emotions were in poor control and her behavior off balance. All of this she understood. Moreover, she was keenly aware of the fact that she had made a mess of her life and occasionally confessed this realization. One day I intimated to her that Tom was in danger of a relapse unless domestic friction was avoided. I caught her in a soft mood and obtained a frank confession of her shortcomings. Finally she exclaimed, “What is wrong with me, I guess, is that I have no aim in life. Perhaps I need a new set of valuations.” I have heard repeatedly statements of this kind from “nervous” patients. They knew, exactly like Margaret, that they failed of their objective, confessed in utter sincerity that they were disgusted with themselves and protested that what they needed was a new table of valuations and an absorbing aim in life. Yet, in spite of this evidence of an almost penetrating insight, friends and neighbors accused them of lack of understanding.

*Superficial Versus Subtle Understanding*

Obviously, there is more than one variety of understanding. Somebody speaks a sentence and you understand that it is a command or request or plain announcement of an objective fact. Understanding of this sort is superficial and the result of common school knowledge. When people speak of lack of understanding they have a more subtle variety in mind. And there is abundant subtlety in daily life to cause mountains of misunderstanding.

One day Tom retired to his room intent on working on accounts which had to be prepared for the morning. Before leaving the dining room he turned to Margaret, requesting her not to disturb him. He had hardly been sitting a few minutes when the door opened and Margaret inquired whether she could have the pencil on the table. Soon she appeared again, “Honey, are you really busy? I am so lonesome. Couldn’t we chat for a while?” Tom pleaded the urgency of his work but Margaret coaxed and cajoled and when finally Tom succeeded in shoving her gently through the door he was far behind in his work schedule. All evening Margaret persisted in interrupting Tom’s work, entering the room under every kind of pretense. Once it was the newspaper which, she “was sure” he had in his briefcase: then it was an inquiry about the telephone address of a friend or an entirely unnecessary reminder about a social engagement which, she was afraid, “honey” might have forgotten.

Disturbances of this kind were routine in the household. They happened when Tom seated himself comfortably to read the evening paper and Margaret chose precisely this occasion to ask his help in lifting a package to the upper shelf of the pantry. The interference became almost unbearable when Tom was closeted with his bookkeeper and the radio was set going full blast in the adjoining room drowning conversation in a blare of noise. I could finish an almost endless list of similar instances of petty misbehavior, but the pattern would merely repeat itself.

*Temperamental Persons Are Impelled by the Will to Misunderstand*

Understanding is the *will to understand* but temperamental persons are impelled by the *will to misunderstand*. The misunderstandings furnish them the reasons and excuses for practicing their temper. The classical example is the husband who goes into a rage because dinner is not ready the moment he enters the home. If this enraged husband had the will to understand he would not have to dig deep to find the reason for the delay. He would easily understand, without effort of
thought or special inquiry, that domestic affairs are never expected to run to schedule. He could discern by a mere flicker of reflection that a wife is frequently handicapped by the necessity of caring for the children, by an occasional defect in the gas range, by the failure of the grocer to deliver in time, by something going wrong in the preparation of the food, or by unexpected visitors dropping in at an inopportune moment. To understand all these possibilities requires nothing but the will to understand. If the husband fails to consider the possibilities be certain he is guided by nothing but the will to misunderstand.

With a Vast Capacity for Understanding Others Margaret Had the Will to Misunderstand Tom

I told you that Margaret's friends and Tom's associates ascribed the marital woes of the couple to a lack of understanding. The phrase is incorrect. There is no such thing as lack of understanding among adult persons who belong to approximately the same social and educational group. It does not require a super mind to analyze properly the meaning of those "trifles and trivialities" which lead to temperamental outbursts. Margaret had perfect understanding for the sensibilities and idiosyncrasies of those she met at social functions. She was friendly to grocer, butcher, scrub woman and window washer, and with the neighbors she enjoyed the reputation of being a sympathetic and understanding person. With so much capacity to understand she could not possibly be charged with lack of understanding, and if she currently misunderstood Tom the only reason imaginable was the will to misunderstand.

Goal Ideas and Pattern Ideas

A will is a feeling linked to a so-called goal idea. You have here again a combination of a feeling joined to a thought. I shall try to explain to you what is meant by the term "goal idea." This house which you see through the window gives rise to the idea of a brick structure rising five stories above the ground, being topped by a flat roof and having a clean appearance. What is here described is all form and pattern. The thought which went through your mind at the sight of the house may, therefore, be called a form idea or a pattern idea. You do not own the house, nor do you wish to buy it, nor do you occupy a room or apartment in it. This being the case, the house does not represent any goal to you. Should you intend to acquire the property, or to live in it, the house would be related to you as a goal, and the thought of the house would be one of your goal ideas.

A mother possesses form and pattern but has, in the main, the status of a goal. Your goal is to please her, to consider her comfort and welfare, to sacrifice time and effort in her behalf. If linked to a strong feeling of love the goal idea creates the will to be a devoted son. Similarly, your craving (feeling) for privacy and security, linked to the goal idea of a home, may create the will to buy a house. These examples, I think, will illustrate to you what is meant by a goal idea, and you will now understand what I intended to express when I said that a will is a feeling linked to a goal idea.

Will to Peace as Opposed to Will to Power

In a group (marriage, friendship, business partnership) there are two principal goal ideas: cooperation or competition, mutuality or rivalry. The feeling of fellowship linked to the goal ideas of cooperation and mutuality, gives rise to the will to peace. The feeling of self-importance, linked to the goal ideas of competition or rivalry, yields the will to power. The will to peace makes for understanding, the will to power for misunderstanding.

When months ago I discussed the development of the normal child I painted the picture of an unbounded will to power. Power means many things to the child. It means, for instance, demanding a piggy-back ride precisely at the moment when father is busy with an important task; it means yelling, sulking and whining if the ride is denied, or insistence on repetition after repetition if it is granted. Power also means resisting being put to bed or, once in bed, complaining that the blanket is too warm and making mother change it, asking for a drink of water and making mother bring it, discovering a fanciful cold and asking mother to fetch a handkerchief. Add the subsequent demand to "get the other doll" and the plea that mother stay with the tot "just a little while," and the infantile will to power is adequately characterized as that tendency which secures satisfaction at the expense of others' discomfort.

Children Have Lack of Understanding, Adults Have Will to Misunderstand

In a child you expect reactions of this kind and excuse them on the grounds that intellect is in its infancy and knowledge has not ripened. Let the child break china or make a vicious pass at other children and the mother, even if she gives him a spanking, will, nevertheless, excuse the youngster because he is "just a child that doesn't know what he is doing." You see, in the child the will to power is or may be linked to a "lack of understanding." But, mark it, in the child only. There, one actually gains the impression that some children at least are naughty without being aware of their naughtiness. That adult
persons should engage in a persistent course of demanding, opposing, stalling and obstructing without the knowledge that their behavior is offending against rules and disturbing peace can hardly be assumed. You may take it for granted that if an adult person exercises the will to power he does so from a will to misunderstand, not from a lack of understanding.

The average person is born with the will to power and acquires, through education, the will to peace. As the child passes through adolescence to maturity the will to peace takes the lead over the will to power. This is accomplished by the influence of home, school, church and other educational forces. What the educators do is to make the child adopt the adult goal ideas of cooperation and mutuality and to crowd back the infantile goal ideas of competition and rivalry. After imbibing the adult goal ideas the individual establishes the will to peace and the corresponding will to understand. An education of his kind presupposes that intellect (goal ideas) has the power to curb or release socially undesirable feelings, emotions and impulses. If guided by peace ideas they are curbed, if driven on by power ideas they are currently released.

_Margaret's Re-education Was Effected through Influencing Her Goal Ideas_

As concerns the acquisition of adult goal ideas, education miscarried in the case of Margaret. After reaching adulthood she still maintained an immoderate will to power and an implacable will to misunderstand. This was true, however, of her marital relations only. As friend, hostess, guest and customer she was courteous and accommodating and not at all impelled by a drive for power. Even in her marital life, moreover, she was frequently sweet and sympathetic, considerate and affectionate. In this manner she was at the same time driven by the will to power and guided by the will to peace. Margaret was sufficiently sophisticated and introspective to be aware of the clash of the two wills. She sensed the implied contradiction when she practiced infantile goal ideas with Tom and adult goal ideas with others. The contradiction confused her and weakened her self-assurance. As a result, her self-regard suffered. She pertinently analyzed her sorry plight when she confessed that she had no aim in life and needed a new set of valuations. Of course, the analysis was half correct only. It was not true that she had no aim; the truth was that she had two contradictory aims (power and peace) and was guided by two mutually exclusive goal ideas (mutuality and rivalry). In consequence of this duality of wills and goal ideas her behavior gave the appearance of conflicting, ill balanced and unstable action. I hope you will now realize that her difficulties were less in the sphere of emotions than in that of intellect and that what appeared to be "emotional conflicts," "emotional imbalance," and "emotional instability" should preferably be called "intellectual conflicts," "intellectual imbalance" and "intellectual instability." Let me add in conclusion that when Margaret joined Recovery, Inc. and underwent a process of reeducation it was not so much her emotions which were reeducated as it was the more intellectual functions of will and goal ideas.
Gertrude was elected representative to the Good Will Club of the organization for which she works. As such she had to attend meetings in which she was the only woman member. This alone made her very uncomfortable, and when she was to take the floor she "became tense and had all sorts of symptoms, palpitations, tremors, air-hunger and the thought that I simply can’t do this. But with my Recovery training I knew that this was merely discomfort and I can bear it and make my muscles do the job of addressing the crowd. But one day the Club decided to hold a raffle for the benefit of an employee who was chronically ill. Somebody had to run the raffle and, lo and behold, they picked me to organize it. I got scared and thought that I certainly can’t do that. But I spotted this immediately as the fear of making mistakes and knew that I had to have the courage to make mistakes. I accepted and felt proud that I had the nerve to tackle this business. And here I was a nervous patient, and many of those present refused to take on that responsibility, and as far as I know they were not nervous patients.

I do not know the men and women who work for the company which employs Gertrude. Nevertheless, assuming they are an average group, I will not hesitate to assert that all of them are nervous persons. This means that all of them are, in varying degrees, tense, self-conscious, unsure of themselves. I can make this statement with confidence because the many people which I meet or know, including myself, give ample evidence of inner restlessness, lack of assurance, preoccupation and lowered spontaneity. And these qualities connote nervousness; and people possessing them are nervous persons which means that all average men and women who do not happen to be heroes, saints or angels belong in this category of nervous persons. The clearest evidence of this universal nervousness I obtain when I observe myself. I then notice that it would be easy for me to duplicate most of the symptoms, dispositions and attitudes of which my patients complain. There is a difference, of course, between my reactions and those of my patients. They develop severe vicious cycles, and I produce none or very mild ones; they go into panics and tantrums while I avoid or escape them; they release volleys of complaints, and I practice silence. Other differences come to mind: The symptoms of my patients have gained intensity, and mine are calm experiences; theirs are protracted agonies, and mine are merely transient annoyances. If you list all these differences which obtain between me and my patients you may be inclined to infer that what distinguishes a nervous person, like I, from a nervous patient is the capacity to release tantrums and panics and vicious cycles and to endow symptoms with a high degree of intensity, with long duration and endless verbal explosions. That this is not true is obvious because you and I know many relatives, friends and neighbors who display, occasionally or frequently, all the features which I mentioned, from intense panics to never-ending complaint-marathons, and yet are merely nervous persons instead of nervous patients. What, then, is the basic difference between the two groups?

An intelligent answer to this question cannot be given unless you know what the word "basic" means. If you watch the behavior of a large body of water, let me say, Lake Michigan, you will find that the surface is frequently smooth, calm, serene. If that is the case we say the lake is at peace. At times, however, you will observe that the lake develops motion, at first gentle ripples, than rolling waves, finally spouting billows. The water is now active, perhaps slightly agitated but not turbulent. On some days a storm rises. The waves become tempestuous, raging for hours or days, and the body of water appears shaken with wild passion and fierce commotion. This is what you might call a violent symptom or uncontrolled tantrum, intense, protracted, raging. Should you be asked to describe the general nature and character of the lake you might explain that, basically and fundamentally, it is a fine piece of water with excellent opportunities for recreation, a valuable reservoir for sea-food, a convenient traffic lane for navigation, and above all, an unparalleled asset in point of scenic beauty. These, you will add, are the basic features of the lake. But some phases of its nature and action, you will continue, admit of

Excerpts from Selections From Dr. Low’s Works (Low, 1966)

DR. LOW’S COLUMN (Low, 1966, pp. 6-10)
NERVOUS PATIENTS AND NERVOUS PERSONS

Gertrude was assigned a difficult and responsible task. She accepted and felt proud of the confidence she inspired and the distinction she gained but wondered why the others who “were not nervous patients” had refused while she who “was a nervous patient” had accepted. When she spoke of her reaction she mentioned that when she was asked to attend meetings as a representative she had “All sorts of symptoms… and the thought that I simply can’t do this.” Later, when she was chosen for the job of organizing the raffle she again "got scared and thought that I certainly can’t do that." These statements so well expressed by Gertrude point up the chief difficulty of the "nervous patient" whose main characteristic is to be scared of responsibilities which means to lack the confidence and courage to assume a task. The fact remains, however, that the others who "were not nervous patients" were by no means oozing courage and confidence, and the prospect of being offered a responsible assignment did not seem to rouse their enthusiasm or fire their ambition. From this and many kindred observations which I am currently able to make I conclude that the person who is not a nervous patient differs little from that specimen of humanity who happens to be afflicted with a nervous ailment. The one is a "nervous person"; the other is a "nervous patient." In the instance quoted by Gertrude, the nervous persons shied away from responsibilities, the nervous patient faced and braved them.

I know many relatives, friends and neighbors who display, occasionally or frequently, all the features which I mentioned, from intense panics to never-ending complaint-marathons, and yet are merely nervous persons instead of nervous patients. What then, is the basic difference between the two groups?

An intelligent answer to this question cannot be given unless you know what the word “basic” means. If you watch the behavior of a large body of water, let me say, Lake Michigan, you will find that the surface is frequently smooth, calm, serene. If that is the case we say the lake is at peace. At times, however, you will observe that the lake develops motion, at first gentle ripples, than rolling waves, finally spouting billows. The water is now active, perhaps slightly agitated but not turbulent. On some days a storm rises. The waves become tempestuous, raging for hours or days, and the body of water appears shaken with wild passion and fierce commotion. This is what you might call a violent symptom or uncontrolled tantrum, intense, protracted, raging. Should you be asked to describe the general nature and character of the lake you might explain that, basically and fundamentally, it is a fine piece of water with excellent opportunities for recreation, a valuable reservoir for sea-food, a convenient traffic lane for navigation, and above all, an unparalleled asset in point of scenic beauty. These, you will add, are the basic features of the lake. But some phases of its nature and action, you will continue, admit of

APPENDIX (Continued)
a less glowing description: there are gales and squalls and mighty storms lashing the shores, and ships go aground and human lives are destroyed, etc. etc.... In giving an account of this sort you made a pointed distinction between the basic nature of the lake and certain of its phases which, being phasic, are not basic to its fundamental character. Essentially, you took the position that in giving the description of an object you meant to stress what is at its base and foundation, not what are merely certain phases of its behavior. Basically, you wanted to point out, Lake Michigan is a marvel of beauty and bounty, but phasically it may at times be forbidding and treacherous.

When Gertrude arrived at the self-depreciating conclusion that being a nervous patient she was less qualified for a responsible job than her co-workers who "were not nervous patients" she overemphasized certain phases of her behavior, ignoring or minimizing what was at its base. Her judgment was focused on the shifting and phasic elements of her conduct, not on its permanent and basic foundation. On the other hand, her co-workers when passing judgment on their own qualities, were inclined to play down their phasic defects and to play up their basic merits. They did not deny their disturbances and defects. They knew and did not link the fact that they had occasional palpitations and air-hunger. But that did not suggest to them the wild idea that their circulation and respiration were basically damaged. Instead, they were certain that the present disturbance was merely an occasional or momentary phase of their basically sound behavior. At times it happened that some of them went into the living room to fetch an object and stood there not remembering what they had come for. Or, there was the experience that after parking the automobile they forgot where they had left it. On such occasions it was perfectly clear to them that the present act of forgetting was merely a transient phase of their memory function and that the latter was basically intact and dependable. This was different in the case of Gertrude. Whenever incidents of this character occurred in her life she was likely to condemn her functions as basically and fundamentally untrustworthy, disintegrating, defective. You see the difference: Gertrude had about the same type of experiences as her co-workers, defects of memory, disturbances of organ functions, scares, tempers, undesirable impulses and what not. But whereas Gertrude indicted her basic functions her co-workers put the blame on some phase of their conduct only. Basically, they approved of their behavior. If they condemned at all, their condemnations were directed at some of its phasic portions only.

The incident which Gertrude reported on the panel was of recent occurrence. At the time it happened she had lost her fears and her disturbing sensations and had made such a good adjustment that the co-workers thought her capable of being entrusted with a responsible task. Which means that they had trust in her capacities. Had they known her previous ailment they might have marvelled at the thoroughness of her recovery. They had faith in her basic qualities but Gertrude had none. She knew that she still had difficulties. She knew that occasionally her palpitations, sweats and weaknesses returned. True, she had to admit that they were no longer intense, no longer sustained or incapacitating. In other words, she had graduated from the status of a nervous patient to that of a nervous person. This was the manner in which those of her co-workers judged her who knew or might have known of her nervous ailment. It is also the manner in which I judge her. But Gertrude thought otherwise. To her, the recurring symptoms were a reminder that she had once gone through torturing agonies. Now she was seized with the fear that the agonies might return and stay with her. The recurring nervous symptoms made her anticipate a return of the nervous ailment. This is what we call the stigma of nervous illness—once nervously ill, always nervously ill. To feel stigmatized means to experience a basic self-distrust. Gertrude distrusted her self because it still produced nervous symptoms. But nervous symptoms do not signify that the one having them is a nervous patient. Nor do they mean the threatening return of a nervous ailment. They merely indicate that average people, being neither heroes, saints or angels, are nervous persons. All of them have nervous reactions; all of them are, in varying degrees, tense, self-conscious, unsure of themselves. And their tenseness, self-consciousness and lack of assurance may at any time give rise to any kind of nervous symptoms. Gertrude had recovered, that is, she had again become an average nervous person. But not knowing that average persons have nervous symptoms she feared a return of her ailment when her symptoms "kicked up" again. What she and all my patients will have to learn is that nervousness and nervous symptoms are universal and average and that to get well means to become again an average nervous person who experiences nervous reactions in many phases of his life but has implicit confidence in the trustworthiness of his basic functions.
Margaret, on the Saturday panel, recalled an occasion in which a customer asked for skirt shields to keep skirts from wrinkling. "I did not know what these shields were and where they were kept. So I asked the girl in charge of stock if she could tell me where they were. She said, 'Do you really mean to say you don't know yet where these things are kept?' Then she showed me the drawer which was for the shields, and I realized I should have known because I had sold some of them recently. That made me feel embarrassed because I had made a fool of myself, and I also felt provoked and thought who does she think she is talking to me like that? I was ready to come back with a sharp remark but then I spotted this as temper and said to myself, I am not going to work myself up, and if she thinks she is smart and I am dumb, well, I have learned in Recovery to be average and not to mind making mistakes. Then I went on helping my customer and thought nothing more of my feelings..."

Margaret did not know where to look for a skirt shield, and asked the girl in charge of stock—let us call her Lillian—to show her where to find it. Lillian obliged Margaret showing her the drawer which contained the article. This was cooperation and team-work which means group-mindedness. Had nothing else happened we should not hesitate to call Lillian an essentially group-minded person. Unfortunately, something else did happen. In granting Margaret’s request, Lillian asked, "Do you really mean to say you don’t know yet where these things are kept?" This inquiry, though couched in tolerably courteous language, contains nevertheless a good deal of discourteous innuendo. By implication, Lillian said: You have been working in this store for several weeks, and it cannot be the real truth that you have not yet learned where the shields are. A little child, with a mere trace of intelligence and memory, would learn faster. If we read this meaning into Lillian’s remark we shall agree that it was heavily spiced with irony and plainly meant to hurt Margaret’s feelings. If this is so, we must assume that Lillian had the will to help and the will to hurt at the same time, that she expressed group-mindedness and self-mindedness in the same act, good-will and ill-will in the same breath. Which indicates that Lillian’s behavior was governed by two contradictory wills, the one group-oriented, the other starkly individualistic. This accords well with what I have stressed repeatedly, namely, that in this imperfect world of ours, there is no purity of character, personality and will. The average human being who is neither saintly nor heroic nor angelic, is served by two wills, ruled by two characters and obsessed of two personalities. The average person is dual, not unified.

Lillian could have acted differently. She could have shown the drawer to Margaret, saying, “Here it is. Any time you will be in trouble, just ask me, and I shall be glad to help you if I can.” Had she done that, she would have expressed, both in act and phrasing, a unified will, an integrated personality, a consistent character. No doubt, she could have adopted this unified course of conduct. If she did not we must conclude that she preferred another course. She preferred or chose a mode of behavior in which she could display, at will, both courtesy and discourtesy, kindliness and churlishness, service and domination. Her preference was for duality, not for unity of action.

If I speak of unity and duality I do not refer to any profound and complex philosophical teaching. What I have in mind is the fact that everybody demands of his fellows—perhaps not so much of himself—that there must be no double-talking nor double-dealing. The group does not require or expect you to be helpful and generous all the time. You may on occasion refuse to be accommodating or courteous. At times, you may even be rude and aggressive without incurring disapproval, provided you have some acceptable reason for your antagonistic attitude. But you must not permit yourself to be courteous in language and rude in action or vice versa in one and the same performance, no matter what may be your reason. This double-dealing will not be forgiven by the average person who, sensing the duality of conduct—in others—is offended by what he considers duplicity. The offense is experienced as an insult to the intellect and a hurt to one’s feelings. Margaret expressed the situation clearly when she said that Lillian’s behavior “made me feel embarrassed... and I also felt provoked.” The implication was that her feelings were hurt by Lillian’s act of double-dealing. Margaret’s subsequent comment that “if she thinks she is smart and I am dumb” indicates that she also felt her intellect was insulted. You may be inclined to pass off Lillian’s “talking out of turn” as a triviality and to condemn Margaret’s response as excessive sensitiveness. But the fact remains that, on an average, people resent having their intellect insulted and their feelings hurt by what they please to judge as dual behavior, be it ever so trivial. The average person demands unification and reacts sharply against duality—unfortunately, in others mainly.

I told you repeatedly that your daily life consists chiefly of trivialities. You may be certain that the bulk of your talk, action and feeling are what most of your daily experience is: trivial. But if trivialities are likely to wound your feelings and insult your intellect they may be trivial to others but not to you. To you they become most significant. For nervous patients particularly it is of the utmost significance to shield their sensibilities from being assaulted too frequently or too harshly. Let my patients’ feelings be merely scratched or lanced, and the result will be symptoms and suffering. Let their intellect be merely mildly doubted or subtly questioned, and temper tantrums may be released. The trivial encounter between Margaret and Lillian demonstrates that what people consider double-action is most apt to inflict hurt and injury to a sensitive soul. And my patients are without exception sensitive souls. They are highly sensitized to hidden meanings, vague implications and
suggestive remarks. They wince in response to innocent pranks, harmless irony and good natured teasing. Consider the meaning of teasing. If you tease a person you may mean and usually do mean no harm. The words which you use may be wholly inoffensive, your tone of voice may indicate warmth and sympathy; the smile on your face may testify to the essentially friendly attitude expressed in the act. Yet, the hidden meaning and indirect implication of the performance are that you do not treat your “victim” with respect, that you do not take him seriously. You are kind and warm and sympathetic in your approach, but at the same time you treat your conversational partner as a baby, refusing or failing to respect his intellect as mature and his feelings as important. The person whom you chose as target for teasing may notice the underlying kindness, but he will not overlook the implied lack of respect for his personal importance. As a teaser you act double, befriending and torturing a person in one and the same utterance. And if the individual whom you tease is a sensitive soul his feelings will be hurt and his intellect insulted by your dual approach. It may still be a triviality but oh, how painful it can be. Lillian merely teased Margaret, or she was merely ironical. Whether it was the one or the other, in essence, it was a trifling affair. But Margaret was provoked by the dual behavior and escaped serious disturbance only because in Recovery she was trained to spot feelings of self-importance as temper and through spotting, to cut short symptoms. Recovery had enabled her to have her feelings exposed to the acid of dual behavior without getting them corroded, without having them even so much as ruffled, except for a brief instant. Having spotted successfully the triviality of the event she dismissed it and was calm.

What precisely was the nature of the feeling which was provoked and insulted and hurt by the ironical thrust which Lillian levelled against Margaret? I have spoken to you about the meaning of feelings repeatedly. And while neither I nor anybody else are able to give an exhaustive statement of what feelings are, nevertheless, a reasonably correct explanation can be attempted. Having thus, with due humility, stated the difficulty of the task let me now tell you, not what feelings are but what my patients ought to know about them. What you should know is that feelings are (1) predominantly physiological which we shall call physical, (2) predominantly psychological which we shall call mental. The physical feelings are mainly in the nature of sensations. It is with your senses that you feel the hardness or softness of wood (touch), the brightness or paleness of colors (vision), the pleasing or shrill character of a sound (hearing), the sweet or sour quality of food (taste), the agreeable or disagreeable odor of a substance (smell). These feelings are conveyed to you through the so-called five senses. There are other physical feelings: heat and cold, wetness and dryness, shivers and shudders, pain and pressure, pullings and twisting, dizziness and faintness, and the well nigh inexhaustible host of disturbing sensations with which you have acquired a very painful familiarity. I take it you will understand now what is meant by physical feelings. If you do, then, you will realize that feelings of this kind can be irritated but not hurt in the sense of being provoked or insulted. Mental feelings are subject to hurts and provocations and insults. I have dealt with these mental feelings in an address which was published under the title of “Temper Masquerading as Feeling” (Recovery News, March 1949). There I told you that the mental feelings can be grouped under three headings: sympathy, apathy, antipathy. I can tell you now that all three are closely linked to beliefs. You show sympathy toward somebody who you believe is close to you or who you feel (believe) is in distress. The same feelings of sympathy you may direct toward yourself experiencing self-love, self-pity, self-complacency, self-importance, self-respect. That these are beliefs (in one’s or someone’s worth) requires no comment. Beliefs of a similar nature enter into the composition of the apathetic and antipathic feelings. In apathy you are swayed by the belief that things or persons or yourself are worthless, unimportant, uninspiring, uninteresting. In antipathy, you are repelled by yourself or someone, and the result is that you fear or resent or are disgusted with or revolted by yourself or another person. And fear presupposes the belief in danger; and resentment implies the belief that somebody is wrong or did wrong; and similar beliefs are at the base of disgust or discouragement or other antipathic feelings. I hope I made it clear to you that when you claim that your feelings are hurt, what you actually mean is that some cherished belief of yours has been doubted, questioned, ignored, rejected or, worse yet, ridiculed, treated with irony, not taken seriously. The beliefs which you cherish most are that your opinion is relevant, your judgment mature, your action vital, your conduct worthy. If a person, directly or implicitly, contradicts any of these beliefs he or she indicates that they do not share them, that they consider them incorrect, childish, unbalanced, out of focus, not worth ridicule, treated with irony, not taken seriously. The beliefs which you cherish most are that your opinion is relevant, your judgment mature, your action vital, your conduct worthy. If a person, directly or implicitly, contradicts any of these beliefs he or she indicates that they do not share them, that they consider them incorrect, childish, unbalanced, out of focus, not worth

You will now be in a better position to understand the trivial but painful scene in which Margaret’s “feelings” were hurt by Lillian. Lillian treated Margaret with courtesy in action but with irony in words. Her act expressed a measure of respect, but her ironical phrasing implied disrespect. This was double-acting or duality. Margaret resented the duplicity and felt (believed) that she was treated as unimportant, as unequal, as below Lillian’s standard. Her cherished belief that she was as important as anybody else was offended. But in Recovery Margaret had learned that the supreme task of the nervous patient is to avoid symptoms and temper and that both symptoms and temper are easily aroused by the insistence on being treated as important. You know that, in our Recovery language, the sense of one’s importance goes by the name of exceptionality.
or singularity. What we ask our patients to do is to cultivate the thought of averageness. If they do, they will not feel (believe to be) overly important. Then they will escape the "hurt feelings" of having their importance doubted, questioned, ridiculed and not taken seriously. Margaret expressed this Recovery philosophy beautifully when she reflected, "I was ready to come back with a sharp remark but . . . spotted this as temper and said to myself I am not going to work myself up . . . I have learned in Recovery to be average... Then... I thought nothing more of "my feelings." Her "feelings" were the belief in her importance, and when belief in averageness was substituted, calm and poise took the place of hurt feelings which is a misnomer for beliefs not shared.
Agnes, on the Saturday panel, described a severe panic which she suffered about a year previous, just after she started her Recovery training. "One night I awakened from sleep and felt a jerking sensation in my head. The top of my head seemed to be slowly lifting into the air. The sensation kept repeating, and I soon had palpitations and heavy chest pressure. My breathing seemed to be cut off. I gasped and broke into a cold sweat, and I was so nauseated that I feared I would vomit before I could get out of bed. The room seemed to spin around me. I was sure I had a heart attack and woke my husband. He became alarmed and this alarmed me more. My husband rushed downstairs to call the family physician. The moment he stepped out of the room the thought came to me, 'now you are alone; now it will strike.' I screamed, and my scream made my husband rush back, and I begged him not to leave me alone. By this time my mother was up, and she stayed with me while my husband made the call to the physician. When he returned he told me that the physician couldn’t come. He wanted me to take a sedative and to come to his office tomorrow. I was frantic and said, 'I won’t be here tomorrow. What kind of doctor is he? A doctor who would not attend a sick and dying patient? Wait ‘till I see him tomorrow. I am certainly going to give him a piece of my mind.' When my husband brought the tablets I refused to take them. I knew they were too strong for my weak heart and I might not awaken if I fell asleep. Finally I consented to take one tablet. Then I wrapped myself in a blanket, went down to the living room and sat in a big chair. They were not going to get rid of me that easily! I was going to sit up and fight off the effect of the sedative. But finally I fell asleep, and in the morning I was exhausted and felt all in for weeks." Agnes then mentioned that recently she had a similar panic at night. "My first impulse was to wake my husband. But I immediately knew that this was sabotage. So I decided not to work myself up but to do something objective, something entirely without emotion, as the doctor says in the article. I then looked at the reflection of the street light across the wall of my bedroom. I began to follow its pattern trying to figure out what it represented. I studied every line of it tracing all of them with my eyes. Soon I noticed I was breathing normally; the palpitations, the nausea and sweats were gone in no time. Before long I was asleep again...."

Agnes was in panic. She felt it was a heart attack and death seemed imminent. The husband rushed to call the doctor which ought to have reassured Agnes but did not. Her reaction was, "Now you are alone, now it will strike." But it is not at all clear why death should contrive cunningly to strike its victim while it is alone. Agnes knew well, as everybody knows, that death has a conspicuous preference for doing its deadly business precisely in the presence of people, particularly in the presence of physicians, nurses or close relatives. If this is so, then, Agnes’ statement was grossly contrary to common experience and common logic. Nor was this her only offense against the rules of logical thinking. When her husband returned from the unsuccessful call for the doctor, Agnes was understandably provoked by the physician’s refusal to attend her in person. Then she delivered herself of utterances which cannot possibly be harmonized with even the shakiest logical rules. She said in reference to the physician’s advice to visit his office on the day following, “I won ‘t be here tomorrow. What kind of doctor is he?... Wait till I see him tomorrow.” The logical contradiction is here glaring and startling. Agnes was convinced she would not live “tomorrow” but prepared herself to give the doctor “a piece of her mind” on that same “tomorrow.” There are sundry other logical absurdities in Agnes’ narrative, but I shall point merely to one more piece of twisted thinking. You will recall that Agnes feared that if she were left alone death would strike. But when the husband made her take the tablet she feared it might kill her and, to avert the danger of dying, she seated herself in a big chair in the living room, apart from husband and mother. You will admit that a logic which says that death strikes when you are alone and then proclaims that the best method of cheating death is to sit alone in a separate room is a bit weird, strange and not a little delirious. All of this adds up to the realization that Agnes, endowed with a keen intelligence managed successfully to ignore logic when she was seized with a panic.

You remember that Agnes, while telling her story, smiled and laughed and at times broke into loud guffaws. We all shared her mirth responding with roars of laughter, which means that we noticed the absurdities in her account and refused to give them serious thought. Anybody in his right mind would laugh at such grotesque contradictions. Why, then, did Agnes fail to laugh on that night in which her brain produced those ridiculous fears? You might advance the theory that going through the frenzy of a panic she was “out of her mind”, unable to use her reason. Unfortunately for this theory we have ample evidence that all through the panic Agnes reasoned with perfect logic about a doctor’s duty to attend a dying patient, about his villainy of forsaking her, about her determination to call him to account the following morning. The reasoning was by no means realistic; it was romanticized, but its formal logic was flawless. She certainly demonstrated a good power of reasoning when she reflected that two tablets might kill her while one might be the proper dose; that the surest method of counteracting the deadening effect of a sedative was to stay awake. Obviously, Agnes had a good control over her reason but used it with an almost uncanny discrimination: She employed it correctly in one train of thought and incorrectly in another.

Reasoning is a tool, the tool of thinking. If a man, wielding a hammer (tool), drives all the nails correctly into the right half of a board but misses all or most of them in the left half, there must be something wrong with the man, not with the tool. Even if the man was intoxicated or panicky or fatigued, nevertheless, the perfect discrimination between the right
and left side of the board shows that a pattern was followed and a choice made. The choice was to favor the right side of the board. That choice may have been unreflective, that is, not conscious. But it was a choice, guided by well contrived discrimination. And choice and discrimination are functions of the Will. Did Agnes choose to make a faulty use of her reasoning power? Was it her Will to be absurd and illogical?

Whether an act is against reason and logic depends on the purpose it serves. If on a hot summer day I suffer from extreme heat it is good logic to seek comfort in the shade. If I do that I demonstrate that my realistic purpose was to secure relief in a cool spot. But if complaining of the “intolerable” heat, I step into the middle of the street exposing myself to the blazing sun; if all the while I yell at the top of my voice that I am boiling and sweating and roasting but do nothing to seek the shade; if I do all of this, then it is clear that my purpose was not to escape the heat but to attract attention, to be theatrical, to do something which other people would not do, to be exceptional, different and singular. All of this is called romanticism. To be romantic is not necessarily illogical. If it is your set purpose to indulge in silly heroics, a romantic improbability will be a good means for realizing that purpose. It is absurd only if judged by the standard of realism. Realism demands sound reasoning, common sense and common logic. Romanticism requires nothing of the sort. Indeed, if it is to function and survive, it will have to shut off sense and logic. If you apply logic to a romanticist performance, you make it look ridiculous and kill the effect. In other words, it is good logic to shut off logical thinking if you want to relish your romantic absurdities. Realism thrives by logical reasoning, romanticism dies of it.

When Agnes threw her tantrum, she engaged in the romanticist game of staging a scene full of excitement, danger and drama. She played, with coarse and boisterous dramatization, the role of one threatened with death and destruction, posing as the helpless victim of a fatal emergency, all the while striking well calculated terror into the minds of husband and mother. A theatrical performance of this kind, being grotesque and ridiculous and utterly illogical, cannot be maintained convincingly unless the actor or actress blind themselves against the protest and cynical smile of logic and reason. Shut off reason and you can be a romanticist; employ reason and you must become a realist. When Agnes, a year after her gruesome midnight performance, had a similar experience with torturing symptoms, she turned realist, did a good piece of sound, logical thinking, and the developing tantrum was aborted in the space of seconds or minutes. Which method did she employ to eliminate romanticism and replace it with realism?

I do not know whether you are acquainted with the fact that the human eye is endowed with one spot in which vision does not function. It is called the blind spot, and an object on which this spot is focused is shut out from sight. That object is then blind-spotted. The human eye has another tiny part which, when directed at an object, sees it with the clearest vision. That object is then spotlighted. The mind has a similar structure. Its function is to view things and experiences in order to discover their meanings. In this process the mind can, exactly as the physical eye, either blindspot or spotlight the things it views. If it turns its full attention on them, exploring them by means of reason and logic, then, it spotlights them and obtains their logical and realistic meaning. On the other hand, if the experience is painful or disturbing or unwelcome, it turns off attention, logic and reason, and the experience is blindspotted. You see here that what in Recovery we call “spotting” has two aspects. The one is blindspotting, the other spotlighting. If you want to indulge your silly romantic-intellectualisms, you will have to blind yourself to the realistic meanings of your experiences, that means, you will have to blindspot them. If you desire to see clearly and realistically, you will have to turn the full light of logic and reason on them, that means, you will have to spotlight them. The romantic-intellectualist blindspots reality, the realist spotlights it. Agnes was given to blindspotting before she joined Recovery but became an accomplished spotlighter as a result of the training she received in our midst. What she demonstrated here with her telling the panel an example was that Recovery has developed a singularly successful method of converting as confirmed a romantic-intellectualist as Agnes used to be, into a logic-wielding realist as she is now. The substance of the method is to train patients to scrap their blindspotting and to practice spotlighting with regard to experiences, particularly with regard to symptoms and temper.
APPENDIX (Continued)

EXCERPTS FROM DR. LOW’S ADDRESSES (Low, 1966, pp. 58-61)

I. The Patient’s Disabilities, Will or Fate?

The patient, a man of mature age, had been suffering from a depression for two years when I first saw him. His symptoms were of the ordinary description: difficulty of sleeping, mechanical appetite, reduced interests and lowered feelings. His spontaneity was gravely affected, hence, even simple tasks required the utmost in effort. Previously, a person brimming with energy and confidence, he was now left without ambition and initiative, fearful of making up his mind, unable to plan and decide. Adding to the misfortune was the fact that in his protracted career of idleness, he developed ugly and disturbing habits. He paced the floor in rapid strides and abrupt turns practically all day and a good part of the night, all the while emitting peculiar yells, a strange mixture of sobbing, moaning, barking and screaming. “He acts like a caged animal,” was the way his wife described his behavior. Finally, the neighbors complained to the landlord, and the couple were in danger of being evicted.

I asked the patient, “Why do you yell so that the neighbors become aroused? And why do you keep pacing the floor until you are exhausted?” His reply was, “I have to do it. If I stop I get so tense that I fear I’ll burst.” I remarked, “I have observed you in classes and noticed that you are able to sit through addresses and interviews for an hour and longer without rising from your seat and without voicing even a feeble sound. I also know that you control your behavior to perfection while sitting in my reception room, waiting for your turn of treatment. I watched you on several of these occasions and witnessed an almost spectacular tenseness on your face. Nevertheless, you made no move to dash out of the room, nor did you yell or bark. My conclusion is that you are well able, even with an extreme tenseness working toward the “bursting” point, to hold down the impulse to race or scream when you are in Recovery or in my office. If you can check your reactions in some places, why do you have to release them in others?” “Well” said the patient, “I don’t understand it myself. But it is true that I can control on the outside, and at home I can’t.”

What I want you to note here are the phrases “I have to” and “I can’t.” All the complaints of my patients can be reduced to and properly fitted into the pattern of these two phrases. All of them complain that they have to do things which they do not want to do at all, and that they cannot do other things which they want to do badly. There is the patient with the “intolerable” nervous cough. At home he embarks on an unrestrained campaign of furious coughing and rasping, claiming the tickle in the throat is “unbearable.” But when he is among people, his versatile tracheal and bronchial tissues somehow manage to exhibit a perfect set of “company manners,” behaving as well-bred throats always do, neither coughing nor rasping. A similar situation obtains in the case of the patient who, troubled with an “intractable” itch, scratches ferociously at home but conveniently suspends both the itching and the scratching on the street, in buses, at parties and theatres. Outside the home these patients have no difficulty controlling and stopping the same ugly habit which they have to indulge and can’t stop once they step inside the home. How is it possible that a person can use his Will at 10 PM at the theatre but is utterly deprived of even a trace of that same Will at 11 PM at home? There are legitimate occasions when an individual has to do things opposed by his Will and can’t do other things approved by it. Situations of this kind are produced by organic diseases. A man who has sustained a fracture of the leg has the Will to go to work but “can’t” and has no Will to lie in bed but “has to.” The same rule applies to cancers, pneumonias, infections, and all manner of organic ailments. Patients afflicted with any of these organic disorders cannot perform as they would and have to perform as they would not. In conditions of this nature the disease ordained by Fate submerges the Will possessed by the personality. But have you ever heard of a cancer which is always present at home and regularly disappears at special times in special localities? Or of a fracture in which the bones dangle wildly whenever the patient is among the members of his family but are invariably well set and conducting themselves properly at social functions? How can cancerous organs and fractured extremities distinguish between the social meaning of the home where they can act as they please (exercising sovereignty) and outside engagements where they have to submit to rules and standards (practicing fellowship)? You will agree that this would be the height of absurdity. Organic diseases do not, of course, change their behavior in accord with the social meaning of the situation. Such selective and discriminating is impossible under conditions in which Fate reigns. Organic disturbances, that is complications created by Fate, act indiscriminately and without selection. They may strike any person at any time in any place. Once they have struck they do not pick out shrewdly certain occasions in which they will make a stage appearance or certain others in which they will keep cunningly off the stage. If a symptom is regularly present in one set of conditions and regularly absent in another, the judicious choice cannot be the result of Fate which is never selective. It must be the outflow of Will whose very function is to choose and select.

In stating that “choosy” and selective symptoms point to a Will making the choice and determining the selection, I do not mean to imply that the patient wants to create or retain his disturbance. Nothing is further from my mind than an insinuation of this kind. My patients want to get well, of course. And if they are ill, the illness is certainly not of their choosing. It would be preposterous to hold them responsible for their condition. That condition is produced by Fate, not by Will. It is Fate, and nothing else, which saddles a person with choking sensations and fatigue and depressions. And whether
it is possible to prevent the development and onset of nervous conditions. I simply do not know. I have seen multitudes of persons who were as well as anybody might wish to be efficient, gay, generous, well-adjusted personally and socially, and yet they contracted a nervous ailment. Many of them were struck by their nervous trouble “out of a blue sky” without warning, without any preceding disturbance. They were suddenly seized with a spell of air-hunger while they were waiting for the next street car to pass by. Or, they attended a show in the pink of health, and while they were enjoying the performance, fully absorbed and not a bit tense or self-conscious, an arm went limp, or an ear went deaf, or an “explosion” rocked the brain. Nothing in the present or previous behavior of the victims could possibly explain the abrupt occurrences which were utterly unexpected. A great number of my patients experienced their first symptoms during a pleasure-packed party or on the occasion of a stimulating card game, at innocent family gatherings or on a carefree walk, or under similar circumstances which were singularly free from irritation. The affliction came out of nowhere. It simply “happened” and was undoubtedly not created by any intention on the part of the stricken person. It was Fate and not Will which initiated the disorder and the attendant panic. But once the patient was examined and given instructions how to get well, once a program was mapped out for him for the purpose of piloting his nervous system back to adjustment, did he honestly accept the plan and sincerely carry out the instructions? The answer is clear: Some of my patients cooperate and some sabotage. And whether you are given to thorough cooperation or indulge in reckless sabotage does not depend on Fate but entirely on your Will. My patients are not responsible for the type of their ailment or the mode of its onset. But emphatically, they are responsible for the type and degree of their cooperation. And what I here call Will is primarily the determination to cooperate wholly and faithfully. If I instruct a patient to use his muscles, to give up self-diagnosing and to control his temper and he counters with the silly excuses of “I can’t,” “I have to,” “I try my best but can I help it if I don’t succeed?” mean that the patient diagnoses his condition as a physical disease in which Fate has paralyzed his Will. No matter how skillfully fitting is the context in which phrases of this kind are used, they mean nothing less than the diagnosis of an organic ailment. They mean that the patient refuses to accept the physician’s diagnosis of a distressing but harmless nervous disturbance insisting on self-diagnosing it as a serious organic ailment. The tragedy is that self-diagnosing is anything but an innocent pastime. It breeds defeatism and fatalism, continued tenseness and endless agony. If the nervous patient is to escape the tragedy of self-diagnosing, he will have to employ our spotting techniques with particular force whenever he thinks or voices the defeatist and fatalistic phrases “I have to,” “I can’t,” or “Can I help it if...?”
Philosophies are of two kinds. The one presumes to tell you what the world is and means, how it came into being and what will be its fate. This is what is called a philosophy of the world. One of these philosophies claims that in this world of ours everything is matter, another that all is mind. The one insists that the world was created, the other that it evolved. There are philosophies of optimism which conceive of the universe as moving toward progressive development, and others which preach a bleak pessimism according to which chance and fate alone govern our destiny with the road leading ultimately and unavoidably to a final annihilation of life and disintegration of matter. We in Recovery have nothing to do with philosophical constructions of this sort. They may be true or false, noble or vulgar, inspiring or depressing, but to us they are irrelevant because they do not touch on the principle of our vital issue which is concerned with daily life and not with universal existence or eternal being. If we are to formulate a philosophy it will have to be a philosophy of life, more particularly one of daily life, emphatically not a philosophy of the world. If in the following remarks I shall use the word philosophy you will know that what I refer to is not what makes the world go around but rather what keeps the functions of this our body and of this our daily life in healthy order or throws them into ailing disorder.

When a patient comes to consult me his complaint is in essence that some of his functions are out of order. He remembers that prior to his present nervous ailment his heart used to beat "in perfect order," while now it sets up wild palpitations; that his previously "orderly" breathing is now frequently "disordered" by recurring spells of air-hunger; that his thought processes which were wont to proceed in well-ordered progression are now deranged (disordered) by "brain storms," "racing thoughts," obsessions and compulsions. In all these instances, the patient holds the view that his nervous and mental functions, that is, his thoughts, feelings, sensations and impulses ought to be governed by a set pattern of concrete order. A theory of this kind is a philosophy. It carries the philosophical belief that life is or ought to be ordered by a stable, relatively unchanging principle. That principle, the patient thinks, calls for such elements as balance equilibrium, perhaps for the golden rule and the solid middle road. All of these he reflects, constitute order which is health. If they are absent or disturbed, it means disorder which is disease. There can be hardly any disagreement concerning this part of the patient's philosophy. It is compounded of common sense and common experience, hence, can become part and parcel of the philosophy of Recovery.

Order is either stable or unstable. The manner in which the individual particles of a stone are arranged (ordered) is always the same. Kick the stone with violence, hurl it with force against another stone, expose it to rain, fire, hurricane, it will nevertheless retain its "natural order," its character and stability. If you lop off one half of its bulk or grind it into innumerable bits of matter, each part will be smaller in size but will still have the character of a stone. We say: a stone has a stable order. The simplest example which I can offer of unstable order occurring in nature is a river. In winter its surface freezes; in spring it swells beyond its ordinary level; in summer it loses moisture and shrinks. Sometimes it is muddy, at other times it is crystal-clear. But no matter how spectacular and dramatic may be its changes, its fundamental character is forever the same. It is always and unchangeably a body of water, frozen water, running water, muddy water, limpid water. We say in the realm of material nature the order of things is not basically influenced by changes in weather, season and other environmental factors. Stable or unstable, things in nature invariably maintain their order. This is different in the case of human nature. A mature human being, let me say, an adult man, lives on many levels. In the family he is father, husband, son, brother. In the community he is neighbor, friend, employer, employee, member of a club, citizen, teacher, adviser, leader, follower. Consider his function as a husband. Having been an "orderly" husband for years, loving his wife, adoring the children, working for them, sharing their joys and sorrows, he is suddenly seized with an ugly suspicion that his wife is not loyal. Previously the pattern on which his marital life was ordered was that of implicit trust. Now the pattern has changed into an abiding distrust, bitterness and craving for revenge. In past days, he never thought of questioning the wife's character, of doubting her morals, of spying on her activities and movements, or of torturing her with revolting insinuations. Now he does nothing else. Formerly he was a loving marriage partner, now he is a hating partisan. His home life, once the source of untold delights, of peace and happiness, is now a place of turmoil, strife, gloom and cheerlessness. Everything within and around him has undergone a radical change. In days bygone he used to turn his interest and attention to a multitude of topics and endeavors, delighting in joint family action, in picnics, shows, sports and trips. He took part in civic affairs, visited freely back and forth, puttered gayly around the house. But now his mind is invariably and exclusively focused on his wild obsessions and fierce suspicions. You see here how in a human being the order in which life is adjusted is so unstable that one single element—in our example, suspicion—can lastingly upset it so that it turns into its exact opposite.

A suspicion is a belief. If I say, "I believe," I wish to indicate that "I do not know," that, instead, "I merely believe." On the other hand, if I say, "This is a lamp," I mean to imply that I know for certain what the object is. I do not merely believe that "this is a lamp" but have certain knowledge that it is one. Should I say, "I believe this is a lamp"; I would suggest that my statement represents a belief instead of knowledge, moreover, that I am aware of not knowing for sure whether the object in question is a lamp. Which means that by using the phrase, "I believe," I intend to state that I am aware of the fact that I do not know for certain what kind of an object or person I deal with. To put it differently: The moment I use the word "belief" or "believing" or any of its synonyms, I want it to be understood that I voice a tentative opinion, that my assumption may be incorrect, and that should I discover its incorrectness I am ready to drop and change the belief. Strange as it may sound, the philosophy of Recovery is based unqualifiedly and unreservedly on this matter of belief. All its techniques have for their aim the intention to plant in the patient's mind the correct beliefs (about nervous health) offered by the physician and to purge it of the false beliefs held by himself. The reason for our almost fanatical preoccupation with the subject of beliefs is that it is they which either order or disorder the lives of mature human beings. With us in Recovery it is an axiom that while a nervous ailment is not necessarily caused by distorted beliefs, nevertheless, if it persists beyond a reasonable time, its continuance, stubbornness and "resistance" are produced by continuing, stubborn and "resisting" beliefs. The above quoted case of the jealous husband whose whole life was "thrown out of order" by a disrupting belief (jealousy) ought to be sufficiently convincing. But jealousy, it may be objected, is not exactly a nervous ailment, and whether or not beliefs have actually a decisive impact on the course of psychoneurotic conditions ought to be demonstrated by the quotation of the case history of a "real" psychoneurotic patient. Here, then, is the case of Harold: One day he was sitting at his desk, thinking of nothing in particular, relaxed to the point of being serene. Suddenly, "out of a blue sky," he was stricken with a wave of fear. What precisely he feared he did not know. He merely knew that fear was "coursing through the body." He felt faint and numb, had the impulse to yell and rush for help but controlled himself. Soon the fear left while a subtle apprehension remained. In the morning, the scare was gone but the apprehension still persisted, although its intensity lessened. After a few days Harold was "his former self again," except that an occasional fatigue or some fleeting pain and ache tended to remind him for a minute or so of the frightening incident. All went well until, one evening, he came across an article in the daily health column in which a medical journalist told his unsuspecting readers that heart diseases may begin with fatigue, pain over the chest and a fast heart-beat on exertion. Harold instantly felt a sharp pain over the left chest. He remembered the fatigue which he had recently experienced, recalled that "frightful" spell of some weeks ago and was convinced he had a heart ailment and was doomed to lead the life of a cripple or was threatened with collapse.

Harold's case is instructive. Before the wave of fear struck him he was tolerably relaxed. Being relaxed he felt (believed he was) secure. The suddenly rising fear and the subsequent apprehension changed the belief of security into that of insecurity. He recovered, however, spontaneously which means that he dropped his belief of insecurity and returned to his original belief of security. But when after reading the health column which, striking unnecessary terror into the hearts of innocent readers, ought to be called more properly the health calumny, his feeling (belief) of insecurity returned with elemental strength. This strength it gathered from the fact that the belief was now fortified by the authority of a medical editor. The loose belief had now become a solid conviction.

This example aptly portrays the condition in which all our patients find themselves. Up to a certain turn in their lives they are able to relax with reasonable success. Then the belief grips them, on the occasion of some harmless but frightening spell, that they are in danger and in need of help. That belief may not gain the strength of a firm conviction until some suggestion is offered by some questionable "authority," usually a radio announcer or journalist, that their condition may be the beginning of a dreadful disease. The "authority" which sometimes may be nothing more authentic than the story told by a neighbor of "a similar case" which ended fatally, clinches the weak belief into a firm conviction. In time, the conviction becomes more convincing. It gathers unto itself the strength of a dogma and resists every attempt to drop or change it. The longer the conviction lasts the more thoroughly does it disorder the life of the patient. It creates sustained tenseness, panics and vicious cycles, finally, the well known chain of nervous symptoms. On seeing the patient at that stage, the physician endeavors to divest him of the conviction of insecurity. But whether he will be successful depends on whether the patient will or will not accept (be convinced of) the physician's assurances. If the patient balks, engaging in the familiar game of self-diagnosing, a fight ensues between the convictions of the physician and those of the patient. This is called "resistance" or "sabotage." What the patient resists and sabotages is the physician's knowledge that nervous ailments require Will-training, Self-discipline and Self-control. What he fights for is his own conviction that he needs outside help for an ailment which has nothing to do with Will, discipline or control. The clash of the two antagonists is backed by two philosophies, mutually exclusive, contradictory and irreconcilable. The one is the philosophy of Self-control, the other that of Self-indulgence. If the philosophy of the physician prevails the result will be health, that is, restoration of order. If that of the patient wins, the ultimate outcome will be chronicity, that is, enduring disorder.

The distinction between loose beliefs and firm convictions is basic to an understanding of the Recovery philosophy. If my patients had nothing but beliefs with regard to their tempers and symptoms my therapeutic task would be easy. I would tell them that their beliefs are incorrect; that they are based on "nothing more convincing" than faulty conceptions, untenable.
premises and deficient experience. As against this, I would remind them that my conceptions, premises and experience have the merit of long years of study, research and training. This bit of instruction alone, if willingly accepted, might be sufficient to effect a change of attitude. Professional expertness would be pitted against lay ignorance, and the fair minded sufferer might be ready to exchange good-naturedly his own naive guess for the authoritative knowledge of the expert. The process might require a measure of discussion and explanation, and—in Recovery—the demonstration in classes that other patients regained their health after they changed their beliefs. Unfortunately, the finest demonstration, the most skillful discussion and most lucid explanation are no match for a solidly entrenched conviction. A person who holds a settled conviction is committed to it; he is ready, and perhaps eager, to defend it, to fight for it, to uphold it against evidence. With a person of this kind there is no discussion, no healthy exchange of views, no realistic testing of opinions. What he is itching for is to battle for his own conviction and to "knock out" the conviction of the partner. This person, be he a nervous patient or some other representative of the romanto-intellectualist breed, has no relish for getting things explained or discussed. What he wants is a fiery debate, not a calm discussion. Otherwise, how could you understand the paradox that my patients, supposedly seeking help and advice, resent and reject the advice which I offer. The answer is that, though suffering acutely, my patients are for some reason vitally interested in maintaining and upholding what they conceive of as their convictions. The one, being depressed, is convinced that all hope is lost, and if I assure him that his conviction is wrong he makes an heroic effort to convince me that I am wrong. The other has palpitations and along with it the conviction that his heart is damaged, and when I offer him my authoritative knowledge that his heart is in good order he clings to his conviction that his diagnosis is correct and mine incorrect. It is all weird, unsound and absurd, but that is precisely what naive, untested and haphazard convictions are likely to be: weird, unsound and absurd.
Frank R.: One Saturday last fall I had occasion to go to the Union Station after the Saturday meeting. Harriette and I were going out of town to visit her parents. As Harriette was working I was to meet her at the station before train time. I left the Recovery office around five o'clock which was plenty early as the train didn't leave until six. I walked over to the bus stop to get the Jackson Blvd. bus. I expected one to arrive in a very few minutes. A number of buses passed and I was beginning to get a little anxious and tense. I still had plenty of time but it was growing shorter. Then I started looking toward Michigan Blvd. where the bus should turn from the South. I noticed that numerous buses passed along the Boulevard but none of them turned, all continued going North. The endless procession of North side buses went on. Now twenty minutes had passed and I really was worried because my time was running short. I began to think I would take a cab. Just then a person who had also been waiting for a bus for some time came up to me and asked me what bus I was waiting for. I said, "I am waiting for the #26 Jackson Blvd. bus." This stranger said, "If I am not mistaken I believe that that bus turns on Jackson Blvd." I was dumbfounded. Here I, a man who has lived in Chicago for 35 years, had waited a half hour on Adams for the Jackson bus.

By the time the stranger had straightened me out there was so little time left that I scurried about and got a cab. I was too taken up with this business to notice any symptoms but a couple of minutes later when I was seated in the cab I noticed them. I was extremely tense and was sitting on the edge of my seat, my stomach was knotted up, I was so disgusted with myself that I almost felt like crying. I had an acute headache and my vision was blurred. A few minutes before I had been in good spirits and now I was deeply depressed. I kept thinking, over and over to myself how stupid I had been, not knowing the difference between Adams and Jackson after 35 years.

More symptoms developed. I got chest pressures and numbness in my legs, and my thoughts were racing a mile a minute.

Soon I spotted what I was doing. I was working myself up by continuously blaming myself and by dwelling on the fact that I had stood on the wrong corner. I decided that the working up process had to stop. I remembered that it is average to make mistakes. And that countless people must have waited on wrong corners as I had done. In fact, I then recalled that I had done the same thing several times before. I also recalled that on the train I ride every night it practically never fails that there isn't at least one person who has taken the wrong train by mistake. I began to relax, sat back on my seat and waited until we reached the station.

By the time I met Harriette at the station my symptoms had evaporated. I told her what had happened and she just laughed. Sometime later when we had returned from our trip I told several of the Recovery members about the incident. None of them seemed to regard the incident as a cataclysmic event. I later told a fellow at work and he didn't seem a bit astonished either.

Before I had my Recovery training the fear of making mistakes was, with me, the preoccupation of my every waking moment. It was an obsession with me, my every waking moment was devoted to past, present and future mistakes. I ate, slept and breathed mistakes. The result of this never ending preoccupation with mistakes were constant symptoms such as: poor sleep; poor appetite; fatigue; depression; my thoughts were the dreariest and most pessimistic kind; palpitations; tremors, night sweats; confusion; indecision; self-disgust; lack of self-confidence and constant tenseness. Today I get symptoms but spot and stop them quickly. I can do that now because in Recovery I have learned to have the COURAGE TO MAKE MISTAKES in the trivialities of daily life.

Dr. Low's Comment:

After reading Frank's example Dr. Low declared that Frank gave such an excellent description of his sabotaging and subsequent spotting and self-control that no further comment seems to be called for.
Phil C.—

“A Miss Johnson, who works for the same company that I work for, was married a few weeks ago and she invited me to her wedding. On the day that I had planned to buy a wedding gift for her I brought the wedding invitation with me so that I would have the address to which the gift was to be delivered. Later that day I went to one of the downtown stores and, having made what I thought was a good selection, I pulled out the invitation to give the sales lady the address. But I noticed that Miss Johnson’s home address wasn’t on the invitation. There was only the address of the church where the wedding was to take place and the address of the hall where the reception was to be held. For some reason I guess I had thought that the reception was to be held at the bride’s home.”

“I became a little embarrassed but I thought I remembered that Miss Johnson’s father’s first name was ‘Wayne’ so that, since I knew the locality where they lived, I thought I could look up the address in the phone book. The sales lady obligingly gave me one but I found that none of the ‘Wayne Johnsons’ lived in the right locality. Then I suddenly remembered that ‘Wayne’ was the groom’s name, not the father’s name. Again I became embarrassed. I asked the sales lady if she would hold the gift a few minutes while I made a phone call to find out the correct address. She replied good naturedly that she would.”

“By this time I could notice that I was becoming pretty tense but I commanded my muscles to walk slowly to the nearest phone, where I intended to call the company where I work to find out Miss Johnson’s address. Then, just as I was about to put the dime in the phone box, it occurred to me that the father’s first name must be on the wedding invitation. I looked and there it was, ‘Alfred.’ After that it was a very simple matter to look up the bride’s address.”

“When I returned to the sales lady she said, smiling, ‘Well, it didn’t take you long did it?’ ‘No,’ I replied, feeling my face blush a little, with the thought of self blame for the mistakes I had made rising up in my mind. But even while she wrote out the sales ticket and I wrote out a card to go with the gift, my Recovery training began to come to the fore. I spotted my experience in the store as being average. I knew that it is average to forget addresses and to confuse names. I knew, also, that with a sense of humor I should be able to view my mistakes as trivial and myself as average.”

“My Recovery training has enabled me to reject the thought of self blame for trivial mistakes and to check the working up process. I no longer make an all-out, sustained condemnation of my mental capacity—as I did in pre-Recovery days—with the result that I now avoid the mounting tenseness and the severe symptoms.”

Dr. Low’s Comment:

Phil says: “I knew it is average to forget addresses and to confuse names. I knew, also, that... I should be able to view my mistakes as trivial and myself as average.” This reminds me that I know how silly it is to worry; I know, also, that worry does much harm and gives little aid; I know all of this but hardly an hour passes in my life but I worry—about myself, my future, my family, my patients. I could mention other things which I know I should not do, yet, I do them, one of them being smoking, another getting angry, a third blaming myself for banal offenses. I know but the knowledge helps little. You know, Phil, what I am driving at because I have mentioned it so frequently: Knowledge is good and indispensable for action and planning. But with all the knowledge of the good you will bungle and slip and frequently do the bad. The reason is that after you have learned and know the good you must practice and practice and practice again what you know. It is practice that gives you the skill, the assurance and mastery for correct action. Knowledge teaches you what to do, but practice tells you how to do it. This goes for ordinary performances, but also for such complex conduct as the art of acting average, the skill in avoiding self-diagnosis and holding down temper. All the theoretical knowledge you may have about them will avail you little unless you add practical training—in self-control. And one of the great accomplishments of our Recovery techniques has been to deflate the value of knowledge and to emphasize the supreme importance of training, and continuous training at that. The continuous training, guided by continuous spotting, yields what we will call: self-management and self-control, both of which combine to furnish self-help.
Frank盲点，我将介绍你到《精神健康》第三部分

所有他需要做的是记得他有数百个糟糕的夜晚，会崩溃。明显的可能性是显而易见的，如果他想实现，他就能意识到，如果他想实现，他的假设就是荒谬的。

我会解释这个元素的危险性。它被夸大了。对其他证据的否认是如此的可怕，以至于他自己都很难意识到，他的假设是荒谬的。

在说他的盲点是自欺欺人，是阴谋、故意和系统性的。参考文章《盲点和聚光》在《复苏新闻》，8月1950年。

如果我看到一张桌子在我面前并坚持它不是一张桌子，否认只能是忽视我自己的荒谬努力。

“我很久以前就厌倦了我的‘大’例子，然后我就迷茫了。它几乎不可能让我选择一个。有一天，我被邀请坐在周六下午的现场面板上作短暂的演讲。我没有一个好例子。在考虑这个例子之后，我惊讶地发现我没有处理任何‘大’的例子。我告诉如何。

“它正是因为我在一天中没有收到一份信，然后我确信我失去了理智。如果我的食欲不好，我确信我会患上非常严重的疾病。但如果我忘记了一封信，那么我就会失去友谊。然后我就会失去我的食欲，我想我会得非常严重的疾病。我总是寻找一个重要的事，一个使我失去理智的因素。那是因为我想，那是一个严重的危险。

“我很快就开始在周六下午和家庭会议面板上给出例子，我有很大的困难。其他的例子是：工作中的错误我害怕被解雇。如果我睡眠不好，我会担心我会身体上崩溃。……”

Dr. Low's Comment:

Frank R.——

“当我第一次尝试提供例子时，我在周六下午和家庭会议面板上，我有很大的困难。在选择我想要的例子时，我有了一个好主意。我喜欢这个例子，因为它是一个好例子。我有这个想法，如果我没有提供一个好例子，我就会拒绝另一次预约。其他的例子是：工作中的错误我害怕被解雇。我预先愿意做的就是不要做任何事，因为我不认为这是个好例子。我必须做的是，我必须做的是，我不想做的是，我必须做的是，我不想做的是，我必须做的是，我不想做的是，我必须做的是，我不想做的是，我必须做的是。如果我同意的话，我就会失去他的友谊。如果我在考虑这个例子之后，我就会失去他的友谊。如果我在考虑这个例子之后，我就会失去他的友谊。

“它是因为我一次又一次地告诉他，我曾经告诉过他，如果他想一个例子，他就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。我告诉如何。

“它是因为我一次又一次地告诉他，我曾经告诉他，如果他想一个例子，他就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。如果我想一个例子，我就会失去他的友谊。我告诉如何。
that. The absurdities voiced by others the patients spotlight; their own absurdities they blindspot. I wish that all my patients performed this little experiment on themselves. When they fear that their dizziness or numbness will lead them to destruction, I wish they would ask themselves the question: If Mr. X had my dizziness or numbness and feared they would kill him or cripple him, would I believe that? If you ask this question all the time you might be well all the time.
Excerpts from Mental Illness, Stigma and Self Help: The Founding of Recovery, Inc. (Low, 1991)

CHAPTER ONE (Low, 1991, pp1-5)

Introduction

An average of ten thousand patients are yearly admitted to the state hospitals of Illinois. An additional two or three thousand victims of mental disease find their way every year to sanitariums and privately endowed hospitals. Interpolated for the nation as a whole, staggering figures are reached telling a depressing tale of anguish, helplessness and despair. Are there means for checking the disastrous wreckage wrought by mental disease?

Ten years ago the answer was an unqualified no. Then the shock treatments were introduced, and the unqualified no gave way to a cautious maybe. After ten years of extensive experience with the new therapies a positive answer ought to be available. If it is not, what are the underlying reasons?

The fact is that the shock treatments have successfully maintained their dominant position in the therapeutic scheme of the mental hospitals. This in spite of the general knowledge that they are potentially and actually dangerous and that the ultimate results in terms of sustained recoveries are disappointing. If this is true, why are they still running the tide? Why have they not been discarded? Ten years must be considered a reasonable test period. Is it common practice in the field of medicine to disqualify a therapeutic measure if extensive and intensive tests have demonstrated conclusively that the dangers inherent in its use are not generously overbalanced by beneficial results. On the strength of this generally accepted rule, the shock treatments ought to be relegated by now to the rubbish heap of discarded procedures. Instead, they still enjoy the highest priority rating in the list of available remedies. What is the reason for this paradoxical situation?

Whether or not a given treatment is satisfactory depends on what is expected of it. In the instance of the shock therapies, it is clear that they are of limited usefulness only if they are expected to yield large numbers of sustained remissions, that is, if they are counted on to check the increase in hospital population. However, if what is expected is a sizable or considerable increase in immediate remissions (frequently followed by relapse after weeks or months), the results may be accounted exceptional and unparalleled by any known therapeutic agent. Obviously, if the mental hospitals continue to favor the shock treatments they do so for the sake of their supreme capacity to "shock" the patient into temporary sanity. Is the exorbitant price paid in terms of time, effort and financial outlay warranted if the effect is merely a transient suspension of mental illness?

Treatment, if successful, results in permanent cure or temporary relief. The former is called curative, the latter palliative. On the score of this distinction, the net effect of shock treatment must be considered to be palliative in nature. If it is to aid in the emptying of the mental hospitals, it will have to be raised from its present lowly status of a mere relief-bringer to that of a cure-worker. Can this be accomplished?

The common variety of sedative drugs is credited with palliative action only. Yet, in the hands of the experienced psychiatrist they are frequently used to pave the way for the ultimate cure. A good night's rest secured through administration of a barbiturate eliminates—temporarily—panics and anxieties, thus enabling the therapist to effect a sustained or permanent cure through psychotherapy. That this is by no means a freakish and exceptional incident is attested by common psychotherapeutic experience. In the field of psychoneuroses, the sequence of chemotherapy followed by psychotherapy has long been an established practice. Substitute "psychosis" for "psychoneurosis," and "shock treatment" for "sedatives," and the principle of the chemo-psychotherapeutic sequence finds a new fruitful field of application.

As long as the psychoneurotic patient is in the throes of uncontrolled emotion, panicky or agitated by acute anxiety, he is not approachable. In psychiatric lingo, he is in poor contact or out of contact, as the case may be. After the sedative reestablishes or improves contact, the road is opened to curative effort. If the shock treatments are indicted because they do "nothing more" than produce temporary remissions, the absurdity of the charge is revealed if the indictment is made to read that they do "nothing more" than reestablish contact. The irrationality of the allegation is brought into better focus if it is remembered that, in the pre-shock era, nothing was more fervently hoped for by psychiatrists than some means for creating contact with the stuporous, confused or withdrawn patient. Contact was rightly conceived in those days as the entering wedge for curative psychotherapy. Today when the shock treatments have provided us with a highly productive bonanza we behold the bonanza but the mine is left unexploited. How is it bonanza and prospectors do not meet?
One reason was mentioned: overcrowding and understaffing. The plea of overcrowding is begging the question. There would hardly be an issue but for the pressure of hospital population against hospital space. The real issue is the understaffing. This means that the number of physicians is insufficient for the magnitude of the task. To give the problem this phrasing is to reduce it to the well-known question of man-hour ratio. Here are 100 patients requiring, let us say, an aggregate of 2,000 hours of psychotherapy. The ten physicians who may be available for the task can supply no more than 50 or 100 hours. Result: the psychotherapeutic mine must be left unworked. This is not the reasoning of the energetic prospector. The obstacles of the man-hour ratio have little meaning for him. If the exploitation of the mine calls for more men than can be profitably employed, he uses machinery. He solves his difficulties by a change in technique. The introduction of new methods does away with the handicap of man shortage.

This is the point: What is needed are new methods. The shortage of men must be relieved by time-saving and men-sparing techniques. That 100 patients need 2,000 hours of psychotherapy is true only if the treatment is given singly and individually. Should the physician consent and be prepared to administer his therapy in groups, he could assemble 50 of his patients in one and the same room and dispense 50 treatments in the space of 60 minutes. The above mentioned 2,000 hours could be reduced by this group procedure to the manageable figure of 40 hours. If the group were enlarged to comprise 100 patients in one class, as this writer has successfully done, the 2,000 hours would dwindle to a mere 20. The troublesome man-hour ratio would lose its embarrassing aspect. Nor is group psychotherapy the only technique available for the purpose. In the past six years, an imposing system of group techniques was evolved by the ex-patients organized in Recovery, Inc., the Association of Former Mental Patients. The system is there for the asking. The ex-patients as well as this writer claim that they are an adequate, if not final, answer to the vexing question of how to check the steadily mounting rise in hospital population. The claim may be exaggerated or incorrect, but it cannot be disposed of without a thorough investigation of its validity. It was with a view to facilitating an investigation of this kind that the executive committee of the Recovery Association decided to publish several volumes outlining its history and objectives together with a tolerably extensive description of its system of group techniques.

The techniques are designed to provide after-care for the discharged patient. After-care, however, requires adequate preparation of the patient while he is still a resident on the ward. This creates an unavoidable overlap between hospital treatment and extramural after-care. That a happy synthesis was effected between the two discrete phases of the same problem ought to be evident from a perusal of the report given in this booklet.

After-care has two divisions. The one supplies instruction and is superintended by the physician. It goes by the name of "hospital-directed after-care." Essentially it consists of lectures and group psychotherapy classes. Of far greater importance is that part of the system which is operated independently by the ex-patients themselves. This is called "self-directed after-care." The present volume is exclusively devoted to a description of the latter variety of techniques. The techniques of group psychotherapy and the system of lecture elaborated by Recovery will be treated in subsequent publications.

All articles and items here reproduced were originally contributed by the author and published in *Lost & Found*, the bi-monthly Bulletin of the Recovery Association. As will be pointed out, *Lost & Found* was discontinued in September 1941 after it had been in existence for over three years (July 1938 to September 1941).
In November 1937, thirty patients discharged as recovered from the Illinois Psychiatric Institute, jointly conducted by the University of Illinois and the State Department of Public Welfare, resented their STIGMATIZED status in the community and formed Recovery, the Association of Former Patients. The purpose of the Association is a concerted fight against the STIGMA of mental disease.

In the thirty months which have since passed, Recovery has evolved a decided view on the issue of the STIGMA, with particular emphasis on the role of the family as the propagator of the STIGMA idea. Recovery holds that the STIGMA is (1) public opinion, (2) family opinion, (3) the patient’s opinion.

The public merely holds the STIGMATIZING view. It is not permeated with it nor does it translate it into a living, dynamic creed. If a member of the Smith family contracts a mental ailment, the neighbors do not consider the Smiths disgraced or tainted. The Smiths are still invited and visited and accorded their due social and civic privileges as if nothing had happened. Thus, the STIGMA idea held by the public is relatively inert and academic. However, the public legislates and incorporates the STIGMA idea in the statute books. Public opinion, as embodied in the law, is an important aspect of the STIGMA. Public opinion with regard to STIGMA is also important in matters of employment. The public is both legislator and employer. Briefly, both the legal and economic varieties of the STIGMA attitude could be changed through “popular education.”

The STIGMA idea is not merely loosely held but firmly upheld by the patient’s family. The Smiths imbibe and absorb and live the STIGMA philosophy. When the patient returns from the hospital he is infected with the idea. With the patient the notion of STIGMATIZATION is not merely alive but burning and torturing.

To Recovery, the STIGMA is a contagion, with the family as soil or source of infection and the patient as the host. The public, through legislative and economic discrimination merely gives its official sanction.

Recovery’s fight against the STIGMA is mainly concentrated on family and patient. The patient must be immunized and the family disinfected as a protective measure against the contagion of STIGMATIZATION. Incidentally, both patient and family must be freed and emancipated from an antiquated law which sanctions the operation of the contagion.

The family is infected with a motley combination of ideas:
(1) Mental disease is incurable—“once mentally ill, always mentally ill.”
(2) Mental disease is “madness” and calls for incarceration of the patient as protection to himself and the community.
(3) Mental disease is not really a disease but a derangement of thought and emotion. The person who neglects to control thought and emotion is held “responsible” for the failure. The patient is “guilty,” an “offender,” hence, an object of moral and legal STIGMATIZATION. Part of the guilt and responsibility attaches to the family. Hence, both patient and family are “tainted.”
(4) Mental disease is hereditary. This consideration saddles the family with a particularly galling “guilt,” the hereditary taint.

When the patient returns from the hospital he is placed in an environment which is dominated by two main sentiments:
(1) The patient, “incurable,” is distrusted. He must be watched because he may relapse, and “anyhow, he is not cured and may do the wrong thing.” Being held in tutelage and under supervision, the patient is deprived of his freedom of action.
(2) The family, “disgraced,” maintains a “hush and secrecy” policy. Concealment is the watchword. The patient is not permitted to speak of his hospital experiences. The neighbors are told the boy was in the country. The son is cautioned to maintain silence on his past. Being silenced and muzzled, the patient is deprived of his freedom of opinion.

The family is the group in which the individual can relax. Everybody has the privilege of speaking, acting and thinking freely at home. The mask of conventionality which must be worn on the outside, can be thrown off when the home is entered. At home, one is “understood” and can be outspoken without danger of being “misunderstood.” One can afford the luxury of committing errors, slips and petty offenses without risking enduring enmities. Home essentially means you can be frank, i.e., you do not have to conceal or to be on your guard; you are - at home. The returned patient is not at home in his family. Deprived of his freedom of opinion and action he feels friendless and homeless.

As a person who lives under a shadow, friendless and homeless, the returned patient has the sense of isolation and psychological insecurity. As a result, he lacks self-reliance.

Recovery’s program, being based on the tripartite necessity to (1) immunize the patient, (2) disinfect the family, (3) emancipate both patient and family from legal STIGMATIZATION, can merely be outlined here.

IMMUNIZATION—The patient is trained to think of mental ailment as bona fide disease, not different from any other disease. He is trained to form a group of his own, where he is “at home” and can relax. He is trained to associate with other recovered patients, at regular meetings, at parties, shows and informal social gatherings. Recovery restores to the patient his lost freedom of action and opinion.
As a result, his sense of isolation and psychological insecurity are weakened or eliminated, and his self-reliance repaired or recreated. An economic self-help program which is intended to attack the problem of economic STIGMATIZATION is too complex to be given in brief outline.

DISINFECTION OF THE FAMILY—The parents and relatives are given systematic courses of instruction, are induced or forced by the ex-patients to attend the courses, parties and shows and are there made to associate with the patients as a group. The fact that the patients as a group "take matters in hand" and show initiative, together with formal instruction, convinces many relatives that "once mentally ill is not "always mentally ill."
TEMPER AND TEMPERAMENT
18 Minutes
Recorded Saturday, October 3, 1953

The panel will discuss the subject of “Temper and Temperament.” It is remarkable that in textbooks, psychiatric or sociological or psychological, you will seldom, if ever, find the word temper. It is simply not discussed. You know that I distinguish between feelings; second, sentiments; third, emotions, into which both feelings and sentiments can be worked up; and finally temper. My colleagues only use the word emotions for this whole spectrum of reactions. But, of course, they sometimes also use the word feeling. But in the main, they speak of emotions, of emotional conflicts. They hardly ever—if they mention it at all—they hardly ever mention the word temper. But you know that in Recovery the word temper dominates practically every discussion of ours. We do not speak much of temperament because with patients, temperament is almost always worked up into temper, just as patients are in the habit of working up their feelings and sentiments into emotions. If you want to know more about these matters, read up in my book, and you’ll find it explained. It is in the third part of the book under the heading “Sabotage.”

Today I’ll tell you something about temper and temperament, and I will best, perhaps, choose an example. If you have a family in which there is a baby, then the following thing may happen. The baby may begin to cry and, as babies do, the crying develops into yelling. Now how will the mother react, how will the father react, and how will or may, perhaps, the maid react? The answer is: That depends on their temperament.

The mother, the moment she hears the yell of the child, will immediately jump up and go, or run, to the nursery. Her temperament has been touched or stirred, and now it develops feelings, the feeling of sympathy or the feeling of apprehensiveness; mainly, of course, of sympathy.

Now the father may react differently. I don’t say he will always react the way I want to describe. I will only say that some fathers may at times react as I will point out. He may become angry because there he was sitting reading, and his temperament was even, peaceful, and now this baby dares yell. And he may become angry that his peace is disturbed, that his temperament has been stirred up while previously it was calm, relaxed and even. And he may make some unpleasant remarks. He may, at any rate, ask the temperamental question, “Can there never be any peace in this home?” I hope you will understand the meaning of such a statement. With the father, we’ll say the temperament that had been even, placid and calm while he was reading and the baby was sleeping, now his temperament has been stirred up, and it has risen to anger, to an emotion, anger. How the emotion then develops into temper, I’ll mention later on.

Now the maid. The maid may hear the baby’s yell and not be stined by it. She may be indifferent to the baby, and her temperament will remain even, calm and placid before. We say that the maid is indifferent. This means her temperament is not stirred by anything the baby might do. I do not say that maids generally are like that, but they may be reacting in this manner. In these three examples, we will say the maid’s temperament rests placidly on its resting level and is not stirred.

Now the mother’s temperament, with regard to the baby, is sunny, always ready to enjoy the baby, even if it yells. The mother, with regard to the baby, has a sunny temperament. With regard to others, she may be anything else. She may be very sullen, temperamental, contentious, belligerent. But with regard to the baby, the average mother has a warm, sunny temperament. The father has at this moment—not regularly, I presume—developed a temperamental reaction of anger, of resentment.

And let me tell you that temperament is of these three types. Either it cannot be moved or stirred at all because the person is indifferent, stolid. Or it is stirred, in the mother’s case, into a reaction of warmth, of warm feelings, of joy, particularly of seeing the baby. In the father, it has been raised to dark feelings. He is angry, and he may also be fearful. He may be fearful that if the mother can’t pacify the baby, he will be in trouble and wouldn’t be able to read and rest.

And you know that I distinguish between angry temper and fearful temper and that’s all. The mother’s reaction does not fall into the category of temper at all. Joy doesn’t become temperamental. It arises from temperament, but is—as far as I know—never worked up into temper. So, if you will understand that there is a certain thing in us that is ordinarily placid, calm, restful, and that’s what we call our temperament. But if something happens on the outside or inside that disturbs the situation, then temperament is aroused. Then it develops feelings or sentiments, and the feelings and sentiments may be worked up into temper. And I will merely tell you, and the rest you can read up in the book, that temper is either fearful: then it is linked up to the belief that there is danger. Or it is angry: then it is linked up to the belief that somebody did wrong.

Now the father, who became resentful and made this stinging remark, developed temper. He thought the baby was wrong or the mother was wrong in not pacifying the baby, and he had also the fearful temper because he was afraid that now his peace will be disturbed. But he was angry and fearful only for a minute, for two minutes, for a short period of time. And then we call that an emotion. An emotion always rises and goes down the moment the disturbance is gone. An emotion lasts.
only as long as the disturbance lasts. It may still have an aftereffect, but if the aftereffect goes on for hours and days and
weeks, then it's held up by temper. Temper has duration. Emotions have very little duration. I hope you understand that, and, assuming that you do, I will now tell you that essentially I am not interested in the relationship between the ordinary father and his baby and the ordinary mother and her baby, and certainly I am not interested in the relationship of the maid to the baby. I am interested in patients, and I want you to know how you develop your temper and how you give it duration.

You see, in the case that I mentioned, something outside—the baby—was yelling and disturbing mother and [raising] her into joy and disturbing father and [raising] him into anger and fear. With my patients, I am not interested [in] whether they are disturbed by a baby or by somebody making noise or by somebody insulting them. I am not interested in that. I am only interested in the fact that they may be disturbed by their nerves inside, by fatigue, by dizziness, by palpitations, by pains and pressures that are caused inside by their nervous system, and then they become temperamental. This means they add to their disturbance the idea, "There is danger," or the idea, "I am angry at myself. I do wrong. I ought to be able to control my body, and I don't do it, and that's wrong." Then you become disgusted with yourself, and you become discouraged about yourself, and that is temper directed against yourself.

We are not interested—not primarily interested—in Recovery whether you develop temper against somebody else. We are interested in that, too, but not primarily. We are mainly interested in the fact that our patients are likely to develop temper against themselves when they experience nervous disturbances. And if my patients conceive the idea that they do wrong, then they ordinarily make a habit of continuing this idea or this belief, and so their temper gains duration. As long as they are disgusted with themselves, as long as they are ashamed of themselves, or fear themselves (or fear their symptoms, in other words), as long as they do that, the reaction is maintained. And you know that patients are likely to have fears for days, for weeks, for months, even for years. Even for decades, I have seen patients maintaining fears almost continuously.

Well, you will understand that if a patient has developed temper, if he has permitted his temperament to rise to the height of temper, then we must devise means of getting him rid of it.

The father and the mother that I quoted developed reactions but only for a short period of time. And outside in life you see temperamental reactions of this short nature, of this short duration, all over. We are not interested in short-living emotions or temper. We are interested in that temper that the patient develops and that has duration, usually for years, or months. And if it has duration, that means that the patient has developed a habit, a deep-seated habit, of constantly worrying and constantly being disgusted with himself. And such a habit of long standing develops strength. That habit becomes deeply rooted in the patient's temperament. And that habit, being of long standing and gaining strength, is easily precipitated, easily aroused. And the more it is aroused, the more it gains strength, the deeper it roots itself into the ground. And you will understand that a habit of this kind will take a long time to be uprooted by the doctor who treats you. And if you think there is a short circuit around the disease towards health, well, you are mistaken, painfully mistaken. And on this occasion I want to remind you again that your habits of temper, of fear, anger, disgust, discouragement, and disappointment are deep-rooted and require a long period of time to be uprooted through treatment.

Thank you.
The panel will discuss today the subject of "Feelings Are Not Facts." In a sense, that is nonsense. Feelings are, of course, facts. Feelings can upset you to the point that you shake all over. They can inspire you to a point where you forget yourself. So feelings are, of course, facts. But, for instance, when you state that you feel there is something pressing in the brain, and it feels like a tumor—patients make such statements—although I don’t know how a tumor feels. I have never known that a tumor feels at all, or that a person can feel a tumor. A person can only feel pressure. But patients are fond of saying, "I feel it. How can you then say it is not a fact?" When I tell a patient, "Why, there is no tumor," then this is the common answer: "But I feel it, Doctor."

And many people speak in this manner. They feel something, therefore it is there. That’s, of course, blank nonsense. Feelings are very emphatic facts. This means they can shake you. They can inspire you. They can make your heart beat faster. They can have any kind of effect, and therefore they are facts. But in ordinary life when we speak of facts, we mean something else, nothing of the kind that feelings tell you about. We say, "It is ten o’clock," and we say, "It is a fact." Why is that a fact? The reason is that you then can say, "Look at the watch, and you will find out."

What we usually mean by "fact" is something that happens, or something that exists, that somebody else can verify. And he then can state, "Well, you are right. It is a fact." If you say, "This is a brown table," then anybody can find out whether it is brown or blue, and if he finds it’s brown, then he says, "It’s a fact that it is brown." Will you understand, therefore, that there are subjective facts that the subject feels, and objective facts that everybody who has eyes, ears, hands, and certain intelligence can verify.

And so the title of that article should read, "Feelings Are Subjective Facts but Not Objective Facts." But that title would take up about two lines in the book, and we don’t want that. Therefore, we merely let it read, "Feelings Are Not Facts." But you should supplement in your mind the adjective objective and say, "Feelings Are Not Objective Facts."

But patients come along and tell me, "I eat, I drink, I take a tablespoon of food in my mouth, and it doesn’t go down. It gets stuck in the esophagus. It gets stuck." Some patients go farther and say, "It gets stuck behind the tube, not in the tube." And you can’t say that such a thing is a fact. So, I tell the patients, "That’s impossible. No food can ever get behind the tube. It could possibly get stuck within the tube." Then some patients say again, "But, Doctor, I feel it." And they mean, well, that proves it if they feel it.

Patients come to me and tell me they feel that something jumps in the chest. They feel that the heart expands. And then again, I have the greatest trouble making clear to these patients that these are merely subjective feelings and not objective facts. Then these patients again come along with the statement, "But, Doctor, I feel it." Again implying that feeling, subjective feeling, enables them to find an objective fact.

Now the implication I hope you will understand—the implication that this has for patients. If a patient says that his feelings, his subjective feelings, are equivalent to objective facts, then he can make a diagnosis. And he can then act on his own diagnosis and, according to his own diagnosis, his heart expands because he feels it. You know if somebody should actually be afflicted with an expanding heart, well, that’s an extremely serious, fatal condition. That patient really passes the verdict of death and destruction on him, and if he is to avoid that course, then he must learn the difference between feelings and facts: this means between subjective feelings and objective facts.

A diagnosis must naturally not be based on feelings. It must be based on objective facts that can be diagnosed, for instance, by tests, by examinations, by x-rays, by all kinds of evidence that only the physician can supply and which the physician only can interpret. Only the physician knows what can be seen by tests, can be diagnosed, can be decided. But my patients trust their feelings. And once they begin to go on the evidence of feelings, then I try to explain to them again what feelings are, the kind of feelings they speak of.

I know, of course, what the common feelings are. I know what is love, hatred, fear. But look here, somebody says he loves somebody else. Then I’ll ask him or her, "What do you love in him?" Then they become flustered. They don’t know what the question means. I merely want to tell you these few remarks that I am going to make about love. I merely want to tell you that even in such a simple matter as love, people are not competent to state what it is.

If a mother tells me she loves her daughter, well, I have no doubt that she loves the daughter. Should I, however, ask her, "What attracts you to your daughter?" that wouldn’t be a silly question. Not at all. The attraction could be very varied. A mother may love the daughter just because she’s a mother and she loves the daughter, I grant you, and that doesn’t need any explanation. But if I ask the question, "What attracts you to your daughter?" that may be something else than love. A mother may be attracted to the daughter, for instance, by the desire to take care of her, to guide her. But then if the daughter is already eighteen, or twenty, or twenty-five years of age, and the mother wants still to take care of her, although the daughter...
is married and has perhaps children, then I'll ask the mother again, "What attracts you to your daughter?" And if she is again flustered by this question, I'll tell her what attracts her to her. It is the desire to possess the daughter, not to give up the possession of her daughter, and that's what we call possessiveness.

There is nobody else perhaps in this world that will want to be possessed by this mother, that will tolerate her possessing her. What we call possessive mothers are certainly mothers that love their children. They would want to take care of their daughter, not of strangers. But along with this love goes this desire to possess the body and the soul, and every act, and every decision of that daughter. And I have seen mothers who don't let their daughters even boil two eggs. They immediately rush up and say, "Let me do it." You can't tell me that this is love.

And if a father loves his children and constantly teases them so that they really become distracted, or he constantly says no when they ask for something, don't tell me that is love. That father may still love the children, but his love is outstripped by something that we call domination. He has no respect for the desires of the children. The children have no desire to constantly [be] teased. They have certainly no desire to be constantly treated with no, with negativism.

And, in conclusion, let me tell you, let me sum up. Even such familiar feelings as love are of such a complex structure, that your judgement about them is not competent. Anybody who has studied this subject of marital love, and has studied it critically, he can perhaps give you an opinion of whether this love in a certain condition is genuine or intermingled with all kinds of other factors, and, therefore, not genuine, not even approaching the state of purity and singleness.

And if that is true, you can now draw the conclusion that whenever you feel something in your body and then you make a pronouncement, you know what it is, you know that it is a swollen gland that you feel somewhere within the body, you know that the food doesn't pass through the esophagus, you know that the pressure in the brain—this means in your skull—is due to a high blood pressure, and you feel now the blood pressure has risen—right now, mind you—whenever you have the intention to make a statement, my advice is, stop it, first, as a diagnosis, and, second, as the result of a feeling. And feelings of the kind that I mentioned should never be trusted as revealing and representing facts.

Thank you.
You remember what Fanny told you. She was asked by the boss to do something, to compile some numbers, some figures, and she did. And then some girls complimented her, and one girl made some slurring remark. The majority of the workers apparently paid her compliments. That's not the point that I want to touch on, although I could bring out the fact that Fanny, years ago, would not have been able to stand up under such a situation. This situation would have been an ordeal for her, this means for her nerves. And today she manages this situation with skill, without getting ruffled, without becoming aroused to fear or anger. So she has really learned how to spot in the manner which our patients are taught to do in Recovery. But, as I said, I will not discuss this aspect of the event that she reported. I will rather tell you that most of you who are my patients have come to me at one time or other and have criticized these panel discussions.

I am part of this panel event, in that I discuss what the panel members say. And I must admit none of these patients have ever criticized my part in the panel discussion. I am grateful to them for that. But they criticize severely what the patients say. They don't say that the patients talk nonsense. They don't criticize the contents, the logical contents, of what the patients say. But they come up to me with the remark, "Well, what the patients at the Saturday panel say are trivialities." And I tell them, "I hope they are. I don't want them to discuss anything but trivialities."

Briefly, I will tell you life consists of trivialities, of very little else. If you find out, if you try to find out what you worry about, it's trivialities. Whether you should, for instance, buy a certain item or not. Whether you should buy it now or wait till the price goes down, you know. Should you spend money on certain unnecessary things, or should you save the money, and so forth? These are trivialities. And if you begin to worry about your children, the children don't do anything but what we call trivialities. They don't start political action, be sure not. And let's hope they don't commit crimes. I hope they don't. And it has not yet come to the point where crime has become a triviality, this means an average happening.

But the average person deals with average happenings that are naturally in the nature of trivialities. You eat, you sleep, you walk, you visit, you talk over the phone. That takes up perhaps 90 percent of your waking day, if not 98 percent. Life consists of trivialities mainly. How often does it happen in the average family that the father dies? Well, once in a lifetime, naturally. Or that somebody else dies? Once in a lifetime. It's not a common, average, trivial thing. How often does it happen that somebody in the family gets married, that somebody gets born, and so forth? The big item, well, how often does it happen that the house burns down, and so forth? I could go on indefinitely. Whatever you call a big item happens once in a lifetime, as a rule, and sometimes never.

Even of this I didn't want to speak. I could have mentioned that the critics should consider this matter of life being trivial. It's very important as a total, but its individual events and actions are naturally trivialities. There are only a few persons that must constantly watch out in matters of their responsibilities, who must establish a high record of responsible action, of vigilance, of constant looking out. Well, that's a mayor of a big city, or the mayor of a city, the President of the United States, and a few other people, a general in the army, they, of course, deal with very important items. Their lives are not or should not be filled with trivialities. But the average individual lives a life choked with trivialities. As I set out, about this I didn't want to tell you much either. I only wanted to mention it.

What I wanted to tell you is as follows: These trivialities of everyday life have one peculiarity: that they either are not noticed because they don't interest you, or they cheer you because they please you, or they anger you or scare you. Even the simplest triviality can scare you. If your children are misbehaved, after all, if it's not a high degree of misbehavior, it's a triviality. But it can scare the mother that her darling is so unmannered. It can give her all kinds of misgivings about the future of her son. You see, trivialities crowd the life, but any one of them may arouse your anger, your fear, your disgust, your terror, and so forth. Any one of them. After all, in the life of a mother, the fact that the baby cries is a triviality. The fact that the baby today doesn't eat is a triviality. And a thousand things that the baby does are trivialities. But the mother may work herself up over each and every of these trivialities. And will you understand, the closer is a relation between one individual and the other, the more can the trivialities performed by the one person irritate and frustrate and anger and scare the other person if they are a close unit, like mother and baby, or other such associations.

Now, we are interested here in nervous reactions. Our purpose is to get our patients rid of their nervous symptoms, of their fears, of their obsessions, of their palpitations, fatigue, inabilty to sleep, and whatever these reactions and symptoms are. Now, you would never have developed your symptoms—or, if you had developed them, they wouldn't have continued with you and taken on duration—if you had not developed the process that I call processing. This means working yourself up. And that means to be irritated, to become angry, to become fearful, to become disgusted. If you hadn't developed the habit of getting disgusted so easily, of getting scared in a moment, and of keeping up the scare, and the fear, and the disgust for days, weeks, months and years—if you had not done that, in other words, if you had avoided both outside temper and inner
temper (I told you about the inner temper this afternoon)—if you had avoided the outer and inner temper, you would have lost your symptoms in no time. Your symptoms. In no time. Symptoms don’t develop duration if people keep calm, if they keep relaxed. And you can’t relax if the trivialities of daily life irritate you and scare you and anger you.

Well, I could go on endlessly in this list. I’ll rather call it: There is temper, and temper creates tenseness, and if you develop tenseness, then the tenseness presses against your nerves, and your nerves will develop symptoms. Not necessarily mine. I can tolerate tenseness, the tenseness of worry and of anger, very beautifully. And, therefore, the anger disappears soon, and the tenseness disappears soon, and I develop symptoms that last only a second or a few seconds, at the most a number of minutes. But you are so riled by the events, the trivial events of average daily life, that you develop a monstrous temper that lasts for days, for weeks, for months. And then your nerves are put under this heavy pressure of tenseness for months or for weeks, with some of you, for years.

And do you understand now what is the meaning of the trivialities of everyday life? Don’t snub them. Don’t sneer at them. I want my patients to learn how to deal with trivialities. I want you to learn not to get upset by trivialities, or except for a moment, for a few moments. And I don’t know how to treat nervous conditions except by beating down your temper, precisely by making you handle without temper the trivialities of daily life.

And if you wish to be trained in Recovery, then I advise you, be prepared when you come here or when you come to the daily classes, to listen to nothing but to trivialities. Whenever a patient here at the panel mentions big things as examples, after the meeting, I take him aside—if I don’t forget to do it—I take him aside and tell him, “Will you kindly go back in your next example to the trivialities of everyday life? We don’t want anything else discussed here but trivialities.” That means but life. That’s life.

And if you think that discussing the Republicans and Democrats is life, that’s nonsense. Life is to get sore at a fellow who doesn’t look at you or a fellow who stares at you, a fellow who talks too much or a fellow who doesn’t talk at all. That’s life. In addition, it is also to eat a poor meal or a good meal. If you eat a poor meal, then you live up to your anger. If you could eat a good meal, then you are filled with joy. That’s life. Utterly trivial.

But there are people, and you know, you read about them in my book till you get nauseated, perhaps, and they are called intellectuals. I once have been one of them until I gave up. I didn’t give up my intellect but my intellectualism. That’s an awful thing that somebody should be an intellectualist. This means he should show his cleverness. He should be insistent that he is right and somebody else wrong in arguments. He should start arguments with everybody, with his closest friends. These intellectuals meet in order to have arguments about politics, about the economy and about private life perhaps, too. Mostly about art, economy, religion, politics—precisely the things that can offend people. That’s what they like to discuss, you know. My patients have no business discussing intellectualist subjects. I never do that when I am home. Never. I guess never. Very seldom, at least.

When I am home, then I want to enjoy the trivialities of my family life. That’s grand. When anything big happens in my family life, well, that’s a sector of our life. That’s a small sector of life. And people come to me and tell me, “Well, yesterday or last week or three months ago, something terrible happened, and I couldn’t tolerate it. I couldn’t get adjusted to it. I’m still awfully excited, and whenever anybody mentions something that reminds me of this event, well, I go all to pieces.” I have observed such patients repeatedly, and whether they go to pieces, I don’t know. I haven’t seen the pieces of them yet, but that’s how they talk. They go to pieces. And when you ask them what happened, well, an uncle died, or perhaps an aunt died.

Now, the fact a mother dies is really not a triviality. You will understand. That’s a very significant event. But why should anybody go to pieces over that? It was to be expected that anybody will die. Do you understand, these daughters and sons that go to pieces over the death of their mothers do something that they must never do, that they should learn not to do: and that is, they work themselves up. Naturally, there is no going to pieces over a natural event. Everybody naturally expects a mother and a father and everybody to die. And if they die, then you should have the proper response, the proper feeling. And the proper feeling is to think, to have a loving remembrance of your mother. But if you work yourself up and go to pieces, then you think of yourself and not of the mother. Then you think in what danger you are because you are so shaken up. Then you think of yourself.

And if a mother has a sick child, and she yells and cries, “Oh, how can I stand it?” then she thinks of herself and not of the child. The child now needs a calm mother that will do the right thing. And that mother should be sad and not excited. If she really wants to do something about her child, or if the mother dies and she wants to retain a loving, kind remembrance of the mother, then she must not work herself up. If she does, then she thinks of herself and not of the mother.

And that’s what our patients do. Something happens that is trivial—that is to be expected to happen, that’s an average event—and they go to pieces, as they say. They go to pieces. This means they are always afraid that they can’t adjust to the thing. There, again, see they think of themselves and not of the thing that happened. And my patients do that regularly, almost regularly. And what they do essentially is this: A thing that was to be expected, an average happening, whatever it was—whether it was death, or an insult that one was exposed to, or some damage that was inflicted on you—that’s all
average daily life. That happens right and left. And you consider it a terrific blow to you that you cannot survive, or, at any rate, you cannot live through. Then you declare yourself as very important, and that’s what the intellectuals do.

They only talk about themselves, or the pet theories that they have. And that’s what the patients do. And, therefore, I say with regard to health, my patients are intellectualists, rank intellectualists. They love to complain, this means to have an argument. The members of the family tell them, “Well, yours is a nervous condition. Why make a fuss about it?” But the patient says, “Well, if you knew how I suffer.” They always think of themselves. Always how they suffer. And all of this is called self-pity.

And if you want stirring arguments here at this table, try to get them. Here you will not get them. We are not intellectualists. I have fortunately trained my patients to have respect for intellect and therefore not to think that they are intellectualists. They are average people. Their intellect has not been thoroughly trained as, let me say, as a great scientist’s intellect. Let them know that they are average people and let them talk about average trivialities. And whoever wants to talk of something else—of stirring events in politics, in art, in literature—let them listen to other panels. Maybe they are held. I don’t know. But don’t let them listen to my patients. My patients are obliged by me to speak of nothing but trivialities, that means of life as it pulsates, as it lives, as it is close, and not of artificial issues like politics, economy, and other things that are artificial in the mouth of somebody who has no special knowledge in these fields.

Thank you.
I shall make some remarks about what Elizabeth said here, at this table, while she sat amidst the panel members. You remember that she prefaced her panel example by some such statement which I may not quote correctly, because I don't remember the wording clearly. She said, "I have a trivial example." I am reasonably certain that she said something to this effect. If she did not, then we will assume that she has made this statement. And if she did, then why did she make this statement? Why did she say that? Did she expect that we want our members to present spectacular examples? She did not. But she still has the habit from former days, before she went through her training in Recovery, to think like people think. But not in Recovery. We don't want certain aspects of popular thinking in Recovery. And it's the most astonishing thing, and yet it's common, that people in general think that life—the life of the average individual—is anything but trivialities.

There are very few things in life that are not trivial. I have told you repeatedly, spectacular things happen in the life of an individual very seldom. How often does your house get burned down? I ask patients, "How often do people go bankrupt? How often is a child born to a family?" Or "How often does somebody die in a family?" And so forth. The important items in life count for very little in point of behavior, for very little.

A mother doesn't have to be taught how to grieve over her child. And the average young man and young woman don't have to be coached how to fall in love and how to get married. They do that routinely. Sometimes they may want a consultation over the issues. But usually things roll along in life, especially with regard to the big items. Because they usually happen, and once they are there, you find out you had very little to do with their production and their course. The child didn't die because you did something. It simply died. And people get married not because somebody planned it, but they get married because that's the thing to do, or that's the thing that happens.

Well, that's all right. But be sure that Elizabeth no longer thinks in terms of spectacular life. Whatever romanticist inclination she has had before she joined Recovery, be certain, has by now been replaced largely by a realistic attitude. And what we call reality has a certain corner in which a person sometimes dies, and another person gets married, and a house burns down, and a bankruptcy happens. But in the vast expanse of the remainder of reality, what is called reality could just as well be called triviality. Reality really consists of trivialities, mainly.

But the patient, before he reaches Recovery, doesn't know that. And he doesn't know that his trouble has started as a triviality. Go back into the history of any of my patients, and there are only a few in which something happened to their impulses, to their beliefs, to their sensations out of a clear sky. These are, I wouldn't say rare cases, but they are the minority of the cases, vastly in the minority.

And if that happens, that something befalls the patient, it happens to him as, well, as a very rapid occurrence, a sudden development. If that happens, then in the overwhelming majority of my experience, and be sure in the experience of others, this abrupt onset of a nervous condition passes in a few minutes or in a day. That's the average experience. And so it really was a triviality that scared you. If it passes after a few minutes or after a day, then be sure it was a triviality with regard to consequences and with regard to its essential importance. What happens then?

The patient has had something terrible occurring in his life, but he got over it, and quickly as a rule. And the patient then is reassured. He doesn't know what happened to him, but he is reassured because the next day he feels better, and then he goes on feeling better. And after a few weeks, in most instances, the patient has as much as forgotten the incident. Should anybody remind him of it, should anything remind him of it, he will remember it. But essentially he forgets about it, so it was a triviality.

But after two or three weeks what happens? And that's the typical occurrence. Suppose this thing that has happened to the patient, and I mention an example, that he stood waiting for a street car, and all of a sudden his head felt like ballooning out. That's a terrible experience. The experience itself I will not call a triviality, even if it happens only once. It's far more than a triviality. But what follows was a triviality. It developed that this terrible experience had no consequences for the next two weeks. So essentially, in point of importance, it was a triviality. It was only so spectacular and frightening because of its intensity, but not in point of what it did, in point of consequences. But now it happens that two weeks or three weeks later that same person that stood waiting at the street car and his head produced the sensation of ballooning, three weeks later he stands again at the street car and there the ballooning comes again. That's the remarkable thing that in many patients, the original scary event that produced a frightful nervous reaction repeats itself precisely when the patient is brought into a similar or identical situation. The street car again did it.

And now the patient puts two and two together. Or you can say, in this instance, one and one he puts together, the first experience and then the other experience. And he tells himself, "Well, during the past three weeks I felt good, but now
the thing came back. How if it comes back again, if I am now doomed to go through these experiences for good . . . ? And all you have to do is to engage in such a course of thought, and what you do is that you create inner doubt, distrust of your body, distrust of your constitution, of your disposition. And any distrust that you create within you against somebody else, but more so against yourself, will create tenseness. And as long as this self-distrust is maintained, the tenseness will stay with you. It will endure. It will gain duration. And that's the principal characteristic of the nervous patient: that he is likely to produce what other people don't have to produce, and this is enduring tenseness, because he is enduringly disturbed now by his self-distrust.

Of course during the first three, four, or five days, the distrust may not be enduring yet. But if it crops up again and disappears, crops up again and disappears again, and comes at closer intervals, stays at longer periods, then the patient becomes alarmed and is likely to develop a panic. And the more he is alarmed, the more intense becomes his panic. And the more he is panicky, the more is he alarmed. And the more alarmed, the more panicky. And then comes the vicious cycle between alarm, fear, and panic. And then the panic produces or produces tenseness. And the more tense he becomes, the more the patient becomes afraid. And the more afraid he becomes, the more goes the tenseness. And this patient is now in the grip by himself, but not the tenseness. And this simple example will show you what we mean by spotting, and spotting doesn't tell but essentially it is a belief. But there are many things that people know and don't know. They don't know that they know

If I tell somebody, "Well, fear is a belief," well, everybody will agree with this, I hope. It is a few other things, too, but essentially it is a belief. But there are many things that people know and don't know. They don't know that they know...
That's important to know, that you don't know that you know something. And sometimes you believe that you do know something, and you don't know. But you think you know. And therefore, in order to make you look through the meaning of disturbing events, you have to be trained to know what you do know, what you do know anyhow. And everybody knows that a fear is a belief. But they don't think in these terms. People don't call fear a belief. They call it a feeling, an emotion, not belief. And they are right. It's a feeling, it's emotion, it's a thought, too. It's sensations, palpitations; everything is in a belief.

But the most important thing there is in the belief, people don't think about. They know it. They know it's a belief in danger, but they don't think about it. Nobody has taught them how to do it. Those psychologists that speak to people about fear always call it "feeling" or "emotion." I doubt whether I ever heard anybody or saw anybody write a sentence in a book that fear is a belief. I doubt it. At any rate, if it has been done, it happened so seldom that I don't remember having read it. And when it came to me once, well, I can't get my patients rid of fears. How can I do that except over years and years of analysis—you know, that's usually the method—then I began to search for some method that is simpler. And it took me time to find out this trivial truth: that, after all, fear is a belief, the belief that there is danger. Now I knew what to do about fear. If it's a belief, well, then I can train the patient to do what I do every few minutes, certainly every few hours.

I accept beliefs, and then I drop them, then I pick them up again. Everybody can do that. I wait for somebody, then it comes to me, well, there he is, so I believe he's coming. Then I look, I see it isn't he, so I drop the belief. And then I begin to think of him, that he may be out of town. Then I get the belief that I am in danger, that I will not find him. Then I begin to think about it and realize, well, he couldn't be out of town because I just saw him this morning or spoke to him over the phone. Now I change the belief that the man is out of town, and I pick up the belief that he is in town. And these are in important situations where I am eager to meet somebody. These are not even trivialities. They may be important situations. And in such important situations, you drop beliefs, you pick them up, you retain them, you don't, or you try to get rid of them. Beliefs can be manipulated.

But fears, I didn't know how to manipulate fears. And I still don't know except if I make the patient change his beliefs. And so I must give him my beliefs, and I must form my beliefs first. And so some day I formed the belief that the patient suffered from beliefs, from the belief of danger, or, in angry temper, from the belief that somebody did him wrong. That's what Elizabeth mentioned, her angry temper, where she formed the belief that somebody wronged her or did wrong.

But look here. It's a simple method. You just tell somebody to drop his belief, and he could do it. It's simple, but he doesn't drop it. He keeps his belief. And if I want the patient to drop beliefs, well, he makes an effort, but they don't work. They certainly don't work immediately. And there was one thing that I forgot about it when I formulated this theory: I forgot the fact that humans develop habits, and that habits are stubborn.

If they have been developed and retained for months and years, like with my patients, then the habits resist being changed. And if it is a habit of thinking in a certain manner, a habitual belief, then the patient particularly is likely to become addicted to the belief. And then how am I going to remove that addiction? We call it an obsession, and patients have plenty of obsessions. But that's no problem, and I soon found out it wasn't a problem. Oh, it was a problem, but not an insuperable problem, not a problem impossible of solution.

And the answer to this problem was simply take your time and give training, continuous training, persevering training, and then you overcome the handicap of time. Time can be crowded out by other time. This stale time, this time that got stuck, can be eliminated by waiting, by your spending time till this thing that got stuck will disappear. And in life everything disappears. It may come back, but in life everything moves provided you let the thing go. Then it will gradually go, provided you let it come back, it will come back. And that requires training, and you must learn the technique of not working up an experience. But of this I can't speak.

I wanted only to show you that, first, Elizabeth started from her fear that she spoke of trivialities, and I wanted to tell you there is practically nothing in average life but trivialities. And I wanted to show you that the patient starts out with a thing that could have taken a trivial course if he hadn't worked it up. And then I wanted to go on to tell you that the method with which to deal with all these conditions is again a trivial method. Relax, remove the belief of fear, replace it by a belief that you can put in its place. But you must wait. That's again trivial. And everything that counts in life constitutes a triviality, and don't let these trivialities scare you.

Goodbye.
The panel will discuss today the subject of “Wants and Needs.” Wants and needs. I repeat the phrase because it is of extreme importance for patients. Now, everybody has wants, and everybody has needs. But they must be kept apart. The patient must get to know what is a need, and that must be supplied; and what is merely a want, and that may be supplied. It may be legitimate to supply it, but not when it clashes with a need. You know, naturally, that this is so in the physical sphere. There is a need, an absolute need, for air, of course for food and certainly for fluids. And we call them the necessities of life. And that a necessity is needed, well, that does not have to be discussed. But, mark it: Water and air and food [are] necessary and important and of greatest value, if you wish, to the individual, not the group. The group doesn’t eat food. It doesn’t even breathe air. The group has no such needs as I mentioned.

Now, it is a bad thing even in trifles that somebody should think he needs candy. That may have bad consequences—well, addition of weight, for instance. It may injure health. And you will understand that candy is a want, not a need by any scale. And it’s not so that people need to talk a lot. They merely want to talk a lot. Well, these examples should be sufficient in order to make you distinguish between want and need.

Now, it may surprise you, but it is a truth, that my system of training patients is mainly based on the distinction between needs, which are objective, and wants, which are purely subjective. I guess I have explained that with the examples that I mentioned. But, of course, I am not much interested with candy and talking only. I am interested in what the patient does. And the patient is eager to express his wants, mainly. He is not so eager to pursue his needs. His need is health, nothing else, aside from what I mentioned, necessities of existence. But his supreme need is health, and you will not deny that. But that’s not what he wants. He merely wishes it. He wishes to be well. He wishes, naturally, to get rid of his suffering. And this he can only do if he gets well. But he doesn’t want it. Now I made a mistake. He doesn’t even want it; he only wishes it. With him, health is not even a want, it’s a wish, but you will agree that it is a dire need. And the patient will agree to that, too, but he will work on his wants and wishes and not on his needs. Of course, one understands that the patient suffers acutely, and he wishes and wants to get rid of it. And that is a legitimate wish and a legitimate want. But the way he wants to get rid of it is very harmful.

He is, for instance, seized with palpitations. Naturally, he wants to get rid of them. But what does he do then? He suffers, and what he wants now is help, which is legitimate. But what kind of help does he want? Well, I am here to help him, but he wants help right now. And I’ll tell you later that in some respects I can supply it. But, generally speaking, the patient has to wait. Health cannot be secured in five seconds, but the patient wants relief in five seconds and preferably in half a second. Oh, it sounds laughable, I agree with you. And yet the patient can get some relief in a second or two. He can, for instance, at that moment, get attention, and sympathy, and affection. And he can be given the opportunity to talk about his suffering. That gives him some relief. All of this. The attention that is given him supplies a modicum, almost a minimum, of relief. But it’s gone in a second. The moment the patient gets relief from the attention he receives, from the fact that the husband listens to the patient’s complaint and gives a sympathetic ear to it—which the patient receives very seldom—but should the husband supply that sympathetic ear, the patient would feel better, but only for a second. And then the relief goes, and the palpitations go on, and the headache grows [more severe]. And then the patient thinks he has had relief for half a second. He will go on talking again and demand attention. Maybe he will get another second of relief.

And the patient is now continually on the hunt for this second of relief. And so he doesn’t stop hunting for attention. And since he can only get attention (he thinks) when he talks, when he asks for the attention, when he tells the partner how terribly he suffers, then he goes on constantly talking about his suffering, always in the hunt for this second of relief. And so the condition gets worse and worse because the second, the third, the fourth time, the husband becomes tired of the procedure. And he withdraws his attention and his affection. And so the patient is worse than ever. And mark it: If I have now the impulse, or the wish, or desire to ask for help, then I naturally want to get this help immediately, right now, if I suffer severely. And that’s what we call the short-range goal. The goal that is now in the patient’s mind is meant to bring something on this minute. It’s a momentary, short-range goal. But when I tell the patient I am going to get him well, naturally, I don’t mean that I’m going to do it this second.

My goal that I set before the patient is not meant to get into action or to be reached this moment. It is meant to be reached in weeks or months. So the goal that I have set for the patient is a long range goal. The patient who suffers is not particularly interested in what is going to happen in five, six or ten months. He wants relief now and not a minute later. And you will now understand that that’s what the patient wants. That’s his want, but the goal that I set for him is his need.

So you will understand that the patient, in my opinion, is little interested in what he needs, and all interested in what he wants. And the result is that the patient who constantly hunts for attention, who tries to force those around him to offer the attention, that this patient, with his constant drive for affection, attention and sympathy, alienates those around him. And
what he wants to get right now is against him and prevents him from reaching his long-range goal, his need. He himself blocks his path toward reaching the goal that he needs to reach, because he alienates everybody around him. And the poor wretch cannot help it. He is driven by an overpowering impulse to do it, to do that thing that neither brings fulfillment for what he wants, nor for what he needs. And the patient is lost, both with regard to his wants and his needs. He cannot reach any of them. And then he comes to Recovery, those of them that come. And what am I going to do, or what are we going to do with this patient who is not interested in long-range goals? Our remedies are long-range.

I tell the patient, “Well, I can give you relief in seconds, too. I can give you excellent relief.” If I tell the patient that his symptoms are distressing but not dangerous, should he really accept what I have told him, he would get relaxation in a second. But he would have to accept it. And some people don’t know how to accept. They have an uncanny knowledge of how to not accept, how to reject a notion, but not how to accept it. And there has never been a human being living that—I mean a human, a patient, a human being that is a nervous patient—who would not lose his symptoms instantly, if he actually accepted this dictum that there is no danger, there is only distress. It is true, even with this formula, if the patient gets immediate relief, nevertheless, the suffering may come back in a second, or in two seconds. But then the patient has now something in his own hands that he can apply and get relief another second. He can do that without the help of his wife or husband or brother and sister. He can now use this formula as he previously used this mechanism of constantly complaining and driving the members of the family frantic. He can now get exactly what he wants of the relatives by this simple formula. And there is no harm done. But the patient doesn’t want it.

He doesn’t want it because he has the idea a human being needs sympathy and attention. That’s nonsense. That’s not a need. In some respect it is, but not for the patient. That is a want, and the patient constantly confuses the term need with the term want. And again, what are we going to do? Now this method that I mentioned, this accepting the dictum there is no danger, the patient could use to much better advantage than I described.

Anybody who has really accepted that there is no danger gets relief when he first applies this dictum for a few seconds. Then the symptom comes back. If then the patient goes on undeterred to apply the dictum again, the next time when he relaxes, he will relax for five seconds, for seven seconds. The next time he will relax for two minutes; the next time, for an ever-lengthening interval. And I have seen patients getting well quickly because they applied this dictum with determination. And I gave you another means of getting instant relief, and I will merely mention it and not explain it in detail: the motionless sitting. I will not explain it.

I have again yet to see the person who, if he applies this mechanism of motionless sitting as I want it applied, I have yet to see that patient who doesn’t get sustained relief from it for a far longer period than can be measured in seconds. But again, the patient sticks to his wants. And I have offered to him, as I told you now, a formula for fulfilling his needs, the need for health. I have offered him this method of accepting the dictum that there is no danger. I have also offered him the method of motionless sitting, which has an unfailing effect. But the patient sticks to his wanting—not needing—attention, sympathy, affection.

Well, do you understand that here in Recovery we have only one way out of this deplorable situation? We have to wait till the patient will be willing to pursue his needs for health instead of his wanting attention. And while the patient is impatient and refuses to wait patiently, fortunately, I and my organization are very willing to wait. And we make the patient wait. And so, so many of our patients don’t mind it. They learn quickly that they have to wait. And once we keep them waiting, and in the meantime indoctrinate them with the idea that nervous symptoms are never dangerous, and that a steadying of the body, by means of motionless sitting, gives instant relief which at first is brief, but then lengthens and lengthens and produces a real sustained relief. And let us hope that our patients, all of them, will finally realize that in Recovery they are offered both fulfillment of their needs and fulfillment of their short-range wants.

Thank you.
CITED LITERATURE


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