

The Application of Individual Psychology to Psychosomatic Medicine¹

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In discussing any aspect of Psychosomatic Medicine, before any further elaboration, a definition of what is encompassed by this concept should be presented.

Psychosomatic Medicine is construed here to mean the study of those mind-body inter-relationships and manifestations which play a part in the production of that state which we call disease. It encompasses the study of organismal reactions as a whole, rather than a study of the component parts. Inasmuch as this integrative aspect has been repeatedly stressed, it might appear superfluous to repeat it. Yet, an evaluation of the expositions and present day approaches to this problem reveals a definitive statement similar to the one presented, with almost in the next phrase a dichotomous mind-body orientation as a corollary.

At this point, it would be valuable to give a short summary of the work of the representative schools of thought in the field of Psychosomatic Medicine, their relationship to each other and a criticism and evaluation.

Flanders Dunbar has presented an approach to Psychosomatic disorders based on various personality profiles and their somatic counterparts. These profiles are assumed to be of diagnostic, prognostic and therapeutic significance. Also, this investigator borrowing from the first two laws of thermodynamics, applies them psychologically as follows:

- 1) Psychic energy, not expressed through higher levels, seeks its outlet through physical symptoms, hence energy is conserved.
- 2) If these symptoms are the result of prominent structural damage energy is correspondingly dissipated and made unavailable. Thus somatic dysfunction is a waste or dissipation of energy, due to the faulty design of the personality.

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The main and most damaging criticism of this approach remains simply that any consideration of the *total* organism as a dynamic psychosomatic process is completely bypassed.

Franz Alexander and his school have played a considerable role in the development of modern Psychosomatic Medicine. His position may be summarily expressed as follows:

Emotions are associated with autonomic reaction patterns which are specific. Emotions not expressed lead to tensions, with their accompanying excessive autonomic reactions. These excessive autonomic reactions, unexpressed, lead to disturbances of function which may eventually lead to morphological tissue changes. The question as to whether a specific vegetative activity is always associated with a specific affect and its suggested end results, as well as the liberties taken with neurophysiologic and physiologic data in the presentations by this school, represent some of the main defects in their theoretical position, as presented. The implied holism and subsequent dichotomous practical application, however, remains the main criticism in my opinion.

Harold Wolff and his school have also been among the leaders in modern Psychosomatic Medicine. His position is best epitomized by the following:

Stresses which affect man arise not only from his biological and physical environment, but also from threats and symbols of past dangers, from failures and frustrations of his needs and aspirations and from cultural pressures and rapid social changes. Bodily reactions to stress or attempts at adaptation may be generalized or local and in varying degrees successful. Wolff feels that the dominant reaction patterns to stress are either hereditary, constitutional or developmental through early life experiences. The main criticism which might be leveled at Wolff's work is its superficiality, especially in its psychological formulations and applications. However, the accuracy and scientific efficiency of Wolff's medical applications are to be commended and can well be exemplary in methodology to the other schools.

The work of Jurgen Ruesch is especially interesting in that his postulates bear a more than considerable similarity to the main theme to be discussed. His theoretical position maintains that all psychosomatic disease processes occur in immature individuals who remain socially isolated because of an inability to master the prevailing system of communication of adulthood. With them, the body becomes the essential instrument of communication.

An attempt has been made in the summarized formulations above to give a short resumé and critique of the main theoretical positions held in the field of Psychosomatic Medecine. It is to be stressed that no full discussion is presented of the various divergent opinions within each approach, i.e., the conception of Psychosomatic disorders as extreme regressive phenomena, interchangeable with the psychoses (utilized as an operational concept by Margolin in his anaclitic therapy) and the divergent opinion of Psychosomatic Disorders as near normal ego defense mechanisms by Saul, both investigators falling into the Freudian Psychoanalytic school. The purpose of the above was simply to introduce our main theme and to enable us to see the necessity for an integrated rather than a dichotomous approach, with all its pitfalls. Lest it appear that I am inferring that this integrated approach is necessary only in Psychosomatic research, I wish to state, at the risk of being redundant, that it should be universal in all scientific investigation.

It would seem obvious from an analysis of the various schools of thought that what is necessary for an adequate attack on psychosomatic problems, is an integrated bivalent approach, both from the standpoint of the internist and the psychiatrist, which is capable of being accepted, utilized, assimilated and understood from the viewpoint of either specialty. It seems almost prophetic, therefore, when in the introduction to Alfred Adler's book on *The Neurotic Constitution* translated into English and published in 1916, William Alanson White made the following statement:

It will also be perfectly evident that the helpfulness of the Adler theories is in the orientation which the physician gets toward the problem, presented by the patient, whether he approach it from the point of view of the internist or the psychologist. Adler's theories are admirably calculated to help the internist to grasp the possibilities of organ inferiority as they affect the psyche and to help the psychoanalyst to grasp the origin and meaning of the neurosis as he sees it at the psychological level and perhaps to see more clearly upon what his limitations are based. In any event the two groups of physicians heretofore separated all too far, both in theory and practice may find in Adler's views a common ground upon which to meet.

Concerning Adler's contributions to this aspect of medicine, I wish to quote, as a sample, the following in the same book from the concluding paragraphs in the chapter on "The Accentuated Fiction."

Aside from the organic diseases of later life which go with an inferior alimentary apparatus, and among which I have emphasized ulcer of the stomach, appendicitis, cancer, diabetes, liver disease, gall bladder disease, there is manifested in the neurosis a stronger participation and frequent employment of functional disturbances of the digestive tract. Its ultimate relation to the psyche is reflected in many neurotic and psychotic symptoms. I believe I am on the track of a special expedient of this sort, without being able to present conclusive facts. A number of neurotic symptoms such as erythrophobia, neurotic obstipation and colic, asthma, probably also vertigo, vomiting, headache, and migraine, stand in some sort of relation, which is as yet not entirely clear to me, with a voluntary but unconsciously cooperating activity of anus contraction ("cramp" of other authors) (Spasms of the Sigmoid Flexure, Holz, Knecht, Singer) and that of abdominal pressure; symbolic acts which are accomplished through the domination of the reinforced fiction.

It is evident that the Adlerian approach to Psychology had Psychosomatic roots early in its development and it would appear that its study and application should aid greatly our understanding of these problems.

Work in this field, however, shows that attempts to cover the entirety of this application of Individual Psychology would necessitate not one, but several volumes to describe and would be completely outside the scope of this paper. Therefore, I believe that a practical presentation of several clinical cases with an analysis of the disease process and therapeutic aid offered by Adlerian methods would best serve our purposes for this paper. I am presenting, therefore, the clinical summaries and discussion of several cases which I have analyzed and treated, utilizing the Adlerian psychological orientation.

The first case I am going to describe, Mr. LX, is that of a white male, age 39 in 1950, who presented himself for treatment for a chief complaint of "excessive feelings of tension and dizziness." He divulged the information in his initial interview, however, that he had suffered from a psychoneurosis since puberty, dating the onset of his illness from the time a barber had accidentally tightened the sheet cover about his neck, with a resultant subjective violent feeling of "blacking out." When he recovered from his momentary lapse, he then ran home in a great panic. From the time of this episode at age 11, symptoms of an obsessive and phobic nature had gradually increased in severity to the point where he was almost disabled at the present. His symp-

toms were characterized by fear of being alone, fear of open places, fear of heights, fear of crossing bridges, obsessive preoccupation with a feeling of generalized tension and an almost "panic producing" fear of unconsciousness. As an aside it is of special interest to note that the patient's more classic fears of heights, open places and crossing bridges were in a sense taught to him by a friend, who suffered a severe obsessive compulsive state and who described the various classical phobic manifestations to this patient when they were adolescents. With each description which his friend read to him from a psychiatric text, Mr. LX proceeded to develop an almost identical symptom complex. Yet despite his symptomatology, which was mild at this time, he lived a fairly unfettered, non-disabling existence during his adolescence and early twenties.

Mr. LX was the oldest of a Jewish household comprising a compulsive, rather stupid father; a hysterical, overbearing, overprotective mother, and a compulsive, immature sister. His father worked in the garment industry, earning an income at times marginal, at times comfortable, but never secure. He was an extremely strict disciplinarian, yet made it quite obvious to the patient that as his son, he was the favorite, almost completely disregarding his daughter.

Some of the patient's memories were rife with experiences of severe beatings from his father for poor school work, yet the father treated him with almost tender care and consideration when he was ill as a child. The head of this chaotic household made defecation an extremely embarrassing activity inasmuch as the inevitable odors were considered to be shameful and inconsiderate. This attitude had a deep seated effect on both the patient and his sister as regards elimination and toilet habits; both siblings regarded defecation as an extremely embarrassing action. The mother during the patient's childhood utilized illness and guilt feelings as a whip to force the patient to accede to her wishes. She would frequently stage death scenes, frightening the patient into doing her bidding. These episodes were quite constant until early adulthood. The patient's sister, at least consciously, accepted her inferior familial role until late adolescence, when she too developed neurotic symptoms.

Mr. LX, as a child, was extremely sensitive about his long nose. He would sit for hours in front of the mirror curling his hair and alternately admiring and deploring his looks. He apparently was fearless at this time, engaging in episodes such as hanging from a railroad trestle, to secure the plaudits of his chums. With the onset

of adolescence, he developed the technique of acting the clown at social gatherings as a means of both securing attention and compensating for his intense inferiority feelings. His efforts in this regard became so obnoxious to his companions of both sexes that he became a virtual social pariah for a time. It was then that he met his neurotic friend who helped to instruct him so well and at so propitious a time for the development of his neurosis. Of interest also, is his practice during this period of travelling under an alias, as far as social purposes were concerned. The name chosen "Lee Spaulding" gives interesting clues to the nature of his guiding fiction, in view of his background. The patient worked sporadically at various positions at the ages 16 to 21 after leaving an educational career that left considerable to be desired.

His neurotic symptoms at this time were non-disabling and only embryonic in their outward form. At age 21 he met a young lady of whom he became enamored. His sexual life up to this time had consisted of masturbation and occasional experiences with promiscuous girls and prostitutes. He denied any homosexual activity. After a short courtship he proposed marriage but was rudely and brutally refused by both the young lady and her outraged male parent who, in rejecting the unlucky suitor, made it exceedingly plain that he was no suitable candidate physically, mentally, occupationally, or morally for his daughter's hand.

At this point, the face-saving function of his neurosis came to the fore and what had been only the embryonic rootlets of a psychasthenic neurosis burst forth in full severity. He developed extreme fears of being alone, making it necessary for his mother or father to accompany him to work and on his sales calls. He would not go above the second floor of a building, ride elevators, or cross bridges. Yet during this period he courted and married, fathered a son, and divorced the unfortunate wife, seduced his best friend's wife and carried on frequent affairs with various neighborhood girls. He had always been a good salesman and, with his mother's continuous companionship on his sales trips, was capable of earning considerable sums as a vacuum cleaner salesman. Yet he claimed that his illness and the terrible tensions he suffered, especially in his lower back, his dizziness and black-outs prevented him from working more than three hours daily. Despite this he was never prevented from relaxing in the local pool hall for the rest of the day (a considerable distance from home), without his mother. The patient always stressed his interest in sexual matters to the therapist, his invincibility with women and his need for adequate

sexual outlet. This need apparently became so great at a certain period following his divorce that when he could not secure any cooperative partner, he even approached his sister.

He had consulted numerous psychiatrists during his twenties and early thirties with no therapeutic gain or insight into his condition. Approximately two years prior to consulting me in 1950, he had married a divorcee who also had one child by a previous marriage. His marriage with this woman was doomed to failure because of his extreme jealousy for the affection and interest of his wife to the exclusion of her daughter. He also refused to accept the responsibility of sharing even the cost of their apartment or food, insisting that his illness and his commitments in supporting his son by his previous marriage prevented him from assuming these responsibilities. He felt that his ability to sexually gratify her more than made up for his lack of material support.

It was during this period that this patient consulted me for the treatment of his symptoms. His earliest memory concerned itself with being lost and alone at the age of four, and the horrible feeling of psychic pain and physical dizziness it was associated with. The significance of this will be referred to later. He was under treatment for one year and during this time acquired considerable insight into the psychopathology of his condition with some symptomatic relief and assumption of responsibilities.

During his therapy he suffered a consistent weight loss and despite frequent suggestions to be studied physically, he refused, insisting it was due to his tensions and poor appetite. He was under the care of a practitioner for the treatment of "hemorrhoids" during this time. Another of his complaints was that of difficulty in swallowing and sighing and difficult respiration. Despite the fact that these were classical neurotic somatic symptoms, I felt an adequate medical study was in order in view of the weight loss, but he consistently refused.

After apparently being close to a therapeutic success with full insight, the patient consulted me one day and with an extreme emotional display informed me of the following events. It appeared that he had been selling his company's vacuum cleaners without turning in the funds, and the inevitable discovery had caught up with him. In addition to this, he had fallen in arrears in the support of his son, with a subsequent summons to the domestic court, and was also suffering domestic difficulties with his present spouse. *Without further ado, he informed me that life without his symptoms would be impossible under*

the circumstances and that health would mean facing the demands of life the same as anyone else without excuse and with courage.

This was impossible for him at the present; therefore he felt that he would like to interrupt therapy. Inasmuch as any further attempt to help him was doomed to failure, according to him, I felt that insisting on further treatment would be to no avail in view of this and his environmental difficulties, and made no effort to influence his decision. Approximately six months later, the patient again consulted me asking me to recommend a proctologist. He informed me that he was to be hospitalized for a rectal biopsy and felt I might aid him in choosing some one other than the man his doctor, a general practitioner, had recommended. I agreed on the competency of the surgeon recommended, yet felt that under the circumstances, considering the type of family and possible repercussions in case of an unfavorable report, a more imposing surgical figure be consulted. His practitioner agreed.

Unfortunately, Mr. LX had developed a carcinoma of the rectum, was operated on with the formation of a colostomy; developed metastasis and died within a year, after suffering the untold agonies of metastatic malignant disease, the urologic complications of a colostomy, 2 bouts of bowel obstruction with electrolyte imbalance and the psychologic trauma inherent in the knowledge of approaching death, a state which he had feared all his life with all the conscious terror that he unconsciously felt for life itself.

This case is interesting because it illustrates one of the main things I am going to stress, namely that one must look at the individual from the standpoint of a purposive unity, if one is to adequately understand all organismal reactions. In regards to this the salient points are

- 1) In his earliest memory—he was alone—felt lost. This mirrors his basic insecurity and feeling of being at the mercy of the world with an inability to cope with its demands.
- 2) His organic inferiority as regards his large nose and his attempts as a child to compensate for it by dressing his hair and stressing his sexual attractiveness to women in later life.

(In treatment he often related the common fallacy of the connection of virility with a large nose.)

His early harsh training with cruel whipping for academic failure, and pampering and acceptance when ill.

His mother's use of a death scene as a means of compulsion sensitized him to the value of his neurotic symptoms which he later developed.

- 3) His insecure financial state as a child and his social position which he resented considerably, his use of an alias of Lee Spaulding instead of his real name which was obviously Jewish, is interesting in this regard.
- 4) His father's training in toilet habits: Later in life he would return 40 miles from another city to move his bowels, rather than suffer what he considered the embarrassment of creating a foul odor which others might resent. (I am sure this was not an example of his social feeling, or consideration, but rather an attempt to achieve the state of god-like perfection he felt necessary to compensate for his intense inferiority feelings.)
- 5) His position in the family as the eldest and a son gave him a "Crown Prince" feeling that was difficult for him to deny himself and certainly acted as the lorelei that coaxed him back to the family in times of stress.

The precipitating episode in the barber's chair from which he dates his illness is interesting in that his vertigo and blackout may well have been brought about by an accidental stimulation of the carotid sinus, yet it is obvious that it was the demands of approaching adolescence that necessitated the help of a symptom and keyed this in to create distance and hesitation to compensate for his inferiority feelings. Of particular interest is the possible relationship between the expression of a feeling of inferiority as regards defecation ingrained by training, vertigo and tenseness of the lower back associated with anal spasm, (noted earlier in this paper as being described by Dr. Adler), and the subsequent development of carcinoma of the rectum in a 39 year old man with a lifelong history of a classical neurosis. The other features of the case, such as the obvious face-saving function of the neurosis after the refusal of his first offer of marriage, his retreat to the safety and ego satisfying position of his family as the oldest son, where his use of his illness to manipulate his environment was accepted without question by his parents and sister, are all obvious to the trained observer. These neurotic features are important in that they are part of the life style and show us the direction and purposiveness of his other symptoms and characteristics, the most important in relation to the final outcome of this case being anal spasm. This has been described

by proctologists as leading to various types of ano-rectal pathology. Certainly it is not far fetched to consider the possibility that in a pre-disposed individual the chronic irritation might subsequently lead to malignant degeneration, which might not have taken place without this precipitating factor.

I wish to stress that I am not stating that the etiology of the malignant degeneration was secondary to, or directly related to the events I have discussed; but rather that as previously stated, it is unfortunately a rather common sequella to chronic rectal pathology which is in many cases associated with and secondary to poor ano-rectal hygiene and functional spasm. This functional ano-rectal spasm can be understood in the light of our foregoing discussion to be not an isolated somatic phenomenon specifically bound to an autonomic discharge associated with an emotion, but rather the somatic expression of this patient's guiding fiction. It is merely one part of a purposive whole manifested by the patient's attempts as a total organism to compensate for extreme feelings of inadequacy based on an organ inferiority, what he considered an inferior social and economic position, the need for achievement he felt the world demanded of him as a male, which his woeful educational record and training made almost impossible to him, and the other factors which have already been discussed. It is only in this light that a consideration of this case as a dynamic psychosomatic process can be achieved.

The second case I wish to present is that of a white male, Mr. SK, age 27 when he consulted me in 1953. He was referred by a dermatologist who had treated him for a severe neurodermatitis of six months duration with only a rapid progression of the disease and a concomitant aggravation of the psychological factors involved.

This patient is the youngest son of a middle class Jewish family, the oldest sibling being a daughter, nine years his senior. The father is an overbearing, expansive, extremely voluble individual who felt that his position as the head of the family entitled him to vent his aggressions in any way and at any time he saw fit. The mother is a complaining, compulsive individual, with a martyr-like, long suffering complex. Both parents are extremely insecure individuals with marked feelings of inferiority. The patient's sister is a dependent, anxious individual who lived her life in exactly the way mapped out by her parents.

Mr. SK was enuretic until the age of nine. He is extremely sensitive about this, relating numerous incidents associated with his feelings

of inferiority about this condition. His mother flagrantly made him aware of the burden involved in washing the extra sheets. She would show him her red, traumatized hands, instilling a tremendous sense of guilt in him, for his supposed weakness. One of his earliest memories is that associated with a horribly shameful experience at a boy's camp where a counselor beat him publicly for wetting the bed. Constitutionally the patient is the fair, red-haired type with the pallid, weak, atrophic type of skin so prone to trauma and sunburn. Even now he must be completely covered when he ventures into the sun at a bathing beach or suffer severe burns with resultant dermatitis. The family was not economically secure during his younger years during the economic depression, but in his later adolescence and early adulthood achieved upper middle class status.

Mr. SK was a rather poor student during his high school years. He attended an academic high school, noted for its superior scholarship. He would act the clown, cut classes, refuse to study and was a problem to both the school counselor and his parents. He recognized, however, even early in treatment, that his comedian tactics were attempts to compensate for his supposed lack of scholarship, thus saving face and attracting attention. He also recognized that cutting classes was an attempt to place distance between himself and an unbearable test situation. As a child and even into adulthood the patient had a distinct streak of cruelty, was a bully, and was easily moved to attack violently both verbally and even at times physically any person or thing which conflicted with the strict morality and rigid code of conduct instilled in him by his parents. Yet despite this, his best friend whom he idolized was a promiscuous individual whose main drive in his sexual relations with women was to conquer them sexually so that as he stated, "he could have it on them." As would be expected from his early history and organ inferiority (the common observation that enuretics often compensate with genital overactivity) the patient was extremely interested in sexual matters and engaged in relations with the opposite sex from early adolescence. He also admitted to several polymorphously perverse homosexual episodes during childhood. His sexual relations with women were often perverse, he being the passive participant. It was obvious that he was unconsciously following the example of his best friend and his own inclination, in that these relations were attempts to depreciate and lower the sexual partner (a common neurotic character trait whose purpose is compensatory to assuage inferiority feelings).

Prior to entering the army at the age of seventeen, the patient worked for a firm where one of the personnel had an altercation with him about his racial background. This incident remained as an intense, frustrating, ego-lowering affair in that he felt he should have risen physically to take exception to the insult which he did not do. Despite his physical immaturity at the time and the tremendous difference in size between him and his antagonist, he still feels and felt that he should have reacted in what he considered a less cowardly way. This is typical of the numerous impossible demands he felt he must satisfy.

He served as a radio operator on a B-17 during the war, flew thirty missions, and was decorated for bravery. His army service was without incident and he made numerous friends and adjusted well.

After his discharge he went into business with his father. The inevitable conflict between the two arose, the father having the son do most of the hard work and resorting to frequent incidents when he shouted, found fault, and in every way attempted to show his authority as the "boss." The patient resented this intensely yet his dependency and disciplinary training kept him from leaving, despite frequent conflicts and altercations, the main purpose of which seemed to be attempts on the part of both to achieve the superior status in their relationship.

The patient met a young woman six months prior to the onset of his condition. She was attracted to him mainly because of his brutal tactics which she felt to be "masculine" (a clear view into the nature of her personality). The patient's illness began just prior to their marriage and flared during their honeymoon when she told the patient she did not love him. They had engaged in perverse sexual practices prior to marriage and continued an extremely active sexual life after marriage, despite continuous bickering. The patient continuously found fault with his wife's housekeeping, conduct and demeanor, unconsciously comparing her to his mother's way of doing things. He was extremely compulsive in his criticism and it was clear early in therapy that the "madonna and prostitute dichotomy," with his wife filling the prostitute role, was prominent in his thinking.

Within a short period of psychotherapy, the patient's dermatologic manifestations improved and his itching and scratching diminished to about nil. He expressed the wish to tackle the underlying personality factors and reactions which he felt interfered with his efficiency as an individual and were at the basis of his admitted maladjustment as a person. He had the usual remissions and exacerbations during

therapy, yet did remarkably well considering the psychopathology and underlying obsessive compulsive trend in his illness.

After a year in therapy, at the insistence of his wife and following his own inclinations, he left his father and went into his own business, functioning admirably in overcoming many obstacles. Despite a great personality change toward the better, his marital adjustment did not improve and it soon became apparent that his wife was more ill, from an emotional standpoint, than he. She was referred to another therapist for treatment because the relationship between them made simultaneous therapy impossible. In the following year Mr. SK lived successfully through an extremely traumatic economic situation with failure of his business and severe marital difficulties, which he handled very well. At present he is free from his neurodermatitis, is economically stable, has two children whom he loves dearly, is helping his wife to overcome her difficulties and is living a fairly stable marital existence, considering the periodic uncooperative periods of his wife. He has developed into an extremely personable individual, sincerely interested in others, and extremely successful from the standpoint of his functioning in interpersonal relations.

This case is presented in order to demonstrate several interesting features. The patient's unusually persistent sexual drives with a selfish mode of genital gratification bears a definite relationship to (1) his enuretic organ inferiority as a child and its genital compensation, (2) the characteristic neurotic need to depreciate the sex partner in order to achieve a superior state, and (3) his pampered position as the youngest child. His dermatological organ inferiority and the subsequent development of a neurodermatitis also bear a relationship to each other. There is no doubt that he had become aware of the value of illness as a face saving device in childhood and it came to his rescue when he was faced with the demands of marriage. Its "distance function" became more apparent when it threatened the contamination of his marriage early in its inception. (He repeatedly and compulsively questioned me as to whether he would have to give up his wife, due to his condition, when he first consulted me.) This distance function is also demonstrated very well in the frequent exacerbations early in therapy when he was faced with a threat to the superior god-like ideal which he felt was necessary, or suffer the limbo of being a nothing. The resistance function of these exacerbations and their purposiveness in depreciating the therapist were obvious early in therapy (to the patient) and this insight resulted in a rapid symptomatic arrest.

With the realization of the uselessness of his neurotic and psychosomatic symptoms in the attainment of the new goals, which automatically developed with the relinquishing of the old due to his unmasking, this patient's psychosomatic illness was arrested.

Thus again we see that the dermatological symptom was not an isolated dermatological manifestation of an autonomic reaction secondary to emotional changes, nor even the localized reaction of an organ system to a stressful experience. Rather this phenomenon can be best understood only as a functional part of a purposive unity, as one aspect of the total functioning, goal-directed behavior of this personality.

It is only in this light that it has real meaning as a dynamic, inter-relating, psychosomatic unity. It is this last paragraph that represents the theme I wish to stress, at the risk of redundancy: namely, that it is my belief that only by analyzing the psychosomatic symptom or any other neurotic symptom, as one aspect of the dynamic reactions of a functioning purposive unity, can one fully understand and intelligently appreciate it as a phenomenon, in order that the most efficient therapy can be instituted.

BIBLIOGRAPHY

1. Adler, Alfred. *The Neurotic Constitution* (trans. Bernard Gleuck, M.D.). Moffat Yard & Co., 1917.
2. Adler, Alfred. *Practice and Theory of Individual Psychology* (trans. by R. Radin). London: Kegan Paul & Co., 1929.
3. Adler, Alfred. *Understanding Human Nature* (trans. by W. Beran Wolfe). London: Geo. Allen & Unwin, 1929.
4. Adler, Alexandra. *Guiding Human Misfits*. Philosophical Library, 1948.
5. Alexander, F. *Psychosomatic Medicine*. New York: Norton, 1950.
6. Dunbar, F. *Psychosomatic Diagnosis*. New York: Hoeber, 1943.
7. Grinker, Roy. *Psychosomatic Research*. W. W. Norton & Company, 1953.
8. Ruesch, J. The infantile personality—the core problem of psychosomatic medicine. *Psychosom. Med.*, 10:134, 1948.
9. Wexberg, Erwin. *Individual Psychology*. Cosmopolitan Book Corp., 1929.
10. Wexberg, Erwin. *Individual Psychology and Sex*. (trans. by W. Beran Wolfe). London: Jonathan Cope, 1931.
11. Wolff, H. G. Life Stress and Bodily Disease—A formulation. *Proc. Assoc. for Research in Nervous and Mental Diseases*, 29:1059, 1950.