WARD PSYCHOTHERAPY WITH SCHIZOPHRENICS THROUGH CONCERTED ENCOURAGEMENT

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This report represents experiences gained over a five-year period while a mental hospital ward, to which the author was attached as psychologist, gradually changed its program for chronic schizophrenics from custodial care to the beginnings of a continuous treatment system. Motivating this approach was the belief, strongly reinforced by empirical events, that applied humanism is not "do-goodism" but the most appropriate curative agent available for schizophrenic sufferers at the present time.

Here schizophrenia is regarded as an extreme reaction of alienation and isolation, which has for many years been of some value to the patient as defense against catastrophically low self-esteem. Viewing low self-respect as a concomitant of the schizophrenic style of life is not a novel idea, but to regard such as "the hard core" of the reaction is a perception that only recently has found new expression in the literature (2, 10, 11, 15, 32, 36, 38).

One significant aspect of the approach to be reported here is that the psychologist can serve in the novel role of *therapeutic catalyst*, combining facets hitherto considered incapable of a rational synthesis. In addition to interpreting psychological testing and carrying out psychotherapy, he interacts with line personnel,[1] functioning as philosopher, scientist, and teacher. This is held to be not only a practical but an essential element in expediting psychotherapeutic success with chronic schizophrenics.

For an isolated hospital psychotherapist the task of attempting to cope with the schizophrenic's insatiable hunger (and frequent initial indigestion) for esteem is almost overwhelming. Thus we hold that cooperation and "ultimate concern" of hospital personnel for the patient's self-esteem is paramount for psychotherapeutic success, if it is to be more than a monumental *tour de force*.

Ward Learning Sessions

Formal aspects. Gross misperceptions and biases in the reports of the line personnel, and the excessive number of subtle clashes between personnel and patients, which grew from mutual misinformation and

[1]Line personnel is used as a generic term to include personnel who traditionally maintain face-to-face contacts with patients (34).

irrational expectations, led to the initiation of a teaching program by the ward psychologist with the constant encouragement and support from the ward psychiatrist.[2] Weekly sessions were attended by 15-20 personnel, mostly nurses and nursing assistants. Others were occupational, corrective, and recreational therapists, and at times chaplains and trainees in psychology.

Our first attempt, the teaching of elementary psychodynamics, was a definite failure, yet must be considered an invaluable learning experience for us. Group silences and signs of boredom (which vanished when the abstract dynamics were centered around an individual patient) told us that the line personnel can be best engaged by couching lectures in *their* terms about *their* problems.[3]

We then adopted the following procedure. One patient a month was selected from among those mentioned frequently by the nursing group, and presented to the session to illustrate the operation of psychological concepts and dynamics. The remaining weekly meetings during the month revolved about possible ways of helping this patient find reality worth accepting. Psychological reports were usually available. Social and psychiatric material was also given, frequently by the social worker and the psychiatrist. Two needs became evident here: for the rewording of esoteric reports to fit the lowest common denominator of understanding, and for the tactful handling of confidential psychotherapy communication. An increased discussion of patients' problems within the group, and a halt in the clandestine interchange of gossip pertaining to patients' sexual and hostile behavior, gave some clue that these two needs were met tolerably well.

Fourteen patients, male veterans with chronic schizophrenic diagnoses, participating in individual and group psychotherapies, were given this additional indirect treatment by the didactic-discussion-group approach with personnel. All patients had been treated in the past, without remission, by electro-shock, and two by insulin shock. All were on maintenance dosages of tranquilizers, with the exception of two patients whose medication was discontinued during

[2]The writer is deeply indebted to Louis W. Leskin, M. D., for providing a living example of the blessings inherent in wearing the crown of status lightly.

[3]This lesson has even greater ramifications in terms of hospital, and not patient, rigidities. Most hospital programs, from teaching through psychotherapy and all forms of rehabilitation, are conducted primarily out of the covert needs of those directing the activity, with little attention to the needs of the respondent, be he patient or personnel.

the study, in a non-crucial test of a clinical hypothesis entertained by the author. Ages ranged from 20-39, hospitalization from one to five years, and no first admissions were in the group.

To start the group meeting, the chief complaint of personnel regarding the patient, the "calling card," was used. For example: "Keeps wanting to change assignments." "His constant stare and silly grin scare me." "Always interrupts any aide and nurse talking. Watches us like a 'peeping-tom,' then grabs us with those clammy hands." "He looks like he's got all the physical assets, but he rushes by us and never looks at us. What have we done to him?" "Always looking for a fight, but complains he's picked on." "Wants to sleep all the time."

Each presentation and the following weekly discussions were designed to illustrate important topics in the psychogenesis of schizophrenia from the life style of the individual patient: identifications (9, 12, 30, 33), communications (19, 20, 25, 27), chronicity (7, 8, 17, 20), double binds (5, 18, 19, 24), manifestation of the "core theory" (23, 38), types of "love" (6, 22, 33, 37), etc.

Psychodynamics were explored mainly in terms of operation in the daily life of the average man and couched in such learning theory terms as to capture the interest of ward personnel. Personnel then interviewed the patient and vice versa, with mutual edification.

Content and theory. This in *essence* is the theory presented in the weekly sessions, in the terminology used.

Whatever the etiology of schizophrenia may be, in many cases a necessary (but perhaps not sufficient) causal factor is a primary family relationship in which the victim learns very definitely and early in life a belief that he is worthless, helpless, hopeless and defenseless against a hostile alien world. Such a lonely *Weltschmerz* develops in a habitual "double binding" atmosphere in which a correct recognition of human motives is never rewarded and massive denial and avoidance become the values of existence (5, 18, 19). The inner universe of the victim becomes a veritable hell-on-earth, and subsequent catastrophic interpersonal experiences serve strongly to reinforce his rigid myopic philosophy of life. "I am unlovable; I am worthless." Along with such low self-esteem there are failure of a positive, integrated "I-feeling," and perceived complete ineffectualness and weakness. It is no wonder that such a nonentity flounders in a morass of excessive demands on others, and reacts with intolerable hostility of which he may be unaware, but which is reflected to others in his bizarre symp-

toms. He is the proverbial drowning man attempting to clutch at or swallow (and simultaneously avoid) straws of affection. Often, by a highly developed system of denials and compensation, he displays the brittle facade of grandiosity.

Our core concept of schizophrenic dis-ease, then, is an untoward response to a deficiency of essential self-esteem. No substantial improvement can take place without the involvement of this core process. The latest proferred panacea, the tranquilizer, in spite of its value as an antidote to anxiety, has failed to live up to its advanced miracle-drug publicity. In gross terms, temperament or energy outflow can at present be medically manipulated, but an individual's response to objects, other people, and the self, must initially be learned via reinforcement from others, for the most part.

Our formulation, arrived at empirically and from many other sources, parallels the Adlerian characterization of schizophrenia.

> Due to the greater self-centeredness it engenders, a greater feeling of inferiority interferes with the development of social interest. Such a child . . . will, of necessity, have a hard time in the pursuit of his goals; his mode of operation is based on exploitation of others. . . . He is bound to find increasing opposition as soon as he steps outside the limits of his family group. The outside world, therefore, will seem to him increasingly made up of enemies who frustrate his desires. The fictional goal of his self, of his greatness, will become so threatened that he will tend to withdraw from people and real life problems which all demand cooperation for their solutions. Lacking the social feeling of belonging, all people will appear to him as enemies . . . for he cannot, in such a negativistic state, imagine others to be cooperative (2, p. 70).

EFFECTS ON PERSONNEL

Understanding the patient. We assume that an individual's behavior is isomorphic with his constructs, meanings, philosophy, or world-design. His actions vis-a-vis chronic schizophrenics are partly decided by what schizophrenia connotes to him. It is my most unequivocal piece of learning from ten years as an aide and psychologist, that in spite of the effort which has been expended in lectures on understanding and accepting patients, the non-therapeutic biases have changed very little, if at all. Line personnel seldom realize the restorative values of *understanding* because the word is isolated from the remainder of the treatment theory, and impersonal, peripheral aspects of training are highlighted. Initially, discussion periods were occupied with observations by personnel of patient behavior worded in abstract phrases. Many times such reports were almost caricatures of psychological reports. But when members of staff and patient populations develop concern for the self-esteem theory and begin to

do their "homework" (studious attempts to perceive themselves and others from the core perspective), noticeable and often remarkable changes occur. Peripheral matters of routinized care drop out of discussions, and the penchant for interpretations based on word magic decreases sharply.

The more easily understood self-esteem core theory not only increased healthy interest in the patient, but also gave personnel a more optimistic orientation to patient treatment.

At the same time, discussion groups tended to encourage a healthy detachment from the patient whenever personnel became overly enthusiastic and preoccupied with a particular individual.

Seeing patients like oneself. One function of the unstructured discussion periods was the reduction of a rigid dichotomy between patient and personnel. It is difficult to imagine therapeutic concern emanating from personnel who perceive a vast gulf between themselves and schizophrenia and are so mesmerized by the jargon of professionals as to discount completely their own possible value in the treatment process. When schizophrenia loses some of its mystical aura and becomes more a matter of the patient's "being" than his "having" something (a virus, a communicable disease, etc.), progress is made in the worker's ability to relate to the patient. Research with the dyad (13) and empathy (26) corroborates the view that meaningful relationships are formed not by accident but by perceiving others as being essentially like ourselves.

The discussions brought out that *everyone is alike*, e.g., in the necessity for a certain amount of self-esteem for mental health, based upon satisfaction of psychological and physiological needs through the "loving" (22) concern of the self and/or significant others. Yet in another perspective, *everyone is different*, e.g., possessing varying amounts of self-esteem and different gestalts of learned motives and values.

Joining with staff. Another function of the weekly sessions was to break down the barrier between line personnel and staff. When staff remains exclusive, over-zealous beginning therapists, adjured to achieve an understanding participation with patients, sometimes reverse identification with patients (27), or develop guilt over a presumed lack of patient progress (28). When staff and line interact in these discussions, removing exclusiveness, with mutual acceptance of a self-esteem core theory, they both will view their parts in the treat-

ment process more realistically. They will see that one can by his actions enhance patients' self-respect (or self-hatred) but that he is no *deus ex machina.*

Gaining status and stability. The realization of the personnel member's unique contribution to the treatment process should increase his status in his own estimation and in that of patients. One may assume that everyone may potentially be able to establish a satisfying relationship with a patient on a tension-reduction basis, but that a person's significance as a model of secondary identification will vary with his status (earned or reflected) in the eyes of patients.

The program has quid pro quo tenets. Personnel attempting to help a patient toward greater stability and maturity, are thereby contributing to their own continuing stability. Humanistic attitudes are good medicine in general, and people fall sick because of the habitual want of such feelings in themselves. The reward from such attitudes is not other-worldly "pie-in-the-sky," but in substantial returns from social hedonism (16), and understanding and respect for the human foibles in oneself.

APPLICATIONS, SPECIFIC TECHNIQUES

We now come to the central question: What can people do to aid others suffering from rigid negative ideation and consequential emotions? Initially, the therapist's total efforts are directed toward reducing tensions and becoming a significant secondary reinforcer (30). Usually simple acts such as giving information, listening without demanding, displaying various facets of "warmth" (37), and a thorough faith in the patient's own potential for improvement with the support of others, precipitate rudimentary movements toward people. The successful therapist gives the immediate impression of "strength" and "friendliness" (38), that is, the ability to satisfy the patient's needs and the inclination to do so.

A complete and simple account of a therapeutic attitude in line with our core theory which is also a part of Adlerian theory can be found in Kurt Adler.

> . . . the main weapon in combatting the schizophrenic's style of life (is) encouragement, and . . . to cure schizophrenia, first of all, the physician must be more hopeful than the patient. Second, the therapist must become the first meaningful relationship that the patient ever had, by use of the kindliest and friendliest approach and by unfailing, constant cooperation and obvious interest in the patient and his welfare. At the same time, the therapist must be constantly aware of the patient's exaggerated sensitivity to even the slightest hints at humiliation. This approach has to be continued until the patient becomes convinced that fruitful cooperation

with another human being is possible, until he becomes more hopeful as to the achievement of some of his goals, and until he learns to feel less of an isolate, and more like a fellow human being (2, p. 72).

As others put it, "Allow the patient self-expression without ever taking away from his impoverished self-esteem, until be can maintain self-esteem in the shared world with others" (36, p. 78).

Emphasize the positive; ignore the negative. When line personnel become sensitive to the fears and anxieties of the individual who regards himself as flagrantly weak, alienated from his own human powers, and uncontrovertibly separated from others, they can also understand how "little things mean a lot" in establishing relationships with such individuals. The frequency of "What's the matter with you?" and "You don't look very good today" decrease, as ward personnel comprehend the potentially destructive influence a few words can have. Once the value of people in treatment becomes a conviction with personnel (still a rarity) and they begin to acquire a rational view on rewards and punishments, they appreciate the maxim of changing what can be changed and ignoring what cannot, i.e., rewarding behavior in which the patient behaves in an essentially human manner, and ignoring untoward incidents. This attitude of letting-be is perhaps best exemplified in the rational psychotherapy of Ellis (16). Adler put it well in these words:

It is the greatest mistake to expect an insane person to act as a normal person. Almost everyone is annoyed and irritated because the insane do not respond like ordinary beings. They do not eat, they tear their clothes, and so on. Let them do it. There is no other possibility of helping them (1, pp. 316-317).

If we can precipitate no "good," we should at least not instigate any "bad" through untoward emotional reactions to patient's behavior. A key prohibition is never to reinforce general statements of unworthiness such as "I am bad and cannot change." Line personnel are instructed to ignore such and give attention to more positive responses. Once the initial relationship is solidified, the psychotherapist becomes more adamant in his refusal to brook such defeat-laden statements. As an example, the patient might be informed: "I'm aware you've had these feelings about yourself for a long time. They came about because experiences have led you to think of yourself as worthless and unchangeable. But I won't stand for that kind of talk. Judging from what you say, I like you more than you do. I want to hear good things about you. What do you think of that?" Some of the strongest emotional reactions of futility are emitted by

schizophrenic patients when they are encouraged to mention "good things," even among those who were previously considered grandiose and narcissistic.

Humor. The dictum "ignore the behavior and act deaf and blind whenever it occurs," finds much supporting evidence in research and anecdotes (4), and is perhaps the substrate of humor. Humor in this sense is the way Freud uses the term, as a non-hostile jest in the face of inescapable stress, in contrast to wit which he defines as hostile (21). The ability to formulate and/or appreciate the humorous retort might be regarded as everyman's *desideratum* (31). Like wit, it is in some circumstances a relatively innocuous release mechanism for frustration. Even so, humor is an extremely rare and neglected virtue, and its appearance has never been encouraged within the hospital setting. All too frequently the bias of staff personnel has been to analyze away such "acting out" propensities. In small doses this anodyne for tensions frequently leads to the recognition of problems nurtured by institutional life, and thereby precludes destructive double binding by organizations which harbor extensive denials as a *modus operandi* (5). The remedial device of humor therefore warrants considerable attention.

Letting one's foibles show. Personal involvement in the form of anecdotes highlighting the therapist's foibles tends to correct the schizophrenic delusion that sick patients have problems and normals are always happy and omnipotent. These ploys also minimize the transference potentialities encouraged by a shadowy, withholding authority figure. An honest expressive relationship with the patient frequently reduces his delusions that he has no positive impact and a wholly derogatory effect on other people. The disrupting possibilities of the patient expecting too much from the therapist and hating him for perceived neglect, or expecting extreme rejection and cowering from authority, are handled by rapid confrontations. In psychodrama, for example, the psychiatrist or psychologist playing the patient's roles in a double binding, infantilizing family scene might readily admit his feelings of anxiety and hopelessness (e.g. "How can anyone handle this situation except by feeling powerful enough to leave them alone, without hate and loneliness? I sure couldn't live here! Can You?").

Repetition. One of the neglected techniques of psychotherapy, repetition (14), assumes great importance; e.g. repetition of appropriate segments of the core theory, repetitions of alternative respons-

es to that of "bad"-patient-happy-rejecting-authority compulsion, repetitions of encouragement and rewards for success.

Self-help. When personnel in discussion groups receive the impact of the importance of their own awareness of the context, their feelings and goals, upon their perception of patients' actions, they are wont, like the typical psychotherapy patient, to request oracular assistance from the psychotherapist. They want to be told what to do for, or to, the patient. Rather than refer them to some unconscious motives of their own (28), we simply offer them encouragement to search their own consciousness for suitable alternatives and, if such are not forthcoming, we give direct answers with appropriate reasons. The hope motivating these tactics is that through increased contacts of this type, line personnel will focus more upon their own personality resources as secondary reinforcers to aid the patient and demand no continuous support from others.

RESULTS

The goal of this pilot approach to spreading therapeutic effectiveness was to inculcate line personnel with a theory of schizophrenia which would motivate them to avoid actions which might compound schizophrenic unworthiness, and to reinforce the patients' struggle to realize human values.

In spite of the lack of conclusive statistics and controls, this tentative approach must be judged successful. Ten of the fourteen patients exposed to this "total psychological push" therapy derived from the core theory of schizophrenia have been making satisfactory extrahospital adjustment for from one to eighteen months. To be sure, this fact in itself does not demonstrate the efficacy of work with line personnel, for in some instances the changes have come about from efforts by relatives in that direction. More evidence comes from the ward atmosphere, where clashes between patients and line personnel have become less frequent.

A typical case showing the kind of effect achieved with the new understanding by personnel if that of SS. SS was a living composite of classic schizophrenic symptoms. His sensitivity to perceive rebuffs extended to uncontrolled sobbing whenever his name was called for medicine. Like most chronic schizophrenics he never had a friend or developed social skills. His primitive efforts to engage attention (and satisfy other needs as well) included clasping arms of other patients and intruding into any conversation. He soon ran afoul of a nursing assistant who adamantly prohibited such displays of "homosexuality" and precipitated a storm of nail-biting and tearing of clothes by the patient. When the nursing assistant

was able to ignore such behavior, mindful of letting-be, until SS's self-esteem was increased, improvement was more steady. SS has recently entered a foster home and is engaged in community welfare work.

General patient-personnel interaction has increased. A psychodrama group was formed in which personnel have been eager to take part. Another new activity is a monthly picnic of patients and personnel, from psychiatrist to nursing assistant. In this connection the popular remark of the thawing patient is, "Well, so doctors are human after all." To this remark one might add that personnel are making the same inferences about patients.

DISCUSSION

Gains have certainly accrued, but the going has been rough. Anyone familiar with the social structure of traditional mental hospitals must be aware of the terrific inertia to change which can be brought to bear both from the top and the bottom of the hierarchy (29). The frequent threat to medical omniscience posed by psychology results in chronic double binding from the apex. Sometimes one can almost hear the silent prayer for the "good old days" and for the demise of psychology (3, 35). There are still wards where psychiatrists will not work with psychologists or social workers, and the main treatment is making the patients swallow pills and push lawn mowers (i.e., "industrial therapy").

From the other end of the totem pole, line personnel can set up their own barriers which are equally difficult to obviate. Evening and night shifts are not available for meetings and have offered much passive resistance. Their brand of omniscience is less glaring but nevertheless formidable. They have had years of "experience," so they know how "to handle" patients. The islands of non-authoritarian treatment where therapists can admit to puzzlement are small and the seas of omnipotence wild and engulfing.

There is no intention here to present therapeutic interventions with schizophrenics as a sinecure. Certainly, when a schizophrenic spends a lifetime derogating himself and the world and fearing retaliation and annihilation, he does not easily slough this view. What is described here is a directive method of psychotherapy which has a goal of moving the schizophrenic back into the world of reality without panic. Providing the patient with gratifying reality experiences and rewards for re-entering the human race is the big challenge and the Gordian knot of any therapy program and provides one of the salient indictments against the conventional mental hospital. Psychotherapy

succeeds to the extent it aids in replacing the schizophrenic equivalent of "I am worthless forever and will be annihilated because of my weakness" with "I am human and worthy of living a fairly happy life." The therapist operates as a reinforcer of high incentive value from consistent association with need reduction. Therapeutic strategy calls for obviating generalized and intense self-accusations, and for reinforcing assertion, humor, and all positive human responses in patients (and personnel at times).

SUMMARY

This paper reports on a complex project which includes the following aspects: The ward psychologist's traditional role of tester-therapist *in vacuo* is expanded to include teaching, case presentations, and group work with line personnel. By this method line personnel are instructed in their value as people in a total treatment program. The frame of reference is a core theory of schizophrenia as habitually deflated self-esteem with consequent dependent-reactive hostility. The approach to the patient is general encouragement rather than specific attack on symptoms. Results were judged successful in that 10 out of the 14 patients involved have made good extra-hospital adjustment, ward relations are much improved, and there is more interaction between all the personnel and patients. The paper gives form and content of the training sessions, gains from them for both patients and personnel, and specific therapeutic techniques employed.

REFERENCES

1. ADLER, A. *The Individual Psychology of Alfred Adler.* New York: Basic Books, 1956.
2. ADLER, K. A. Life style in schizophrenia. *J. Indiv. Psychol.*, 1958, 14, 68-72.
3. AUSUBEL, D. Relationships between psychology and psychiatry: the hidden issues. *Amer. Psychologist*, 1956, 11, 99-105.
4. AYLLON, T., & MICHAEL, J. The psychiatric nurse as a behavioral engineer. *J. exp. Anal. Behav.*, 1959, 4, 323-334.
5. BATESON, G., JACKSON, D., HALEY, J., & WEAKLAND, J. Toward a theory of schizophrenia. *Behav. Sci.*, 1956, 1, 251-264.
6. BORDIN, E. S. Inside the therapeutic hour. In E. A. Rubenstein & M. B. Parloff (Eds.), *Research in psychotherapy.* Washington, D. C.: Amer. Psychol. Assoc., 1959. Pp. 235-246.
7. BORMAN, L. D. The chronic patient in hospital culture. *V. A. Newsltr coop. Res. Psychol.*, 1960, 2, 7-11.
8. BOVERMAN, M. Rigidity, chronicity, schizophrenia. *AMA Arch. gen. Psychiat.*, 1959, 1, 235-242.
9. BRONFENBRENNER, U. Freudian theories of identification and their derivatives. *Child Develpm.*, 1960, 31, 15-40.
10. BROOKS, G. W., DEANE, W. N., & ANSBACHER, H. L. Rehabilitation of chronic schizophrenic patients for social living. *J. Indiv. Psychol.*, 1960, 16, 189-196.

11. BULLARD, D. M. Psychotherapy of paranoid patients. *AMA Arch. gen. Psychiat.*, 1960, 2, 137-141.
12. BURTON, R. V., & WHITING, J. W. M. *The absent father: effects on the developing child.* Washintgton, D. C.: Nat. Inst. Ment. Hlth, 1960.
13. BYRNE, D. Interpersonal attraction and attitude dissimilarity. Paper read at Southwest. Psychol. Ass., Galveston, Texas, April, 1960.
14. CAMERON, D. Images of tomorrow. *Amer. J. Psychother.*, 1960, 14, 97-103.
15. DAVIS, T. N. Some principles in the psychotherapy of patients following hospitalization for schizophrenia. *Psychiat. Quart.*, 1958, 32, 110-117.
16. ELLIS, A. Rational psychotherapy. *J. gen. Psychol.*, 1958, 59, 35-49.
17. FERREIRA, A. J. Psychotherapy with regressed schizophrenics. *Psychiat. Quart.*, 1959, 33, 664-682.
18. FERREIRA, A. J. The "double bind" and delinquent behavior. *AMA Arch. gen. Psychiat.*, 1960, 3, 359-367.
19. FERREIRA, A. J. The semantics and the context of the schizophrenics' language. *AMA Arch. gen. Psychiat.*, 1960, 3, 128-138.
20. FREEMAN, T., CAMERON, J. L., & MCGHIE. *Chronic schizophrenia.* New York: Int. Univer. Press, 1958.
21. FREUD, S. Humor. *Int. J. Psychoanal.*, 1928, 9, 1-6.
22. FROMM, E. *The art of loving.* New York: Harper, 1959.
23. FROMM-REICHMANN, FRIEDA. Basic problems in the psychotherapy of schizophrenia. *Psychiatry*, 1958, 21, 1-6.
24. FRY, W. F. Destructive behavior on hospital wards. *Psychiat. Quart. Suppl.*, 1959, 33, 1-35.
25. HALEY, J. An interactional description of schizophrenia. *Psychiatry*, 1959, 22, 321-332.
26 HALPERN, H. M., & LESSER, LEONA. Empathy in infants, adults, and psychotherapists. *Psychoanal. psychoanal. Rev.*, 1960, 47, 32-42.
27. HANKOFF, L. D. Interaction patterns among military prison personnel. *U. S. Armed Forces med. J.*, 1959, 10, 1416-1427.
28. HILL, L. On being rather than doing in psychotherapy. *Int. J. Group Psychother.*, 1959, 8, 115-122.
29. ISHIYAMA, T., & GROVER, W. The phenomenon of resistance to change in a large psychiatric institution. *Psychiat. Quat. Suppl.*, 1960, 34, 1-11.
30. MOWRER, O. H. Two-factor learning theory reconsidered, with special reference to secondary reinforcement and the concept of habit. *Psychol. Rev.*, 1956, 63, 114-128.
31. O'CONNELL, W. The adaptive functions of wit and humor. *J. abnorm. soc. Psychol.*, 1960, 61, 263-270.
32. SALZMAN, L. Paranoid state: theory and therapy. *AMA Arch. gen. Psychiat.*, 1960, 2, 679-693.
33. SHOBEN, E. J. Love, loneliness, and logic. *J. Indiv. Psychol.*, 1960, 16, 11-24.
34. SOMMER, R., & CLANCY, I. Ambiguities in the role of clinical psychologist in a mental hospital. *J. clin. Psychol.*, 1958, 14, 264-268.
35. SZASZ, T. The uses of naming and the origin of the myth of mental illness. *Amer. Psychologist*, 1961, 16, 59-65.
36. VAN DUSEN, W., & ANSBACHER, H. L. Adler and Binswanger on schizophrenia. *J. Indiv. Psychol.*, 1960, 16, 77-80.
37. WHITMAN, R. W., & REECE, M. M. "Warmth" and verbal reinforcement. Paper read at Midwest. Psychol. Assoc., St. Louis, April, 1960.
38. WOLMAN, B. B. Psychotherapy with latent schizophrenics. *Amer. J. Psychother.*, 1959, 13, 343-359.