book review

Die schizophrenen Geistesstörungen im Lichte langjähriger Kranken- und Familiengeschichten, by Manfred Bleuler

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Introduction

With a title as long as it is difficult to pronounce, a book summarizing a life of study and research by one of the great men in psychiatry has finally appeared. Certainly, it will be a classic. But it also marks the swan song of a school of research that is no longer possible in our time of ever increasing specialization. This book attempts to present the whole picture of schizophrenia in all its aspects and in all its depths.

Let us first describe the basic task that Manfred Bleuler set for himself. Emil Kraepelin devised his diagnostic categories of dementia praecox and manic-depressive illness according to favorable or unfavorable outcome. Patients suffering from dementia praecox, or schizophrenia, were the ones who did not get better. Ever since, this bleak outlook has been challenged, mainly by following schizophrenic patients over more or less extended periods of time. The idea has been to maintain the concept of schizophrenia without assuming a disastrous outcome. It has been shown that there are people who contract schizophrenia and return to a more or less normal life; in fact, they make up a sizable proportion of the schizophrenic population. But there remains a lingering, nagging thought that such recovered patients may not have been true schizophrenics, but rather aberrant cases of manic-depressive illness.

What has been needed is a study which: (a) diagnoses a cohort of mentally ill people as definitely schizophrenic; and (b) follows the course of their illnesses over a lengthy timespan while collecting as much information as possible. Thus far, all studies have failed to meet these basic criteria. The most important shortcomings have been questionable diagnoses, short followup times, inadequate outcome criteria, or outcomes judged only at one or a few points in time without regard for the intervals in between.

How does the study by Manfred Bleuler, Eugen Bleuler’s son, measure up to these criteria? In 1942-43, when the terrain was nearly virgin, he set out to do this study and followed 208 schizophrenics very closely over 23 years. Of his original 212 cases, only four were lost—an incredible figure. In terms of completeness, length, and thoroughness of followup, he definitely has set a rigorous standard, although some questions remain open. One could say that he erred more on the conservative side, i.e., only including patients about whose diagnoses as schizophrenics he was absolutely certain and excluding patients who might have been diagnosed “probably schizophrenic” by American psychiatrists.

Today, 35 years later, we might require different diagnostic criteria, but Bleuler’s methods were considered advanced at the time the study was conducted. He attempted to answer a host of related questions regarding schizophrenia—the question of inheritance, the impact of early life experience on the illness, the influence of family life, the importance of precipitating factors,
and the influence of treatment on the course of schizophrenia.

Let us now look at Manfred Bleuler's book in more detail.

**Bleuler's Selection Criteria**

Bleuler selected a sample size of 100 men and 100 women for inclusion in his followup study. His criteria were simply that the patients be admitted to the Burghölzli during 1942-43 with a diagnosis of schizophrenia. In order to achieve his sample size, Bleuler originally accepted 212 subjects, but since attrition was less than expected, he ended up with 208 subjects—100 male and 108 female. Ninety percent were Swiss, and 10 percent foreigners. The average age was 40, and the range was 16 to 67 years of age. Upon entry into the study, 55 percent had never married. Occupation did not differ much from the average population, and ranged from manual labor to academics. Since Bleuler believed that it is not easy to determine the first schizophrenic episode with certainty, he did not concentrate on a sample of first admissions.

The disadvantages of not having first admissions are obvious: patients at both extremes are underrepresented, namely those who remain hospitalized after the first admission, due to unusually bleak prognosis, and those who after the first admission are never admitted again. Overrepresented are those patients whose illness runs its course in waves of more or less acute relapses and recoveries. Finally, a longitudinal study that begins with subjects whose average age is 40 clearly cannot capture a full view of the schizophrenic life course.

Nevertheless, Bleuler felt that these 208 patients were representative of the 653 schizophrenics admitted to the Burghölzli during 1942 and 1943. In turn, these 653 represented 45 percent of all schizophrenics hospitalized during that period in the Kanton of Zürich. There was a slight tendency for sicker and poorer patients to come to the Burghölzli, a university hospital, and for younger patients and those with strong church affiliations to go to one of three private hospitals. Insofar as the Kanton of Zürich, a cluster of small towns and villages around a large city, can be considered representative of the rest of Switzerland, so too can Bleuler's sample be viewed as crudely representative of schizophrenics in the whole of Switzerland.

Although in any study of schizophrenia diagnostic criteria are one of the most important problems, Bleuler merely mentions that his diagnoses were monitored by colleagues and were found to be reliable. Nevertheless, in 1942-43, he attempted in a rudimentary way to establish firmer and more concise criteria. In general he relied heavily upon his father's criteria and those developed by the German descriptive school. He rejected the concept of latent schizophrenia and also eschewed projective tests as diagnostic tools. He states very clearly that for a psychosis to qualify as schizophrenia there must be a manifest "eigentliche" psychosis present. To be diagnosed as schizophrenic, a patient had only to exhibit one single outbreak of the illness. Apparently, Bleuler developed two sets of criteria and used the first set to diagnose the original study subjects and the second set to reflect his diagnostic criteria after he completed the study 23 years later.

His first set of criteria involved at least three of the following:

- Confusion
- Completely unintelligible ("uneinfühlbares" actually means not being able to feel with somebody, to empathize) emotional life
- Extreme excitement or stupor lasting several days
- Hallucinations over extended periods of time
- Delusional ideas
- Complete change of one's own activities, frequently involving negligence of common responsibilities or violence against others
- The conviction of healthy relatives or friends that the patient has changed completely and that his actions have become unintelligible
Bleuler's second set of criteria are as follows:

- Split between most serious psychotic symptoms and normal intellectual functioning
- Clearly recognizable dissociation ("Zerfahrenheit") in thinking which is distinguishable from a number of other thought disorders
- Extreme disjunction ("Zerrissenheit") of all affective expressions ("inappropriate affect")
- Severe depersonalization experiences
- Severe catatonic muscular experiences
- Delusional ideas
- Typical hallucinations
- Secondary severe memory hallucinations

All study subjects had several of these symptoms (second set). Yet Bleuler's diagnosis was not based on the sum of certain symptoms, but on the total picture (gestalt).

There were two sources of difficulty in making the correct diagnosis of schizophrenia. In older patients, physiological involutinal changes made it difficult to distinguish schizophrenics from patients with organic brain syndromes. Bleuler also had difficulties with patients who showed symptoms suggestive of manic-depressive psychosis; he considered a patient schizophrenic if there had ever been a period when his symptomatology clearly pointed toward schizophrenia. At other times, however, such patients might have had a hospitalization for manic or depressive illness.

In light of the above criteria, Bleuler felt that the diagnosis of schizophrenia was uncertain in only 23 of his 208 subjects. Among these 23, there were 9 men who could have been called manic-depressive; 3 women whose onset of schizophrenia occurred after age 60; 3 men who had initially presented with alcohol hallucinosis, only to have it gradually evolve into chronic psychosis; 3 men and 3 women who experienced brief psychoses following severe psychological trauma; and, finally, 2 cases that could well have been diagnosed as paranoia.

Bleuler observed that the conventional subcategories—hebephrenic, catatonic, paranoid, and simple—were arbitrary and not useful. When he looked at the course of schizophrenia over two decades he found that almost all cases showed changing symptomatology.

Methodology of Followup

Followup data were collected through personal knowledge of study subjects and relatives, through written hospital records, and through followup of the subjects and their relatives. Usually followup was carried out through interviews, letters or telephone.

Bleuler knew all of his subjects and many of their relatives personally. This intimacy with his clinical population was greatly facilitated by the fact that, like his father, he lived in the Burghölzli.

The data collected on each patient were extensive and included data on mental status, personal and family history, premorbid personality, and specific environmental factors. In order to get as objective a picture as possible, he collected information about the indexed case from various angles—from the patient himself and from several family members. Everybody in the immediate family, and almost everybody in the extended family, was interviewed.

Followup data were collected several times during the 23-year period of the study. Every patient or relative was contacted on at least three occasions. It was deemed important to protect some subjects from the psychiatric system as much as possible. In these cases information was gathered from hospital records and through relatives.

Bleuler's Views on the Etiology of Schizophrenia

Bleuler found that about 5 to 7 percent of the parents of his subjects had schizophrenia, but he noted that the illnesses of both parents and index cases were usually less severe. Manic-depressive illness was more frequent among the parents of his patients than in the general population, but not so frequent as among the parents of patients with manic-depressive psychosis. Compared with other studies, Bleuler's figure for schizophrenia in
parents is too low, and the incidence of manic-depressive psychosis is too high, suggesting that his sample included many patients whom others might have called manic-depressive. In the parents of his subjects, he found senile psychoses more frequently than in the general population; he noted that alcoholism occurred at about the same rate as expected in the general population.

In order to study the relevance of premature loss of a parent, Bleuler pooled the data of his 208 subjects with data from 4 other studies of schizophrenics (for a total of 1,319 schizophrenics). He compared parental loss in this sample with that among 1,505 normal adults and among 531 alcoholics, depressives, and neurotics. He defined early death of a parent or lack of a parent because of illegitimate birth as "premature loss," and he defined divorce, separation, or giving the child up into foster care before the 18th birthday as a "broken home." He found no higher frequency of premature loss of a parent or lack of a parent in schizophrenics than in the general population, which seemed to him to disprove the hypothesis that maternal deprivation could explain the genesis of schizophrenia.

Bleuler assessed the childhood environment of his schizophrenics as either "just right" ("recht") or "horrible" ("schauerhaft") or as lying in between. He combined the children coming from "broken homes" with those whose childhood environment was called "horrible." His conclusion was that alcoholics were brought up under conditions worse than those of schizophrenics and that normal children enjoyed better conditions. Bleuler found that the schizophrenic's relationship to his father in childhood could be called good in half of the cases, and that to his mother could be called good in three quarters of the cases. The relationship to the parent of the opposite sex was usually better than to the parent of the same sex, especially for women. Although Bleuler perceived most schizophrenics as having experienced difficulties in a more general sense in their childhood, there did not seem to him to be a specific factor in the family that could predict a schizophrenic denouement.

Bleuler looked at the number of years the patients in his study had actually spent with a schizophrenic parent. Of 208 subjects, only 27 had had schizophrenic parents. During their first 5 years of life the 27 subjects had spent only a total of 13 out of the 135 years at risk with a manifestly schizophrenic parent. In their first 20 years, out of a possible 540 years, they had spent only 77 years with a manifestly schizophrenic parent while a roughly equal amount of time was spent with a parent whose schizophrenic illness was in social remission. Bleuler’s conclusion was that living with schizophrenic parents could not be construed as an important etiological factor in the development of schizophrenia.

To examine the premorbid personality of the schizophrenic, Bleuler used information gathered both from the subjects themselves and from their relatives and friends. He relied heavily on two concepts used by the German descriptive school: schizoidia and psychopathy (personalities whose mental abnormality imposes suffering on themselves or the surrounding society). Fortunately, Bleuler presented a number of examples to illustrate his diagnostic classifications.

Bleuler classified the premorbid personality of his subjects as 30 percent unremarkable, 32 percent intermediate, 24 percent schizoid, and 13 percent psychopathic in a nonschizoid fashion. The intelligence of his subjects was found to be average.

The Long-Term Course of Schizophrenia

This was by far the most interesting part of the book. First, Bleuler reviewed the shortcomings of previous prognostic studies. Often, followup was too short, the criterion for improvement was simply the presence or absence of rehospitalization, the outcome or course was judged at only one point in time, the sample size was too small, and a nonrandom selection process biased conclusions.

Next, Bleuler offered some useful definitions that may provide the baseline for standardizing some of the terms used in research in schizophrenia. He describes a concept called the final outcome ("Endzustand"). Obviously, he was aware that there could be no "final outcome," and that relapses and improvements are always
SCHIZOPHRENIA BULLETIN

possible. Nevertheless, he found that when final outcome was defined as a plateau lasting 5 years or longer, such a plateau could be identified in 152 of his 208 study subjects.

Bleuler defines four such final outcomes:

- **Most severe:** Continuously in need of care, autistic, and unable to work except in the most ritualized manner.
- **Medium severe:** Similar to "most severe" except that there is at least one area in which the mind functions appropriately.
- **Less severe:** Despite clear signs of schizophrenia, there is adequate functioning outside of a rather circumscribed pathology. Schizophrenics in this group either live outside the hospital or on so-called "quiet wards." They suffer primarily from delusions and hallucinations without deterioration of their personality.
- **Cured:** Once afflicted, but fully functioning for at least 5 years; not seen as mentally ill by the family. A brief mental status examination does not reveal psychotic signs, although a more detailed investigation may reveal remaining psychotic symptoms.

In reporting the final outcomes of his subjects, Bleuler found that 152 out of the 208 study subjects had achieved the required 5-7 year plateaus. Twenty-four percent fell in the "most severe" outcome category; 24 percent fell in the "medium severe" category; 33 percent fell in the "less severe" category; and 20 percent could be classified as "cured" (rounded figures). The type of schizophrenia found most frequently in the "cured" cases was one which ran its course in several episodes, which Bleuler termed *Phasen*.

Bleuler than compared his data with previous studies. He reported that from half to three quarters of patients in any long-term followup achieved the outcome plateaus that he observed. He noted that the most severe cases, those in which the disorder leads quickly to severe deterioration, had almost disappeared. He felt that such extremely unfavorable outcome was seen in 5 to 18 percent of cases before 1941, but in less than 1 percent of his own material—a change he cited as the most outstanding result of modern treatment. However, he observed no increase in the percentage of schizophrenics falling in the "cured" category.

Seventy of Bleuler's study subjects died during the time of observation. Of these, 12 died in severe psychotic states immediately following the onset of a course of treatment, 9 committed suicide, mostly late in the course of their illness, and 8 died of tuberculosis. The remaining 41 died from conventional causes (e.g., cancer, heart disease).

Of equal interest is Bleuler's observation that although there was usually a rather stable course established after many years, one could sometimes see, even after 20 to 35 years of illness, a noticeable tendency toward improvement, but only rarely toward further deterioration.

The 208 schizophrenics in Bleuler's study had 818 siblings. Among these were 57 certain and 6 probable cases of schizophrenia. Reports of illness in the siblings did not differ appreciably from the first breaks described for schizophrenics in the study. Only two of the schizophrenic siblings were never hospitalized. There was not a higher frequency of manic-depressive illness in the siblings than in the general population. However, the rate of suicides, schizoid character, and other personality disorders was much higher.

Bleuler compared the schizophrenic picture within sibling pairs in terms of age of onset and premorbid personality. He found that although One of Bleuler's main goals was to describe the course of schizophrenia over many decades. He observed that more than 90 percent of schizophrenics can be classified either into consistently episodic courses or into a consistently chronic picture that does not progress after the first 5 years.

Bleuler contrasted the course of schizophrenia in his subjects with the course of schizophrenia observed in long-term followup studies conducted before 1941. He noted that the most severe cases, those in which the disorder leads quickly to severe deterioration, had almost disappeared. He felt that such extremely unfavorable outcome was seen in 5 to 18 percent of cases before 1941, but in less than 1 percent of his own material—a change he cited as the most outstanding result of modern treatment. However, he observed no increase in the percentage of schizophrenics falling in the "cured" category.

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quite different courses were possible, the similarities were more striking than the differences. Most prominent was the tendency for the more benign episodic forms to run in families. This would support the many studies suggesting that the genetic background of schizophreniform or remitting schizophrenics is different from that of chronic schizophrenics.

Half of the study subjects remained single, and the remaining subjects had a total of 184 children. Thus, the frequent observation that the fertility rate of schizophrenics is lower than that of the general population was confirmed in Bleuler's study. At the time of followup, 10 of the 184 children were themselves diagnosed schizophrenic. Although only a quarter of the children had grown up in good conditions with both parents present, about half to two thirds of them seemed without serious psychiatric disability. However, Bleuler quite frequently perceived neurotic development, inferiority feelings, anxiety, and a lack of sociability.

Bleuler tried to determine whether there was a recognizable downward social drift in the 143 children of the study subjects who were over 20 years of age at the end of the followup period. Over 80 percent of such children appeared able to maintain the social and educational status of their parents.

Bleuler also examined how the total time a child spent with a schizophrenic parent during the first 20 years of life affected the likelihood of later developing schizophrenia. He observed that living with a schizophrenic parent did not seem more related to the development of schizophrenia in these children than living out of contact with the afflicted parent.

To allow comparison with other studies, Bleuler used hospitalization as a further criterion of the course of illness. Six percent of the study subjects (13 out of 208) remained continuously hospitalized. The most common reasons for continuous hospitalization were either a difficult psychological situation that seemed impossible to solve, or a hopeless social situation with rejection by the immediate family. There were no unfavorable prognostic signs in the history of such patients that predicted chronic hospitalization. Bleuler determined the rate of hospitalization in his subjects 2, 5, 10, and 20 years after the first hospitalization. He found that the ratio of hospitalized to nonhospitalized subjects remained roughly the same, with one-third being hospitalized at any one time. When Bleuler focused only on first admissions, he found that 25 percent of patients were hospitalized at a given time. He also found that in some hospitalized subjects there was little residual symptomatology. Often the hospitalization appeared to be more for social than for clinical reasons. After 20 years, 55 subjects remained hospitalized, though only 30 had symptoms that justified hospitalization.

Bleuler also investigated the relationship between childhood conditions of the study subjects and different clinical courses. Although no significant correlation emerged, there was a weak correlation between healthy premorbid personality and good outcome. He feels that poor outcomes quite often seem to be the result of unfavorable external circumstances, rather than of an unfavorable genetic load.

Regarding the importance of precipitating events, Bleuler offered his own formulation—hopeless environmental situations associated with the onset of schizophrenia lead to a poor prognosis, and precipitating situations that can be alleviated improve prognosis.

Bleuler used parental death as an example. In 34 cases (25 female, 9 male), Bleuler recorded a relevant change in the psychological state of the patient following the death of a parent, usually the mother. In 7 cases there was an improvement, and in 27 a worsening of the condition. In all of the improved cases the patient exhibited, before the death of his parent, a very strong ambivalent attitude toward this parent, and the death was seen as relieving a burden. In the worsened cases there was a strong dependency on the deceased parent that left the patient helpless and caused a retreat into fantasy life.

Finally, the social status of patients was assessed for the last 5 years of observation or the last 5 years before death. Thirty-one percent of all subjects were working and living without care; 45 percent were hospitalized (21 percent remained on wards for the severely ill); the remaining 24
percent were outpatients. The corresponding percentages for first admission subjects were 40 percent, 29 percent (13 percent), and 31 percent, respectively.

Bleuler also studied the effect of the family's attitude on the course of schizophrenia. He focused on one group of 58 patients who were cared for by their relatives in a concerned way, and on another group of 27 patients who had been deserted by their families. Not surprisingly, there were a few more cures and episodically benign cases in the first group. However, he found it impossible to say that the better course reflected better care by the family, or vice versa.

Bleuler also examined the effect of treatment on the clinical course. He observed that with appropriate treatment, catastrophic psychotic episodes could be forestalled or abated. There was no indication, however, that poor long-term outcome could be avoided with the available treatments. During the course of the study, several different treatment methods were in vogue: insulin treatment, electroconvulsive therapy, leukotomies (in nine patients), psychotherapy, and, since 1953, psychopharmacological agents. Bleuler believed that many so-called treatment successes could be ascribed to spontaneous remissions or nonspecific therapeutic effects. He did not feel that there was any one specific treatment modality in schizophrenia. Rather, he felt that both somatic and psychotherapeutic modalities were successful, provided that they followed three basic principles. First, one should work on the healthy sides, or the strengths, of the schizophrenic and foster an active milieu in which the schizophrenic can maintain himself. Second, surprises and sudden changes may stir up the schizophrenic and open the way for change out of an already established pathological pattern. Third, most of the time there should be a general effort to help the schizophrenic to calm down.

In Switzerland, psychopharmacological agents were introduced during the midpoint of the study period. Bleuler felt that they not only proved their worth during the acute phases, but also helped during the more chronic phases. However, over time, most patients reached a point where they did equally well with or without medication. None of the patients considered “cured” or who achieved sustained social remission continued to take medicine on a continuous basis. Bleuler suggested that continuous medication is warranted only if it is proven that a relapse occurs after its discontinuation. He identified as one of the most important factors in treatment the long-lasting psychotherapeutic and social guidance of the patient and his family. He does not subscribe, however, to any single school of psychotherapy, but rather defines psychotherapy broadly. Occasionally Bleuler found it beneficial to the patient to break off contact with the psychiatric system.

Conclusions

What, then, remains as the permanent impression in the mind of this reader of Bleuler's monograph? First of all, it is an extremely difficult book to read. The reader feels as if he were taking a trip into difficult terrain—not to enjoy the wilderness or beauty of the landscape—but to explore the geology of the region through tedious and devoted labor. Bleuler's style is laborious, meticulous, repetitious—at times at the expense of clarity. One can sense the sweat of years of hard scientific labor, of poring through letters and records of telephone conversations, and looking through charts. Only in Bleuler's case histories does one find fresh, dramatic, real-life detail. But more important, one is impressed with the boldness of the undertaking. Here is a man who almost singlehandedly dispels a host of myths on which psychiatry has relied for generations. Bleuler dispels the myth that schizophrenia is a terrible, intractable disease and that such a diagnosis almost certainly condemns the patient to a life of permanent disability and slow degeneration. Only a quarter of the first admissions were hospitalized at any given time during the 23 years of followup, and many of these were hospitalized for social rather than clinical reasons. Furthermore, as decades passed, there was a tendency toward improvement, rather than deterioration.

Bleuler disputes the belief that schizophrenia is essentially treatment resistant and can only be symptomatically controlled. Instead, he suggests that treatment has a major impact on the illness.
He lists as important therapeutic factors: providing a stable milieu which fosters the strengths of a patient; long-term psychotherapeutic guidance (not in the sense of insight therapy); calming the patient down when upset; and shaking the patient up when he or she has established an unhealthy stability. Bleuler points out that as a result of modern treatment, the most serious cases of the illness have all but disappeared and the general tendency is toward milder courses. But it must make us modest to know that the rate of "cures" has not increased over the past three decades.

Bleuler denies that an unfavorable family constellation alone can produce schizophrenia. Even living with a schizophrenic patient did not seem to predispose a patient to schizophrenia.

He points to the importance of genetic factors—but less for the severe cases than for the episodic and benign cases. In his opinion, the most severe cases are usually the result of bad treatment or unfavorable psychological factors.

Finally, Bleuler disproves the importance of the classic diagnostic categories of schizophrenia: paranoid, simple, catatonic, and hebephrenic. He observed that all categories might appear in the course of an illness. In general, as one of the most useful results of this book, he turns our attention away from the current preoccupation with cross-sectional views of the illness to one that suggests a more fruitful approach to the illness: we must learn to regard schizophrenia as process over time.

Summary

Manfred Bleuler conducted a 23-year followup study on a cohort of 208 schizophrenics admitted during 1942–43 to the Burghälzli Hospital (68 were first admissions). Using his own criteria, Bleuler considered the diagnosis of schizophrenia certain in all but 23 cases. The conventional diagnostic subcategories (paranoid, simple, hebephrenic, catatonic) did not prove to be useful. Extensive followup investigations were made several times during the 23-year period. Bleuler did not find any specific traumatic factors in the families of schizophrenics, except a generally worse than average family situation. (This was even more true for families of alcoholics.) He did see, however, the clear influence of genetic factors in that schizophrenics with a more benign, episodic course showed a higher genetic "loading." Bleuler classified patients according to severity of long-term course and outcome: 24 percent fell into the most severe outcome category, 24 percent had a moderately severe outcome, 33 percent had a less severe outcome, and 20 percent were considered cured. He noted that the most severe outcomes were rarer than formerly, but the number of cures was approximately the same as in previous studies. About one third of the total, or one fourth of the first admissions, were hospitalized at any given point in time, more due to social factors than to the course of the illness itself.

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