Psychological Differentiation of Psychopathological Disorders

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The differentiation of mental or psychopathological disorders has been made in the past mostly on the basis of symptoms. Psychiatry was first—and for a long time exclusively—concerned with the *description* of the various types of disorders and their symptoms. Attempts to define groups led to the establishment of three main types of disorders which are still recognized today in their fundamental differences. They are the neuroses, the psychoses and the psychopathic personalities or states. A dynamic and psychological understanding was first achieved in regard to neuroses. Despite the extensive research to gain insight into the mechanism of the psychoses, no generally accepted understanding of their dynamics has yet been reached. The psychopathic personalities are still causing complete confusion, although psychiatrists try to classify and interpret them psychologically.

Individual Psychology has made its contribution towards an understanding of the various disorders. Alfred Adler pointed to the defects in Social Interest, to the faulty life style and the discouragement which can be found in any case of mental or emotional disorder. However, this common background of psychopathological disturbances leads frequently to a summarizing reference in regard to all of them. Neurotics and psychotics are often mentioned in the same breath with criminals, drunkards, and perverts, indicating their common deficiencies.

A differentiation between them has so far rarely been attempted, because we are fundamentally more interested in the individual patient and his unique personality than in any more or less artificial grouping and classification. However, the step toward a sensible demarcation and an understanding of the fundamental difference seems to be necessary. The theory and technique of Individual Psychology provide us with a key to a dynamic understanding, which is sought today by psychiatry in general. If we can shed light on the fundamental structure of all psychiatric disorders, if we can come to understand psychoses and psychopathic personalities as well as we understand neuroses, much confusion can be avoided in our own thinking and in the field of psychiatry as a whole.

General Differentiation

Due to the lack of other criteria, the differentiation of the various disorders has often been based on the assumed diversity of degree. However, the distinction between neurosis and psychosis is not a quantitative one. It is not permissible to say that a neurosis is so severe that it is "almost" a psychosis. Psychotic cases may be so slight that they are very little disturbed in symptoms and functions, so that they can continue to work and keep in social circulation, while a neurosis may be so severe as to keep a patient bed-ridden and produce complete invalidism. The dif-

ference between psychosis and neurosis is structural. The conflicts in each case are solved, or at least answered, in a different way.

All conflicts of any human being are social conflicts, resulting from a disturbance or straining in the social relationship of the individual, impairing his integration into the community and obstructing his participation in the social functions. It seems that the nature of the social conflict and the attitude of the individual to his own social maladjustment distinguish the various types of psychiatric disorders. In any case we find the Social Interest restricted. However, this restriction is not uniform. Again, it is not a question of degree. A person suffering from a neurosis might have more, or less, Social Interest than a psychotic, and even than a criminal. The degree of discouragement, of inferiority feeling, and of social antagonism may well be expressed in the *severity* of the case, but not in the *type* of disturbance. The structure of the inner conflict is different in each type.

As our social adjustment remains incomplete, we all have conflicts in regard to our social participation. This conflict is regarded by some as an expression of man's fundamental inability to become a truly social being. There seems to be no reason to assume any intrinsic obstacle in human nature which would prevent man from adjusting himself to the social atmosphere in which he lives and which makes him what he is, namely, human. We know, too, the factors which prevent in each case the harmonious development of the social personality. We know the obstacles to the development of sufficient Social Interest, namely inferiority feelings and discouragement.

We can watch the social growth of individuals when we lead them out of their inferiority complex and help them to change their faulty life styles, which had been based on their wrong interpretation of the logic of living together. The old saying, "The spirit is willing, but the flesh is weak," characterizes the general social maladjustment during an epoch of human history when man has not yet learned to live with his fellowman peacefully. This obvious conflict between the "spirit" and the "flesh" is the crucial point for our investigation.

Many attempts have been made to understand this inner conflict found in most contemporaries and caused by their inadequate social adjustment. *Freud* described the Super-ego as the instance of social values and ideals which come in conflict with the urges and drives of the Ego, forcing those tendencies, which are not socially acceptable, into the Unconscious, the Id. In more popular terms, the conflict is recognized as existing between the conscience and the "weaknesses" or "faults" of an individual.

Adler clarified the issue considerably by formulating the terms Common Sense and Private Sense. Under Common Sense we understand our thinking in common, our participation in general ideas, in values and morals accepted by the whole group to which we belong. The normal

individual knows what he should do, what is right and what is wrong, how one should behave and act. But very few act always according to their own understanding, to their Common Sense. While we do not deny, principally, the desirability of a certain behavior, we do not follow this pattern if our understanding of ourselves leads us to move in another direction. What we think of ourselves is not always conducive to following our Common Sense. One should work; but if one considers himself incapable of doing a good job, he might refrain from working. The Private Sense, as Adler called it, conflicts with the general rules of common understanding.

It might be well expressed in the sentence, "I know how one should act; but that is only true for the others; I myself gain more if I act differently." The interest of the others, of the community, conflicts in these instances with what the individual considers his own interest. His private goals, his life style, his interpretation of his own needs, interfere with his willingness to bring himself in line with the social demands, with evolution. Instead of following his social interest, he is concerned with his own security, with his prestige.

These universal conflicts find different answers in the various psychiatric disorders. The neurotic person meets the conflict by hiding his Private Sense from his own consciousness, by not admitting his own tendencies when they conflict with his conscience, his Common Sense. He looks for alibis to excuse his social shortcomings. If this description is correct, and we have every reason to believe it is, then it leads to the conclusion that we are all neurotic, fundamentally and structurally. It is then only a question of degree whether our alibis and our lack of social participation are more, or less, conspicuous and impressive. The line between normal and pathologic is very indistinct. It might be drawn by the existence or nonexistence of a subjective feeling of being *sick*. If sickness or symptoms of diseases are used as alibis, the diagnosis of a neurosis is justified.

The person who becomes psychotic suffers from similar conflicts. However, in his case, the answer to the conflict is different. Under certain conditions, either on the basis of an organ inferiority of the central nervous system, or of infection or exhaustion, of toxic agents or of organic brain lesions, an individual may be able to resolve his inner conflict by changing, temporarily or indefinitely, his recognition of the Common Sense. Through delusions or hallucinations, he can impress himself with an assumed reality, which then conforms with his Private Sense. He lives in a world of his own, in which his personal goals find complete justification. He no longer adheres to the logic of life; he has his own logic shared by none.

The psychopathic personality, as I understand it, is a person who also deviates in his actions from the logic of living together, from the social obligations to which he is exposed. However, unlike the neurotic, he has no inner conflict. He has failed to develop sufficient Common Sense. He

denies the logic of the others, never accepts their values and morals, and considers his own interests as the only motivation which counts. Therefore, he needs no alibis and flaunts his own interests and tendencies.

There is some fluctuating and overlapping between these three groups of personality disorders, which will be discussed later in greater detail. However, for practical purposes, these distinctions which I have formulated hold true. They explain the different behavior of these three types of disturbances. We find insight into the condition only among the neurotics, as the psychotic and the psychopath have no realization of the conflict. One avoids this realization by adjusting his Common Sense and the other by not having such a sense. Of course, the conflicts exist in either case, but they are not recognized as such. The psychotic suffers from what he believes is reality, and the psychopath suffers from society itself. Neither of them considers himself sick, at least not in regard to his conflicts. Therefore, neither asks for help or is willing to accept treatment.

Only the neurotic recognizes his disturbance, as he uses and benefits by it. There are exceptions to this rule in any group, as some psychopathic personalities might, in certain phases of their lives, act as neurotics; and even psychotic patients, either before the fully developed psychosis or in the period of recovery, might act more as a neurotic. This distinction has also far-reaching implications for treatment and therapy.

A more detailed examination of the three groups of personality disorders and of some psychological mechanisms is necessary to understanding certain types and syndromes.

Neurosis

The diagnosis of a neurosis must be made on the basis of its psychological structure. Before adequate knowledge of the dynamics was available, the diagnosis of neurosis was merely made by default. If a person complained of symptoms for which no organic reason could be found, and which could not be explained on the basis of clinical and laboratory findings, then the patient was classified as neurotic and his symptoms as "functional" disturbances. Today we recognize the possible neurotic nature of any disturbances, independent of the existence of any organic pathology. Even organic pathology can be used for neurotic purposes, as an alibi for non-participation in life and as excuse for failure. In order to establish a definite diagnosis, one must recognize for which psychological purpose the neurosis is used.

The nervous symptoms begin invariably at a moment of personal difficulties in life. This is a moment of discouragement, when the individual decides that the social problems which he has to face are too difficult. It is the moment when he withdraws from some life task, either from work or from social relations with friends or relatives, or from love and marriage. A feeling of personal inadequacy always creates the inner ten-

sion, the apprehension with which the neurotic disorders began. There is no objective measurement for the decision whether any particular situation, or any particular social obligation, is actually too much and too difficult. All depends on the subjective interpretation of the patient, on his goal in life, on his life style.

A person with a very highly developed ambition, one who believes that he must be the first or he will be lost, the perfectionist, will get discouraged where someone else sees no danger to his social status. The person with Social Interest, who is less interested in his own prestige than in the welfare of others, who enjoys being useful and knows how to be, the individual with courage, who knows that he can stand anything and that he will be able to make the best of any situation, will stand greater hardships without withdrawing, without becoming afraid, nervous, and sick.

As any nervous symptom is directed against some particular situation, against some social task, against some duty or some person, one question is helpful in determining the meaning of any particular neurotic disturbance. If a patient is asked what he would do or how his life would change if he were well, he invariably will reveal the direction of his neurosis. "I would get married," or, "I would get a job," or, "I would be able to do a better job," or, "I would go out and meet friends," or, "I would get along better with my wife," are some of the characteristic answers. They indicate that the patient is sick because he wants to avoid marriage or work, or because he needs an excuse for his failure at work, at social contacts, or in his family life.

The patient is not aware that he uses his ailment as an excuse. If he would admit to himself that his symptoms are not, as he believes, the *cause* of his failure, but only a device for avoiding his responsibility—if the patient could see these relationships, the symptoms would become futile. The neurosis is, therefore, a human creation built after the image of a disease. However, as the patient believes himself to be sick, and actually experiences the symptoms which he creates, he really *is* sick, for all practical purposes.

The distinction between various types of neuroses has been generally based on symptoms. However, all these differentiations connected with a host of names are very incidental and rarely significant. The neurotic symptoms are as various as the human functions. There is no limitation in the symptomatology of neuroses, as any human function can be disturbed by an individual, who then regards himself as the *victim* of the disturbance which he himself has created.

It seems difficult to comprehend how one can develop symptoms in accordance with one's needs. No doubt, nobody can produce symptoms deliberately. And yet there can be no doubt, either, that the neurotic patient himself *has* created his symptoms. How can this be done? We know today the mechanism of establishing nervous symptoms. Two factors seem to be required. One is the psychic tension, provided by the

apprehension in regard to some life task. It is fundamentally the fear of obligations, the fear of failure and of inadequacy. With this psychological strain the whole body is placed under tension. No symptom can be developed without this tension. It affects the vegetative system and through it influences all bodily functions.

The second requirement seems to be paradoxical, but there can be little doubt of the correctness of the observation. It is a desire to *overcome* some disturbance which *creates* the symptoms. In other words, the symptoms can only develop *against* the conscious intentions of the patient. As long as the patient does not mind being sleepless during the night, either because he wants to think something through or because he wants to read or to do anything else, he does not suffer from insomnia. This disturbance starts when the patient decides he *must* sleep. He does not realize that, while trying so hard, he actually disturbs his slumber. He would fall asleep without any effort, if he were not, for some reason, interested in being sleepless. There are many purposes for which insomnia can be used; as an adequate excuse for a possible failure at an examination; as a logical reason for an otherwise unexplainable lack of efficiency; as a demonstration for being overburdened with responsibilities. The patient fails to realize for what reasons he uses sleeplessness. However, he could not develop his symptom—in this case insomnia—if he did not try so hard to fall asleep. The efforts to overcome the symptom serve the purpose of demonstrating the good intentions of the patient, while he, struggling with himself, merely increases his tension, which in turn helps to continue and aggravate the symptom.

It can be demonstrated beyond doubt that the patient has it in his power to produce or stop any symptom. If one succeeds in persuading a patient to produce the symptoms deliberately, they will disappear. This technique, called "antisuggestion" (Wexberg) is not a method of *treatment* because it does not even touch the deeper reasons for the development of a neurosis. But the prompt effect of the antisuggestion proves that no symptom can be maintained when the patient stops trying to overcome it.

It is, therefore, obvious that it makes little difference what kind of symptoms a patient develops. The neurosis remains the same fundamental structure, though some symptoms disappear and others are substituted. For the sake of classification we can, however, divide all symptoms into three groups: Disturbances of *feeling,* of *thinking,* and of *bodily functions.*

In the first category fall all emotional disturbances *per se.* There is, first of all, *fear,* which is most pronounced in phobias and anxiety states, but which exists more or less in any neurosis, as fear is the basis of the neurotic attitude toward life. To this group belong the various types of phobias like agoraphobia, claustrophobia, erythrophobia, fear of

height, of disease of any kind, of death. Other disturbances of feeling are depression, temper, worries, irritability.

In the category of disturbances of thinking belong first the obsessive compulsive neurosis, but also all obsessive ideas, overexactness, querulousness, jealousy, lack of memory, inability to concentrate.

The third group, disturbed bodily functions, includes the wide field of organ-neurotic symptoms; they are the object of special study, for which Psycho-Somatic Medicine was inaugurated. The first type of neurosis which was recognized and described as a special disease consisted of organ-neurotic symptoms. It was called "Hysteria," because it was assumed that in old maids the womb (Greek: (*hysteria*) was floating in the body due to lack of sexual gratification. The symptoms of hysteria are rather primitive reactions of simple muscular and sensory functions, convulsions and pareses, anesthesias and other disturbances of feeling, deafness and blindness, connected with various pains and emotional excitement. Later in the development of medicine, when nervous reactions were recognized also to affect men, a new syndrome of organ-neurotic symptoms was described and called "neurasthenia."

This complex of symptoms is connected with symptoms of weakness and general "nervousness," and often regarded as an expression of an assumed weakness of the nervous system. It has been attributed to mental or physical exhaustion, due to inherited deficiency, overexertion, sexual over-indulgence, excessive mental stress, abuse of stimulants and drugs, and other similar excesses. However, fatigue and irritability are typical neurotic mechanisms of a defensive attitude toward some life problem. The emphasis on the physical sensation is the typical evasion of the actual conflict, which is of a social nature.

Other syndromes of similar nature were described and were given names, like "psychasthenia." In this group belong all the small symptoms of our daily life, irritability, weariness, sleeplessness, lack of memory, difficulty in concentration, various pains and aches, impotence and frigidity. These symptoms are often superimposed upon some minor organic ailment, as in arthritic conditions, polyneuritis, sinus infections, and similar chronic disorders of organic nature. The neurotic disturbances might affect certain organ groups and create gastrointestinal, cardiovascular, glandular, and vegetative disturbances, all through the channels of the vegetative system. They are originally without pathological foundation, but through constant abuse of certain organs pathological conditions may develop, like gastric ulcers, hyperthyroidism, and many other organic disfunctions. Most neuroses begin with rather simple symptoms and may then develop into quite complicated and organized psychopathological disturbances. They are dynamically and structurally alike, and their differences are more incidental than the emphasis on various terms may indicate.

There are no definite rules why certain symptoms are produced and not others. In some cases the symptoms develop in an organ group which

offers less resistance to the strain of life. Inherited organ inferiorities make some organs more irritable and more responsive to nervous tension. Organs which were used early in childhood in an attempt to gain attention, sympathy, or special favors from parents remain always a *locus minoris resistentiae*. Such early training may produce certain character traits conducive to certain symptoms. Timid children may always incline toward phobias; overprotected children trained to watch the smallest physical ailment may develop hypochondriacal tendencies and somatic preoccupations; children exposed to pressure and trained to use symptoms as counter-pressure may develop an obsessive compulsive character.

Symptoms are often continuations of an incidental disturbance; upset stomach may lead to a "nervous" stomach; an incidental acceleration of the pulse rate may be maintained and repeated, an actual frightening event be used to establish lasting violent fears. Such "causes" are merely occasions which are used by a person who is under stress. Some symptoms develop as imitations of neurotic or organic ailments observed in others. Parents by their example often invite children to develop similar symptoms which have proved their efficiency. As a rule, every symptom presents the best and most effective answer a person has found in regard to his psychological needs. But we must keep in mind that these symptoms are chosen without any realization on the part of the patient. He remains completely unaware of his actions. Otherwise he could not satisfy his conscience; he would not suffer as acutely as he does. The suffering is the price which the patient pays to demand absolution. Only psychotherapy can clarify the issue and help the patient back on the way to participation in life.

Psychosis

The mechanism of psychotic disturbances is completely different from the structure of a neurosis. The defensiveness against life is complete. A psychosis starts when the bridges between the individual and his social atmosphere are either completely, or on the verge of being, broken up. Psychosis is no longer directed against one or another situation, but against social living altogether. It takes certain predisposing factors to break completely with the logic of life.

However, it must be emphasized that psychotic mechanisms are not at all alien to the normal personality. The dreams of the normal person have the same pattern and structure as the delusions and hallucinations of a psychotic patient. During our sleep we are removed from the social atmosphere of our waking life, from the logic of social life and the grammar of conscious talking and thinking. Our inner life creates its expression in dreams as does the private sense of the psychotic, who is similarly not bound by any logic of life or thought, nor by grammar or any other superimposed rule. He obeys his inner order, his private sense, as does the dreamer. This principle is true for all psychoses, regardless of the

nature of the psychosis; the various types of psychoses vary only in regard to the outlets which they provide for the expression of the inner self.

There are first the so-called functional psychoses—schizophrenia, manic-depressive psychosis, and paranoia. They are called functional, because no brain pathology has yet been found to substantiate the mental disorder. The psychological understanding of these psychoses is still limited, as research has so far been mainly directed toward the structure of the symptoms and their mechanism. Few reports are available on the personalities of the patients and their life-styles, to clarify the role which the psychosis plays in the life of the patient. The family relationship seems to play an important part and deserves more illumination.

The onset of schizophrenia is very often connected with a shocking experience that throws the patient off balance. Predisposing factors are probably organ inferiority in regard to certain brain functions, tendencies to withdraw and to concentrate on inner life experiences, exhaustion, or drastic changes in the body equilibrium, like puberty or pregnancy. These predispositions alone seem not to be sufficient as long as the individual is not exposed to tasks which he is not prepared to solve or situations which he, according to his life style, cannot meet successfully. The psychosis is the admission of complete inner defeat.

Experiences with war schizophrenia will probably shed more light on the structure of schizophrenic breakdowns. Some observations point to a type of schizophrenic disorders which seem to include more neurotic elements and to approach the picture of hysteria. They are similar to psychoses observed in prisoners and seem to offer a better prognosis. One significant factor may be that the logic of life for these people is confined to the social atmosphere of army or prison life against which the psychosis is directed—from which the patient withdraws completely. Brought back to civilian life, he may be capable and willing to participate again and to accept anew the logic of living together.

The disturbances in the manic-depressive psychosis are more on the emotional side. The logic of life is also defied, but in a different way than in schizophrenia. Delusions are less violent, hallucinations less extensive and frequent; nevertheless, the patient follows his Private Sense at the expense of the Common Sense without inner conflict. Even the remorse and self-accusation of the melancholiac is not in line with Common Sense, but is used as a weapon of attack against social responsibilities.

The element of anger seems to play an important part in manic- depressive psychosis, although it is converted and not obvious, as the patients very often are persons who do not permit themselves to express anger without losing self-respect. Suppressed anger probably plays a more important part in the so-called reactive depressions, which are more the type of a neurosis, and directed to a limited object, such as a person or situation. Release of anger very often removes the depression. In a melancholic psychosis, however, the antagonistic attitude involves the whole

world. In the manic phase, the defiance and aggression of the patient are more obvious, while he conceals these tendencies behind inertia and immobility during the depressive phase. The manic phase is the overt overcompensation for the feeling of complete defeat, "a flight into reality" (W. A. White), whereby the reality is rearranged according to the inner demands of the patient.

The periodic appearance or disappearance of depressions is less indiscriminate than might appear at superficial observation. The provoking agent in the life situation at the start of a relapse can be discovered only by careful analysis of the patient's life style and the relative significance of the conditions under which he lives.

An extremely interesting type of psychosis is paranoia. Here we deal with a psychosis which has not affected the ability of logical thinking. Very few individuals seem to have the capacity to impose their own logic and their Private Sense upon the logic of life without excuse of neurotic symptoms or without alienating their own logic from the Common Sense of others. Most such attempts lead to schizophrenic processes, and the difference between the inner logic, the Private Sense of the patient, with the logic of the rest of the world becomes apparent. The paranoic concept puts the individual in the center of the world; the significance of a defensive and intimidated individual is overcompensated into an object of general attention. The logic—or perhaps better, the distortion of logic—of the paranoic resembles somewhat the type of thinking we find in psychopathic personalities. Both are refractory to persuasion and, unlike a neurotic person, reveal by their rigidity their denial of the Common Sense.

In organic or toxic psychosis the apparent inability to participate in our mutual social sphere seems to be adequately explained by the organic damage to the brain. It can be on the basis of brain pathology due to tumors or other diseases of the brain; due to cerebral arteriosclerosis, senile changes, or syphilitic process; or as a consequence of endogenous or exogenous intoxication as through alcohol, various drugs and poisons; through acute infections like influenza, rheumatic fever, scarlet fever, typhoid, and others; or through disfunction of the inner metabolism in connection with childbirth, glandular disfunctions, and pathology of the blood picture. However, we seem justified in assuming that the various disturbances do not actually cause the mental disorder, but only provide a tool which can be used, under favorable circumstances, for pathological mental reactions. Exactly the same pathological condition can be found in patients with a psychosis and in those who are not mentally ill. The location of the damage plays a role, but not conclusively. It influences the type of mental disturbance, inducing and facilitating certain mental reactions. Organic psychoses tend to affect judgment, memory, and emotional stability, while toxic psychoses generally show vivid hallucinations of a delirious type, deep confusion, and agitation. These two syndromes already indicate the reasons why the patients lose their ability to maintain their

Common Sense sufficiently intact. As the perception of our *common* world vanishes or disintegrates, the inner world of the patient becomes dominant.

New types of treatment have been found to be effective with various types of psychoses. Although the reasons for the success of shock treatment are not yet clear, their efficiency cannot be doubted. It seems that the breaking up of rigid channels of thinking and feeling is the determining factor. It is significant that in certain cases the psychotic derangement disappeared under treatment while the presumably "causal" brain pathology remained unchanged. Such cases seem to indicate the rather loose connection between cause and effect, which we should better understand as a relationship of stimulation and response.

Organic and toxic conditions offer possibilities to which the patient with his attitudes, intentions, and life pattern may or may not respond. The problems with which he is confronted, the personality he has developed, may very well determine whether he responds with a psychosis, and even with which symptoms. We know, for instance, that alcohol may produce a great variety of psychotic disturbances, some almost entirely in the nature of an organic psychosis, like the Korsakoff Psychosis; others typically acute toxic, like Delirium Tremens; and others again with schizophrenic or with manic depressive symptoms in the foreground.

We will see later that the same agent, alcohol, may as well produce disturbances of a neurotic or psychopathic type. It seems, therefore, that organic and toxic agents on one side and social conflicts on the other confront the individual, and that it is the patient who determines the outcome of the impact. Shock therapy does not remove the causing disturbance, but offers a new possibility for a new and better reaction. The solution of the psychological conflict and pressure can be attempted only through psychotherapy. In certain cases the tension and the conflict may be removed by managing the life situations of the patients after shock therapy in such a way that they become more favorable to the patients' needs. The limitations of shock therapy may well be provided by psychological factors. The treatment attacks only the tool, the mechanism, but not the attitude of the patient.

Psychopathic Personality

The term "psychopathic personality" has been widely used and much abused. This type of mental disorder still presents psychiatry and culture with many puzzling and confusing problems. Very little agreement or clarity exists about the nature of this disorder and its origin. Many terms are used, such as constitutional psychopathic states, constitutional psychopathic inferiority, sociopathy and similar terms. There was a trend—and it still exists—to consider a person who is not insane in the sense of a psychotic, but who does not act like a normal person, nor feel sick like a neurotic, as constitutionally deficient. Inheritance is and has always been the outlet for an etiological understanding when no more specific and con-

crete etiological factors could be found. Most classifications of psychopathic personalities are based on a mere description of their various emotional and social maladjustments. A dynamic understanding of these disorders seems to be missing.

However, attention of psychiatry and the public in general will probably center more and more on the problems of psychopathy. Psychiatry first was mainly interested in and dealt exclusively with psychoses. At the end of the past century, the emphasis shifted to the neuroses which occupy the first place in psychiatric interest and practice. Physicians of all specialties, and medicine in general, became interested in the problems of neurosis as it was recognized as an integral factor of a great number of diseases. Right now we seem to stand on the threshold of a new psychiatric phase: The concern, the understanding, and the effective dealing with psychopathic personalities. Many psychiatric, legal, and social problems could not be solved due to this lack of understanding of the nature of psychopathy. Our dealing with criminals, our efforts to prevent delinquency, our attempts to cure the antisocial, were completely frustrated because there was no basis to rely upon in these efforts.

Psychopathic personalities are characterized, as was said in the beginning of this paper, by a peculiar deficiency of the Common Sense. They are persons who have failed to develop the necessary Common Sense in order to get along with others and behave in a socially acceptable way. Their deficient Common Sense is the causal factor in their maladjustment. This deficiency may originate in an inability to conceive of the moral standards and values of the group in which the person lives. For this reason, I am inclined to regard the mentally deficient as one group of these psychopathic personalities. Some psychologists take exception to regarding mental deficients as part of psychiatry. However, we realize more and more the connection between emotional and social maladjustment and mental deficiency of varying degrees.

In many cases of mentally deficient children, the general inability of parents and teachers to inculcate children with proper social attitudes contributes to the resulting moral and emotional defects. Retarded children, instead of receiving the necessary better care, receive less of it and are therefore prone to become psychopathic personalities. However, psychopathy can in all cases be traced back to deficiencies in upbringing, due either to a lack of supervision and educational facilities or, more frequently, to a lack of ability on the side of the responsible persons who failed in their educational obligations.

The configuration of the Common Sense of psychopathic personality is extremely interesting and revealing. As nobody is completely devoid of Social Interest,—or he would not have been able to survive—so everybody has a certain amount of Common Sense. This Common Sense, however, is identical with the ideals and values of those to whom he feels he belongs. But it ends there also. As this feeling of belonging of a psychopath

is reduced, and as he opposes the society in which he grew up, so his Common Sense is not in line with the generally accepted social ideals and values. However, the gang to which he belongs, the group with which he identifies himself, shares his Common Sense. This peculiar configuration of the Common Sense explains the social fluctuation in regard to certain types of psychopathic personalities. The same social behavior may be regarded as acceptable or as anti-social, depending on the social conventions of a group. Killing may be criminal or heroic, according to the Common Sense of a group. A rebel is regarded as criminal when the rebellion of which he is a part fails, and a hero when he succeeds. The difference can be understood only from the point of view of a *Common Sense,* of a set of values which the individual either shares with the society around him or which distinguishes him from them. In these instances, psychopathy is obviously a question of social order and social nature, and the deficiencies of an individual are expressions of social inadequacies which are not necessarily faults of the individual. These facts should make it clear that delinquency and crime have to be recognized not merely as individual, intrapersonal problems, but as problems of social interaction. Any criminal may be a completely acceptable and dignified member of a group which shares his values.

For this reason, criminals of any kind must be regarded as psychopathic personalities; because their Common Sense and their understanding of good and bad as part of their mental set-up is at variance with the social order around them. They belong in one of the three groups in which psychopathic personalities may be divided: They are (1) the *Indulgent Personalities*: The alcohol and drug addicts, the gamblers, the liars, the perverts, the truants, the swindlers, the eccentric and the excitable, the hoboes and malingerers. Then there are (2) the *Defiant Personalities*: The criminals, the delinquents, the morally insane, the active sex perverts and prostitutes, the impulsive and quarrelsome, and (3) there are the *Mentally Deficient* of all degrees, from feeble-mindedness to idiocy. They all have in common their limited acceptance of what is right and wrong, their limited aknowledgment of good and bad. As they do not feel sick and as they feel justified in their own behavior, they seek no help and accept no therapy. Prevention is the best cure. Helping parents and teachers in understanding and guiding their wards will be recognized as the prime objective. Psychopathic trends must and can be recognized very early. They cannot be suppressed by force, nor mitigated by indulgence. These two methods, predominantly used today with misbehaving children, are mainly responsible for the great number of indulgent and defiant personalities. Psychopathics are the result of our social conditions which do not induce educators and parents to deal with children in a humane, dignified, restrained and encouraging way.

Once such personalities have been developed, the only therapy that seems to affect them is group therapy. They resist personal treatment in

most cases, but they respond to group spirit. It is easier to change the objectives and tendencies of the whole group than of any individual alone. New group values must be developed to increase and improve the social values of the individual. That is the reason why group psychotherapy is so efficient in reconditioning delinquent youth and alcoholics.

This efficiency of group therapy will be increasingly recognized when we are dealing with mental disorders which tend to develop psychopathic personalities. There are some fluctuations between the various groups of disorders. An alcoholic might use his drinking as a neurotic symptom, excusing his failure by his "weakness." He feels sick and asks for help, as is typical of a neurotic. However, the chronic alcoholic very often is a psychopathic individual who refuses assistance. In this case individual therapy is almost hopeless.

Chronic neurotic persons very often react like psychopathic personalities; they are well entrenched and rigid in their indulgent or defiant attitude toward life. Although they maintain their symptoms, and continue to feel sick, they generally establish an attitude of definite declination to recognize and accept social obligations. Especially in cases of compulsive neurosis, one is confronted with a person who often shows a deep sense of justification for not playing a part in the social tasks. Shock therapy fails, as there is no mechanism here which might be broken down; but group psychotherapy, with the possibility of setting up new moral values, proves to be efficient.

The problem of psychopathic personalities will probably confront us with great violence after this war, when readjustment has to be made by the community to the returning soldier and by the veteran to his community. Clash of social values and mutual refutation will create innumerable problems which will require psychological understanding and psychiatric help. Group discussions and group psychotherapy seem to be the methods which offer the most probable help.

I. P. ANECDOTE

The following story has reminded me of the excuses I have seen many discouraged children make for failing to begin on a useful task before them.

It is said that a tourist in New England lost his way and stopped by a field where a farmer was following his plow with spiritless plodding.

"Can you tell me the way to Boston?" the tourist called.

The dour farmer spat disgustedly on his plowshare and scratched his head. "Mister," he said, "if I was going to Boston, I'd never start from here!"

P. Thatcher.