SELECTIONS

FROM

DR. LOW'S WORKS

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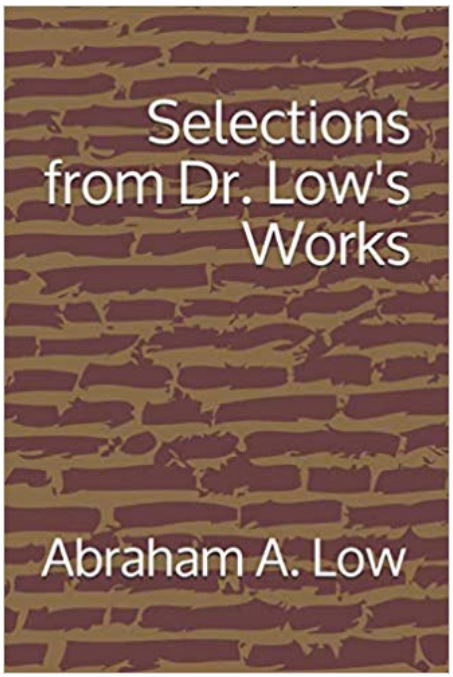
(1950-1953)



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FOREWORD

The articles and comments in this book were written by Dr. Abraham A. Low for the Recovery News which was published every two months by Recovery, Inc. during the years 1950-1953.

Due to the fact that many requests for these articles have been received by Recovery, Inc. they are now being presented in a more permanent binding.

Recovery, Inc. came into existence as a result of many years of research and study by the late Dr. Abraham A. Low. Dr. Low was in an unusually good position to conduct such studies, since from 1931 to 1940 he was the Associate Director and in 1940 and 1941 the Acting Director of the Psychiatric Institute of the University of Illinois.

During these same years he was assistant alienist for the State of Illinois and Associate Professor of Psychiatry at the University of Illinois Medical School. In these various capacities, he saw and treated thousands of nervous and mental patients. As a result of his experience, he founded Recovery in 1937 for the purpose of preventing relapses in former mental patients and chronicity in nervous patients.

Since the decease of Dr. Low in 1954 Recovery, Inc. has been operated, managed, supported and controlled by patients and former patients trained in the Recovery Method.

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HIGHLIGHTED IN BLUE

This volume, selections from Dr. Low's works, 1950-1953, is a combination of the two red books, Volume I and Volume II, and it includes all the articles that were contained in them. The articles that were contained in Volume II begin on page 78.

DR. LOW'S COMMENTS ON
EXAMPLES OF RECOVERY PRACTICE

DR. LOW'S COLUMN
NATURAL AND ARTIFICIAL MODES OF ACTION

Winnifred, on the Saturday afternoon panel, recalled a significant recent experience. "Lunching and daydreaming, I noticed something small and dark on a piece of lettuce. Dreaming as I did I paid little attention and took another forkful of salad and a bite of bread before I fully realized that it was a worm. I whisked it from the plate and jumped up to protest to the waitress. Then I spotted my reaction and felt I had permitted myself to get upset over a harmless little worm and knew that if I hadn't known I wouldn't have been any the worse off for it. Then I took the worm off the plate and was ready to continue the meal when it struck me that where there is one worm there may be more. I stopped eating. By this time my stomach felt queasy and trembly. But it seemed to me that to give up eating altogether would not be good Recovery practice so I finished my bread and drank some milk. I even took a few more bits of the salad. And yet, my stomach has always been squeamish. All a person has to do is to speak of an accident or a sick stomach or snakes and I am ill. Before my Recovery training, I would have rushed to the bathroom, would have thrown up the food and would have gargled several times and would have felt nauseated all day. Also it would have been a long time before I could bring myself to eat lettuce, spinach, or any leafy vegetable for fear it might hide a bug..."

Winnifred found a worm in her food and was ready to jump at the waitress but controlled her temper. She then interrupted the meal but resumed it soon because she thought, "to give up eating altogether would not be good Recovery practice." I shall readily admit that "Recovery practice" disapproves the "common practice" to raise a fuss and jump at people, and when Winnifred refrained from making a scene she gave an inspiring example of temper control which was an authentic piece of "Recovery practice." But when she reflected that the same practice required a person to indulge in the heroics and acrobatics of forcing contaminated food down the throat she obviously misinterpreted our principles of self-discipline. In trying to perform an heroic act, she violated the basic Recovery rule to be average, that means, to avoid being heroic, saintly or angelic. Practicing exceptional behavior of this kind is the very reverse of "good Recovery prac-

tice.'' Recovery stands for averageness and shuns extremism. Winnifred, desirous of establishing an excellent record of perfect Recovery behavior, defaulted on the supreme principle of Recovery's philosophy which frowns on excellence, perfectionism and extremism in the daily round of average existence.

When Winnifred caught sight of the worm on her plate the situation was one of an affront, an insult, a frustration.

Situations of this kind are *not routine but challenging*. They challenge you to make a decision and to take a position. There were three possible ways of meeting the challenge: Winnifred could have ''jumped at'' the waitress, could have released a burst of violent protests, perhaps threatening to report the incident to the health department and to sue for damages. Had she done that her position would have been that of the angry, aggressive temper. The second possibility was that she might have become so frightened and disgusted by the experience that, in utter dismay and revulsion of feelings, she would have left the table, paid the bill and rushed out of the restaurant. This would have been the position of the fearful, retreating temper. The third position she could have taken was to call the waitress asking her to replace the dish. This would have been a realistic, non-temperamental approach. Had Winnifred chosen any of these three positions she would have done what the average person might be expected to do under similar circumstances. Her position, whether temperamental or realistic, would still have been average. When, however, she decided to ignore the worm and to continue the meal she took an heroic position, stepped out of the domain of averageness and chose the exceptional approach.

It will be helpful to you to know that every significant situation in your life may challenge you to choose between the three positions I mentioned. When you are irritated by your mother or your boss, by your government or by a traffic jam, by a fly settling on your cheek or a noisy neighbor disturbing your peace, in all these situations you are free to choose between the two *extreme positions* of the angry or fearful temper and the *middle position* of realistic control. This arrangement of situations into three discreet portions is characteristic of everything that grows and lives. What is called the ''order of things'' or ''ordered existence'' merely means that life is so arranged that things and acts run from one extreme to the other, passing through a middle ground in which

the items lose their extreme size, duration or intensity and reach moderate or modest proportions. That part of your life, for instance, which is called appetite runs from immoderate to minimal desire for food with a region of modest craving in the middle. Similarly, the trees of a forest are ordered or distributed in such a series that the tall and small specimens meet in a middle ground of moderate-sized trees. All feelings, sensations, beliefs, impulses run this common gamut from extreme intensity through moderate excitement to minimal responses. The same principle of distribution holds good for symptoms, temper, intelligence, memory and attention, talents and skills, character and disposition. They all run from one extreme to the other passing through a middle ground of modest, moderate and common manifestations. This type of arrangement of things and actions into a broad middle ground flanked by two narrow extremes, being the commonly found order of nature, has been called the *''natural'' or ''normal'' mode of distribution.* If a forest should consist of tall trees only the distribution would be termed ''unnatural'' or ''abnormal.'' This mode of distribution could not be produced by nature; it would require the art of the gardener and would be artistic or artificial. Nature knows no uniformity; it lives and grows by variety. Its principle is that of the natural or normal distribution. The opposite of nature is manufacture or technique. Technique can produce thousands of cars in one lot all of them looking exactly alike. This is the technical, unnatural, artificial mode of distribution. An existence, ''ordered'' largely by technique, is bound to drift into an artificial mode of living.

Winnifred's determination to ignore the worm on her plate was either heroic or angelic or saintly. But it was not natural. The determination, although containing the elements of Will (to exercise supreme control) and feeling (of nausea), was in the main guided by a thought. It was the realization that here was a unique chance to practice Recovery principles to the limit of possibility. The thought had the character of a rare inspiration, of an extraordinary opportunity, perhaps of singular brilliance. It was romanto-intellectual, exceptional and extreme, not natural and average. Ordinarily, the mental productions of the average individual have their natural distribution. At times, they are brilliant flashes; at other times, they are outright stupidities. But the majority of his intellectual exertions are just average, lacking the ''divine spark,''

moving along lazily in the tracks of a broad middle ground of sound but colorless realistic reasoning, revealing neither intellectual brilliance nor mental sluggishness. The same type of natural distribution governs the average person's record of self-control. His self-discipline may sometimes reach the height of supreme determination, or it may occasionally sink to the depth of extreme vacillation, but the majority of his acts sprawl along a middle course of average limited control. A person who is *always* self-possessed and reserved, or *always* shrinking and cringing, has lost the natural distribution of his traits; he has eliminated everything from his action that spells natural movement, average variety and healthy change. He may have acquired the grandeur of a "lone eagle," or the distinction of a self-sufficient hermit, or the glory of an invincible hero, but he is not a warm, natural and human person. His expressions and actions are rigid, mechanical, one-sided and extreme performances. His traits have an unnatural and artificial distribution.

You who know Winnifred will agree that she is undoubtedly warm, human and natural. There is very little artificiality in her make-up. But she is a nervous patient, and nervous patients tend to be extremists with regard to their symptoms when they are still sick and with regard to the practice of rules after they have improved. As long as they still suffer the tortures of sensations and obsessions they have the extremist fear that they are doomed *forever.* When, after improving, they experience the delight of comfort and relaxation they are likewise extreme in their certainty that they will *never* be sick again. There is little or no middle ground of moderate caution or moderate doubt. It is either black despair all the time, or heavenly bliss without interruption. Their actions, thoughts and impulses know one manner of movement only: the abrupt jump from one extreme to the other, from torturing tenseness to complete relaxation, from the threat of doom to the promise of happiness. The leisurely walk through the middle ground of average experience is unknown to them. Their aches and pressures and fatigues are invariably "unendurable" and "intolerable." The dizziness is never a plain and average reaction but always "the worse ever." The symptoms *never* stop and are *always* of maximum intensity. As the years and months pass the practice of thinking in terms of extreme experiences becomes a deep rooted habit. The entire area of thought is then steeped in

the philosophy of extremism. In Recovery they learn to conquer their symptoms. They regain their self-confidence and retrieve their capacity for relaxation and enjoyment. But the habit of thinking in terms of extremism may persist. Control, then, becomes super-control; spotting turns into an heroic effort to track down every tiny vestige of sabotage. To their minds, health must be complete relaxation, absolute freedom from symptoms, utter absence of discomfort. By the same token, practice of rules means practicing them all the time, in all places, on all occasions, relentlessly, without compromise, without qualification. Winnifred answered this general description of the nervous patient. When she was ill she viewed her symptoms with extreme pessimism; when she recovered her health she thought of control in terms of extreme self-discipline. What she will have to learn is the art of moving in a middle ground of average, natural and human thought and action, steering clear of the unnatural extremes of wanting *always* to be perfection and *never* to tolerate deficiency.

DR. LOW'S COLUMN
NERVOUS PATIENTS AND NERVOUS PERSONS

Gertrude was elected representative to the Good Will Club of the organization for which she works. As such she had to attend meetings in which she was the only woman member. This alone made her very uncomfortable, and when she was to take the floor she "became tense and had all sorts of symptoms, palpitations, tremors, air-hunger and the thought that I simply can't do this. But with my Recovery training I knew that this was merely discomfort and I can bear it and make my muscles do the job of addressing the crowd. But one day the Club decided to hold a raffle for the benefit of an employee who was chronically ill. Somebody had to run the raffle and, lo and behold, they picked me to organize it. I got scared and thought that I certainly can't do that. But I spotted this immediately as the fear of making mistakes and knew that I had to have the courage to make mistakes. I accepted and felt proud that I had the nerve to tackle this business. And here I was a nervous patient, and many of those present refused to take on that responsibility, and as far as I know they were not nervous patients..."

Gertrude was assigned a difficult and responsible task. She accepted and felt proud of the confidence she inspired and the distinction she gained but wondered why the others who "were not nervous patients" had refused while she who "was a nervous patient" had accepted. When she spoke of her reaction she mentioned that when she was asked to attend meetings as a representative she had "all sorts of symptoms...and the thought that I simply can't do this." Later, when she was chosen for the job of organizing the raffle she again "got scared and thought that I certainly can't do that." These statements so well expressed by Gertrude point up the chief difficulty of the "nervous patient" whose main characteristic is to be scared of responsibilities which means to lack the confidence and courage to assume a task. The fact remains, however, that the others who "were not nervous patients" were by no means oozing courage and confidence, and the prospect of being offered a responsible assignment did not seem to rouse their enthusiasm or fire their ambition. From this and many kindred observations which I am currently able to make I conclude that the person who is not a nervous patient differs little from that

specimen of humanity who happens to be afflicted with a nervous ailment. The one is a *"nervous person"*; the other is a *"nervous patient."* In the instance quoted by Gertrude, the nervous persons shied away from responsibilities, the nervous patient faced and braved them.

I do not know the men and women who work for the company which employs Gertrude. Nevertheless, assuming they are an average group, I will not hesitate to assert that all of them are nervous persons. This means that all of them are, in varying degrees, tense, self-conscious, unsure of themselves. I can make this statement with confidence because the many people which I meet or know, including myself, give ample evidence of inner restlessness, lack of assurance, preoccupation and lowered spontaneity. And these qualities connote nervousness; and people possessing them are nervous persons which means that all average men and women who do not happen to be heroes, saints or angels belong in this category of nervous persons. The clearest evidence of this universal nervousness I obtain when I observe myself. I then notice that it would be easy for me to duplicate most of the symptoms, dispositions and attitudes of which my patients complain. There is a difference, of course, between my reactions and those of my patients. They develop severe vicious cycles, and I produce none or very mild ones; they go into panics and tantrums while I avoid or escape them; they release volleys of complaints, and I practice silence. Other differences come to mind: The symptoms of my patients have gained intensity, and mine are calm experiences; theirs are protracted agonies, and mine are merely transient annoyances. If you list all these differences which obtain between me and my patients you may be inclined to infer that what distinguishes a nervous person, like I, from a nervous patient, like Gertrude, is the capacity to release tantrums and panics and vicious cycles and to endow symptoms with a high degree of intensity, with long duration and endless verbal explosions. That this is not true is obvious because you and I know many relatives, friends and neighbors who display, occasionally or frequently, all the features which I mentioned, from intense panics to never-ending complaint-marathons, and yet are merely nervous persons instead of nervous patients. What, then, is the basic difference between the two groups?

An intelligent answer to this question cannot be given unless

you know what the word "basic" means. If you watch the behavior of a large body of water, let me say, Lake Michigan, you will find that the surface is frequently smooth, calm, serene. If that is the case we say the lake is at peace. At times, however, you will observe that the lake develops motion, at first gentle ripples, than rolling waves, finally spouting billows. The water is now active, perhaps slightly agitated but not turbulent. On some days a storm rises. The waves become tempestuous, raging for hours or days, and the body of water appears shaken with wild passion and fierce commotion. This is what you might call a violent symptom or uncontrolled tantrum, intense, protracted, raving. Should you be asked to describe the general nature and character of the lake you might explain that, basically and fundamentally, it is a fine piece of water with excellent opportunities for recreation, a valuable reservoir for sea-food, a convenient traffic lane for navigation, and above all, an unparalleled asset in point of scenic beauty. These, you will add, are the basic features of the lake. But some phases of its nature and action, you will continue, admit of a less glowing description: there are gales and squalls and mighty storms lashing the shores, and ships go aground and human lives are destroyed, etc. etc.... In giving an account of this sort you made a pointed distinction between the basic nature of the lake and certain of its phases which, being *phasic,* are not *basic* to its fundamental character. Essentially, you took the position that in giving the description of an object you meant to stress what is at its base and foundation, not what are merely certain phases of its behavior. Basically, you wanted to point out, Lake Michigan is a marvel of beauty and bounty, but phasically it may at times be forbidding and treacherous.

When Gertrude arrived at the self-depreciating conclusion that being a nervous patient she was less qualified for a responsible job than her co-workers who "were not nervous patients" she overemphasized certain phases of her behavior, ignoring or minimizing what was at its base. Her judgment was focused on the shifting and phasic elements of her conduct, not on its permanent and basic foundation. On the other hand, her co-workers, when passing judgment on their own qualities, were inclined to play down their phasic defects and to play up their basic merits. They did not deny their disturbances and defects. They knew and did not blink the fact that they had occasional palpitations and

air-hunger. But that did not suggest to them the wild idea that their circulation and respiration were basically damaged. Instead, they were certain that the present disturbance was merely an occasional or momentary phase of their basically sound behavior. At times it happened that some of them went into the living room to fetch an object and stood there not remembering what they had come for. Or, there was the experience that after parking the automobile they forgot where they had left it. On such occasions it was perfectly clear to them that the present act of forgetting was merely a transient phase of their memory function and that the latter was basically intact and dependable. This was different in the case of Gertrude. Whenever incidents of this character occurred in her life she was likely to condemn her functions as basically and fundamentally untrustworthy, disintegrating, defective. You see the difference: Gertrude had about the same type of experiences as her co-workers, defects of memory, disturbances of organ functions, scares, tempers, undesirable impulses and what not. But whereas Gertrude indicted her basic functions her co-workers put the blame on some phase of their conduct only. Basically, they approved of their behavior. If they condemned at all, their condemnations were directed at some of its phasic portions only.

The incident which Gertrude reported on the panel was of recent occurrence. At the time it happened she had lost her fears and her disturbing sensations and had made such a good adjustment that the co-workers thought her capable of being entrusted with a responsible task. Which means that they had trust in her capacities. Had they known her previous ailment they might have marvelled at the thoroughness of her recovery. They had faith in her basic qualities but Gertrude had none. She knew that she still had difficulties. She knew that occasionally her palpitations, sweats and weaknesses returned. True, she had to admit that they were no longer intense, no longer sustained or incapacitating. In other words, she had graduated from the status of a nervous patient to that of a nervous person. This was the manner in which those of her co-workers judged her who knew or might have known of her nervous ailment. It is also the manner in which I judge her. But Gertrude thought otherwise. To her, the recurring symptoms were a reminder that she had once gone through torturing agonies. Now she was seized with the fear that the agonies

might return and stay with her. The recurring nervous symptoms made her anticipate a return of the nervous ailment. This is what we call the stigma of nervous illness—once nervously ill, always nervously ill. To feel stigmatized means to experience a basic self-distrust. Gertrude distrusted her Self because it still produced nervous symptoms. But nervous symptoms do not signify that the one having them is a nervous patient. Nor do they mean the threatening return of a nervous ailment. They merely indicate that average people, being neither heroes, saints or angels, are nervous persons. All of them have nervous reactions; all of them are, in varying degrees, tense, self-conscious, unsure of themselves. And their tenseness, self-consciousness and lack of assurance may at any time give rise to any kind of nervous symptoms. Gertrude had recovered, that is, she had again become an average nervous person. But not knowing that average persons have nervous symptoms she feared a return of her ailment when her symptoms "kicked up" again. What she and all my patients will have to learn is that nervousness and nervous symptoms are universal and average and that to get well means to become again an average nervous person who experiences nervous reactions in many phases of his life but has implicit confidence in the trustworthiness of his basic functions.

DR. LOW'S COLUMN
THE MANIA FOR EXAGGERATION AND PASSION FOR PREVENTION

Ada, on the Saturday panel, related that one day last summer she felt a mild pain in the right foot. "I did not notice any swelling or redness so I paid no further attention to it. The pain grew worse but I still didn't see anything so I thought it was nerves. Toward evening the pain got so strong that I had to take off my shoes and wear slippers. By this time I felt quite uncomfortable but I still felt it was a nervous pain and even joked about it to my family. The pain got worse again at night and I could hardly sleep. The following morning when I looked at the foot it was red and swollen, but somehow I still thought it was nerves. Next day the pain was almost unbearable and I decided to call the family physician. He called it an infection and prescribed bedrest and soaking in hot water. All of this time I suffered but was calm. But then the neighbors heard about my foot trouble, and they came to visit me. One said I know you suffer from a nervous condition but, honest, this looks as if all the nerves in your foot had burst. Another visitor said, how can your doctor expect that simple hot water will ever cure a foot like this? A relative said, why, with a foot like that you should have penicillin. I became fearful now and thought I would have to go to the hospital and I would have blood poisoning and the foot will have to be amputated. Finally I called the doctor again, and when he examined the foot he reassured me, and in a few days I was on my feet again. Before I had my Recovery training I would have listened to the women and would have worked myself up to a hysteria..."

Ada felt a pain in the right foot and "thought it was nerves." The pain got worse, and a swelling and redness appeared but she "still thought it was nerves." Finally, when the distress grew in intensity, she called the doctor who considered it a mild infection and prescribed simple remedies. Up to this point the situation was dealt with quietly and dispassionately both by Ada and the doctor. Both made calm observations and gave sober opinions. This changed, however, when neighbors and relatives appeared on the scene. They were loud and dramatic and alarmist and communicated their hysteria to Ada who now conceived dreadful visions of blood poisoning, hospitalization and amputa-

tion of the leg. Even so, Ada managed to shake off the hysteria promptly and recovering her sober mode of thinking summoned the physician again and was cured in the space of a few days.

I know Ada's physician whose professional competence is unquestioned. And if he thought of a mild infection which required nothing more complicated than hot dressings; moreover, if on a second visit he saw no reason to change his diagnosis I shall not hesitate to assume that the swelling and redness were of a moderate degree. The fact that Ada was on her feet within a few days supports my view of an innocent disturbance. Why, then, did the neighbors and relatives think of an emergency that spelled nothing less than mortal danger? Why this senseless passion for seeing danger in things harmless?

I also happen to know some of Ada's neighbors and relatives whom I consider ordinary folk, good natured and well intentioned, ready to help and give comfort. As such they belong in the class of average people. The question may be asked: Are ordinary, average people in the habit of magnifying harmless events into gruesome dangers? Are average people inclined to be irresponsible alarmists? Unfortunately, the answer is an unqualifed YES.

What we call average people are persons who, though generally realistic, have nevertheless a strong tendency to indulge in those types of sentimentalisms and emotionalisms which I call romanto-intellectualist. In the instance of Ada's foot ailment, these worthy people displayed a rank romanticism when they saw in a simple condition of swelling and redness the evidence of something extraordinary and exciting and extremely dangerous. They exhibited a lush intellectualism when they recklessly suggested that they knew the proper remedy and the physician did not, that they were right and he was wrong. The romanticist rejoices in the sight of excitements, stormy events and dangerous situations; the intellectualist relishes a self-imposed mission to prevent storms and dangers. The one has a mania for preposterous exaggeration, the other has a passion for ludicrous prevention. Ada's visitors were what most undisciplined people tend to be: past masters of the gentle art of exaggeration and champions of the tricky game of prevention. In other words, they were consummate romanto-intellectualists.

Life is essentially a matter of routine performance. The heart and lungs perform the routine of circulation and respiration, the

stomach and intestines that of digestion, the nervous system that of receiving impressions and releasing impulses. If the routine goes on undisturbed we speak of physical, mental and social health. The healthy *routine* may at any time be interrupted by mild *complications* or severe *emergencies*. Complications can be corrected either by the passage of time or by simple remedial measures. For instance, a person having palpitations may either wait till they will disappear (time taking care of the complication) or put an ice cap to the chest (simple remedy). If the complication is of a social nature, for instance, friction developing among employees, the employer may, similarly, either decide to let time heal the breach, or call in the contending parties and remedy the situation by a simple ruling. In either case, routine complications were treated by means of routine measures. This is impossible if an emergency is on. If a man collapses or a fire rages it would be silly or criminal to trust to time or to simple measures to prevent the collapse or to stem the conflagration. Emergencies demand instant, perhaps heroic intervention. What is called judgment is mainly the art of distinguishing clearly between simple complications and severe emergencies. A person lacking this discriminating judgment is bound to muddle or even ruin his life through the folly of treating emergencies with routine measures or simple complications with emergency procedures. When Ada decided to let time take care of her sore foot she exhibited sound judgment and good discrimination. When her neighbors and relatives suggested emergency measures their judgment was poor and their discrimination nil. She, the nervous patient, was well adjusted; they, the nervous persons, were grotesquely deficient in adjustment. She was calm, they were hysterical. They were by no means hysterical patients but, emphatically, they were hysterical persons. It is an annoying and dangerous habit of hysterical persons to mistake complications for emergencies and to resort to heroic and dramatic measures when nothing more than simple remedies are called for.

Hysterical persons are average people with an unbridled bent for romanto-intellectualist thought, action and expression. Driven by an unquenched thirst for thrills and excitements, they see emergencies in every paltry occurrence. Magnifying innocent events into physical or social emergencies of vast proportions they are always on the jump to prevent a threat. In the course of time

they acquire a *mania for exaggeration* and a *passion for prevention*. The women who immediately "knew" that Ada's swelling was a threat to her life and urged prompt prevention were hysterical persons though average people.

Prior to going through the discipline of Recovery training my patients are hysterical persons. As such, they have embraced the philosophy of reckless exaggeration and the policy of fortuitous prevention. Magnifying their complaints is the very breath of their life. They feel tired and speak of "utter exhaustion." Going through a period of disturbed sleep they insist they "haven't slept a wink for weeks or months." They notice a few streaks of blood in their stools and exclaim dramatically that "the blood just gushes out of me." They describe a perspiration of ordinary dimensions and add that "the sweat comes out every single pore of mine." They have "millions of the most terrible sensations," their fingers "feel just like icicles," and they do not hesitate to state with solemn emphasis that "if I survived yesterday, honestly, I must be made of iron." In one of their many surgical operations the appendix "was just caught in time before it burst," and in another "all the intestines were already swimming in pus when the surgeon went in." Theirs is the "only case of this kind," and "the pain is more than anybody could possibly stand," and "nobody can make me believe that I can be cured after so many years of suffering." But if their agonies are so overwhelming and their disturbances of such a gigantic nature, instant intervention is, of course, imperative, and so my patients, prior to their Recovery training, are all and sundry hysterical persons, addicted to the mania for exaggeration and the passion for prevention.

I still remember the time when hysterical behavior was generally considered to occur among the uncultured and illiterate only or mainly. The intelligent classes were supposed to be immune to the coarse notions of mass superstition and proof against the crude antics of mob thinking. Today this has changed. All you have to do is listen to the radio or to read your daily newspaper and you will be treated to a hodgepodge of absurd exaggerations coming from professionals, not from fishwives, who will tell you that this great country of ours has 15 million of children with marked defects of hearing, an equal number with significant disturbances of sight, 8 million other children who are seriously crippled, close to 10 million adults who are afflicted with in-

capacitating arthritis. They tell you that two of every three persons die of heart disease, that about half the adult population are the victims of mental ailments, chronic alcoholism, delinquency or similar evidence of abnormal behavior. Let me assure you that nobody is in a position to have even remotely accurate information on the incidence of these ailments and defects. And if you read such fantastically inflated horror statistics be certain they are either wild guesses or feverish fabrications doled out by men who are convulsed with the mania for exaggeration. Unfortunately, these promoters of doom yarns are also a prey to the passion for prevention. They flood street cars and buses and subways with flamboyant posters reminding you that "every three minutes a person dies of cancer" which may be a fact but is an extremely vicious and devilishly cruel suggestion, particularly if followed by the malicious warning that "You may be next." Other members of the tribe solicit your support for a crusade against a certain painful affliction exhorting you to "give before it hurts." I could go on indefinitely describing the pernicious nature of this modern version of the mania for exaggeration and passion for prevention were it not that the mere mention of these horror statistics is apt to cause a revulsion of feeling. If I dwelt on this statistical trickery at all it was done because many of my patients, after hearing the tales of horror over the radio or reading them in print, developed severe reactions until I prevailed on them to ignore all alarmist pronouncements of professional promoters regardless of how worthy the cause may be in whose hire the prophets of disaster plied their sordid trade. Ada demonstrated how irresponsible chit-chat of this kind ought to be treated. She listened politely to the doom message of her visitors but went resolutely her own way which is the way of Recovery, an organization which is dead set against all alarmism be it based on the phony statistics of professional hucksters or on the honest chatter of gossipy housewives. In Recovery she was trained to spot and stop hysterical behavior and to steer clear of the mania for exaggeration and the passion for prevention.

DR. LOW'S COLUMN
FEELINGS AND BELIEF, DUALITY AND UNITY

Margaret, on the Saturday panel, recalled an occasion in which a customer asked for skirt shields to keep skirts from wrinkling. "I did not know what these shields were and where they were kept. So I asked the girl in charge of stock if she could tell me where they were. She said, 'Do you really mean to say you don't know yet where these things are kept?' Then she showed me the drawer which was for the shields, and I realized I should have known because I had sold some of them recently. That made me feel embarrassed because I had made a fool of myself, and I also felt provoked and thought who does she think she is talking to me like that? I was ready to come back with a sharp remark but then I spotted this as temper and said to myself, I am not going to work myself up, and if she thinks she is smart and I am dumb, well, I have learned in Recovery to be average and not to mind making mistakes. Then I went on helping my customer and thought nothing more of my feelings. . . ."

Margaret did not know where to look for a skirt shield, and asked the girl in charge of stock—let us call her Lillian—to show her where to find it. Lillian obliged Margaret showing her the drawer which contained the article. This was cooperation and team-work which means group-mindedness. Had nothing else happened we should not hesitate to call Lillian an essentially group-minded person. Unfortunately, something else did happen. In granting Margaret's request, Lillian asked, "Do you *really* mean to say you *don't know yet* where these things are kept?" This inquiry, though couched in tolerably courteous language, contains nevertheless a good deal of discourteous innuendo. By implication, Lillian said: You have been working in this store for several weeks, and it cannot be the *real* truth that you have *not yet* learned where the shields are. A little child, with a mere trace of intelligence and memory, would learn faster. If we read this meaning into Lillian's remark we shall agree that it was heavily spiced with irony and plainly meant to hurt Margaret's feelings. If this is so, we must assume that Lillian had the will to help and the will to hurt at the same time, that she expressed group-mindedness and self-mindedness in the same act, good-will and ill-will in the same breath. Which indicates that Lillian's behavior

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

Lillian could have acted differently. She could have shown the drawer to Margaret, saying, "Here it is. Any time you will be in trouble, just ask me, and I shall be glad to help you if I can." Had she done that, she would have expressed, both in act and phrasing, a unified will, an integrated personality, a consistent character. No doubt, she could have adopted this unified course of conduct. If she did not we must conclude that she *preferred* another course. She preferred or chose a mode of behavior in which she could display, at will, both courtesy and discourtesy, kindliness and churlishness, service and domination. Her preference was for duality, not for unity of action.

If I speak of unity and duality I do not refer to any profound and complex philosophical teaching. What I have in mind is the fact that everybody demands of his fellows—perhaps not so much of himself—that there must be no *double-talking* nor *double-dealing*. The group does not require or expect you to be helpful and generous all the time. You may on occasion refuse to be accommodating or courteous. At times, you may even be rude and aggressive without incurring disapproval, provided you have some acceptable reson for your antagonistic attitude. But you must not permit yourself to be courteous in language and rude in action or vice versa in one and the same performance, no matter what may be your reason. This double-dealing will not be forgiven by the average person who, sensing the duality of conduct—in others—is offended by what he considers duplicity. The offense is experienced as an insult to the intellect and a hurt to one's feelings. Margaret expressed the situation clearly when she said that Lillian's behavior "made me *feel* embarrassed...and I also *felt* provoked." The implication was that her feelings were hurt by Lillian's act of double-dealing. Margaret's subsequent comment that "if she thinks she is smart and I am dumb" indicates that she also felt her intellect was insulted. You may be inclined to pass off Lillian's "talking out of turn" as a triviality and to condemn

Margaret's response as excessive sensitiveness. But the fact remains that, on an average, people resent having their intellect insulted and their feelings hurt by what they please to judge as dual behavior, be it ever so trivial. The average person demands unification and reacts sharply against duality—unfortunately, in others mainly.

I told you repeatedly that your daily life consists chiefly of trivialities. You may be certain that the bulk of your talk, action and feeling are what most of your daily experience is: trivial. But if trivialities are likely to wound your feelings and insult your intellect they may be trivial to others but not to you. To you they become most significant. For nervous patients particularly it is of the utmost significance to shield their sensibilities from being assaulted too frequently or too harshly. Let my patients' feelings be merely scratched or glanced, and the result will be symptoms and suffering. Let their intellect be merely mildly doubted or subtly questioned, and temper tantrums may be released. The trivial encounter between Margaret and Lillian demonstrates that what people consider double-action is most apt to inflict hurt and injury to a sensitive soul. And my patients are without exception sensitive souls. They are highly sensitized to hidden meanings, vague implications and suggestive remarks. They wince in response to innocent pranks, harmless irony and good natured teasing. Consider the meaning of teasing. If you tease a person you may mean and usually do mean no harm. The words which you use may be wholly inoffensive, your tone of voice may indicate warmth and sympathy; the smile on your face may testify to the essentially friendly attitude expressed in the act. Yet, the hidden meaning and indirect implication of the performance are that you do not treat your "victim" with respect, that you do not take him seriously, You are kind and warm and sympathetic in your approach, but at the same time you treat your conversational partner as a baby, refusing or failing to respect his intellect as mature and his feelings as important. The person whom you chose as target for teasing may notice the underlying kindness, but he will not overlook the implied lack of respect for his personal importance. As a teaser you act double, befriending and torturing a person in one and the same utterance. And if the individual whom you tease is a sensitive soul his feelings will be hurt and his intellect insulted by your dual approach. It may still be a triviality

but oh, how painful it can be. Lillian merely teased Margaret, or she was merely ironical. Whether it was the one or the other, in essence, it was a trifling affair. But Margaret was provoked by the dual behavior and escaped serious disturbance only because in Recovery she was trained to spot feelings of self-importance as temper and through spotting, to cut short symptoms. Recovery had enabled her to have her feelings exposed to the acid of dual behavior without getting them corroded, without having them even so much as ruffled, except for a brief instant. Having spotted successfully the triviality of the event she dismissed it and was calm.

What precisely was the nature of the feeling which was provoked and insulted and hurt by the ironical thrust which Lillian levelled against Margaret? I have spoken to you about the meaning of feelings repeatedly. And while neither I nor anybody else are able to give an exhaustive statement of what feelings are, nevertheless, a reasonably correct explanation can be attempted. Having thus, with due humility, stated the difficulty of the task let me now tell you, not what feelings are but what my patients ought to know about them. What you should know is that feelings are (1) predominantly physiological which we shall call physical, (2) predominantly psychological which we shall call mental. The *physical feelings* are mainly in the nature of sensations. It is with your senses that you feel the hardness or softness of wood (touch), the brightness or paleness of colors (vision), the pleasing or shrill character of a sound (hearing), the sweet or sour quality of food (taste), the agreeable or disagreeable odor of a substance (smell). These feelings are conveyed to you through the so-called five senses. There are other physical feelings: heat and cold, wetness and dryness, shivers and shudders, pain and pressure, pullings and twisting, dizziness and faintness, and the well nigh inexhaustible host of disturbing sensations with which you have acquired a very painful familiarity. I take it you will understand now what is meant by phyical feelings. If you do, then, you will realize that feelings of this kind can be irritated but not hurt in the sense of being provoked or insulted. Mental feelings are subject to hurts and provocations and insults. I have dealt with these mental feelings in an address which was published under the title of "Temper Masquerading as Feeling" (Recovery News, March 1949). There I told you that the mental feelings can be grouped

under three headings: sympathy, apathy, antipathy. I can tell you now that all three are closely linked to *beliefs*. You show sympathy toward somebody who you *believe* is close to you or who you feel (believe) is in distress. The same feelings of sympathy you may direct toward yourself experiencing self-love, self-pity, self-complacency, self-importance, self-respect. That these are beliefs (in one's or someone's worth) requires no comment. Beliefs of a similar nature enter into the composition of the apathetic and antipathic feelings. In apathy you are swayed by the belief that things or persons or yourself are worthless, unimportant, uninspiring, uninteresting. In antipathy, you are repelled by yourself or someone, and the result is that you fear or resent or are disgusted with or revolted by yourself or another person. And fear presupposes the belief in danger; and resentment implies the belief that somebody is wrong or did wrong; and similar beliefs are at the base of disgust or discouragement or other antipathic feelings. I hope I made it clear to you that when you claim that your feelings are hurt, what you actually mean is that some cherished belief of yours has been doubted, questioned, ignored, rejected or, worse yet, ridiculed, treated with irony, not taken seriously. The beliefs which you cherish most are that your opinion is relevant, your judgment mature, your action vital, your conduct worthy. If a person, directly or implicitly, contradicts any of these beliefs he or she indicates that they do not share them, that they consider them incorrect, childish, unbalanced, out of focus, not worth being taken seriously. If this happens, then your (mental) feelings are hurt, which means that one of your cherished or pet beliefs has been offended. That mental feelings are the closest related to beliefs is evident from the manner in which we identify religious beliefs with religious feelings. There is no difference in meaning whether you say, "I believe my prayer was heard" or, "I feel it was heard." Similarly, when we say, "I feel secure (or insecure)", what we actually mean is, "I believe I am secure (or insecure)." The relationship between mental feelings and beliefs is most conspicuous in the case of temper. You feel that somebody did you wrong, and this feeling assuredly is a belief.

You will now be in a better position to understand the trivial but painful scene in which Margaret's "feelings" were hurt by Lillian. Lillian treated Margaret with courtesy in action but with irony in words. Her act expressed a measure of respect, but her

ironical phrasing implied disrespect. This was double-acting or duality. Margaret resented the duplicity and felt (believed) that she was treated as unimportant, as unequal, as below Lillian's standard. Her cherished belief that she was as important as anybody else was offended. But in Recovery Margaret had learned that the supreme task of the nervous patient is to avoid symptoms and temper and that both symptoms and temper are easily aroused by the insistence on being treated as important. You know that, in our Recovery language, the sense of one's importance goes by the name of exceptionality or singularity. What we ask our patients to do is to cultivate the thought of averageness. If they do, they will not feel (believe to be) overly important. Then they will escape the "hurt feelings" of having their importance doubted, questioned, ridiculed and not taken seriously. Margaret expressed this Recovery philosophy beautifully when she reflected, "I was ready to come back with a sharp remark but...spotted this as temper and said to myself I am not going to work myself up...I have learned in Recovery to be average....Then...I thought nothing more of "my feelings." Her "feelings" were the belief in her importance, and when belief in averageness was substituted, calm and poise took the place of hurt feelings which is a misnomer for beliefs not shared.