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THE SYNDROME OF OPERATIONAL FATIGUE IN FLYERS

BY JOHN M. MURRAY, LIEUT. COLONEL, M.C., A.U.S.

War is creating new psychiatric problems. One sees frequently in this war what might be called 'short term neuroses', which arise quickly, respond rapidly to treatment and show a relatively quick recovery. The mechanisms underlying the symptoms are not as yet satisfactorily worked out and it would be premature to attempt any exact formulation of the unconscious dynamics, but the material brought to light during the short term treatment of neurotic symptoms arising under the stress of battle may well answer old questions and raise many difficult new ones.

Neuroses which arise as a result of war experiences show the same basic elements as those of civilian practice, but they have a number of essential differences that do not fit well into current diagnostic categories. Civilian neuroses are reasonably predictable—one may safely say what will happen in the future to a given case; but the war neurosis is different. It arises quickly in the so-called normal person. In a previous paper [1] it was stated: 'In the evaluation of these conditions, there are always two considerations—both old acquaintances of all psychiatrists—the internal conflicts and tensions present in the individual's unconscious emotional life and the powerful external forces which play upon them in the battle situation. Some men break with a minimum of trauma, while others who have a severe preëxisting neurosis never openly crack, though earlier predictions might have said they would be the first to do so. Army life and combat seem to fulfil important emotional needs and thereby to stabilize these individuals. Men who would never have been picked out as "stout fellows"

Read before the American Psychoanalytic Association, May 14, 1944.

[1] Murray, John M.: *Some Special Aspects of Psychotherapy in the Army Air Forces.* Psychosom. Med., VI, 1944, p. 119.

seem to tolerate almost overwhelming situations and come through with flying colors. Still others, who are obviously outstanding as rugged army men and who have behind them years of army training and experience, break at unpredictable times. All of which simply goes to prove that ordinary rule of thumb standards for predicting tolerance for emotional stresses are "hit and miss". One has to know more of an individual's inner life, his needs and his fantasies, his anxieties and their qualities and intensities, and what special situations induce or relieve them. Unfortunately up to this time, due to the pressure of war needs, there has been little opportunity for close study or even individual scrutiny of the deeper factors at play in this new and special situation.'

Neurosis and neurotic symptoms arise from conflicts. Long term conflicts, resulting from chronic frustrations of erotic, dependency or security needs, produce symptoms of a nature distinct from certain types of cases seen in the army. The latter type of symptom arises as a reaction to an acute conflict based on life preservative needs and the ego distress which comes when fear of death overwhelms the individual and threatens to destroy the ego's ability to maintain its integrity in the face of dangers. The symptoms appear decidedly different to the psychiatric clinician who hears the story from the lips of the sufferer. The amount of the personality which is taken up or interfused by the symptoms is less; the intact personality on the whole is more normal. The hope of a rapid cure from acute symptoms is surely much greater.

One might counter this point of view by saying that the fundamental source of today's continued distress, which was precipitated by yesterday's war experiences, ordinarily would have disappeared in the interval between yesterday and today, had it not been for the reverberations and overtones of residual childhood vicissitudes and conflicts reactivated by war experiences. Therefore, one would say they do not fundamentally differ from the run of the mill civilian neuroses—inherently sound personalities do not develop neuroses. But without disagreeing with this basic idea, one must see that the manner in which these neuroses are currently appearing betokens a

different type of reaction from the illnesses routinely met outside of the military setting. Such *a priori* thinking would lead one to the conclusion that the type of neurosis experimentally induced in animals is the same as a classical neurosis.

Kardiner [2] in his excellent descriptions of war neuroses also felt that they differed from those cases upon which Freud had made his earlier observations. The mechanisms at work were different from those seen in routine civilian life, and new work was needed to clarify the problem. Unfortunately Kardiner's case observations were made late in the history of the neurosis, long after the original precipitating events in reality had been left behind. At that time the clinical picture is quite different from that observed in the earlier phases. The nucleus of the neurosis arises from the threat to life itself in the battle situation and from the fear that the ego will not be able to suppress the fear of death and carry on. The nucleus later spreads to other areas of the individual's life, to his sexual activities, to his love relations, to his parental, occupational and broader social relationships. Earlier patterns of a neurotic nature have been condensed into the new anxiety reactions. The factors of secondary gain have come in to color the picture in such a vivid hue that the early expressions of the illness, such as are seen in the army today, are completely covered over. These later phases and not the earlier and original ones are those which Kardiner described.

Different types of illnesses occur in different types of soldiers. These depend upon various factors. The flyer develops a different type of neurosis from the infantryman, or the torpedoed sailor. Later in this paper a clinical picture of the syndrome known as 'operational fatigue' will be presented. A great difference will be noted between this entity and the ego shattered syndromes described so well by Grinker [3] among infantrymen or ground crews in Tunisia. Such cases are practically unknown among air and combat crew personnel.

A number of factors are responsible for these variations.

[2] Kardiner, Abram: *The Traumatic Neuroses of War.* Psychosom. Med. Monograph II-III. Washington: National Research Council, 1941.

[3] Grinker, Roy R.: Restricted Army publication.

Wright [4] has given a masterly description of the uniform behavior of a most diverse and heterogeneous bomber crew under extremely hazardous and trying situations. Apparently identification with a stout-hearted leader enabled all members of the crew to borrow adequate strength to carry them through an amazingly harrowing mission in complete mastery. No evidence of neurotic reactions appeared, though they might easily have been predicted in some of the personalities participating. This again proves that no factor is more important than real leadership. The closely knit kinship of the flying group is important; the readiness of each and every member to admit his fears enables him to adopt more adequate responses than flight from fear by repression; the rigorous training of the flyer and a powerful common love of the plane are themselves great factors. The question arises: in what specific manner do these factors prevent acute anxiety reactions?

These statements are not the preliminary approach to a discussion which will answer this question. Unfortunately the problem is in the early stages of development, and understanding is at present inadequate. The material available from the study of cases seen in their early stages during the last war does not give much insight into the depths of the problem. The answers to these questions therefore must await future developments and observations.

It may be stated that the most important factor in the adequate care of these cases in the early stage of their illness is the lifting of the amnesia for the traumatic war experiences. Repression should be set aside. The use which Grinker and his associates have made of barbiturate drugs, plus a modified analytic therapy, has proved most effective. These techniques must be supplemented with later psychotherapy, aimed at increasing the understanding and total integration, at building up the ego tolerance for the traumatic events, and at preventing the spread of the symptoms to the other areas of the individual's emotional life previously mentioned.

This paper can only raise these theoretical considerations

[4] Wright, David G.: *Psychiatric Experiences of the Eighth Air Force.* Restricted Army Air Forces publication.

and then outline the practical aspects of the problem as they are met in the Army Air Forces. We shall set forth our working techniques for handling these problems as they come to us in numbers which necessitate a short term therapy with limited numbers of competently trained personnel.

The stress of operational flying in the more difficult theaters of operation is such that flyers continually live beyond their psychological means, and it is an accepted fact that neuropsychiatric symptoms are bound to arise in a number of these men during their prescribed tour of combat missions. During this period they must be handled wisely and the flight surgeons assigned to these tactical units are trained to be aware of this problem. Psychiatric consultants are available for their assistance in all questionable cases. It is not unusual for flyers to become so fatigued during the course of their prescribed combat tour that they need to be sent to rest camps, and sometimes to be given periods of continuous sleep induced by one of the barbiturates.

Hence it is the policy of the Army Air Forces to rotate these men and to return them home after a prescribed tour of duty. Some men returning from overseas theaters will show variable degrees of neuropsychiatric symptomatology. This state is diagnosed at this time as 'operational fatigue', which is by definition a reactive state resulting from the physical and emotional stress of continued danger and hardships. The intensity of operational fatigue may vary from minimal reactions to severe emotional disturbances. Minimal reactions are normal under such stress and are not clinically significant. Operational fatigue is used as a diagnostic term for the following reasons: (1) The term neurosis or psychoneurosis ordinarily denotes the presence of symptoms which are *basically* dependent upon unconscious conflicts which arose early in childhood. (2) Operational fatigue is basically dependent upon recent situational experiences and conflicts and as seen at present has not yet become irreversibly bound to earlier unresolved conflicts over instinctual expressions. (3) Although there is often a close similarity in the clinical manifestations of operational fatigue and psychoneurosis, the differences men-

tioned warrant the use of a distinguishing term for those cases which fall into the former category. Later the reactions may spread to and involve earlier residuals and thereby justify the latter diagnosis.

The term 'operational fatigue' as used does not denote the existence of an organic factor as a specific agent. It neither implicitly nor explicitly denies the basic importance of psychological conflict in the production of the state designated. Some authorities deny the validity of the reasons for the use of the term 'operational fatigue' and—remembering the term 'shell shock'—they fear that organically minded opponents of dynamic psychiatry may use this to deny the essential psychological origin of the illness. This need not be the case; although there is most definitely a factor of fatigue in the production of these states, the exhaustion is an emotional one which depends, as was said above, on the situation of living beyond one's psychological means for a long period of time. The weakened ego loses its ability to suppress and repress the normal fear reactions. Physical factors play an accessory, and not a primary, rôle. At this stage the anxiety responses come in to overwhelm the tired ego and produce the classical syndrome. Hence, there need be no confusion as to the essentially dynamic conception of this syndrome because of its designation of operational fatigue. The element of intrapsychic conflict is only too apparent and 'he who runs may read'.

One might call this syndrome 'operational fatigue reaction', but this is a bit too cumbersome and by usage would soon shorten itself to the present term. Some are very fearsome of the word fatigue at all, but the element of the tired-out ego, staggering and dazed under the weight of conflicting emotions, is only too evident to clinical observers. The reactions are comparable to the animal in the experimental situation, which has been set up to frustrate and confuse the animal repeatedly until purposive, adaptive, and solution finding responses become impossible. The rôle of fatigue in the ego of the played-out animal is obvious.

Another pertinent angle needs to be mentioned for purposes of clarification and emphasis. Flying men are practically all

conscious of their fear, openly accept it, and admit it to themselves and others. This is indeed a healthy and helpful attitude so long as the ego is unweakened and strong enough to march forward in the face of all threats. Unconscious ego conflicts are also present, however. Perhaps the most important ones beyond those mentioned develop through the need to preserve the integrity of the identifications with the leader of the group and with admired mates. This relationship, though reassuring and strengthening, is danger-laden, in that at times a deep ambivalence develops. This results in a relationship based upon the aggressive homosexualities of adolescence, which has been described by the author elsewhere as akin to that of the 'dead end kids'. The pathological end result is often a reactive depression. In most cases a sound ego masters these conscious and unconscious conflicts. A tired and played-out one begins to stagger—a reaction which may go on to anxiety and ultimately to the syndrome under consideration.

For practical administrative purposes, the Army Air Forces classify operational fatigue into three groups: minimal, mild and severe. The minimal group shows inordinate feelings of loneliness away from its combat units, indecision regarding future activities, vague and transient somatic concerns, and a need for excitement. Objectively, mild restlessness is noted with difficulty in falling asleep and some slight weight loss, which is in the process of being regained. In general, these men show minor signs of tension which clinical experience has indicated do not require medical attention, as these symptoms will recede with time and with the identification within a new group to which they will be assigned. These men are regarded as fit for full duty status within the United States after a rest period, and it is thought that as soon as they find a new place in the army routine their symptoms will disappear.

In the mild category, some signs and symptoms of anxiety are noted. Subjectively, there is mild irritability, lack of concentration and capacity for sustained effort, including loss of zest for flying. No clear-cut mental depression, personality changes, nor battle dreams should occur in this group. Objectively, these men show some evidence of restlessness, tension,

tremor, mild overactivity of the sympathetic system, slight weight loss, receding insomnia, anorexia, and perhaps mild psychosomatic disturbances. Ordinarily these men require no definitive psychiatric treatment. They may need occasional help in sleeping, such as a mild sedative. They are sent to a convalescent center for rehabilitation. By means of various ego strengthening devices and environmental manipulations they are gradually retrained and brought back to the army setting. Their military program during the retraining period is reduced, and assignments are arranged in accordance with their capacities and wishes. They are made to feel that there is a definite place awaiting them in the program of the Army Air Forces. Sometimes these men are grounded and at other times they are allowed flying duty—excluding instructional duties—limited to the continental United States.

The severe group show subjective symptoms of clear-cut anxieties and phobias. Depressions are present and usually have a definite trend of guilt, both conscious and unconscious. There is a definite inability to concentrate, with some mental confusion and occasional memory disturbances; usually there is preoccupation with battle experiences, and psychosomatic symptoms are generally present. The gastrointestinal tract, the circulatory system and the genitourinary functions may be involved in the process. Stammering is a symptom occasionally encountered. Objective findings of marked restlessness and irritability are present, as well as pronounced signs of overactivity of the sympathetic system. Startle reactions may be present, and there is severe insomnia with battle dreams. Occasionally episodes of abnormally aggressive behavior are encountered. It is customary to find a severe loss of weight and appetite. The disposition of this group of cases is to send them to an Army Air Forces Convalescent Hospital for definitive psychiatric care.

The Army Air Forces have established a convalescent hospital at St. Petersburg, Florida, and have installed a competent staff of psychiatrists with special training in psychotherapy, particularly in the dynamic aspects of the field, to pioneer in the development of new techniques for the definitive care and

rehabilitation of these cases. The aim in the treatment is to uncover and relieve the painful, repressed residuals of war experiences. This is done by the use of the technique described by Grinker, which he calls 'narcosynthesis', which is then followed by the use of ego supporting and developing devices to rebuild the flyer for useful service in the Army Air Forces.

In the latter category there are well-rounded programs of interesting and instructive activities built along the lines of the 'total push' method. These tend to educate and instruct the individual in new spheres of interest and work, which are of his choice and in line with his inherent abilities. This hospital has been activated only a few months but the early statistical results indicate a success in the treatment of individuals that exceeds most optimistic expectations. It is felt that many cases, which in the last war would have developed chronic war neuroses, will be restored and sent on their way with a reasonable expectation of a normal and healthy life.

In order to handle the large number of cases of operational fatigue being returned to this country, the Army Air Forces have organized a Redistribution Program. The men returning from overseas are given three weeks sick leave if they do not require immediate hospitalization. Upon the expiration of their home leave they are sent to a Redistribution Station, where they are given a complete medical and psychiatric examination. To provide for competent examinations, large numbers of trained personnel are needed. An adequate number of trained psychiatrists is not available to the Army Air Forces, and therefore a group of physicians had to be sought from another quarter.

The psychiatric interview is conducted by flight surgeons who have had overseas experience in caring for flying personnel. These men have been carefully interviewed and are specially selected for their particular interest and awareness of psychiatric problems. Those chosen are sent to the convalescent hospital for a special course of concentrated clinical training in psychiatry. Their course of training is specifically designed to teach how to treat and to understand operational

fatigue in its theoretical and practical aspects. After their training these flight surgeons are assigned to Redistribution Stations where they examine the men returned from overseas for evidences of emotional illness as residuals of combat experience. It is the function of this section of the examination simply to determine whether or not the flyer is well or whether he has operational fatigue. If the flyer is found to have operational fatigue, he is sent to a psychiatric consultant who determines the severity of the illness, whether minimal, mild, or severe. When the man is diagnosed and classified the disposition is made as previously discussed.

A review was made of the total number of cases diagnosed as severe operational fatigue which went through the examining line at one of the Army Air Force Redistribution Stations during a two month period. This showed that tenseness, tremor, restlessness and insomnia appeared in practically all of those so diagnosed. Terror dreams rank next in frequency of occurrence. Depressions and preoccupation with battle experiences occur in over half of the number. Startle reactions, excessive fatigue, psychosomatic symptoms, irritability and anxiety attacks follow along behind in the order given. Other symptoms are of relatively infrequent occurrence and so are not discussed here. The depression which occurs in these cases characteristerically has a large component of residual guilt. The guilt feelings are focussed upon lost buddies and deal with the never-ending question of responsibility for the death of these mates. Many times the nuclear situation of the illness is focussed upon these well-rationalized feelings and is relieved only when they are exposed and worked out.

As the war goes on more data will be gathered regarding the dynamics of these reactions, and there will be new work to throw increasing light on these problems. It will be possible to follow the course of these illnesses as they spread from the early locus of battle stress, physical and emotional, to the functions of the total personality. In some cases the end results will show that the neurotic process has drawn into it and condensed around it many of the remainder of the personality

functions. At that time the clinical picture mentioned previously in the work of Kardiner will be present. It is to be hoped that opportunities for therapeutic aid will be given these men so that the pathological process may be broken up in its development and the patient restored. It is the fervid wish and the aim of the army psychiatrists to be as effective in the achievement of this goal as is humanly possible.

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PSYCHOPHYSIOLOGY

THE CONCEPT OF DRIVE AND THE PLEASURE PRINCIPLE

BY CARL M. HEROLD, M.D. (NEW YORK)

Psychological facts are subjective experiences and cannot be proven by objective evidence. Thus psychology is based on introspection, which is the only source of subjective evidence. Even highly emotional behavior of others can be identified only by a combination of identification and introspection, and is reliable only if either very primitive emotions are involved or if verbally confirmed by the emoting person. But even direct introspection is not applicable where the psychology of the unconscious is involved. In this case the entire process of discovering the unconscions has to be experienced and thus made available to introspection. Thus Freud *(1)* postulated that each psychoanalyst be analyzed himself. This is a hard way to learn facts but subjective experience is necessary in a science which deals with subjective facts.

Everybody has subjective experiences and should be able to comprehend basic psychoanalytic discoveries if he is not too inhibited in his self-observation. But one should not say that the refusal of many scientists to accept psychoanalytic discoveries is based exclusively on their emotional resistances. This is too smug an assumption. The theory which presented these psychoanalytic facts may have been unacceptable to other natural scientists, not so much by reason of its content as because of concepts which are alien to all other scientific thinking. Psychoanalytic theory results from the application of objective thinking to subjective material; furthermore its terminology was hastily borrowed, because of the novelty and phenomenal growth of the subject, without giving much time to exact definitions. Terms like 'drive' and 'wish', to describe subjective processes, were used to give a theoretical approximation to what was observed. These subjective concepts, by usage and familiarity, tended mistakenly to become established as referring to concrete objects, and a logical confusion ensued.

Objective methods of elucidating psychic functions, especially the studies of animal behavior, are also not without fault. In a discussion among biologists, physiologists, and psychoanalysts, there was a difference of opinion as to why rats with experimental diabetes insipidus drink so much water. The physiologists refused to say that the rat drank because it was thirsty. 'Thirst', they said, 'is a subjective feeling, and we cannot talk about an animal's subjective feelings because it cannot tell us about them'.

This is perhaps an extreme example, but it is characteristic of the excessive fear animal experimenters have of becoming guilty of anthropomorphism or animism. Why is it necessary to ignore that animals feel pleasure, pain, fear, delight, etc.? [1] Feelings, although subjective, are not less real than objective facts. Being realities they must be accessible to scientific investigation, although they are certainly not directly objectively observable. In his earlier years Pavlov penalized has associates for using the subjective term 'consciousness'; later he permitted it, provided it was well defined. If he had not, he would have been unable to approach the study of truly psychological phenomena. One example from Pavlov's *(3)* well-known experiments will demonstrate that the exclusion of subjective concepts leads psychological thinking to an impasse.

On conditioning a dog to a stimulus applied to a circumscribed area (the paw), the dog will for a while respond to stimuli applied nearby (the leg). After some time it will learn to distinguish between the stimulus applied to the paw, which signals food, from other places which do not. It will then respond with salivation to stimulation of the paw only. Other areas of stimulation become, as Pavlov called it, 'inhibited'. Pavlov proved by experimental investigations that such discrimination on the part of the dog is a function of its cerebral cortex and requires a certain time interval. If, for example, the leg is first stimulated and one fourth of a second later the

[1] Experimentally produced 'sham rage' in animals (Cannon, Bard) for instance is easily distinguishable from real rage by the lack of orientation of the aggressive behavior and by its sudden cessation as soon as the painful stimulus is discontinued. It looks like an automatism and not like an actually felt emotion.

paw is stimulated, in response to the second stimulus the dog secretes either no saliva or only one or two drops. This Pavlov explained by saying that the inhibition has spread or 'irradiates' from the spot in the sensory cortex which represents the negative stimulus to the one which represents the positive stimulus. Or if one introduces the positive stimulus (paw) and the negative (leg) very shortly after, the dog will produce some saliva as a response to the second, negative stimulus. This was attributed to an 'irradiation' of the excitatory stimulus.

Pavlov admitted that he knew nothing about the nature of those excitatory and inhibitory processes which 'irradiate' over the cerebral cortex, nor could he prove that such a process of irradiation existed. It would seem more reasonable to conclude that the time needed for distinguishing the *meaning* of a stimulus might better be accounted for by assuming that it is not simply a localizing function in the sensory cortex, but a much more complicated process of comparing and testing in which the whole psychic apparatus and not only the sensory cortex is involved. Granted that Pavlov may have wanted to be merely descriptive, and ignoring the hidden implications of 'irradiation' and unknown processes of excitation and inhibition, it is still more objective a description of the phenomena to conclude that any conditioning stimulus requires a certain interval of time to register before eliciting the expected response from even a thoroughly conditioned animal. Psychophysiology cannot stop at mere objective description, refuse to coördinate observation with what is known about mental functioning, and get very far.

Since such long training and so much reaction time are required before an individual can benefit from his extremely exact localizing faculties in the sensory cortex, it makes these minute cortical localizations unwieldy, if not impractical, if they are the only localizing apparatus available. However, it is known that the thalamus is also a localizing apparatus of a more primitive and general kind than the cortex. It may be that for reasons of economy (or of phylogenetic priority) the more primitive and general mechanism functions first, and only if this proves to be inadequate are more subtle cortical

mechanisms put into operation. In terms of the experiment, if stimulation of *any* part of the leg signals imminent feeding, why bother about the exact location of the stimulus on the leg?

But this very question raises purposive as well as economic issues. Psychological mechanisms have been introduced into a problem which many may indignantly claim is entirely 'objective' and physiological. Without arguing the merits of the claim, let us call the psychological element introduced 'interest'.

The dog is interested only in the fact that some tactile stimulus of the leg signals food. At first it suffices to signal from the general representation, leg, in the sensory area of the thalamus to the representation of the taste or smell of food which in turn stimulates the salivation center. Only if the dog is disappointed several times, does it pay attention to the part of the leg which is stimulated and employ the more minute localization of the sensory cortex. The chain of stimuli then becomes longer. The stimulus makes a detour from the thalamus to the sensory cortex and from there to the 'food center'. The process is now 'long-circuited'—to use an expression of C. Amsler—and there is a longer interval between stimulus and response.[2] If the stimuli follow in too rapid succession, the phylogenetically older 'short-circuit' pathway with more general localization will prevail, and the dog, no longer able to distinguish sharply between the different stimuli, will show perseveration by reacting to the last clearly recognized stimulus.

Thus the interest of the dog in food compels it to react in a way which prepares it to meet a signaled event. If it has

[2] Time is consumed not only by impulses running from the thalamus to the cortex, but also by a kind of testing. Tentative secondary and tertiary impulses must travel between different centers of the cortex, determining whether a stimulus does or does not signal food. These processes seem to involve difficulties indicated by the distress test animals exhibit when confronted with the task of distinguishing between nearly identical stimuli. This may be compared to the struggle of an unmusical person to 'hit the right tune'; or to the discomfort which accompanies the effort to recall a forgotten name. It should not be forgotten in studying conditioned reflexes that a very complicated and little-known function called memory is involved which can be impaired emotionally, physiologically, or anatomically.

no time to differentiate between signals, it reacts to the last clearly recognized stimulus: with 'inhibition' of salivation if it was recognized as a stimulus to a negative (no food) part of its leg, with salivation if it was the positive (food) place, the paw.[3]

The interest of the dog is in food if he is hungry. In other situations it may be an interest in meeting adequately a discomforting stimulus. That interest is aimed at adjusting bodily needs to environmental conditions as presented to the senses. Perception of bodily needs and of external conditions meet to be tested on one another probably in the cerebral cortex and, in a more primitive and less discriminating manner, in subcortical and diencephalic centers.

Perception is based on the function of the sense organs, or receptors. The sensory receptors are classified as somatoceptors and viscероceptors. The somatoceptors transmit qualities of objects and are subdivided into exteroceptors which include cutaneous, chemical and telereceptors (vision and hearing), and proprioceptors, which transmit muscle and position sense. It is noteworthy that through proprioceptors the parts of one's own body are represented in our imagery as objects of external perception, leading to what is called the body image. Thus, both subdivisions of somatoceptors transmit *objective* perception. They do not signal needs to the central nervous system, simply objective conditions. Collectively they comprise sensual evidence.

The viscероceptors, however, transmit quite different sensory qualities. They give rise either to local visceral and vascular reflexes which remain local and never reach the sensorium, or if they reach the sensorium, signal states of thirst, hunger, sexual desire, well-being, fatigue, nervous tension and kindred perceptions. All these are perceived by the individual as belonging to himself; the quality of these perceptions is *subjective*. The sources of these sensations, the viscera and vascular systems, are not perceived in the sensorium of the individual as objects. One quality, with varying modulations, applies to

[3] This has an important bearing on behavior disturbances not germane to the subject of this discussion as, for example, certain forms of repetitive behavior.

all of these subjective perceptions or feelings. This common quality refers to the way in which one is affected by these feelings: they are either pleasant or unpleasant.

This statement requires amplification and qualification. The total function of subjective perceptions or feelings has to be considered with reference to objective perceptions which represent external reality. The environment and those parts of the body which are perceived by the proprioceptors furnish the means of satisfying the needs of the individual. The visceral organs as such are, *psychologically* speaking, not objects, because they enter the sensorium only as cravings and desires, as subjective expressions of objectively existing biological needs. The consciousness of desire merges with the objective perception of the environment somewhere in the brain, presumably in the diencephalon. At the merging point, where external and internal reality, objective and subjective perceptions meet, must be the point where the perceptions arouse their pleasant or unpleasant affective qualities depending upon whether or not external reality is in accord with the perceived desires and the associated feelings. To be hungry before dinner, when the pleasant smell of a good meal comes from the kitchen, is not at all disagreeable; on the contrary, it is a very pleasant sensation. But to be hungry without any hope of food, or the smell of food if one has severe indigestion, these are very unpleasant experiences indeed. To be sexually excited in the presence of a love object with external conditions promising gratification renders sexual tension as pleasant as it can be unpleasant if those conditions are absent. Pleasure and pain (discomfort) are therefore relative, expressing the compatibility of the presented external circumstances with the biological needs as perceived by internal perception. If an organism is not in the act of satisfying its needs, the pleasure or discomfort felt will depend on whether reality presents signals which, on the basis of former experiences (conditioning) or instincts (inherited unconditioned reflexes or reactions), suggest the arrival in a realizable future of a situation which represents gratification or frustration of biological needs.

'Realizable future' is a variable subjective factor which

involves the faculty of anticipation. Anticipation is a complex phenomenon, involving the sense of time as well as the faculty of imagery which in turn adds new stimuli to the actual sensual stimuli presented by internal and external perception at a given time. The stimuli coming from the imagery stand between truly sensual internal and external stimuli, and influence the reactions of an organism by making it, generally speaking, more tolerant to deferred gratification, and more intolerant of protracted suffering. Imagery being the result of past experiences, its link with a given situation is, especially in human beings, mostly the result of conditioning. A consistently trained (conditioned) individual will develop a much better faculty of anticipation and therefore has a much greater capacity to adjust himself to reality than either a spoiled or a chronically frustrated individual, or an individual who has been made insecure in his anticipations by erratic and arbitrary alternate immediate gratifications and frustrations. Not the need itself is psychologically of such great importance, as every individual has various needs at any given time, but the ability of the individual successfully to adapt his needs and desires to reality (the reality principle). This adaptation is guided by the subjective feeling of pleasure, discomfort or pain. Experimental psychology is doing excellent work in investigating the reactions of individuals to experimentally produced needs, but it should be aware that it is not dealing with psychological facts when it ignores subjective factors (feelings) in test animals. All psychological experimental observation demands psychological interpretation. Interpretation is the domain of psychoanalysis, but if physiologists may profit from psychological thinking, psychoanalysts should gain even more by the application of physiological thinking.

According to Freud, drives are forces with specific aims, libidinal and destructive,[4] which decide the behavior of the individual. Thus the introspectively observed purposiveness of the individual is ascribed to the forces which drive him. In

[4] *Cf.* Herold, Carl M.: *Critical Analysis of the Elements of Psychic Functions.* This QUARTERLY, X, 1941, pp. 513–544; XI, 1942, pp. 59–82 and 187–210. This paper is partly a critique of the concept of drive.

contradistinction to the energy concept of the physicist, Freud's drive energy is conceived as an energy with a specific goal, an energy so to speak endowed with a will. Such a hypothetical energy, so different from all others, cannot have a place in natural science. It is as if one attributed to the force in gasoline the tendency to locomotion because it propels automobiles and airplanes.

Freud's concept of drive, like the concept of soul, is anthropomorphic. Both concepts are based on the experience that we have will. In the soul the will is free, whereas in drive it is determined. Such a concept of drive is not only incompatible with natural science but creates theoretical difficulties. How, for example, can such a specific energy change its specific qualities? There are many instances in which a libidinal drive, deflected from its specific aim, leads to actions which are supposedly specific aims of the destructive drive. These difficulties force us to hypothetical assumptions which are not entirely satisfactory.

The concept of specific drives, stemming from the Hippocratic idea of a life force, was reformulated by G. E. Stahl (1660–1734), and became firmly imbedded in German psychology and in the common language of Germany in the nineteenth century. Freud made use of this concept of *'Trieb'* and constructed a rather intricate system of fusion and defusion of libidinal and destructive drives with which one can, although sometimes in a very complicated way, explain many psychic reactions; but one cannot predict any of them because the basic assumptions, the fusion and defusion of drive quantities, cannot be evidenced. It is possible with Freud's theory to reconstruct the famous experiment of Yerofeyeva *(4)*, one of Pavlov's pupils, although this experiment has a much simpler explanation.

Yerofeyeva conditioned a dog to an electric shock of medium strength as a positive alimentary stimulus. By patient and persistent feeding after applying a moderate electric shock, the dog stopped trying to bite and to free itself from the shock, and began to regard it as a signal for food, showing all signs of pleasurable expectation, wagging its tail and salivating. Increase of the intensity of the electric shock, or its application

to more sensitive places, as the skin over a bone, made the dog revert to its initial aggressive defense-and-escape reaction.

In this example of a dog in what might be called a state of conditioned masochism, it is evident that the conditioning is the coincidence of a progressively weaker external and a stronger internal stimulus which determines the behavior of the dog in accordance with the pleasure principle, and not a specific drive energy or mixture of such energies. The stimuli are the inner hungry state of the dog and the external electric shock. When the latter, at first only painful, stimulus gradually became a signal for a pleasant experience it caused a reversal of the animal's behavior. The energy which determined in both instances the behavior of the dog did not change its quality; it only changed its direction (to a different set of muscles and glands). Hunger itself is an inner stimulation of visceral receptors and is based on disturbances in the viscera. Once we free ourselves from the concept that hunger is the manifestation of a drive and regard it merely as a visceral stimulation, the whole concept of specific drive energies (libido) is thrown out of psychological consideration. We now understand behavior not as the result of hypothetical forces driving from within the organism which external reality can merely modify, but as the resultant of external and internal sensual stimuli which are experienced under categories of pleasure and pain. The illusion of a force by which we are 'driven' is merely a misconception of nervous energy set free by stimuli. This nervous energy is specific in three respects: it is 'nervous' energy set free in nervous substance in the form of chemical and electrical changes in it; it is specific in regard to a specific stimulus; third, in regard to what kind of nerve is stimulated. But it is not specific as to its 'goal', i.e. in which direction it it discharged. The discharge of the free nervous energy is directed by the pleasure principle (unconditioned reflexes). Anticipated pleasure or pain (discomfort) guides behavior the same way (perhaps somewhat less effectively) as actual pleasure or pain.

The pleasure principle is invoked at the point where subjective feelings and objective perceptions are correlated. It motivates the actions of the organism whether it be an amoeba or a human being. An amoeba, exposed to all external stimuli, sustains life by an instantaneous correlation. Human infants have to be exposed gradually to the stimuli of reality because they are born with a nervous system which is only partly developed and functioning, and capable of correlating few and primitive stimuli. Thus education, which is in principle nothing but a process of conditioning, is based upon adjustment to reality under the guidance of the pleasure-pain principle. That principle is the motivation of behavior and the core of all psychological investigation.

Such investigation is the special task of the psychoanalyst. Verbal stimulation is by far the most frequent means of education. Most important human conflicts arise on the basis of word-conditioning. For instance, the first words to which an infant is conditioned are, 'No, no', an inhibitory stimulus reënforced by the unloving or otherwise threatening attitude of the parent or his surrogate. Psychoanalysis, a special field of psychology, is of such outstanding importance because it is a process of verbal reconditioning, reënforced by the transference, which is the reason why it is so lengthy—including the post-analytic period of 'working through' which is essentially further reconditioning. With this change in emphasis, psychoanalysis shifts its concentration from following the vicissitudes of hypothetical drives to analyzing and reorganizing the motivations of behavior. The depreciation of old motivations and the introduction of new ones can only be accomplished by at least temporary interpolation of the sensorium into existing conditioned reflexes. This is the principle involved in making the unconscious conscious, the essence of psychoanalytic work.

SUMMARY

The study of conditioned reflexes becomes fully useful for psychology only with the introduction into it of the concept

of the pleasure principle. It is no undue assumption that all behavior of animals and human beings springs from the tendency to achieve pleasure and to avoid pain. That assumption is a key for translating the objective findings of the physiologist into subjective psychological language and vice versa. The coöperation of both groups of investigators will lead to a new organon of psychology, as the coöperation of experimental physics and mathematical speculation led to the all-important development of modern theoretical physics.

Psychoanalysis has produced two theorems which are of greatest importance to the possibility of a mutual understanding between experimental psychobiologists and psychoanalysts. One, the basic rôle of the pleasure principle in psychic functioning, if introduced into experimental work, should open a way for psychological interpretation of the otherwise too mechanical descriptions of nervous functioning. The fact that animals behave according to the pleasure principle is apparent to any but the most prejudiced observer and cannot be disregarded solely because it disturbs the ideal of 'pure' objectivity. Omission of this subjective factor results in sterile descriptiveness.

The other psychoanalytic theorem is the concept of specific goal-directed drive energies which determine behavior. This concept of energies with specific aims is at variance with all other scientific concepts of energy. It is an animistic projection of subjectively perceived volition on to physical, objective forces. It is one of the chief obstacles to any coöperation of physiologists and biologists with psychoanalysts. Such hypothetical energies which are unacceptable to scientific thinking are as responsible for the rejection of psychoanalysis by other sciences as are the unconscious resistances of individual scientists. A revision of the psychoanalytic theory of drives by the substitution of motivation through stimulation (external and internal) leaves unchanged all the basic facts discovered by Freud and prepares the way for integrating them into the general system of natural science. Psychoanalytic therapy, with this regard, is defined as a specific method of reconditioning based on chiefly verbal stimuli which are emotionally reënforced

by the pleasant or unpleasant factors of transference, and which stimulate the sensorium to reorganize or remotivate established conditioned mechanisms.

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TICS AND IMPULSIONS IN CHILDREN: A STUDY OF MOTILITY

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There is a great divergence of opinion on the meaning of tics. They have been variously considered as mere habits, repetitive motions, or compulsive or hysteric symptoms. Their similarity to certain features of organ neuroses and hypochondriacal states has also been noted, and Ferenczi—who pointed out the highly narcissistic make-up of certain tiqueurs—because tics suggested catatonic symptoms, wished to call them by analogy 'cataclonias'. Nevertheless, he also recognized isolated tics as accessory manifestations with no relationship to the rest of the personality.

It is my belief that a better understanding of the tic may be derived from a study of its pathogenesis in children. This report is based partly on the psychoanalysis of children who presented tics and other neurotic motor symptoms, partly on the clinical findings of a research project at the New York State Psychiatric Institute, and also on information regarding behavioristic and experimental psychophysiological phenomena drawn from the works of Myrtle McGraw, Gesell, August Homburger, and many others. These works have the shortcomings of any preponderantly neurophysiological experimental research. They deal essentially with surface phenomena and stress the neurophysiological aspects of behavior. However, they furnish useful points of departure for investigating motility, if this be also considered a psychodynamic resultant of the interactions of instinctual, ego and social environmental factors.

Motility has been explored by many authors, among whom might be mentioned Hartmann, Bally, Landauer, Fenichel and Kubie. The efficiency and rationality of motor conduct is no doubt the most conspicuous characteristic of adult behavior.

Read before the New York Psychoanalytic Society on October 26, 1943.

It was the 'absolute mastery' of motility which Freud singled out as one of the main functions of the mature ego. From the psychodynamic point of view, the kinetic ego (Nunberg)[1] occupies a unique position. Better than any other system, it demonstrates the principle of multiple functioning (Waelder) as well as the principle of the overdetermination of symptoms.

To understand motility and its disturbances, it is particularly useful to follow the development of expressive or affective motor function, and the performance motor function (*Leistungsmotorik*) of the ego. The separation of these two chief elements of the kinetic function is arbitrary, yet many motor phenomena are formulable as interactions between the two aspects. Expressive motility is much nearer to the id, while performance motility develops as an integral part of the autonomous mature ego.

At the beginning of life the two divisions of motility are inseparable. Prehension, grasping, fixation, turning the head towards the mother, are expressive; yet they become the very foundation of performance motility. Later in development the two types diverge until the affective motor part is reduced to a mere synkinesis with subtle facial mimicry, or to expressiveness in speech and other organized symbolic means of communication.

To review at this point the functions of the neuromuscular system—which as an executive center par excellence serves the libidinal as well as the ego instincts—would entail too extensive a discussion and would overstep the limits of this paper. Let us merely recall that early in life the motor equipment primarily aims to reunite child and mother. Later when the motor function within the ego's autonomy begins to give the child intense narcissistic satisfaction, the neuromuscular system undertakes defensive innervations which ward off threats of narcissistic injury from without and take over vicariously and ward off the more objectionable impulses (oral, anal and phallic, erotic and aggressive) from within.

When object erotic cravings are differentiated (before there

[1] *Cf.* appended bibliography for authors referred to in the text.

is verbal communication) the child seeks rapport and expresses his emotions and desires through both divisions of the kinetic function.

When emotional gestures are increasingly modulated, at about the age of twelve months, the infant gradually begins to communicate a wide range of affects: fear, pleasure, rage, annoyance, affection, jubilation, and the rest. Its expressive jargon is a lalia rather than a representative symbolic language.

As far as performance motility is concerned, Kubie significantly says in a recent paper: '. . . every new skill becomes a language weighted with a steady accretion of secondary and largely unconscious meaning . . . a wordless appeal for love, praise, or help, . . . an expression of unformulated yearnings and wishes.'[2] We know that this holds true preëminently for the first motor achievements of prehension, of bodily locomotor skill, and of vocal skills.

The integration of erect locomotion is the greatest step in the development of the autonomous kinetic function of the ego. In the two-year-old child, simple motor skills are combined in new actions, which in normal development progressively lose their rigid repetitive tendency, with longer periods of quiet occupation and verbalization.

Finally, the fluently mastered partial skills of performance motility are pushed down into deeper preconscious layers of the ego (Hartmann), which ordinarily do not require much cathexis, and thus free libido for new skills and the higher functions of the ego (Landauer). In contrast to pathological striopallidar automatisms, these important normal automatisms are parts of the ego with great libido-economic implications.

Freud in his paper, Formulations Regarding the Two Principles in Mental Functioning, writes, 'A new function was now entrusted to motor discharge, which under the supremacy of the pleasure principle had served to unburden the mental apparatus of accretions of stimuli, and in carrying out this task had sent innervations into the interior of the body (mien, expressions of affect); it was now employed in the appropriate

[2] Kubie, Lawrence S.: *The Repetitive Core of Neurosis.* This QUARTERLY, X, 1941, p. 27.

alteration of reality. It was converted into action. Restraint of motor discharge (of action) had now become necessary, and was provided by means of the process of thought, which was developed from ideation.'[3]

At the age of four and five, performance motility is established firmly enough to be of great emotional value. The ego still bends towards object-related, affectionate demonstrativeness. Its total motility has become the child's most important alloplastic tool to master reality, and at the same time, through 'motor luxury' (to quote August Homburger), a way of indulging in the pleasure of acting out its emotional impulses in play or expressional communications, positive and negative, with parents and siblings. At this point the child is at the peak of his œdipal situation.

As school age is approached, the expressive manifestations of the œdipal claims, because of their overt and obtrusive quality, become more objectionable. The child's ego is called upon to repress the libidinal and aggressive tendencies of the œdipal conflict, to repress *specifically* all direct and indirect motor manifestations which had relieved surplus tension (*cf.* Ferenczi, Fenichel and others). The superego now prohibits the child's seeking release in affective motility, and the ego is faced with the potential eruption of powerfully repressed objectionable impulses.[4]

There are two main possibilities of relief from instinctual tension—discharge and binding of energy. A small child unhesitatingly chooses the first of these because of his relatively weak ego and intolerance of anxiety. Children always act out if

[3] Freud: Coll. Papers, IV, p. 16.

[4] A kind of theoretical and therapeutic preoccupation has crystallized around the problem of the motor release of aggression. It seems that release is considered both the main factor in alleviating anxiety and the principle agent in resolving neurotic symptoms. To me, as to so many other workers in the field, the relation between restraint, restriction, and symptom formation is far more complicated. Dr. Greenacre *(10)* is of the opinion that 'it is not simple hampering of motion that provokes aggressive, ragelike behavior in the young infant; indeed that consistent, moderate and general restriction may first quiet the infant'. We may add that unbiased observation seems to convey the impression that beyond infancy as well, such an attitude helps the growth of the kinetic function of the ego.

they are permitted to do so and only very gradually obtain the ego strength and maturity necessary for control.

Children successfully attain latency only when they are able to replace immediate acting out (impulsions) by trial acting, i.e., thinking. In a great many cases latency, especially where motor manifestations are concerned, is not attained.

There is no more impressive proof of the validity of Freud's basic finding that the œdipus complex is the core of neurosis, than the comparative findings concerning the function of motility. This becomes unusually clear when we study and contrast the function of motility before the peak of the œdipus complex is reached and the motor behavior of children of school age where general repression has been successfully achieved.

Though impoverished in its vivacity, the motor behavior of a child from the age of six to eleven or twelve becomes calmer and more balanced, tends to achieve a certain degree of uniformity (Homburger), and does not easily regress. In those instances in which the libido economy has manifested an imbalance in early life, interactions within the kinetic function of the ego remain defective. Having been continuously submerged by id-related motor manifestations and compelled to take over vicariously surplus libido from other zones, the performance motility becomes disrupted. Play is usually deficient in purposefulness and the kinetic function of the ego conspicuously lacks flexibility; while at the same time there is a tendency to affective motor explosions (tempers). There are also the first alarming signs which indicate to the parents the need for help. In such disturbances of the libido economic balance and of the autonomous ego function—usually manifest in the parent-child relationship—the child is obstinately seeking restitution and compensation through repetitive, impulsive actions.

The term impulsion, partly borrowed from Bender and Schilder, and partly from Whitehorn, is used by us to designate those instances in which the ego condones objectionable motor release with little or no inner conflict. It thus embraces the 'habit disorders' and 'conduct disorders' of clinical psychiatry,

in contradistinction to true motor neurotic manifestations, compulsions, and particularly tics. According to our experience, the latter crystallize in permanent form only after a powerful general repression of libido and motility exerts its highly pathogenic influence upon the motility-controlling function of the ego.

We would differentiate three groups of impulsions: The *first* group comprises repetitive, strongly libidinized simple or complicated motor actions, which essentially serve the purpose of discharge—displacements of other more objectionable component impulses. The impulsions of the *second* group may symbolize an aggressive gesture or magic defensive motor action of the ego against intolerable tension and conflict with the outside world. The *third* group of impulsions is represented by stereotyped performances to obtain mastery of skill (autonomous ego expansion), learning, against interference (narcissistic injury).

The second group of impulsions is frequently and erroneously called 'tic' in psychoanalytic literature. In our opinion, these impulsions, or pseudo-tics, are preferably classified as 'denial by magic repetitive gesture'. They serve as escapes from unacceptable reality—or approximately what Anna Freud in her book, The Ego and the Mechanisms of Defense, has called 'denial in word and act'.

In the disturbed psychosexual development and parent-child relationship, we see an exceptionally violent and complex struggle between the tendency to repetitive and obstinate motor activity (the child's impulsions), and the external forces in the environment that strive to moderate and restrict.

The transition from impulsions to compulsive tics was put into words by one of my tic patients, Teddy, who repeatedly said: 'First I twinkled because I saw it in the movies [he found it interesting] and because Johnnie did it, the friend of my big brother [of whom Teddy was very jealous] and later I couldn't help blinking any more'. Teddy finally succeeded in replacing and warding off this first tic by developing an arm tic instead, and he was very proud of this achievement. Later, he used to exclaim in desperation, pounding the table, 'I got rid of

my blinking. I must be able to suppress these other habits too . . .'.

At this point, this nine-year-old boy had developed vocal tics—animal-like grunting, barking and squealing noises—as well as echolalia and echopraxia. They appeared especially when he was in the movies. These are the forerunners of ideomotor, coprolalic tics. We know that in many cases tics of the body musculature are accompanied by vocal tics, coprolalia, and the so-called echo phenomena. The coincidence with vocal tics, verbigeration, and other echo phenomena, and later on with coprolalic tics, may be viewed psychoanalytically in the same way as the gestural tics of the body muscles. The coprolalic tics may be traced through many intermediate stages. They seem to be ideomotor condensations of the diffuse uncontrolled repetitive vocalizations (the animal sounds) that occur in early childhood, which are usually followed, even in normal four or five-year-old children, by erotic aggressive 'bathroom talk' of a provocative character. Later, through the prohibition of motor release by the superego, these erotized verbalizations turn into a compulsive and repetitive motor symptom.

We see therefore how the ideomotor impulse uses the ego automatism in the intermediate phases of coprolalic tics and echo phenomena, as soon as the inner prohibition interferes with release into expression. Echo phenomena seem to be compromise solutions of the tiqueur's tendency to imitate, and of a repetition compulsion inherent in instinctual processes, which becomes exaggerated when expression is thwarted. In passing it may be noted that oral, anal, and phallic, libidinal and aggressive tendencies appear in equal proportion in the usual four letter words of coprolalic tics.

One analytic hour with Elmer, ten and a half years old, vividly demonstrates the different phases of tic formation. It also illustrates the identical psychodynamics of vocal and gestural tics and their interchangeability. Before we describe the case, it is important for us to state that logorrhœa is one of the features of the child tiqueur, whom we shall refer to

as type 1. We will also see in this type a trend towards self observation and hypochondria.

Elmer gave approximately the following associations during one analytic hour: 'Today I got a tic in my right shoulder and my eye. We gave a play about Columbus in the assembly. . . . Last night I was awfully silly, because my sister Peggy always asks me why I won't go to the bathroom. She smells gas. That made me silly. I made up a joke, because she says, whenever she comes home, "It's an awful smell". I giggled and laughed and danced and shouted, "Smelly gas, ballooni, furters, gas bubble, gas bubble, barrage balloons, balloons, balloons". Mother came in and tried to stop it. She got very angry, yelled at me . . . and Peggy always complains that I belch at the table.' At this point, his tics in the analytic hour were increasingly paroxysmal. He said, 'Gee, this tic is very uncomfortable—the sounds I like to make; I was chewing bubble gum yesterday . . . and when I stopped I just made the noises. The teacher and other people mind the noises, but the eye tic is very uncomfortable to me. It feels better when I do it, and with my arm too . . . It feels as if my arm were stiff and it feels better if I do this, but the more I want it to get better, the more I do it. . . .' A little later he remarked contemplatively and plaintively, 'Everything happens on my right side. I broke my arm on the right side, I tore the cornea of my right eye, I cut myself on my right forehead. When I broke my arm, I couldn't play football; I couldn't play anything! Since then I have always been kind of scared to skate . . . even now I am kind of scared in gymnasium.'

We may differentiate three phases of tic formation in this session. Pent up pregenital and genital instinctual impulses were leading to bizarre, grotesque, exaggerated affective motor and linguistic behavior, such as appeared in his talk with his eight-years-older sister. He was provoking her through coprolalic utterances, belching and flatus, by mimicking her with gestures and imitating the sounds he heard her making in the bathroom. However, when she and his mother tried to stop his diffuse, perverse, expressive behavior, coarse affective motor

acts had already inundated his ego to such an extent that he could no longer stop.

The next day, the tics which had been evident intermittently since Elmer's sixth or seventh year reappeared—but in two forms. The first was the sound tic, which he liked to make, and which he could stop rather easily if necessary. This was volitional, nearer to the pleasurable impulsions, and objectionable only to the environment. The eye and shoulder tics—the second form—were real neurotic symptoms: compulsions, conceived by us as a compromise solution of the ego between the impulse and the superego, and were strongly self-punitive rather than gratifying.

It may be worthy of note that on the previous day, Elmer was unusually excited in anticipation of an important rôle he was to play in the school assembly program. Elmer, as so many other tiqueurs, was a talented actor but the conflict between his exhibitionistic tendencies and the fears related to them was obvious.[5]

This boy was brought to analysis, not primarily because of his tics, but because of his inability to get along with his sister and because of his 'silly', aggressive erotic behavior. He used to work himself up into states of excitement which usually culminated in crying and unhappiness. Though intellectually exceptionally well endowed, he was not able to function up to capacity: each activity engrossed him so much that he could not effect a transition from one to another. He seemed always on the go. His teachers, who liked him very much, called him 'our beloved blunderbus'.

Long before he started analysis, the school wrote, 'Elmer is blind to all other considerations in fulfilling an idea. He frequently knocks down chairs and rushes into people in accomplishing his purpose. These personal collisions are sometimes interpreted as intentional and result in a scuffle.'

[5] The excess tensions brought about by such conflicts always produced a heightened emotional state and expressive motor paroxysms. Thus, the controlling function of the ego became inundated by id-motor acts. These had a definitely orgastic quality and left a subsequent emotional hangover feeling. Or else the ego finally resorted to the intermittently available compromise solution, the tic symptom.

Elmer was the only son, the second and late offspring of his parents, and his birth was eagerly anticipated. He had an unusually difficult childhood, however. Soon after his birth his mother became ill and he was left to the care of a nurse. In his second year he developed severe boils on his face and body, which were treated with poultices. At a time when the developmental freedom of the autonomous kinetic ego function was of utmost importance (locomotor and other skills), the baby was immobilized by pain and by medical treatment.

Due to boils on his buttocks his toilet training was delayed; he was eighteen months old when first put on the pot, which he detested, preferring to soil himself and to retain his fæces. He was given suppositories and enemas. From the age of eight months, he was supposed to be suffering from sinus trouble, and inhalation treatment relieved him, but in analysis it was discovered that the inhalations produced immense fears and sado-masochistic fantasies.

At the age of two, Elmer was placed in the exclusive care of a very energetic maid. With her he was well behaved and in general healthy. His bowel control improved, but he became very excitable. There were indications that he was seduced by excessive genital fondling during this period. When the maid left suddenly, Elmer started to masturbate. This and his polymorphic perverse impulsions at home and in relation to other children became so excessive that he was sent for psychiatric treatment at the age of four and a half years.

The treatment somewhat improved his autoerotic behavior. Acting out of the most objectionable impulses was reduced. Genital and especially anal masturbation was superseded by less objectionable diffuse muscular and vocal activities with a marked masturbatory quality.

It is not easy to place chronologically the crystallization of Elmer's general jerkiness and excited gesticulative motility into multiple intermittent tics. Volitional habits and grimacing were noted at a very early age. Eye blinking and occasional head turning of the torticollis type were noted by the psychiatrist before the age of five. Impulsive repetitious coprolalia was marked from four years on. From camp and school reports

it would appear that Elmer's true tics started as facial tics around the age of seven.

The camp, which he attended at the age of seven, reported: 'Elmer's noises are annoying the children. His excitement in being with the group at bed time is stimulating enough to have a destructive effect on the rest of the group. However, when he is out in space, the story is quite different. He is most constructive for a reasonable length of time. When he becomes fatigued he becomes excited and excessively dominating. His throat noises and facial contortions are still in evidence, particularly so before he goes to sleep.'

One of the findings of our current research project has been that the tic and other hyperkinesias, for example logorrhœa, increase before sleep. In the first stages of tic crystallization, there are initial nightmares, calling out to mother, talking while asleep, and in some cases even sleepwalking. When the ego is fatigued, the motor impulse becomes predominant. In sleep the censorship is loosened and motor release in action may result. On the other hand, both organic and functional tics always subside during sleep.

Another characteristic feature of this type of child tiqueur is poor physical coördination. In Elmer, according to the school report, this was conspicuous, and remained in striking contrast to his extraordinary skill in dramatization and manual work (observed from the beginning of his analysis till the end). The early restriction, imposed by sickness and pain upon Elmer's kinetic functions and performance coördination of the total body, led to a particularly high development and differentiation of normal manual compensatory skills and intellectual ego functions.[6]

To review our material, intermittent and permanent tics may be tentatively classified into three types.

[6] We might give a possible reason why children with a disposition to tic are commonly known as imitative and particularly talented in dramatics and otherwise. Is it not possible that in the common identification tendencies of childhood, because of the hypercathexis of the musculature, these individuals find themselves most successful when they can identify in the kinetic expressive field, whereas other children more readily identify with the ideational and perceptual qualities of their parents?

1. Tics resulting from a conflict between a vicariously used and therefore overtaxed affective motility and the claim for control. These tics, first manifested at a very early age in a conspicuous motor restlessness and hypermotility, are characterized by great interchangeability of the movements involved. They can be stopped voluntarily by the child for a period of time when outside pressures or the demands of the superego call for temporary control. Later, usually at the age of six or seven, the impulsions and 'tics' lose their volitional nature and their high reversibility potential through the catalyzing influence of the general powerful repression. This type of tiqueur never seems to enter latency.

2. Tics which seem to develop after the child has entered school and has made a fair adjustment. There is always, however, a preschool history of fidgetiness and immaturity in the sense of playfulness. An increase of instinctual tension by trauma (auto accident etc.) or a sudden heightening of a sense of guilt (Holy Communion, threat of the consequences of masturbation) are followed by volitional, so-called 'nervous habits', like blinking, picking the nose, or rolling on the stomach. These habits, which are accompanied by an anxiety state, are usually opposed by threats of corporal punishment or of other consequences—a pressure which facilitates the eruption of the impulse. The real tic, frequently coinciding with or followed by a general bodily jerkiness, appears a few weeks after the child has given up the autoerotic activities. The first manifestation is never of a permanent pattern. On the contrary, before long other tics appear as defenses or secondary elaborations of the first manifestation. (This seems to concur with the concept of the 'para-tics' described by Meige and Feindl.) The generalized jerkiness, darting about, and tossing are usually confused with the symptoms of chorea minor. The differential diagnosis between tic and chorea is indeed often very difficult. It sometimes happens that children known to have had multiple tics acquire rheumatic fever and chorea many years later (Wilson). We have seen in our follow-up study at least one case in which a child with severe recurrent chorea and rheumatic endocarditis finally ended up with gen-

eralized incapacitating tics of a gestural and vocal quality (paroxysms).

Another contrast between the first and second type of tiqueur may be mentioned. Whereas the children of the first type are often characterized by an abundance of expressive motility, the representatives of the second group are gravely inhibited in their voluntary expression so that it is sometimes very difficult to get them to talk or to initiate activity. In them, defense and fear of being overpowered by the impulse is uppermost.

3. Tics appearing in adolescents and in adults. These tics seem to have a more localized organ neurotic character and an obstinate local affinity to the eroticized organ, for which the tic muscle group in question is used as symbolization. Their psychodynamics is like that of traumatic neuroses. In all probability, they are those tics which Ferenczi described as single, and living a so-called parasitic life. They are isolated from the ego function and therefore very difficult to reach therapeutically.

The three categories of tics we have just described represent only a preliminary orientation. Like all other psychopathological phenomena, they usually overlap. All tiqueurs have definitely shown highly increased body narcissism as well as a tendency to hypochondriacal self-observation. It cannot be said at this point whether these are *post hoc* or *propter hoc* phenomena.

Clinical and statistical data prove the validity of Ferenczi's remark (in his paper on tics) that children in the latency period appear to be particularly susceptible to tic, chorea, and other motor symptoms. This observation is in complete agreement with our developmental and psychodynamic findings. They are verified by clinical and statistical data which show that the morbidity climax, that is to say, the age incidence of permanent tics is at six or seven, regardless of whether the tic belongs to the functional or to the organic type.

As to the question of a somatic basis for tic, which Freud brings up, our work up to date seems to convey the following: In all three types of tiqueur, overstimulation and fixation of

component impulses have occurred and the neuromuscular apparatus was vicariously or constitutionally hypercathected in infancy and early childhood. In addition, infantilization and absolutely or relatively increased and inconsistent restraint of the affective motor component of the ego's kinetic function was noted in the anamnesis in all three types, whereas simultaneously channeled performance motor function and compensatory ideational functions and skills were on the whole neglected. The kinetic function of the ego was especially damaged in those cases in which there was a lack of consistent and moderate general outside control to aid the development of the normal and balanced synthetic function of the ego. Due to the erotization of the neuromuscular system in these cases, motility lags in development and is not well synthetized.

According to Freud, hypercathexis, i.e., erotization of a system, renders it susceptible of becoming the organ of choice for the establishment of the neurotic conflict in its sphere. Hence, as the data presented above prove, this factor of somatic compliance accounts for Freud's remark: 'In the case of tics we seem to be dealing with something somatic', in that in these susceptible individuals motor symptoms serve the purpose of pathological solution of the conflict.

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CLINICAL ASPECTS OF DEPRESSION

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NONMELANCHOLIC DEPRESSIONS

In some types of neurotic depression [1] there is no overt sense of guilt: the patient makes no self-accusations, nor is he consciously aware of any desire for self-punishment. Briefly, these patients do not manifest symptoms which are generally held to be characteristic of melancholia. In some cases they even protest against their 'undeserved destiny'. However, since the recognized clinical picture of melancholia often develops gradually, a melancholic affection in its early stages may not display these characteristic features.

Sadness, grief, mourning and despondency constitute the usual and quite understandable reaction to the loss of beloved objects, to distressing occurrences and to disillusionments of various kinds. If an individual fails to react with such emotions to serious losses or unhappy experiences, he is not considered mentally healthy.

In some neurotic persons sadness, discouragement and affective inhibition may appear as a direct and understandable consequence of some other neurotic or bodily disturbance. Therefore we would consider as an 'essential' depression a depressive state which is itself the immediate and chief reason for the complaint and which is not secondary to another neurotic condition. On the other hand, we would call a depressive state that is consciously due to some other neurotic condition a 'symptomatic' depression. Our difficulty, however, in maintaining such a distinction is inherent in the fact that all cases of so-called essential depression reveal, during analysis, deep neurotic conditions which are its bases. Thus

[1] The author is well aware of the limitations of a paper which reports observations and analytical findings in circumscribed types of depression. Many psychoanalytic references which deal with the manifold mechanisms in the other varieties of depression are not even mentioned here.

such a distinction, if it is used at all, can refer only to the manifest complaints.

We sometimes meet a disillusionment in regard to the choice of the marital partner as a precipitating cause and conscious motive for a neurotic depression. In addition to such a disillusionment (which occurs perhaps more often in females than in males), a longing recurs for a formerly rejected or missed love object. This love object, for which the patient is yearning, very often reveals itself as a substitute for the parent or sibling of the opposite sex. These are symptomatic depressions or depressive states typical of certain neuroses.

The clinical picture of 'essential' depressions may vary greatly, but all cases have in common the libido-economic factor of a lack of interest in anything. It is significant that in the economic sphere we call the lack of spending money 'depression'. In dreams and neurotic expressions money and richness often stand for interest, libido, while poverty and beggars, in so far as they are related to the dreamer himself, indicate that some affective need, drive, instinct or inclination is neglected—and that the dreamer thus derives inadequate satisfaction chiefly because of an inner repressive factor. Money to spend means free libido, while feelings of being poor and fears of becoming poor are often related to the patient's perception of not having enough free libido.

Reduction of interest leads to inhibition of activity; the patient has to make a great effort to attend to his work. Although not every person who has little interest in anything suffers acutely, yet a lack of enjoyment is common to all such patients. The resultant indifference is reminiscent of the apathy of schizophrenia except for the coherent behavior, clear reasoning and absence of other known schizophrenic features. However, in some cases lack of interest in the external world and the inhibition of work or play are felt to be very distressing and even torturesome; such patients are very sad and gloomy, and often have crying spells. The degree of suffering is for the most part proportionate to the vividness of the ego feeling. Numbness of ego feeling prevents great subjective suffering and often appears as an additional feature of the

above-mentioned symptoms of depression. It may also occur in any other form of neurosis or psychosis.

Many years ago I obtained a clear insight into the reduced vitality of an ego from the analysis of a patient who did not seek treatment for a depressive state but for sexual impotence. He was a twenty-year-old boy who had never experienced a sexual orgasm despite very strong sexual desires, normal erections, and attraction to girls. He was unable to have an emission in waking life although he occasionally experienced it in dreams. Masturbation was meaningless to him because he could not experience even an approach to an orgasm or an emission. Due to the goal blindness of his sexual longings, this unbearably frustrating condition finally led to sexual repression and anxiety states. His family and his friends—not he—reported that he looked very depressed.

The main factor responsible for his sexual disturbance was a strong inhibition of urination which was acquired in childhood as a consequence of threats concerning enuresis. Before puberty the patient had begun to suffer from a functional spasm of the bladder sphincters. After many months of analysis he succeeded in experiencing for the first time in his life a conscious emission during intercourse with a girl, and on this occasion he had an extremely strong orgasm. This experience was, he said, a great revelation to him in that it at once reminded him of the sexual excitements of his early childhood. It is well known that sexual excitement or orgasm in both sexes frequently bears some relation to urination. In this case the ejaculation had a distinct and strong urethral character. The patient described it as an immensely pleasurable urge to urinate which could no longer be controlled. Indeed, as he approached orgasm he momentarily tried to withhold the ejaculation, which nevertheless occurred in spite of his initial attempt to prevent it. From that time on his urinary inhibition also disappeared.

Immediately after this experience the patient noticed with immense relief and enjoyment that he felt much more 'alive'. Every perception was more vivid: he heard and saw better, sounds and colors seemed clearer to him. Everything—people

and their conversation, cars and traffic sounds, street lamps, shop windows—conveyed to him deeper feeling tones. He lived more intensively in his enjoyment of the perception of the world around him. This joyful ego feeling was recognized to be incompatible with anxiety states.

Federn *(3, 4, 5)* found that the ego has a proper cathexis unity which is subjectively experienced as 'ego feeling'. The patient's ego had suddenly obtained a much stronger cathexis and his ego feeling was thus intensified. However, this vivid self-experience was not something new to him. He recognized at once, with sudden clear insight, that he had felt it in his earliest childhood.[2] When he was a little child, playing with his friends and sometimes satisfying his strong sexual curiosity with some little girl, he would become very excited but unable to find an outlet because of his inability to recognize a goal. After his first orgasm he felt exactly as vivacious as he had on the occasions when he accompanied his mother on shopping expeditions as a child. He realized that since childhood he had lost, imperceptibly but progressively, the vividness of psychic life. He had been half asleep and could more easily imagine himself dead, since he was in a sense already partly dead. Only retrospectively, after the reëxperience of the vivid infantile ego feeling, did he notice that he had lost this ability to enjoy life fully. His family and friends, who ignored the precipitating cause of his change, immediately noticed that he looked much more cheerful.

This is the only case in my experience of a *sudden* revivification of the ego feeling, of a return to a full ego cathexis. As Federn stated, every person undergoes more or less marked oscillations in the vividness of his self-experience. After some unexpected happy news, or the perception that our love object reciprocates our affection, and also after a deep, refreshing sleep, we may feel more vivacious. On the other hand, fatigue, or some distressing condition or situation, may depress us and make our ego feeling less intense. Such states are frequently exemplified in poetry and song.

[2] As I pointed out in a recent paper *(12)*, the reappearance of a strong affect or emotion of childhood reawakens the related ego feeling as well.

Inquiry into the feeling of many patients suffering from various neuroses revealed that simple depression is frequently accompanied by a numb ego feeling. Some describe their rapport with the external world by saying that they feel as if between them and the external world there lies an invisible isolating stratum which prevents them from feeling fully in contact with the world. However, in some cases of anxiety neurosis, compulsion neurosis, and in melancholia, the ego feeling may be intensified, a circumstance which causes the patient to suffer more acutely. Such patients often behave 'hysterically' during an anxiety or compulsive state because their subjective suffering is not stunned by the diminution of their ego feeling. In schizophrenia, where deep ego regressions are characteristic, we may find either extreme: a very low and numb ego feeling, or an intense, hypervivacious one.

In summarizing we should say that in cases of simple depression we are often confronted with a decrease in the intensity of the self-experience of the individual; he is less awake and the external world conveys to him a much less intense emotional meaning than it does to other persons. In general, his affective responses are weaker. This phenomenon has to be distinguished from a simple lack of interest, although it may lead to such a lack.

Cheerlessness, lack of interest, inhibitions due to such a lack, and a weak ego feeling are not the sole characteristics of simple depressive states. Very often they are complicated by a pessimistic affective attitude: despondency, the desire to die, pessimism and world-weariness.

Depressive states are frequently due to some strong fixation to a love object who, however, is rejected by the individual himself, so that a great amount of libido remains blocked and unavailable. From the libido-economic point of view we would describe this phenomenon as follows: a great amount of libido remains unconsciously attached to the mother, or to some other love object, or remains directed towards an unattainable goal. Because of some strong disillusionment, a frustrating waiting for some kind of gratification that never comes, the individual begins to devaluate that object or goal, as if he wanted to con-

vince himself of its uselessness as a source of enjoyment. The whole fixated libido exhausts itself in this lasting affective attitude of rejection of a love object or goal which cannot be relinquished. We then obtain the clinical picture of an essential depression—the patient shows no interest in anything.

I owe this economic conception to a reflection on a communication from Professor Freud concerning a twenty-seven-year-old man who came to me for analysis in 1920. In a later publication *(11)* I described him as follows: '. . . a case of simple depression without melancholic traits. The patient displayed apathy amounting almost to abulia; he took no interest in anything except, at most perhaps, his own paintings. At times he suffered from a torturing sense of ennui and he could make no effort to extricate himself from his situation. Analysis could not do much either because it was a matter of indifference to him whether it went on or not. Many an analytic hour passed without his opening his lips. As he himself put it, he was separated from the outside world by an impenetrable isolating layer. His powers of logical thought were of a very high order; he had a gift of rapid and penetrating comprehension and could grasp the most abstruse philosophical and epistemological problems. His speech was coherent. In short, he displayed none of the symptoms which characterize the schizophrenic's unsuccessful attempts to make contact with the outside world; no strongly cathected ideas of objects rose up in his mind . . .' This patient was listless, joyless and inert. He was not pessimistic but indifferent. He never experienced any sexual contact with a girl because he felt that sexuality was impure and unclean without, however, rationally endorsing this affective attitude. As a matter of fact, he liked a girl whom he idolized, but apparently she never perceived it. Although she was the only love object that could be detected, he spoke little about her. He occasionally indulged in masturbation but reacted each time with a greater depression; he felt more detached from the outside world and the isolating layer became thicker. In the summer, when he had an opportunity to take sun baths on the beach, the isolating layer dissolved, as though the sun's rays had dispersed the

mist which surrounded him, thereby purifying him. He had come to me simply because his mother wished him to and did not care whether he was analyzed or not. Nevertheless he had a positive affective attitude toward me and remained for many years in contact with me.

I wrote Professor Freud about this case. His reply bears the date April 4, 1921. Translated into English, it reads: 'From the . . . description of your case I can only understand that it can be considered a "simple depression". The affection is little studied; it should, however, be accessible to analysis. Keep trying patiently. I should say, as a surmise, that it is a matter of a simple fixation of high degree on the mother, whom he rejects from time to time, so that nothing then is left to him. The difficulty of your position lies certainly in the fact that he has to keep this relation secret before you as a man—a father substitute. Technically, it is done by his intentionally holding back some idea through which the analysis then comes to a standstill. Do not let yourself be dissuaded by any assurance on his part; it happens more often than we suspect . . .'

In an effort to make the direction in which his interest was blocked clear to him, I took advantage of every dream and association in which his mother attachment was indicated. He was discharged very much improved when the analysis again came to a standstill. Subsequently, he did not enter into an intimate relationship with any girl, but became more active and dedicated himself to his art.

People are often depressed and inhibited because they grew up in a 'psychic atmosphere of repression of feelings and emotions' in which they lost their ability to enjoy life. In the analyses of these patients we have to take special care in encouraging them to express their emotions, not only during the analytical sessions, but also in their ordinary life towards their fellow beings.

Such cases of depression are typified by female patients who are unable to relinquish their masculine claims and consequently devaluate life in general. If their masculinity complex finds an expression in a neurosis, as for instance in some compulsive symptom, then an ensuing depression appears as a

'symptomatic depression'. If, however, the depressive state is the most apparent symptom, we should be inclined to call it an essential depression, though also in these cases we may meet various symptoms of a hysterical or compulsive nature. In the course of analysis, patients of this group express marked discontent with their sex and deep resentment against the 'injustices' of men and related social institutions. However, in contrast to other clinical pictures, these depressed patients give up their competitive trends (their reappearance is usually an effect of analysis!) and take on the characteristic attitude of 'it is no use, I give up'. The psychic energy thus discharges itself inwardly while no great interest in anything is displayed outwardly.

The end goal of analytic treatment is of course not yet reached when the male patient fully realizes that he is attached to his mother, or the female patient that she is not satisfied with her sex. The much more difficult achievement consists in the detachment from unfit, immature, or unnatural objects or goals. However, these are general achievements for which we strive in every analysis, irrespective of the clinical picture. The male patient must develop a natural understanding and longing for a woman of his own generation, who is for him a very different love object than his mother; and the most infantile traits in his attachment for the 'mother-woman' have to be replaced by mature attitudes which can be satisfied in reality and will not be inevitably frustrated. In every case of neurosis in a female, especially in depression, the femininity must be freed and accepted by the patient if she is to make available the natural fields of libido and emotions, so that the depression and other related symptoms become dissipated.

In conclusion, one may say that the most manifold neurotic conflicts may be hidden behind the clinical picture of depression. The depressive state is largely due to a continuous process of rejection of some infantile love object or goal, chiefly as a defense measure against an unbearable state of frustration or anxiety. If the analyst interrupts the patient's rejection of the corresponding frustrating goal or object, then the depression may easily be substituted by another clinical picture—hys-

teria, compulsion neurosis, or even some psychotic affection —depending on the nature of the 'rejected situation' and on the development and constitution of the ego. Thus a depression is often a defense measure against some more serious psychic affection. From this it appears that one should be very cautious in the analytical approach to cases of depression.

MELANCHOLIC DEPRESSIONS

Abraham *(1, 2)* emphasized the importance of oral fixation in melancholia and depressions in general. Freud *(7)* showed that the melancholics, in common with the compulsion neurotics, have a strongly ambivalent attitude toward their love objects; that melancholics, having introjected (identified themselves with) a love object towards which they are ambivalent, become self-aggressive, their hatred of the object being turned into self-hatred, their aggressive reproaches against the object becoming self-accusations. Thus Freud classifies melancholia with the 'narcissistic neuroses'.

Regardless of the origin of the self-accusations and the self-hatred, melancholia is the clearest example of a narcissistic neurosis. The patient's narcissism is injured in the most obvious way: he has more or less lost the faculty to love himself; indeed, he hates himself. When an individual becomes aware of guilt or inferiority and then becomes depressed, he is not in the same state as when he is unable to love himself. His self-love is merely frustrated. An object love may undergo frustration in an analogous manner if the love object fails to correspond to our expectations. In the melancholic response to an equivalent injury the love object would be abandoned and/or hated.

The characteristic feature of melancholia is loss of self-love and the development of self-hatred, due, in the clinical picture, to feelings of guilt and inferiority, regardless of the origin of such feelings. Self-accusations may in some measure correspond to reality; they may contain at least some kernel of truth. I briefly mentioned such a case *(11)*, a thirty-four-year-old female patient who suffered from a severe melancholia

whom I analyzed for two and a half years with good results.[3] Although this patient behaved as a conscientious wife and mother, analysis revealed that her self-accusations contained some truth. Unconsciously she had not yet accepted her femininity and wanted to rob any man of his masculine attributes. She once dreamed that her husband came to her and then somehow vanished, but left her his penis. Her self-accusations contained both a reproach and a complaint: the reproach that she could not fully feel like a woman, the complaint that she was lacking the organ for certain feelings.

As a child this patient was intensely self-willed and envious of the masculinity of males. Later she seemed to have adapted herself to womanhood and to have called her sense of humor to her aid in dealing with her masculine complex. At times she tended to be slightly hypomanic (as a reactive mood) until suddenly, while still quite young, she became low-spirited and began to weep without a conscious reason. She had married a very understanding man with whom she was at first quite happy. She wanted a son but unfortunately for her she gave birth to three girls. This circumstance favored the outbreak of her melancholia in the following way: the patient's self-accusations show that she had adopted a strongly cathected social and ethical superego which demanded the proper feminine behavior from her. It is characteristic of melancholic patients that their ability to love themselves is more dependent on the consent of their superego than it is in other people. To be more exact, the narcissistic satisfaction of melancholics is obtained almost exclusively from the libido that the superego directs to the ego; self-love is achieved through superego channels. *In our patient the superego's claims that she accept her femininity did not however weaken her masculine trends, and thus robbed her at the same time of the ability to love herself.* If we correctly interpret the manifest self-accusations we

[3] The improvement was maintained after treatment, her condition remaining for several years far more satisfactory than it had ever been previously in the intervals of remission. While she had never been without relapses for more than one and a half years before she started analysis, I was able to keep track of her from the end of her analysis in 1931 until December, 1938.

shall realize that they were somewhat justified. Her guilt consisted in her refusal to accept her femininity, to be a woman and a mother; hence she could not feel like a proper woman and a proper mother. The hope for a son with whom she could have identified herself had lessened the emotional tension of her masculine wishes, but as this hope was frustrated by the birth of the third daughter these needs became overwhelming.

In our analytic practice we find melancholic manifestations in every kind of neurosis since many patients experience transitory melancholic states during the course of analytic treatment. The provocation for such reactions is often found in the patients' growing awareness of their own objectionable features.

Everybody has aggressive and antisocial drives which have manifold fates. Different drives, incompatible with each other, can be bound to determined ego states. Since different ego states ('integrative patterns'—Thomas French) can be alternatively cathected, the one excluding the other, a 'Dr. Jekyll and Mr. Hyde personality' may arise. Dr. Jekyll and Mr. Hyde correspond to two ego states, different and incompatible.

In every analysis we have to bring the patient's egotistical and cruel tendencies to consciousness. Every patient must become aware of his perversions, hypocrisies and rationalizations under cover of which he gives vent to the most selfish, ambitious and aggressive urges as he tries to satisfy various envies at the expense of the rights of his fellow men. The analyst must not, of course, become a moralist but must show the patient the actual effects of his behavior whenever his rationalizations prevent him from admitting them to himself. Whenever a patient takes analysis seriously and wants to gain a clear insight into himself in order to control his drives in accordance with some free but reasonable principles compatible with social life, he can be helped. In many cases the analysis may or should be combined with some prudent educational attitude on the part of the analyst. Such an educational attitude, in exploitation of the positive transference of the patient to the analyst, is sometimes indispensable in making up for the lack of such favorable influence in early life.

In melancholic episodes which are a reaction to the realization of those aspects of the personality which are antisocial, dishonest or egotistical, the patient's awareness of such traits (Jung would call them his 'shadow') is exaggerated. He may feel that he is a despicable person, an unworthy individual. This state may not yet be a melancholic depression but if he can no longer love himself then he manifests melancholic characteristics. Our analytic attitude will be different in each case.

During the analysis of the 'shadowy' traits of the patient his ego feeling has been concentrated on the objectionable, recently analyzed aspects of his ego, of which he has become fully aware. It is a common occurrence that psychic contents which arise freshly to consciousness, or those of which the patient becomes more aware than formerly, obtain, in a transitory way, a strong cathexis at the expense of the remaining elements of the conscious mind, thus occasionally causing slight, or sometimes even severe, melancholic-like reactions. In such cases some ego ideal or superego claim is also strongly cathected with ego feeling. The inability of the patient to reach an integration between his antisocial wishes and his moral standards causes an unevenness in his ego feeling (a tension), and since in these cases the self-love depends on the attitude of the superego, the patient begins to hate himself. This, then, is a melancholic depression. If a patient does not succeed in properly controlling his antisocial drives we generally welcome any feeling of uneasiness or depression with which he may react to the realization of his antisocial attitudes and for a certain time we leave him in a low-spirited or depressed mood. Only by so doing may we hope that he can achieve the ability to control these drives. Such a depression may be justified and constitutes the normal mental incentive for the development of a controlling power, of learning how to deal with all sorts of instinctual situations. Thus depression and feelings of guilt may have an objectively valid motivation. Only if the guilt reaction is exaggerated or especially if the patient displays signs of melancholia (self-hatred, lack of self-love) do we have to intervene.

In the first place we, as superego substitutes, must convey to the patient the feeling that we do not reject him but accept him as a whole, that is, with his bad features, while at the same time we attempt to show him his good points. Secondly, we try to make clear to him that every person has some antisocial attitudes, that perfection does not exist.

The patient's realization of the fact that he is covering some antisocial, selfish, overambitious, or instinctual, unfeeling behavior with rationalizations, makes it possible for him to learn to adopt a conscious and reasonable attitude towards such inclinations or to the deeds which he has actually committed. However, a person may often repeat misdeeds or crimes at irregular intervals so that we have to bring to consciousness the precise, unconscious motives which underlie the antisocial attitudes and behavior. Often only in this way can we forestall its repetition. If he fails to pay the necessary attention to such aspects of himself, he may be confronted with various and sometimes serious consequences in his later life. He may acquire a melancholic depression at some future time or he may be overwhelmed either suddenly or gradually by drives of which he was previously unaware.

There remain in every person a great many antisocial and unethical traits which are not fully integrated in the personality so as to avoid unevenness in the ego, and for which some individuals, whether they have become fully aware of this or not, may feel guilty and inferior. The stricter their superego, the greater the unevenness. Freud *(8)* describes the superego as a step *(Stufe)* in the ego. According to Federn's views this step is subjectively felt whenever there arises a tension between some conscious id demand and the opposing superego. The superego integrates several past ego states which have arisen by means of identification with the guiding and educating persons of childhood, these integrated ego states being distinguished from other ego states.

Another possible effect of the tension between the above-mentioned category of tendencies, on the one hand, and the ego ideal, superego and social demands, on the other, is projection. People who project because of this tension are not at all

tolerant of their fellows; on the contrary, they very often project just those qualities and tendencies which they do not want to see critically within themselves. This condition is reminiscent of some cases of mania which will be discussed shortly. In dreams, burglars and rascals, Negroes and Jews, often stand for such aspects of the dreamer himself, since society chooses targets for projection. We find an accurate analysis of such a projection in the excellent paper of Fritz Moellenhoff *(9)*, who explains how the Nazi Germans have found in the Jews the target for the projection of the worst attitudes and tendencies in themselves. It is very important to realize that projection does not make the individual better. It seems that its main function is the diversion of self-criticism and self-punishment. Thus the process of projection in such cases provides the superego with the needed targets for its aggression, while the ego itself feels free and uninhibited in unscrupulously indulging itself in all kinds of gratifications. In its aggression the ego is almost completely covered by (identical with) the superego. As a matter of fact, the superego feels itself highly moral in demanding morality from others and affiliating with those who are moral, but its immorality is very close to becoming conscious and therefore its judgments become aggressive, its condemnations even cruel.

In a paper published nearly twenty years ago *(10)* I made several statements regarding the interrelationships of melancholia, mania and paranoia. These statements were based solely on the classical freudian mechanism of melancholia—the patient's identification with the criticized or condemned love object. Since the melancholic is persecuted by his own superego, which is also derived from introjections, I distinguished a persecuting from a persecuted 'introject' (it was on this occasion that the term 'introject' was created). In melancholia both introjects are located in the patient himself so that he persecutes himself or, more correctly, one ego aspect persecutes another ego aspect. As stated above, in the melancholic individual self-love and self-hatred have become dependent on the attitude of the superego and the result of this inner persecution is self-destruction or inability of any part of the ego to love

itself. In their active rôle of loving and hating, ego and superego fuse together in melancholia, a fusion which is very resistant. This condition is clearly noted in the manic phase when the 'objectionable' introject (the passive one) is projected, while the ego completely assumes the active rôle of the superego because it no longer feels able to embrace the condemned attitudes. Indeed, the manic patient frequently persecutes and condemns other persons or groups of persons from ethical, social or pseudosocial points of view. Manic patients sometimes insult other persons, calling them rascals, thieves, betrayers and the like, while they concede all kinds of licenses to themselves. Thus, in the manic phase the dominating ego state is the superego state, while other, condemned ego states appear detached from the ego feeling and are projected onto other objects.

We may call this process a 'structural splitting': the ego aspects are split into two parts, the one subjectively felt as the proper ego (the self), the other projected. The ego cleavage occurs along the line of demarcation between 'id ego' and 'superego'. This is a clear example, among many others, showing how great a strain the superego formation imposes on the ego, which is often unable to stand it. Some identifications—acquired ego states—make the integration task of the ego very difficult indeed. In the manic-depressive psychosis the superego usurps the loving-hating rôle of the ego.

The melancholic frequently reproaches himself for deeds committed during a preceding manic phase. By means of the above-mentioned projection the patient succeeds, in the manic phase, in avoiding conscious mortification and conflict. But since this projection can be withdrawn, allowing such mortifications to become conscious, he is continually threatened by the possibility of melancholia. The manic patient tries to protect himself from the danger of becoming melancholic not only by feeling himself the policeman (superego), but also by projecting some of his own impulses onto other individuals.

Not every splitting of the ego into some of its different states occurs along structural lines of demarcation. In schizophrenia —in which all kinds of ego states are recathected, even those

incompatible with each other, largely because of regressions to former ego states which go back to earliest childhood—the split ego parts may belong indiscriminately to the id ego (impulses, drives, emotions, and so on) or to the superego (identification) constituents of the personality.

What is an apparent melancholic picture from the clinical standpoint may turn into a paranoiac one. Such a case is not true melancholia but a prodromal phase of paranoia. The ego does not cling strongly to the superego and it is the persecuting introject (the superego), not the persecuted one as in mania, which has been projected with the result that the patient feels himself the target of persecution. Prior to this projection the ego was obviously 'melancholic', a melancholic state, however, which is resolved in an opposite manner. Thus where the paranoiac succeeds in preserving his narcissistic position, the melancholic fails.

From all studies we learn how correct Freud is in his statement that the systems, introduced by him, of id, ego and superego can be maintained only in a dynamic sense and not in a topical one.

While I still maintain the concept of the 'persecuted' and 'persecuting' part of the personality, I would not classify the persecuted part simply as an 'introject', because it may or may not have arisen exclusively from an identification with another object. Often the identification with a love object—the mechanism discovered by Freud—whom the patient reproaches may only play the rôle of a precipitating additional factor in the outbreak of the melancholic condition.

The relationships of criminality, mania and paranoia to melancholia certainly deserve a thorough investigation which should take into account the ego structure of different personalities. The common criminal is actually persecuted by society, while the paranoiac has only the delusion of being persecuted and does not behave, at least consciously, in a criminal manner. The more paranoid a personality, the fewer are its possibilities of melancholia. The manic is the persecutor himself and indulges in objectionable deeds also without feeling persecuted.

All these clinical pictures show how difficult it is for many individuals to reach a suitable integration of their personality, how great the drive of the ego is to feel 'even', and what a variety of symptom pictures can result from an unsolved resolution between id, ego and superego tension in the ego. As a matter of fact, superego formations constitute imposed elements of the ego structure, restricting the naturalness of the personality.

A successful early analysis in which the dynamic factors explained in this paper are not neglected is the best preventive of a climacteric and presenile depression or melancholia, and also of criminality, when hormonal changes present the ego with too difficult a task of integration.

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PRODROMAL TRAUMATIC CYCLES IN ADULTHOOD

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It is at present held that psychoneuroses have three determinants: (1) a constitutional factor; (2) the infantile history and infantile traumata; (3) a possible adult trauma. Any physical or emotional shock contributing to the development of a neurosis is called a trauma. When such a shock occurs in adulthood and immediately precedes the outbreak of a neurosis, we call this shock an adult trauma.

The psychiatric conception of the pathogenic significance of this adult trauma has a varied and interesting history. At first it was assumed to be essential to the production of a neurosis. In the latter half of the nineteenth century, Charcot and the French psychiatrists attempted to explain its mode of action. According to them it gives rise to such sudden terror in the patient that he falls victim to it as he would to a hypnotic command; that is, the fright, once it has been experienced, acts upon the patient from within, like a command received under hypnosis. Moebius, to whom Breuer and Freud make reference, introduces a new factor which he claims to be just as important to the pathogenesis of hysteria as the hysterical constitution—a so-called hypnoid state.[1]

The nature of this hypnoid state is not clearly known. All that Moebius knows about it is that in this state the patient has no resistance and becomes the plaything of outward circumstances which act upon him. This hypnoid state can be brought about by hypnosis, by great physical debility, or by unusual emotional upheavals.

Breuer and Freud, in their publication of 1893, *Über den psychischen Mechanismus hysterischer Phänomene,* which marked the beginning of psychoanalysis, also came to the same conclusion. Two years later, in *Studien über Hysterie,* Breuer

Read in part before the New York Psychoanalytic Society on February 25, 1944.

[1] In his book published in 1890, *Über Astasie-Abasie.*

dealt particularly with the hypnoid states. He found their great significance in the fact that in such a state the patient is unable to abreact his emotions, so that relatively undisturbing ideas become pathogenic, and the whole ideational content, lost through amnesia, becomes inaccessible. Breuer includes many things under the name of 'hypnoid state'. Among them are not only the states preceding hysteria, but also those vague states belonging to the fully developed clinical picture which today we would be more apt to call 'Ganser's syndrome'. In addition he includes certain hypnotic, semihypnotic, and autohypnotic states, great emotional upheavals, rage, as well as mental states connected with a weakened physical condition. It will be noted that both the French schools and the literature discussed so far speak of these states only in conjunction with hysteria.

Although Freud does not mention the hypnoid state again in his later works, the concept is retained in the psychoanalytic literature by Simmel, who uses it in explaining the pathogenesis of the so-called traumatic and war neuroses. Freud, however, in spite of dropping the name 'hypnoid state', assigned a decisive importance to the existence of a state in which there is not time enough to prepare, by means of protective anxiety, for oncoming danger. Thus in analyzing traumatic situations stemming from danger and fright,[2] he gives first importance to the element of unforeseen shock or sudden fright not preceded by anxiety, and reiterates his previous view that hysterical neuroses differ from traumatic neuroses only in certain ego conflicts.

It is generally assumed that when there is an adult trauma present in the pathogenesis of a neurosis, the patient was struck by the trauma unexpectedly, like an accident, and that it is precisely this unexpected, accidental quality which gives the trauma its power because there is not enough time for protective preparation. In 1940, after several years of analytic study of psychoneuroses in which the onset of symptoms could be traced back to a particular adult trauma, I reported to

[2] Freud: *Beyond the Pleasure Principle.* Int. Psa. Press, 1922.

the Hungarian Psychoanalytic Society that in these patients, when the adult trauma was examined in the context of the patient's mental life, it was found to be neither accidental nor unexpected. Furthermore, the patient could often have avoided it but did not. I gained the impression that it was an occurrence to some extent both anticipated and brought about by the patient, and that it fitted into his personality like a piece of a mosaic. The patient seemed to strive systematically toward it. Moreover, in all these cases the patient met the trauma in a specific emotional state which is comparable to the hypnoid states and is essentially equivalent to a whirlpool of masochistic anxiety. There was no question of a trauma which overcomes a passive individual and disturbs the normal course of his life, but rather the trauma fits into an integrated series of events corresponding with the patient's personality.

Since 1940 the analyses of these patients have been completed and in the process yielded certain new material by means of which some seemingly contradictory impressions about the adult trauma may now be clarified. Brief summaries of the analyses of four of these psychoneuroses, in which the symptoms appeared suddenly in conjunction with a traumatic experience, will illustrate my arguments. Three of the four were cured, while one stopped his analysis when he was symptom free.

Case One is a young man of twenty-four who flirted with a married woman. Her husband gave him a beating on the street, after which he suddenly developed an anxiety hysteria.

His mental life preceding the trauma was characterized by an unresolved œdipus complex and a strong castration anxiety. He was very reserved, had never enjoyed coitus, and masturbated with fantasies of mother images.

The young man was a clerk. In his office a considerably older married woman tried with sly artfulness to start a flirtation with him. She finally got him to take her home in the evenings and promptly utilized this conquest to make her husband jealous.

The traumatic experience took place one evening as the

patient and the woman were leaving the office. The woman saw her husband on the other side of the street and called the young man's attention to his presence, saying, 'My husband is on the other side. He is spying on us, and he is sure to follow us, but don't let it worry you; he is such a coward, he would not dare to start anything with anyone but me.' The young man at first felt a mild anxiety, but soon terror overtook him and paralyzed his thinking until at last he could 'neither see nor hear', as he said, but was possessed by only one idea: 'in another moment he is going to beat me to death; the sooner he gets it over with, the better'. The world began to turn around him and a frightful figure struck him in the face several times. Blood rushed to his face and his vertigo increased. Afterward he retained only a few phrases of what the husband said, such as 'I'll teach you, you brat', and 'Aren't you ashamed, with a kid'. He did not remember how he got home or what he said at home. Next day the patient had an anxiety attack on the street. A few days later he could only go out when accompanied by his parents; still later he almost never left the house. Even at home he preferred to remain close to his parents.

A detailed interpretation of his agoraphobia and other symptoms is outside our present scope, but several interesting circumstances are worthy of attention. The patient did not mention the insult for a long time and recognized the connection between the agoraphobia and the trauma only after long analysis. When the details of the traumatic situation were exposed, it came to light that the trauma had not struck him as entirely unexpected and surprising. In reconstructing the event, it became evident that at least ten minutes had elapsed between the emergence of the pair from the office and their arrival at the street car stop where the husband finally crossed over to them from the other side of the street—ten minutes between the beginning of anxiety and the occurrence of the trauma.

The question could be raised whether the patient, as he unsuspectingly emerged from the door and noticed the husband, did not experience precisely that lack of preparatory

anxiety described by Freud. Perhaps what he remembered as anxiety, during those ten minutes before the trauma, was really terror. This question is answered to a certain extent by the fact that a great deal of preparatory anxiety preceded the event. The woman had often mentioned that her husband was jealous, suspicious and vengeful. These qualities, which were also characteristic of the patient's father, had disquieted and filled him with anxiety for some time—one might say they had reactivated and reinforced his castration anxiety.

In the patient's pretraumatic state there was already present a certain expectation which the patient defined as a 'kind of *pleasurable expectation*'. This had existed for weeks. The patient knew that he was 'playing with fire'. Hermann's comparison of these states to a whirlpool [3] is quite fitting. The beginnings of the flirtation and the relatively minor anxieties that came up in its course represent the slow initial turning at the edge of the whirlpool. As the anxious expectation grew day by day, the patient seemed to be awaiting some punishment. When he saw the husband from the doorway he was drawn into the crater of the pool, and tumbling dizzily into it, he was completely under the spell of the single idea, 'He'll beat me to death; the sooner it happens, the better'. The pretraumatic state, therefore, contained an element of expectation and the trauma itself one of gratification.

Needless to say other related masochistic tendencies were also present in this patient's personality.

The trauma was followed by a kind of latency period of eighteen to twenty hours. Then came the first symptoms which developed in a rapid crescendo. It may be assumed that during this latency period the connection was strengthened between trauma, castration anxiety, and repressed sense of guilt, while at the same time the phobia, whose aim was the avoidance of anxiety, began to form. This phobia increased turbulently during the next few days and one might say it carried the patient into a second whirlpool.

[3] Hermann, Imre: *A tudattalan és az ösztönöknek orvény elmélete. Dr. Ferenczi emlékkönyv,* Budapest, 1933. *(The Whirlpool Theory of the Unconscious and the Instincts.* In Memorial Volume for Dr. Ferenczi, Budapest, 1933.)

What, we might ask, was the connection which existed between trauma, castration anxiety, and repressed sense of guilt? The patient's analysis revealed his childhood hatred for his father accompanied by an intense sense of guilt and consequent castration anxiety. For example, when his father slept in the afternoon he felt anxious lest his father fall asleep forever. In his anxiety he used to fuss around in the room until he awakened his father, who then spanked him mercilessly for the disturbance, which aroused another anxiety—that of being beaten to death. After the spanking he would go into the bathroom, curse his father, cry, and bite his own knuckles. These fears formed an intermediate station between actual castration threats in his third or fourth year and the horror stories his mother told him at puberty. The point of these stories was that men who enjoy a sexual life are exploited by women, grow old before their time and become helpless invalids.

In time, by repression and under the compelling influence of reality, these threats lost their conscious force and virulence, only to continue unchanged in his unconscious. Finally a compromise was formed between conscious and unconscious to the effect that 'there is no castration for me as long as I will not have a sex life'. This state of equilibrium was upset by his response to the seductions of the woman in the office. His old, repressed anxiety was reactivated, and the beating afforded actual proof of his unconscious belief that one does get beaten to death, that there is such a thing as castration.

Thus a detailed analysis showed that the trauma was no accident which occurred incalculably and unexpectedly, but rather an event which fitted accurately into the continuity of the patient's mental life in each of its details. As supporting evidence of this assertion we have on the one hand many hours during which he enumerated all the possibilities of avoiding the assault, such as turning back, saying goodbye, going into a phone booth, catching a street car, running away, resisting the attack and finally, not starting the flirtation in the first place. On the other hand, it is questionable whether any other slap would have had the same effect on him, for

at this time he had frequent fights with his brothers, and suffered many rude blows during practical jokes which really struck him unexpectedly.

We can distinguish three cycles in the emotional state immediately preceding the illness: 1. The masochistic cycle, determined by the repressed sense of guilt, which began with the flirtation and culminated in the beating (first hypnoid state). 2. The latency period, lasting until the symptoms appeared, during which the trauma reactivated the castration anxiety. In this period the patient was quite dazed and stupefied (second hypnoid state). 3. The phobic cycle, in which the patient learned to avoid the castration anxiety by means of symptoms.

Case Two is a young girl of twenty-three who observed an erect penis and an ejaculation while she was being kissed, and developed conversion hysteria.

The mechanism in this case was very similar to that in the first. There was an apparently simple trauma which turned out to be part of a complex traumatic period.

The patient's presenting symptom was vomiting. She had been vomiting ever since a summer outing when a young man made love to her against her will and she observed his erection and ejaculation. She became disgusted, especially with the 'brutishness' of the young man's facial expression.

During the analysis an abundance of cunnilingus and fellatio fantasies came to light in the form of denials such as, 'I heard that such things exist but I don't believe them'. These fellatio fantasies led to an older, infantile fantasy complex: an egg is swallowed; then it goes to the stomach, from there to the kidney, and from there to the ovary, where it gorges itself with food. When it has become terribly fat the belly is cut open and the child is taken out. This is how one becomes 'independent of men'.

At the same time another related fantasy came to light: the male sex organ consists of a finger and an egg, plus some sort of spring or piston arrangement which enables it to stand up and move in and out.

When we become aware of yet another of her fantasies, that the penis is something enormous and shattering, we can understand her remark that she wants to be independent of men. She achieves independence thus: 'The penis is large and destructive, but there is no such thing. There is only a finger and an egg, but these are things which I myself possess. The finger satisfies me and the egg fecundates me. In other words, castration anxiety is groundless. There is no castration: I am complete in every way and capable of everything.'

Now let us turn back to the original problem: what kind of mental state preceded the onset of her symptom? At first she claimed that her vomiting came from 'an upset stomach'. Later she recalled the scene when the young man forced himself on her, kept kissing her against her will, while she observed his penis and ejaculation. At this point she remembered the astonishing fact that when this scene took place she had already been vomiting for three days. (This vomiting was not accompanied by pain, diarrhœa, or fever, nor was there any other evidence of food poisoning or gastrointestinal infection.) The patient realized that she had known that she was attractive to the boy. She had looked forward to the adventure of being alone with him. That is to say, the love scene and the young man's ardor were no surprise and not entirely frightening and undesirable. The erection and ejaculation and the boy's excitement were really both expected and desired. They represented a gratification to the patient who was full of complexes of loneliness and feelings of rejection and fantasies of orphanhood.

Thus we see that the trauma in this case too was no accidental occurrence, but an event which fitted well into the continuity of the patient's mental life and desires. Again it can be pointed out that if she had not gone on the outing where she knew that they would be alone, nothing would have happened. Again there was no question of surprise and terror in the sense indicated by Freud, because the patient felt anxiety even before the vomiting began. We may assume that at the first signs of the flirtation her castration anxiety appeared, and this she attempted to resolve by means of the symptom formation of vomiting. Then came the impact of the trauma which

brought to bear the compelling evidence of reality, namely, that the penis and ejaculation do exist. Thus was upset the state of balance which had prevailed between the fantasies and their denial.

As in the first case the patient was not conscious of the relationship of trauma and symptom. The analysis of the pretraumatic state did not come about until the later phases of the treatment. The emotional states immediately preceding and succeeding the symptoms can be divided into three cycles: 1. The cycle of anxiety beginning with the flirtation and culminating in the love scene, by which time the vomiting had already begun (first hypnoid state). 2. The immediate effect of the trauma. After the outing she was bedridden for two days and vomited constantly (second hypnoid state). 3. The cycle of symptoms, the stage of chronic vomiting.

In this case the traumatic experience overcame the patient in a weakened state (due to the vomiting). I stress this for two reasons. First, because the older literature mentions weakness due to hunger as a state predisposing to hysteria (this being one kind of hypnoid state), and secondly, because special physical weakness will play a part in the remaining two cases as well.

Case Three is a thirty-one-year-old man who supposedly contracted an infection on his penis without genital contact and developed a severe syphilophobic hypochondria.

This case best illustrates the complexity of the traumatic experience, as will be seen when we examine its background and try to isolate the trauma itself from the concomitant circumstances.

Analysis showed that the patient had a strong mother fixation. In spite of living with his wife and having marital intercourse, he found gratification only in masturbation.

The circumstances surrounding the trauma were as follows: just after recovery from a severe case of influenza, while taking a walk on his first day out (in other words, while in an abnormally weakened condition), he happened to meet a girl of his acquaintance who invited him up to her house. She eventually

attempted to unbutton his trousers but he evaded her and pushed her hand away. Afterwards he began to worry that even so she might have infected him and he gradually developed an anxiety state. He tried to relieve his anxiety by long continued masturbation and reassuring observations of his penis. After a week or ten days he succeeded in discovering a tiny red spot on his penis, which was probably due to the mechanical irritation of the excessive masturbation. When he found this he felt as though he would go mad and lay in bed for hours almost in a faint. After the first excitement the name of a certain dermatologist, who was notoriously a faker, occurred to him. As an insurance supervisor who was constantly in contact with physicians, he was in a position to know the dermatologist's exact status. Moreover, he had met this man in connection with a fraudulent case a short time before. Nevertheless he felt himself under a compulsion to consult this doctor. The doctor performed one of his notorious tricks. He made a scratch on the red spot, took a smear and prepared a slide without stain or dark field, and pretended to make a careful microscopic examination, inviting the patient to look and see it teeming with spirochætes. The excited patient did not look but readily accepted the offer of a ten day antisyphilitic cure for an exorbitant sum. Immediately after this visit his harassing symptoms set in with tempestuous force. He carried precautionary measures to the most fantastic absurdities, making a constant nuisance of himself to the people around him, driving his whole office staff to distraction, telephoning the doctor at all hours, and indulging in constant self-observation.

If we pose the question what, precisely, was the traumatic moment in this case (the girl's attempt to touch his penis, the discovery of the red spot, or the diagnosis), we become aware of the extremely involved structure of the traumatic experience.

With the pertinent material in mind, let us go back once more to the problem of the pretraumatic emotional state. At first this case seemed deceptively simple. It was very tempting to regard the traumatic experience as truly accidental, that

is, to accept the connection between the innocently contracted syphilis and the consequent syphilophobia as simple and obvious. And it was also tempting to regard the traumatic experience as nonexpected and terror inspiring. The facts, however, spoke otherwise.

The patient experienced anxiety immediately after his meeting with the girl. He was consciously afraid of infection as punishment because he was taught by his father that strange women are equivalent to infection and that all coitus was therefore to be avoided. The patient did not really believe the diagnosis of syphilis. This is indicated by the absurdly and ironically exaggerated precautionary measures and the impossible questions and suppositions with which he tormented the doctor. The infection and the phobia actually put him in a position in which he could not have relations with his wife (because he might infect her). This relieved him from the convention that respectable people must live a decent married life. It opened the way for numerous sadistic and masochistic fantasies, and in the guise of scrupulous caution against infecting himself and others, made it possible for him to annoy his superiors to his heart's content. Lastly, his hypochondria enabled him to assume an infantile narcissistic position in which he could be occupied with himself all day long and could compel his physicians and his whole environment to do the same.

Thus the same factors reappear: before the traumatic experience and to a certain extent while it was going on, the patient was in a weakened physical condition. Analysis showed that the traumatic experience was not purely accidental, but fitted into the pattern of the patient's mental life history. The patient partly looked for the trauma; one might say it came in handy for him; and the trauma again presented proof of a castration threat.

Here, too, there was a sequence in which three cycles can be distinguished: the first is a masochistic cycle, lasting from the visit with the girl to the diagnosis of syphilis (first hypnoid state). The second is the traumatic cycle in which he realized that the castration threat had come true and in which he was

in a near faint. Last is the phobic cycle in which the patient overcame his castration anxiety by means of symptoms.

Case Four is an engaged man of thirty-eight who was told by his fiancée that she had had several love affairs, whereupon he developed a paranoid state.

This patient was a surgeon who had been ill for a year and a half before he began analysis. He traced the beginning of his illness to a traumatic situation experienced during his engagement. He proposed to a girl, whom he had only seen twice, because her coolness and purity attracted him deeply. Her family was reputed 'to stand for the very ideal of honor'. Her father was an influential physician and the patient was himself the son of a physician. The day before the engagement was announced, when both had indulged in perhaps a little too much alcohol, the girl told him of her earlier love affairs, a revelation which shocked him deeply. She said that she was not a virgin, that she first had had an affair with a young doctor and successively with two older gentlemen. But that was all past; she loved him now and wanted to know whether he could disregard her past—yes or no. The effect of all this on the patient was beyond description. He became visibly so upset that next day the girl purposely made him intoxicated. He had asked for twenty-four hours to think it over but was unable to reach a decision either then or later until, again under the influence of alcohol, the girl seduced him. This had a quieting effect on him—he made his decision and they were soon married.

The period of calm was of short duration. Upon their return from the honeymoon he fell into a state which he called even more excruciating than the previous one. This state had two phases, a diurnal and a nocturnal one. By day he wanted practically every reasonably attractive woman who came his way and by night there took place a peculiar drama with his wife. He made her tell every detail of her love affairs over and over again, like a child listening to a fairy tale who will not have a single word of the familiar text omitted. This was followed by a coitus which brought the most complete gratifi-

cation. Next day he would again chase after strange women. Interwoven with all this was the constant, compulsive question: 'Shall I divorce her or not?'.

For a long time he filled his analytic hours with rationalizations of his complaints and symptoms. These rationalizations were mainly the following: due to his upbringing and the circumstances of his home life, he had been constrained to live in almost complete abstinence. His family was very puritanical; sexual things were never mentioned. Any manifestation of sexuality was countered with the saying, 'Nemesis will catch up with him'. The father was an old country doctor, completely dominated by his wife. Due to the mother's behavior the parents were not on speaking terms. The mother's cruelty had driven the patient's sister from home and had wrecked her life. The patient and his much older crippled brother were treated relatively well by their mother.

According to the patient this upbringing was sufficient to explain his reserved attitude toward sex. Moreover, he had had little time for it because, he said, he was so busy. He considered it quite understandable, therefore, that he should now want to make up for lost time and avenge himself on his wife. However, in analysis the father's image finally came into a very different light. He appeared as a strong, cruel, sadistic man whom women appreciated and because of whom the mother had driven her daughter from home. Suspicions also came to light: perhaps his parents had had sexual relations after all, in spite of their pretended enmity and puritanism. The father must have had relations with his daughter too, while the patient was left high and dry between the two women with no one but the crippled brother. In due time his latent homosexuality came to the surface.

Thus we see that the patient, unable to have either his mother or his sister, hit upon homosexuality as a way out of isolation. He expressed the homosexuality towards his father in his striving to be the 'ideal son', and towards his brother in the form of mutual exhibition. His castration anxiety was very strong, due in part to the threats about nemesis, in part to his witnessing his father's cruelties, and finally as a conse-

quence of his wish to be a woman and the father's favorite. A compromise took shape in him very early in life in the form of the fantasy that there are asexual beings. He would find and marry a 'woman of marble'. At sight of his wife he was consciously possessed by this idea: 'She is like the "marble woman" '.

The situation during the traumatic experience could be described as the marble woman tumbling from her pedestal—there is no asexual being. His castration anxiety attained reality in the form that this girl, too, had already been taken from him by others. His old suspicions proved well-grounded: the whole puritanical family life was a fake. Finally his latent homosexual jealousy flared up.

After his marriage the following reactions set in: a wish to 'befoul respectable families', and a playing of the rôle of his father by always keeping two women; he also heightened his castration anxiety by identifying himself with his wife while listening to the stories of her former affairs, then by performing coitus he convinced himself that he was not castrated.

This time the trauma was decidedly unexpected. It is true that the patient had unconscious fantasies (or suspicions) but we cannot assert, as we could in the other cases, that the patient himself reached out for the trauma. However, I do not believe that the girl's confession was the real trauma but that it took place later, when he married and lived with her, because this was a situation full of deep and unresolved conflicts. We are dealing with a personality driven by strong unconscious homosexual wishes who lived in almost complete sexual abstinence prior to his marriage and on whom the obligation of coitus and the constant nearness of a woman put too great a strain.

On the basis of these considerations, one can describe his emotional state prior to symptom formation in the following way: the girl's confession (that is to say, the first so-called traumatic experience) initiated a cycle of anxiety which was resolved in the premarital coitus (first hypnoid state). This was succeeded by the second, one might say chronic traumatic situation, the marriage, which, by way of the incestuous identi-

fication of wife-mother-sister, gave rise to an unresolvable castration anxiety (second hypnoid state). Symptom formation then took place as an attempt at averting this anxiety.

CONCLUSIONS

1. During the analysis of four psychoneuroses with acute onset, there emerged a definite relationship between the onset and a specific trauma.

2. These traumata did not occur unexpectedly, but could be fitted into the psychological continuity of the patient's history in which they were either consciously or unconsciously expected, prepared, or at least avoidable encounters. They were closely related to the patient's sexual life and were essentially castration threats or castration anxiety equivalents.

3. The traumatic period had a certain definite phasic regularity in which the onset and development of the neurosis did not proceed in a straight line but in cycles or whirlpools. Each of these whirlpools was usually followed by a period of latency which in turn ushered in another period of excitement. In my opinion these cycles correspond to those of Hermann's theory of emotional whirlpools. These phases may be designated as first and second hypnoid states in order to show their similarity to the descriptions in the older literature. In these cases I was unable to find a single, isolated, traumatic, pathogenic incident, but found instead a whole traumatic period.

4. These traumatic periods consist of vortices of anxiety in which the patient rushes compulsively towards the pit, which is the object of his castration fear, an actual sexual catastrophe. It seems a contradiction that the patient himself should strive in the direction of his fear, but this contradiction resolves itself when we consider the masochistic gratification involved, and also the fact that the objects of his anxieties and fears are not real but exist only in his fantasy and the patient wants to free himself from these fantasy fears. The pursuit of the trauma is therefore in part an attempt at self-healing by means of which the patient seeks to dispel the threat of a fantasy danger by testing it against the touchstone of reality.

Before the manifestation of their neuroses, these patients were in a state of false psychological equilibrium. This state of false balance was due to the synthetizing activity of the ego which brings about a compromise between 'yes' and 'no', between affirmation and denial. To illustrate with the first case: 'There is such a thing as castration but not for me because I do not live a sexual life'. In the self-healing trial they risk facing reality in the hope that the terrifying danger of castration will prove nonexistent after all. But the pathological, masochistic behavior of the patient brings about the failure of the self-healing attempt. As a result of this failure, the original painful castration fantasies emerge in a strengthened and more plausible form. The newly emerged and strengthened castration fears can only be handled by a manifest neurosis.

5. One phenomenon which has so far not been mentioned was observable in all four cases. They were all persons of a secretive nature who talked little about what really ailed them—so-called uncommunicative, reticent personalities. This is at present no more than an observation.

In comparing these findings with the data in the literature we see that the poor physical condition which is described in the older papers occurred in my patients as weakness in cases two and three and as alcoholic intoxication in case four. But it is my conviction that this has no essential causal, pathogenic significance. The same applies to the so-called amnesia. In place of amnesia it would be better to speak of a hazy recognition of events and their consequences.

In all four cases we had to deal with severe anxiety states in which the patient 'could neither see nor hear'. It may be that such symptoms were interpreted as 'poor physical condition' by earlier investigators. On the other hand we can not deny that when a person meets a real danger while in a poor physical condition, excessive amounts of anxiety appear and there results a pathological mental condition.

Finally, my experiences seem to be in direct contradiction to the so-called traumatic neuroses. Perhaps this contradiction is only apparent. For these patients pursued the danger in

order to convince themselves that the danger is nonexistent. In the traumatic neuroses the situation is different because in some of the traumatic neuroses the impact of the trauma is truly, genuinely unexpected, as a brick falling on one's head, or a madman shooting at one on a quiet street. Freud's concept of the anxiety-free and hence terror-producing traumatic state, fully applies to these, but only to these cases. However, it seems justifiable to distinguish a second group of the traumatic neuroses in which the accidental character of the trauma is not completely convincing. The war neuroses and those who have been in train wrecks would be in this group. For war itself implies that a soldier may be killed and a journey by rail may give rise to the feeling that there may be a wreck. It is therefore highly doubtful whether we have a right to assume the presence of a true anxiety-free condition in such cases. Actually Freud and most other writers concede the alteration of the ego *before* the impact of the trauma in the war neuroses, that is, long before the trauma, the synthetizing function of the ego has been disturbed. This synthetizing activity told the patient in peacetime that 'fatal dangers exist, but not for me because I avoid them'. War makes this function of the ego impossible. In wartime the trauma can become the agent which brings about a new equilibrium by means of a war neurosis. 'I am shell-shocked. Consequently war and death do not exist for me any more.' The literature actually bears out the supposition that the type of traumatic war neuroses which come about in this manner are much more severe and resistent to cure, while those peacetime (pretraumatic anxiety-free) cases which are the result of true accidents are of much shorter duration and more curable.

Another and perhaps the most essential difference between my cases and the so-called traumatic neuroses is that in my cases there was no danger to life itself, no danger of the annihilation of the entire personality, but rather a sexual catastrophe.

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Complementary Neurotic Reactions in Intimate Relationships

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COMPLEMENTARY NEUROTIC REACTIONS IN INTIMATE RELATIONSHIPS

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This paper is a study of the neurotic interreactions of individuals who are in frequent and intimate contact, and an attempt to evaluate the therapeutic necessity of analyzing these reactions in the course of psychoanalytic treatment. Such reactions fall into the following groups: 1. Partnerships in which mutual needs are satisfied although the unconscious strivings are essentially neurotic. Even under these circumstances minor conflicts lead to distress, but the main result is that of gratification and security. 2. Those in which the needs of one individual are satisfied and his anxiety kept at a minimum by the behavior of the other who, in turn, is satisfied only in part while many of his cravings remain unsatisfied and his anxiety is aroused. Thus one individual appears well, whereas the other is manifestly sick. 3. Others in which one individual is motivated by marked anxiety and the other evaluates this fear in terms of his own inner conflicts and reacts to it in a manner which immediately or potentially increases the anxiety of the first person.

Mutually supportive attitudes are always present in the relationship even when the anxiety arousing reactions dominate the picture. In *folie à deux* both reaction patterns are intense, in fact the two individuals are forced on each other's exclusive support by their feelings of helplessness and mutual guilt. Identification and projection dominate the resulting picture and the overt symptoms are then directed towards the rest of the world instead of towards each other.

Relationships of the types described may occur between parents and children, between business partners, employer and

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employee, between siblings *(2)* and between sexual partners. The psychological factors in many of these relationships were obviously significant in the original choice of a mate. In others, such as those between parent and child, or between siblings, the relationship was not one of choice. Neurotic circular interpersonal reactions are never absent in any well established neurosis.

In a paper based on the analysis of nine married couples, Oberndorf *(3, 4)* writes that in narcissistic individuals the idea of the possession of another person persists instead of giving way to the mutual participation inherent in adult love. Wishes of this kind stem from the longing for a parent-child relationship which is revived in the masturbation fantasies of adolescence and carried over into marriage. The narcissistic individual's need for acceptance is acutely exaggerated because of the limitation of his own capacity to give affection. While acceptance by the partner would seem to validate the esteem which the neurotic member has placed on himself, it essentially affords reassurance against his inferiorities, both physical and emotional. Expectations of the miraculous in marriage are doomed to partial disillusionment. Oberndorf concludes that intermarriage difficulties are caused by the emotional immaturity, incest wishes (and their taboo), and identifications with parents of the opposite sex—all inherent in the unresolved œdipus complex.

In the study presented here the complementary reactions were reconstructed from the analysis of one of the mates and from two to twenty interviews with the other mate. In all, fifteen couples were studied, thirteen of them married, two of them homosexual relationships.

The problems mentioned are illustrated by a series of incidents that occurred between homosexual partners *(5)*. A thirty-year-old artist prided himself on some accomplishments but felt that he had not achieved any of the important goals in his life and had difficulty in working towards them. The immediate reason for his seeking help was the suffering he felt in his relationship with his homosexual partner, a successful artist. From

the age of eighteen he was involved in a series of attachments to men, characterized by an overvaluation of their intelligence and strength and by an intense need of their approval. Each affair ended in his humiliation and rejection.

The present relationship followed a repetitive pattern. He felt a strong need for the company of his partner and went to visit him. For a while they got along well, complimenting and praising each other, until they had a sexual relation in which the partner took the dominant rôle. Then the partner began to talk of his dissatisfaction with homosexuality and his desire for relationships with women. This made the patient unhappy and anxious and he pleaded with his partner not to abandon him. The partner then acted in a superior manner or actually became harsh and abusive until the patient left in submissive misery. After a few days the same sequence of events would recur.

This cycle was a continuation of the kind of relationship which had existed between him and his dominant mother. In her handling of him she alternated between demonstrative affection and intimacy on the one hand, and domineering, peremptory, humiliating treatment on the other. He would be tender and resentful, obedient and rebellious, by turns. When he was resentful he would pack his suitcase and leave the house—his mother saying, 'All right go'—only to return in a short time shamefaced, frightened and submissive. When she was tender toward him, she would bathe him, pause at his genitals and say, 'We will call him John; this is a secret between us'. He slept with his father, a quiet, self-effacing individual, and touched his father's penis when the father was either sleeping or possibly pretending to be asleep.

In the patient's current affair, the scenes of pleading and parting became increasingly hectic. Shortly before Christmas, during one of these scenes, the partner threw a champagne glass against an expensive Venetian mirror. The patient correctly interpreted this as violence meant for him and left. He was utterly miserable during the next analytic hour. The analyst remarked to him that obviously his partner was treating

him cruelly, that in fact his constant reference to his desire for women was one way of torturing him. The effect of these comments was ultimately quite dramatic. The patient decided not to go to see the partner again. At Christmas he received a pair of expensive fur slippers from him as a gift with the note, 'You will need these to warm your cold feet'. The patient became enraged and started out to return them. Finding his partner out, he left the package with the note, 'Warm your own god-damned feet'. This was his first act of openly defiant self-assertion towards him. When the partner found this note he became so disturbed that he made a suicidal gesture by attempting to cut the blood vessels in his wrist. This led to a reconciliation and the partner started analysis with a separate analyst. They got along fairly well with each other for a while, the patient not tolerating sharp abuse and the partner somewhat restraining himself. The patient ultimately terminated the relationship and it seems probable that he will succeed in making a heterosexual adjustment.

This series of incidents illustrates the following points: 1. Both partners were obviously attempting to solve their conflicts and psychobiological needs through homosexual relationship. As will be shown later, heterosexual activity between marriage partners may also represent attempts at a solution of personality problems. Such relationships with all their misery and suffering fulfil vital needs for both participants as adequately as the partners are capable of at the time. Such a fulfilment was most evident during those phases when the partners praised each other's accomplishments and engaged in sexual relations.

2. The emotional pattern of the two individuals complemented each other in such a manner as to perpetuate their pathological reactions. Those of the patient were dependency and submissiveness. He had no insight into the intense anxiety, helplessness and guilt that the relationship was meant to allay. It later became evident that he felt threatened and humiliated by his dependent, submissive position and that it aroused intense resentment in him towards his partner. In fact, after

the initial satisfying phase, he would regularly humiliate and degrade his partner in subtle ways, particularly by reference to his intellectual superiority. The partner's anxiety, helplessness and guilt were no less intense despite the fact that he compensated for them—no doubt without insight—by a dominating, aggressive behavior. Although his need for affection was satisfied when the patient returned to him in a hang-dog manner, it seems that this very affection aroused his anxiety which was further intensified by the patient's subtle vengeance during the second phase of the relationship. When the partner hit back the patient became panic-stricken, was afraid of abandonment and bodily injury, and became submissive and pleading. This intensified the partner's aggressive desires which in turn increased the patient's submissive behavior. When the patient left, the situation ended in victory for the partner and submission for the patient.

It is to be noted that both partners followed an intrapsychic vicious circle of reactions *(6)* which they acted out in an external vicious circle. When, as a result of psychotherapy, the patient's behavior suddenly changed, the partner felt that he was now really being abandoned and punished for all his past aggression. He reacted by cutting his wrist, thus simultaneously punishing himself further and pleading for forgiveness in his desperate state.

3. The conflicts inherent in attempts to gain satisfaction by means of identification with the opposite sex—and the symbolic representation of this struggle—were quite striking. The patient attempted to obtain love and its attendant physical satisfaction through submission and at the price of self-castration. Having accomplished this, he immediately tried to recover his masculinity, in relation to the partner, by means of subtle attempts to castrate him. They felt hostile towards each other because of the humiliation they suffered at each other's hands in their passive feminine rôles. In the patient, submission and self-castration dominated; in the partner, hostility and the recovery of masculinity. The fur slippers and the note expressed contempt and aggression towards the patient's genitals. The

aggressor's subsequent cutting of his wrist was the punishment which exactly 'fitted the crime'.

In actual instances, the following complementary patterns between marriage partners may be found in combination. The nature and intensity of disturbances in genital function, and the relationship of childhood fixations to the dominant adult behavior, may both vary even though the complementary pattern is the same. Such genital disturbances and infantile background will be presented as were found to be most commonly associated with the dominant complementary patterns.

One such pattern between marriage partners is of a type similar to that described between the two homosexual partners. In view of the lengthy example given, this pattern will be described but briefly. One member is dominant, sadistic, out to humiliate and hurt the partner, and in this manner relieve his own anxiety aroused by the relationship. The other member is chiefly dependent, submissive and enduring. The wife or husband may play either rôle. Both rôles, as in the homosexual partners, are charged with conflicting trends leading to outward disturbances.

Another common pattern is that of an attempt at self-sufficiency through emotional detachment on the part of one partner (usually the man), and an intense, open demand for love on the part of the other (usually the woman). When the woman's violent demand for love and support arouses the man's fears, he becomes more detached while she evaluates this detachment as a humiliating rejection. Her guilt and fear of abandonment keep pace with the violence of her demand. Concomitantly, the man, who is warding off his desire for dependency and submission, becomes afraid of being completely dominated by these excessive demands for affection and defends himself by increasing his detachment. At the same time this detachment is an expression of his anger toward her, aroused by his interpretation of her resentment and criticism as a frustration of his own need to be loved. The complementary reactions are further overdetermined by the fact that both partners project the guilt arising from their mutually aggressive

attitudes and blame each other for their difficulties. Such a marriage often takes place under a complementary illusion. The woman, who is in search of a strong mate on whom she can lean, evaluates the man's detached calm as strength. The man evaluates the woman's vivaciousness, particularly if she has an occupation, as independence, and thinks that she will not make a demand on him for support and open affection. The first difficulties in the marriage often arise through the growing disillusionment in both parties in the sphere of genital satisfaction. At other times the marital difficulties are precipitated by external events.

A twenty-eight-year-old chemist tried to arrange his whole life in such a way as to maintain a calm, unruffled existence. The wife, aged twenty-five, was a kindergarten teacher who wanted warmth and affection. When they married, she thought him a strong, calm man, with an ingratiating sense of humor; he thought her feminine, charming but independent. The woman was partially frigid, the man had premature ejaculations and preferred masturbation to intercourse, but by and large the marriage was successful for four years. Then the man failed in his first attempt at an examination on which advancement in his job depended. In response to this failure he developed anxiety attacks during which he leaned heavily on his wife for support. The wife was helpful, but at the same time was disappointed and resentful that he did not prove to be the strong male on whom she had hoped to lean. After a while she wanted much more affection from him. However, partly because he felt humiliated for having leaned on her and partly as a reaction against his own submissive desires, he not only became detached but also became critical of her. The complementary pattern described above then followed, accompanied and heightened by ever increasing sexual difficulties.

This man was an only child with a domineering, oversolicitous mother. In addition, he was sickly and could not compete with his classmates who bullied him; this gave the mother a reason for babying him all the more until she was actively taking care of his physical needs. The patient's defen-

sive detachment, clearly evident in his late adolescence, was patterned on his father who was a calm individual and did not attempt to oppose the mother in any way.

The woman was the oldest of three siblings. Her father went through periods of depression when he would be quick-tempered and break furniture in the house. To this, of course, she reacted with fear of injury and abandonment, which was partly relieved by her mother's affection. Later, when she felt displaced by other siblings, her search for love to obtain relief from anxiety became an all absorbing interest.

Another type of complementary pattern between marriage partners consists of a mutual attempt at domination, coupled with a violent defense. In such situations the relationship is a stormy one: there may be as many as seven or eight major quarrels a day. Both partners are critical of each other, feel constantly insulted and humiliated, and without insight set out to humiliate each other. Both sides, of course, are in need of affection and their intense longing for dependency is either unconscious and results only in greater sensitiveness and readiness to feel humiliated, or it is not recognized in its full intensity and is presented as a frustrated genuine desire for affection. This raises the obvious question of why the mates remain together in such a situation. The answer is twofold: each wants to win a complete victory over the other at any cost, and each has strong dependency needs and is alarmed by the prospect of losing the other.

A woman physician, aged thirty-five, was emotional, tense and argumentative. Her attitude towards her husband, who was also a physician of the same age, alternated between moments of needing marked tenderness and moments when she wanted to outshine him. This was her second marriage. She admitted her desire for affection but considered it to be within healthy bounds and declared that her husband was cold because he was a weakling. When she wanted to outshine him, she was not aware of the fact that she wanted to humiliate him and surpass him, but acknowledged only the 'search for truth'. The husband wanted to maintain calm in all situations and

looked down on her emotionality. He would not admit any longing for dependency because he considered such a thing humiliating. He was ready to take offense—and would argue endlessly with his wife—both with and without provocation. At first he was reluctant to enter analytic treatment because he considered both himself and his wife emotionally well, even though his wife was already under treatment. Only after his continuous self-justification was pointed out to him did he agree to treatment.

Although their genital function was not grossly disturbed (as is often the case in this pattern), she was flirtatious with other men and this always initiated a quarrel. She also had dreams in which female figures were endowed with masculine characteristics. He had very occasional premature ejaculations, was never in the least attracted to any other woman and had dreams of 'men manipulating wires and switches' and his nearly being run over by trains. The couple either engaged in sexual relations after a quarrel, as a method of pacification, or the sexual relation was followed by a quarrel because sexuality represented being conquered, dominated and pushed into a female rôle.

Neurotic illness with a plea of helplessness on the part of one mate, and an attempt at extreme considerateness on the part of the other, creates another type of complementary pattern. The difficulty in such situations arises from a number of factors. The partner suffering from the frank neurosis expects omnipotence and perfection in the mate which is to be used to relieve the sick individual's suffering. He should always say and do the perfect thing. The ill individual is always disappointed in these expectations and expresses his unconscious resentment through depression and an exacerbation of symptoms. The considerate mate, on the other hand, is not considerate out of love alone, but is forced to be extremely patient because of a lack of self-confidence, while he is at the same time strengthened by the idea of helping a weaker individual. Ultimately, however, in spite of the self-imposition of endless restrictions on his activity—even though he tries everything—

he fails. The resultant loss of self-confidence, reinforced by an intuitive recognition of the ill person's criticism and disapproval inevitably leads to intense resentment.

The main symptoms of a woman, aged twenty-four, were depression, anxiety and a compulsion to pick her face for hours before a mirror. Her husband, aged twenty-nine, mild mannered and shy in company, was very patient in encouraging his wife when she was disheartened, in making decisions for her about the most trivial problems, and in helping her to stop picking her face at night and go to bed. She was completely frigid, both vaginally and clitorally. She was the youngest of four siblings. Her mother died when she was two years old and her stepmother never showed any affection for her but humiliated her. She frequently heard the sounds of sexual intimacies from her parents' bedroom. She also felt rejected by her father and on the rare occasions when he showed any tenderness toward her she was afraid that he would attack her sexually. Her hunger for love together with an utter helplessness in the face of rejection and fear of injury were the source of her longing for unlimited considerateness by an omnipotent individual.

The husband usually had difficulty in ejaculation, and occasionally, when she was too critical of him, in having a satisfactory erection. She blamed him for her sexual difficulty particularly when he manifested either of these symptoms. She was also disappointed because he 'did not have a brilliant mind' and because 'he did not understand her perfectly', since she had married him for his 'great tenderness and versatile mind'. Finally, she was utterly shattered if he showed the slightest impatience of her criticism. He brought her out of this state by endless considerateness, only to be criticized again by her if he was not 'as good at conversation' as some of their friends. His main satisfaction in the relationship was that of giving guidance and support to a helpless individual. It raised his self-esteem, eliminated his fear of a stronger woman, and gave him a feeling of masculine strength.

A more complex complementary reaction pattern is seen in

a syndrome consisting of periods of helplessness and suffering followed by periods of intense self-assertion on the part of one mate, and periods of shouldering responsibility followed by a disappointed desire for love and support on the part of the other.

A thirty-year-old woman, a very gifted laboratory worker, applied for treatment because of depressions of the hysterical type. Her husband, a thirty-five-year-old bacteriologist, suffered from headaches, nausea and a feeling of hopelessness when he encountered difficulties in his work. Whenever he was in such a state the wife considered it her duty to give him full support, and during such periods he appreciated the help he was given.

The events preceding the depression which brought her to treatment illustrate the complementary reaction pattern. The husband was going to leave the city for the summer to do some research and his wife was unable to accompany him. After having just gone through a particularly bad winter with one of his illnesses, she could not bear being left alone in the city without his affection and support. At the same time he refused her request to postpone the trip because, as he later said in an interview, 'this would have established a precedent for her to dominate my life and to be my master'. The wife did not give the reason for her request because she considered it humiliating; nor did he tell her why he would not stay because he considered his reason self-evident. After he left the city she felt resentful and became depressed. Upon his return she felt better for a while but then again became depressed. The pattern was obvious.

Therapeutic Considerations

If the complementary reactions are not of a serious nature, it will suffice to explain to the patient, on the basis of daily reactions, how his behavior is affecting the marriage partner and how he in turn reacts to the behavior of the marriage partner. Such interpretations should be given in every analysis of this type of illness because the patient's neurosis has one of its strongest points of anchorage in the marriage relationship. If

the patient's analysis is successful, the complementary reactions of the marriage partner often disappear without direct therapeutic measures.

If the partner's reactions are of greater severity, it is advisable for him as well to have at least weekly psychotherapeutic interviews, either during periods of severe stress to lessen anxiety, or when the patient's analysis has arrived at a point where it seems that progress will be slowed or altogether stopped unless the complementary reactions in the mate are also treated. If the complementary reactions are of great severity, that is if the mate has a serious neurosis of his own, the mate should also be analyzed *(7, 8)*.

An important question arises as to the point at which the complementary reactions can best be taken up during the course of the analysis. If the patient insists on putting all the blame for his difficulties on the mate early in the analysis, some discussion about the mate's behavior and the patient's reaction to it should immediately take place. It is impossible, however, to discuss the details and dynamics of the complementary reactions at this period. Before this can be done the patient's transference reactions and his unconscious childhood wishes must have been analyzed to a considerable extent. Further, the complementary reactions can be discussed extensively only when the patient no longer reacts to such interpretations as if they were criticisms, and as if the analyst were taking the mate's part against him.

Although the mate is customarily treated by another therapist, the transference problems are not insurmountable if both mates are treated by the same analyst. In fact Oberndorf *(3)* considers this the preferable arrangement. There is an advantage in the therapist's knowing the details of the reactions of both mates, but he must be careful to limit his activity to analytic interpretations and avoid taking sides or rendering judgment on the qualities of either mate.

In this study the author analyzed one member of each couple reported on, interviewed the mate some time in the course of the treatment at least twice and in some instances gave him

protracted weekly psychotherapeutic interviews. The analysis of the mate when necessary was always conducted by another analyst. In this series the intramarital difficulties were resolved in all instances without dissolution of the marriage.

Conclusions

Because of the continuous and intimate nature of marriage, every neurosis in a married person is strongly anchored in the marriage relationship. The presence of a complementary neurotic reaction in the marriage partner is an important aspect of the married patient's neurosis and of the psychoanalytic therapeutic problem. Some of these complementary reactions afford relief for the patient, others are of such a type as to perpetuate and renew his pathological reactions. It is a useful and at times indispensable therapeutic measure to concentrate the analytic discussion on these complementary patterns, and if necessary to have both mates treated.

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Psychosomatic Diagnosis. By Flanders Dunbar. New York: Paul B. Hoeber, Inc., 1943. 741 pp.

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BOOK REVIEWS

PSYCHOSOMATIC DIAGNOSIS. By Flanders Dunbar. New York: Paul B. Hoeber, Inc., 1943. 741 pp.

This 'textbook in embryo', as the author calls it, reviews a twelve year period of study which was carried on under grants from the Josiah Macy, Jr. Foundation, through the Departments of Medicine, Surgery, and Psychiatry of the Columbia University College of Physicians and Surgeons. The Introduction presents statistics on the lengthening life-span and the consequent shift from the medicine of acute disease to that of chronic disease in which neurotic factors play a disproportionately larger rôle. These statistics indicate the need for corresponding changes in the emphasis in medical education.

The first chapter deals with the psychosomatic history, the second with special techniques of examination to supplement the psychosomatic history, the third with a general review of hospital admissions during the study. These chapters demonstrate that many clinical errors can be corrected by adequate history procedures alone (pp. 19–20). On pages 28 *et seq.*, the nature of an adequate psychosomatic history is made clear, the level which it should strive to reach, and the circumstances under which unconscious material must be probed and where it can be held in abeyance. The psychosomatic history is never focussed exclusively on symptoms, environment, or history. Specifically it must describe a process of inner evolution, to wit, the evolution of chronic conflicts, the repressed components of the personality, the patterns of discharge of this repressed source of energy through organ systems or through behavior, and finally the patient's methods of defense against anxiety and other repressed emotions. Indeed, every medical and surgical anamnesis should bring out in this way the patient's *preparation for illness* (p. 39), through the influence of constitutional, physiological, and experiential factors (summarized in what the author calls the 'Psychosomatic Profile [*vide infra*]). The anamnestic procedures which medical students learn are far from this.

The author demonstrates well the limitations and fallacies of the question-answer method of history taking, and (pp. 48 to 100)

the advantages of using free associations (approximately modified) in attempting to establish correlations between unconscious conflicts and 'somatic short circuits'. On pages 88 to 93 there is a particularly good example of a condensed yet complete anamnesis, which brings together both conscious and unconscious material.

These introductory chapters labor under the difficulty of having been written for three audiences: advanced medical students and house officers, medical educators and hospital administrators, and finally the experienced practitioner who has long felt the need for just such a guide. To address the same material to three such different audiences leads inevitably to a certain amount of confusion. Yet the deficiencies of these chapters measure those of our medical education. To bring up generations of medical students with no knowledge of the laws of unconscious psychodynamics is equivalent to teaching physiology without chemistry, or pathology without microscopy. Not within the limits of this volume, nor in several more, could the author fill this gap in the education of her readers. We must look forward to a future in which the authors of such texts can take for granted that general familiarity with the basic principles of unconscious psychological processes which is essential for a mature approach to their subject.

Chapters IV through X consist of a systematic presentation of the *psychosomatic profiles* which the author and her co-workers have found in fractures, in various types of cardiovascular disease, in rheumatic disease, in cardiac arrhythmias, in recurrent decompensation, and in diabetes.

During the first years of the investigation only those cases were studied which were referred to the psychiatrist by other services. Thereafter, because such samples are atypical, serial admissions were studied of each disease under investigation. This is a unique and invaluable aspect of the material of this report. In all, 1,600 patients were studied, of which 1,128 were serial admissions between 1934 and 1938. For many reasons, however, not every patient could be explored in detail. Therefore in the end the records of 565 patients form the basis of the study, i.e. 322 cardiovascular, 92 diabetics, and 151 fractures. The diabetic and fracture groups are statistically adequate samples. The cardiovascular group, however, is subdivided into eight subgroups, among which the numerical distribution and statistical adequacy is not clearly indicated. (The author states, however, that the impression derived from

these serial admissions was confirmed in a later study of additional serial admissions, and that many details were confirmed in charts which, taken as a whole, had to be excluded as unsuitable because of other deficiencies (cf. p. 166 to end of first paragraph on p. 168).

In the chapter on contrasting profiles, the author stresses (p. 542) the fact that under the first four headings, the group statistics are nonspecific, whereas the last six headings and the final dynamic formulation constitute a description of psychological processes and mechanisms which seem to have some measure of specificity for each syndrome in from 80 per cent to 100 per cent, while occurring in less than 15 per cent of patients suffering from any other syndrome. Such findings are of definitive significance for the three numerically larger groups (diabetics, fractures and rheumatic disease), but are of less certain significance for the numerically smaller subgroups of the cardiovascular syndrome. However, the cardiovascular groups have a family resemblance and when taken together form the largest single group of cases studied. This is a statistically adequate sample. Therefore irrespective of the final status of these studies, they constitute a stimulus for immediate specific research. Psychosomatic investigation of the processes of disease should focus sharply on comparing patients with typical and with atypical profiles within each disease group.

The fracture group was studied on the assumption that it would serve as a normal control. It soon became apparent, however, that because of the accident habit, fracture cases could not serve as 'normal' controls. Much of this material has been described in previous reports and it need not be summarized here. We will attempt only to estimate the values and the limitations of the method which has been used in formulating the psychosomatic profiles.

Out of the material of this volume, the profiles will be the main subject of general interest, criticism, and future research. It should be borne in mind, therefore, that the author does not attempt here to give in detail the statistical evidence for every point in each profile. She explains and describes them, but does not try to prove them. Efforts at proof would have cluttered the book with hundreds of pages of statistical analyses, which would have been of no value at this stage in the development of the underlying concepts. Case histories have been selected which illustrate the full range of variations in the profiles but the author finds it

possible to characterize the typical representative of each group in simple terms.

Thus, on page 575 she writes: 'The *accident-prone* patient says: "I always have to keep working. I can't stand around doing nothing. When I get mad, I don't say anything, I do something. I act before I think."

'The *hypertensive* patient says: "I always have to say 'yes.' I don't know why. I am always furious afterwards"; or "I'm angry but I never like to fight—I don't know why—something must have happened once. . . . Argument is my long suit. I could argue all day long."

'The *coronary* patient says: "I have worked hard all my life. I always have to keep on working. I have to be the boss."

'The *anginal* patient says: "I've always been ambitious, trying to succeed. When something happens I feel it in my heart."

'The patient with *rheumatic fever* says: "Everything I do hurts, but I have to keep on moving."

'The patient with *rheumatic heart disease* says: "I have such terrible dreams." Or "I guess I was born to be a martyr."

'The patient with *cardiac arrhythmia* says: "I wanted to amount to something, but I guess I am destined to be a failure. I am afraid of people. I am happiest in imagining things."

'The patient with *diabetes* says: "Doctor, it's terrible. I don't know what I might do. I'm constantly on the verge of hurting somebody or injuring myself, you've got to help me, I'm not responsible for myself, I can't decide things." '

Taking her lead from Alvarez's *mot* that the patient with a gastric ulcer is a 'go-getter', the author on pages 577 and 578 attempts a series of pithy epigrammatic characterizations. She describes the accident habit as occurring among the 'hobo' type, coronary occlusion and hypertensive cardiovascular disease among the 'top dogs' and the 'would-be-top-dogs', the anginal syndrome among the 'prima donnas' or the 'big frogs in small puddles', rheumatic fever and rheumatic heart disease among 'teacher's pets' and 'martyrs', cardiac arrhythmia in 'children in the dark' and diabetes in the 'muddlers'.

In formulating the profiles, it has been her working hypothesis that the forces which determine the organization of the personality not only determine behavior but also the paths along which 'psychic energy' derived from repressed conflicts may achieve some measure of discharge through various organs (p. 656). The profiles must

therefore include ontogeny and phylogeny both on the organic and on the psychological levels of experience.

There are two parts to each profile. The first consists of 'Group Statistics', i.e., a summary of the statistical incidence of certain facts in each group as a whole. This includes many facts which are omitted from the usual medical, surgical or even psychiatric histories. The group statistics are presented under four major categories: (1) family histories, (2) personal data, (3) sickness records, (4) injury records.

Under *family history* is included not only the average incidence in forebears and collaterals, of accidents, illnesses and deaths, but also the patient's exposure to these as psychological experiences through their occurrence in friends as well, the average ages at the time of such experiences, etc. In other words, 'family history' as used here goes beyond a restricted heredity to include that subtle pseudo-heredity which is the psychological result of exposure to illnesses, accidents, and deaths in others.

These observations can be presented in the following statistical table, culled from the contrasting profiles (pp. 582 *et seq.*):

Incidence (% age)	Fractures	Coronary Disease	Hypertensive Cardio Vasc.	Anginal	Rheum. Fever & Arth.	Rheum. Heart	Cardiac Arrhyth.	Diabetes
of Accidents in parents and sibs.	40%	9%	10%	6%	10%	8%	18%	9%
of Exposure to Accidents in others	46%							
of Cardio Vasc. dis. in parents and sibs.	36%	42%	49%	65%	52%	44%	44%	26%
of Exposure to same or to sudden death	sl.	90%	98%	77%	60%	70%	65%	100%*
of extreme nervousness			75%	24%	35%	36%	56%	35%
of diabetes			19%			20%		35%

* i.e., exposure to one or more of these illnesses.

On page 543 the author points out

'that in no group was there a family history of the illness in question in more than 52 per cent of the cases, although in nearly all groups a history of exposure to the illness in question, including not only living relatives but friends or spouse, occurred at a much higher percentage. Second, family history of the illness in question was just about as high

in the fracture group, where a physical hereditary factor was least likely, as it was in the groups with cardiovascular disease. This was true in spite of the fact that the incidence of accidents in the general population is less than the incidence of cardiovascular disease, and consequently a given person would be more likely to have a cardiovascular than accident heredity, if the distribution were a chance one. Furthermore, apparent heredity of cardiovascular disease was just as high in the cardiac arrhythmia group where no organic basis was found, as it was in the group with coronary occlusion or hypertensive cardiovascular disease. Third, the exposure factor as distinguished from the hereditary, was highest in the groups with serious cardiac damage, being well over 90 per cent for the groups with hypertensive cardiovascular and coronary disease, much lower in the anginal and cardiac arrhythmia groups, and particularly absent in the fracture group in spite of their equivalent cardiovascular heredity. If we consider a high incidence in the family history of the syndrome from which a patient suffers as indicative of heredity, fractures would be the most hereditary of all syndromes. Whereas a family history of cardiovascular disease is more or less equally distributed among all the groups, accident history in the family is concentrated in the fracture group. Since we are not inclined to consider accidents as hereditary, we would attempt to explain this apparent heredity in terms of exposure. This point may further emphasize the importance of the exposure factor in the cardiovascular groups.

'One might infer from these data that the evidence concerning heredity in these diseases was completely inconclusive, tending neither to indicate a heredity predisposition nor to disprove it. They do strongly suggest, however, that there is a correlation between *exposure* to a specific illness and susceptibility to that illness, except in the case of accidents. This evidence is so strong that if the diseases were of a kind thought to be contagious, we should be justified in looking for a microbe or virus as a causative agent.'

Under *personal data* is included the general nature and quality of the parents and siblings in each group, and the type of interrelationships which tend to exist between them as evidenced by the marriage and divorce rates, the average family size, and the type of work and play ambitions. Finally the *group incidence of illnesses and accidents,* and their characteristic nature, constitute the third and fourth headings of the group statistics.

This part of the profile thus gives a picture of the statistical expectancy of a variety of factors in each disease group as a whole, making it possible to say to what extent any particular patient conforms to a group norm or deviates from it. The summarizing tables (pp. 582–593) indicate that in these group statistics there are wide areas of overlap. Nevertheless, such basic categories are

of considerable interest, both sociologically and from a teaching point of view. Furthermore, on the basis of deviations from the group norm, it has sometimes been possible for the author and her co-workers to anticipate the development of complications in the course of a patient's illness; and similarly, patients who suffer from mixed or overlapping syndromes (about 20 per cent of the patients studied) frequently reflect this in their group statistics.

The second major division of the profiles consists of subtler individual data. Because such material is subjective, it is more difficult to reproduce, to validate with objective evidence, or to subject to critical checks. The major headings of the individual profiles are (5) General Adjustment, (6) Characteristic Behavior Patterns, (7) Neurotic Traits, (8) Addictions and Interests, (9) Life Situation Immediately Prior to Onset, (10) Reactions to Illness, (11) Area of Focal Conflict and Characteristic Reactions.

General Adjustment summarizes its basic data under six subheadings: (a) education (records, aptitudes and limitations, achievements, special interests, interruptions and reasons for interruptions); (b) work records (types of jobs, quality of work, steadiness of work, changeability), (c) general income and vocational level; (d) quality of social relationships (shy or confident, timid or aggressive, self-effacing or exhibitionistic, emotionally withdrawn or responsive, active or passive, consistent or flighty, etc., etc.).

For the physician who is not trained in the evaluation of material of this kind, these will seem to be the most vulnerable elements in the profiles. He will feel that although the cases which are described tend to bear out the author's descriptions, since these naturally had to be chosen to illustrate the thesis, they cannot be used as evidence for it. Methodologically the criticism may also be made that it is not always clearly indicated as to just how these subtle character traits are determined and what facts are used to establish them. We may hope that in future editions this defect will be remedied.

The other subheadings under *General Adjustment* are: (e) Sexual Adjustment (including not merely the facts of the psychosexual history, but also the fears and fantasies which cluster around sex, the incidence of venereal infection, the attitudes towards pregnancy and childbirth, and the irradiation of these attitudes into all matters having to do with family formation.), As a textbook the volume needs an additional section devoted to the special

problems and techniques of gathering a psychosexual history. The author's own comments indicate that she recognizes this need.

The last subheading is: (f) a summary of the attitudes towards the family. Since family attitudes are both a source of other attitudes and often a product of them as well, they constitute a field in which it is especially difficult to avoid circular reasoning. It is important therefore to provide students with a particularly clear guide to their evaluation.

The next major heading of the profile (6) is called *Characteristic Behavior Pattern.* The descriptive summaries which appear under this heading indicate that the author has in mind the patterns by which the individual achieves a sense of security and reassurance, that is, whether it is by pursuing immediate or distant goals, through ties of human affection or through power, through being in positions of subordination or of authority, through bodily activity, verbalization or the processes of thought and feeling, through taking or avoiding risks, through investing emotions in animate objects or in actions, ideas, dreams, or fantasy, etc.

Five subsequent headings are designed to indicate how the individual's adjustment to internal and external stresses may have broken down. Of these, the first (7) is the incidence of neurotic traits from early infancy onward, and their specific nature. Next (8) comes a summary of addictions and special interests, then (9) a summary of the specific life situation which immediately preceded the onset of the current illness, and (10) the reactions to illness. Finally, (11) there is an effort to boil everything down to a brief summary of the nuclear conflicts from which the major psychic energy seems to derive, and the characteristic reactions to these conflicts.

The profile is thus an inclusive empirical description, in which the appreciation of the rôle of unconscious mechanisms is always implicit and often explicit. Because this is a foreign language to the ordinary physician, the author restricts her consideration of unconscious forces. This sometimes keeps the discussion of psychodynamics on a somewhat superficial plane. For instance, in the discussion of the fracture group, it is clear that the author's characterization of the group proves, by implication, the basic psychoanalytic thesis of unconscious determinism in human affairs. At the same time the cases described make it evident that a fracture

can serve a wide variety of purposes, conscious, preconscious, and unconscious, and that in general the unconscious determinants will tend to show the least variation from one patient to another, the conscious the greatest, with the preconscious perhaps coming between. Similarly, their relationship to the hysterical conversion process calls for elucidation. A full presentation of such issues, with illustrative material, would considerably sharpen the focus of the profiles and enable them to shed light on our maturing conceptions of psychodynamics. Such a discussion, however, would not be possible without a preliminary reëducation of a considerable portion of the audience to which the book is addressed.

That the importance of unconscious mechanisms was always in the author's mind becomes evident from the index as well as the text. What other medical textbook, not specifically psychiatric or psychoanalytic, contains references to such forces in human life as infantile fantasies, reactions to authority, defense against anxiety, conscious and unconscious homosexuality, masochism, all manner of sexual maladjustments, unconscious death wishes, transference forces, and the like? This by itself constitutes a significant innovation. The analyst will regret the absence of adequate consideration of many other psychodynamic forces, such as fixation, historical and topographical regression, the processes of symbolization, loving and hostile identifications, the contrasts between conscious and unconscious guilt and anxiety, etc. This again is a price paid for the unsatisfactory status of medical education in the field of psychopathology. In spite of these unavoidable omissions, the volume brings to the analyst many important contributions, as for instance the table on page 259 which presents vital statistics which are invaluable to psychoanalysts in the study of individual life data.

To this reviewer the least satisfactory sections of the book are the two last chapters. The considerations of theory and of classification seem to be too general and to concede too much. Nor is therapy treated adequately. Transference forces, although mentioned, are inadequately illustrated and evaluated. Possibly some of this impression comes from the separation of the sections of major interest to the psychoanalyst from the sections dealing with objective case history material. In the earlier section, therapeutic results seem to be ascribed to history-taking or relaxation technique, where it would seem clear from the context that transference forces

and various types of deep or superficial catharsis may have played the significant rôle (cf. p. 470). However, this criticism should not in fairness be overstressed since the author herself calls attention to the point; but one may hope that in a later edition of the volume fuller advantage will be taken of the opportunity provided by the material to present a more rounded picture of the psychotherapeutic process.

The reviewer does not feel competent to evaluate the contributions of the Rorschach to the study. This is the most recent aspect of the author's studies and it is possible that had it not been for the current flood-tide of interest in Rorschach procedures through which we are passing, this might have been reserved for a more deliberate evaluation at a later time.

Finally, in spite of any limitations which have been mentioned, one closes the volume with a sense of being present at the birth of a long awaited era in medicine. There can be little doubt of the difference that the volume will help to make in the future of medical science. This 'textbook in embryo' may well turn out to be a significant milestone in medical education, in hospital procedure, and in medical practice. It should be a *vade mecum* for every medical student and for every physician.

LAWRENCE S. KUBIE (NEW YORK)

HUMAN CONSTITUTION IN CLINICAL MEDICINE. By George Draper, C. W. Dupertuis, J. L. Caughey, Jr. New York: Paul B. Hoeber, Inc. 1944. 273 pp.

This volume is addressed to medical students. Its purpose is to persuade the student to think of disease processes as arising out of the whole physiological and psychological life of a human being. In keeping with this purpose it presents a general philosophical point of view, a chapter on history-taking or 'clinical biography', a discussion of genetics, heredity and growth, a review of certain aspects of morphological typology, a discussion of constitutional physiology with some clinical applications, and finally again, a philosophical conclusion.

Such an outline, adequately developed, would include almost all of scientific medicine. It is therefore not surprising that these various subjects receive uneven consideration. Morphology receives some seventy pages; heredity, forty; physiology, thirty. This, of course, is a measure neither of their relative importance,

nor of the ease with which the material can be condensed for brief presentation. It is rather a natural reflection of the authors' special interests and first-hand knowledge. As a consequence, however, neither the chapters on genetics and growth (IV and V), nor those on constitutional physiology (X and XI), meet the needs of the student to whom the book is addressed.

In the chapters on genetics, heredity and growth, most of the cases which are chosen to exemplify the authors' thesis (e.g., case 4, p. 33; case 5, p. 35) tend to be exceptional and extreme. The fact that an occasional patient with arteriosclerosis has a large number of forebears and collaterals who suffered from cerebral vascular disease throws no light on the question what rôle heredity plays in the average case of vascular disease. The authors' treatment of this problem should be contrasted with the statistics presented by Dunbar [1]. Her data not only show that the incidence of a family history of cardiovascular and other diseases is only in exceptional cases higher in patients with that disease than in other patients with an unrelated illness, but also that if one takes into account psychological exposure to a specific illness, the incidence of this type of 'psychological heredity' is much higher than is the heredity by genes to which Draper and his co-authors restrict their attention. Thus the authors' statement (p. 42) that 'diabetes is inherited in Mendelian recessive form' should read that diabetes 'may exceptionally be' so inherited. An argument for hereditary transmission derived from the exceptional case simply misleads the student. Similar doubts must be expressed about the analysis of heredity in ulcer and gall bladder patients, since this study is based on a contrast of only thirty-two cases each of ulcer and of gall bladder, 'selected at random' from among a larger series.

Chapters VI, VII, VIII, and IX, which deal with somatotypes, are the most useful and the least debatable in the book. These can be commended to every student.

On the other hand, the three succeeding chapters seem to miss the very essence of the problem of constitutional physiology, a problem which is the most elusive and at the same time the most critical in psychosomatic medicine. From the context it is clear that in using the term 'constitutional physiology', the authors actually

[1] *Cf.* review of Dunbar's *Psychosomatic Diagnosis* in this issue of this QUARTERLY.

mean the body's *inherent and characteristic physiological* ways of reacting, although they confuse the issue by an earlier definition of constitution in terms of 'success'. Nothing is more important than to discover to what extent the total pattern of behavior depends upon chemical and structural idiosyncrasies which antedate special life experiences, and to point out the means by which such 'constitutional physiology' can be isolated and measured. Yet nowhere are these goals clearly delineated, and nowhere is there a clear presentation of the technical problems which have defeated every effort to differentiate constitutional physiological endowments from the learned components of a man's eventual make-up. No measurements of physiological responses, whether these be reactions to injections, cardiovascular or respiratory changes, alterations in basal metabolic rates, readings of internal or surface temperatures—none of these alone, nor all of them together, can tell us whether the reaction which has been measured is the result of inherent constitutional make-up, a product of experience, or a complex fusion of the two. From the point of view of an experimental and clinical approach to the problem, we must ask whether it is possible ever to isolate these aspects of a physiological response which are constitutional in their origins, from those which are the results of conditioning and of experience in general, and if so, how? Until this question is unequivocally answered, until the methods are clearly defined by which these components of the total physiological pattern can be differentiated one from another, the very words 'constitutional physiology' remain a hypothesis. It is perhaps a reasonable common sense assumption that such constitutional variations exist, but it is important to acknowledge that up to this day they are totally lacking in experimental or clinical verification. Our nearest approach to such verification comes from observations on differences in the behavior of unborn fœtuses and of newborn infants, observations to which the authors do not refer and which have not as yet been correlated with subsequent personality development. Nor do the authors refer to the use of such a psychological method as hypnotic regression, which is the only experimental method available at present by which a partial dissociation of the constitutional from the acquired components of physiological responses can even be attempted.

Indeed the most serious limitations of the book are in its con-

ceptual approach to the psychological aspects of these problems. Its superficiality in this respect becomes seriously misleading. It forces the authors to bridge the gap between assumed psychological manifestations of assumed constitutional idiosyncrasies by the further assumption that anxiety and inner psychic stress arise as a reaction to a subjective sense of limited inherent endowments or as a reaction to the subjective discomfort caused by a supposedly overreactive autonomic system. This oversimplification is pure fantasy. The notion that the neurosis is in any significant way a reaction to the physiological discomfort of an unstable or overreactive autonomic system, or that the so-called constitutional idiosyncrasy causes the psychic stress, places the cart squarely before the horse. Psychological symptoms and the somatic manifestations have their roots in the same unconscious problems which discharge partly on the level of psychic representation through thoughts and feelings, and partly on the physiological level through the autonomic nervous system. Therefore to assume a direct causal interrelationship between the psychological and physiological manifestations of a common underlying neurotic process is to make a fundamental error.

It is an ungrateful task to criticize a book with whose intentions one is sympathetic. Yet its sound purpose, and its healthy protest against studying diseases by cutting human beings into unrelated fragments, are not enough. Similarly, although it is well to encourage students to use intuition in developing a clinical feeling about patients as do the authors, this is insufficient when more precise techniques are available which can be taught them. Indeed if the encouragement to use intuitive feelings is to be brought into harmony with their fundamental scientific training, they must at the same time be taught how to criticize, control, and check their intuitive processes. To this end the medical student needs specific training in how to listen to patients, how to sense the less conscious and symbolic meanings of what patients say, how to allow for and control the influence of transference reactions on the very process of history-taking itself, how to understand the displacements that enter into all doctor-patient relationships. There is no excuse for continuing to train students in simple-minded and unrealistic traditions, however venerable. The dependence on intuition alone fell into disrepute because it is unscientific and uncritical. It can be restored to a useful rôle only if it is taught

as a scientific instrument in the exploration of unconscious processes. This orientation towards the unconscious is an aspect of medical technique with which every future medical student will have to become familiar. Without it, he is like a soldier who is sent forth to battle with no more training than the old-fashioned manual of arms and close order drill.

As a consequence of the lack of this very psychological depth the value of the case material in the book varies considerably. Some of it is excellent, although here and there the psychiatrist has a few misgivings about the diagnosis. Here again, however, the most serious criticism is that many of the cases are too dramatic. Such dramatic material is always dismissed as exceptional and atypical by the sceptic—to him it proves nothing. In the minds of those who are more receptive to the authors' thesis, such examples create the expectation that every case will turn out to have similar dramatic correlations, whereas for the most part psychosomatic correlations must be sought in subtler aspects of the personality.

This is the most serious limitation of the book. It is of such vital importance to give students an inclusive orientation towards these problems that we have no right to accept a half-way orientation. Students must be taught to seek the integration of body and mind on the level of the most profound aspects of human personality where partly conscious and partly unconscious drives conflict, where the individual unconsciously defends himself against these conflicts, and where the central excitatory states which are generated in these conflicts discharge by a system of overflow and feed-back, along existing physiological channels which they appropriate to their own needs. Thus the student must be taught to penetrate through the masks which patients wear and to correlate the masked hospital personality with the personality on the outside, at home, in the community, at work, at play, and asleep. Only then is the student ready to seek correlations between the psychological, the physiological, and the morphological aspects of a human being. Therefore, even if we accept the minor deficiencies of the text in the field of genetics and heredity, or again in the discussions of 'constitutional physiology', it is impossible to accept its psychological and psychiatric deficiencies, because these tend to misdirect the very students for whom the book is intended.

LAWRENCE S. KUBIE (NEW YORK)

PSYCHOSOMATIC MEDICINE: The Clinical Application of Psychopathology to General Medical Problems. Edward Weiss, M.D., and O. Spurgeon English, M.D. Philadelphia and London: W. B. Saunders Company, 1943. 687 pp.

The psychiatrist is frequently accused of using strange and peculiar terminology in his work, so that the average medical man is at a loss to understand him. This applies even more to the psychoanalyst. A medical man looks askance at a psychoanalyst who tells him about 'oral dependency', 'anal aggression', 'castration anxiety', 'screen memories', etc. Of course, each science has a right to use its own symbols, but on the other hand, if one wishes to have the coöperation of medical men, one must present one's data and conclusions in a language intelligible to them.

The present volume is a step in this direction. The authors, one a psychoanalyst, the other an internist, present us with a book on psychosomatic medicine. The material is largely clinical, rather than theoretical, and it is mostly drawn from the clinical practice of the authors. There is an introductory chapter on psychosomatic medicine in which it is stated that all good doctors appreciate the emotional factors in disease. This is followed by another short chapter on Personality Development and Psychopathology, in which the authors give the criteria of a normal personality as outlined by Glover. Then there is a chapter on the various neuroses and major psychoses with their differentiation.

The bulk of the volume is devoted to a review of psychosomatic illnesses related to the various systems of the body with illustrative case material. The last part of the book is taken up by a discussion of psychotherapy with special emphasis on its limitations, combined with a review of the contributions to the subject by the authors.

The authors' interest in 'selling' psychosomatic medicine to the general practitioner is excellent but falls short of its objective. The sort of doctor who is interested in psychosomatic medicine is usually a recent graduate who has excellent training in basic sciences and who is both critical and imaginative. To such a person this monograph would appear superficial and trite because he would be primarily interested in anxiety and its various manifestations and in the translation of emotional states into physical symptoms. These are the cases that he usually refers to the psychotherapist. There is a rich and important physiological and psy-

choanalytic literature on both of these problems which the authors do not even mention, so that, in the words of Campbell, we have Hamlet without the Prince.

In this attempt to present a simplified, streamlined version of psychosomatic medicine one finds banal generalizations, platitudes, vague inhibited allusions to this and that psychoanalytic contribution, and a marked absence of dynamic and genetic points of view. For instance, a psychosomatic disease par excellence is peptic ulcer, about which there has been a great deal of coöperative thinking, if not experimental work, by physiologists, internists, and psychoanalysts. The Balfour lectures of Cushing have given tremendous impetus to the appreciation of psychological factors in the disease by his discussion of the so-called 'neurogenic factors'. Nevertheless in the discussion of peptic ulcers one finds the platitudes of Eusterman instead of the brilliant observations of Alexander and others.

Judged by their previous publications, the authors of the book are competent men in their own field. It is unfortunate that they decided to jump on the bandwagon of psychosomatic medicine, which they treat so superficially. Of course, this is a first attempt to popularize this subject, but the reviewer finds little consolation in this thought.

J. KASANIN (SAN FRANCISCO)

SYNOPSIS OF NEUROPSYCHIATRY. By Lowell S. Selling, M.D., St. Louis: The C. V. Mosby Company. 1944. 500 pp.

'It has been my experience', writes Dr. Selling, 'that the best students have made systematic outlines for themselves because in neuropsychiatry such standardized aids were not at hand, and they found themselves overwhelmed by the detail of conventional medical textbooks.' This synopsis represents such a 'standardized aid' and falls naturally into the neurological part, 296 pages of outline information on the structure, function, and disease of the nervous system; and the psychiatric part, 177 pages on mental disorders. The neurological part is by all odds the most informative, since its subject matter is easier to outline: it conforms to an excellent standard of note-taking, but suffers from a lack of pictures, which so often explain at a glance the meaning of many pages of description. The psychiatric part bites off more than it can chew; it resembles the notes taken on a too compressed course, one which tries to cram the student with all there is to know

of clinical 'Kraepelinian' psychiatry, freudian psychopathology, behavior disorders of childhood, and mental deficiency. The Synopsis, though it vacillates between furnishing too little and too much, might nevertheless serve as a useful reference book under certain circumstances. It is excellently printed and easy to carry.

B. D. L.

RORSCHACH'S TEST. I. BASIC PROCESSES. By Samuel J. Beck, Ph.D. New York: Grune & Stratton, 1944. 223 pp.

In 1937 Beck published a book entitled, Introduction to the Rorschach Method, A Manual of Personality Study. In spite of the title the reader was assumed to be more or less familiar with the test. In the present volume, Basic Processes, the author offers a detailed presentation of the experimental procedure, of the single factors, and of the scoring. The volume comprises sixteen chapters and appendices.

Beck states in his preface: 'The sole purpose here is to provide students with a moderately steady frame of reference'. Dr. W. L. Valentine, in his foreword, goes even further: 'This is a reference book for student and expert alike. As such it is technical, exhaustive, detailed. Each basic problem in scoring is given a separate chapter. As the scoring precepts are developed, card by card, examples of the scoring procedure are given, so that the student does not have to thumb through records searching for examples.'

It was the reviewer's task to probe the clinical material and the statistical method, on which the scoring of the 'literally thousands of detailed and individual responses' is based.

As sources of the responses the author used: patients in milder mental disturbance; adults in the community at large, comprising persons of average, high average and very superior intelligence, overtly in good mental health; adults in psychoanalytic treatment; General Hospital patients; patients in acute schizophrenic disorganizations; a small group of patients with brain pathology. Thus, the subjects whose records were used represent a mixture of overtly sick and of doubtfully healthy people in an unknown proportion. Such clinical material used as a basis for standardizing values of single factors is definitely objectionable, because standards which

are used for comparison must be based on normal clinical material. Out of Beck's six groups, only one group (the second) represents overtly mentally healthy and intelligent people. But how many even intelligent persons, who 'overtly' seem to be in good mental health, are neurotics! A considerable number of our analytic patients belong in this group. On the other hand, there is not one factor in the Rorschach test which may not be affected by even an inconspicuous neurosis.

A case in point is the differentiation between Form responses, F+ and F−, in Chapter XIII. Beck realizes the definite need for such a differentiation as well as the difficulty of carrying it through. Roughly his criteria boil down to the statement that intelligent persons perceive good forms, unintelligent persons and schizophrenics perceive poor forms. Thus in Table 18 Beck classifies many poor responses as F+, e.g., a good number of anatomical and geographical interpretations. His criteria are debatable. Many neurotics score an alarmingly low F+% in spite of a definite potentially good intelligence.

Another case in point is the author's differentiation between Detail and Rare detail responses, dealt with in Chapter III. Here, as well as with the differentiation of Form responses, it stands to reason that the standards should be derived from mentally healthy individuals. Furthermore it is unfortunate that in this very important chapter Beck bases his conclusions on the statistics of someone else, Dr. Ralph R. Brown; nor is it made clear on what material these statistics are based. And, above all, there is a lack of specification as to the differentiation between D and Dd in each single card.

The same objections hold against the author's mode of dealing with the Approach in Chapter VII. Beck cites Rorschach's incidental statement in the latter's posthumously published paper: 'A normal average distribution would be 8 W, 23 D and 3 Dd'. Beck opposes this with his own formula: 6 W, 20 D and 4 Dd, which he considers as 'more consistently representative of the validating facts'. However, he omits the statistical proof. Had he started out with unquestionably mentally healthy and intelligent subjects he would have discovered that the formula derived from such clinical material is nearer to the original Rorschach formula than to his own.

In Chapter XIV the author doubles the Popular responses. The statistics are again Brown's. Unfortunately they are not appended for reasons of space.

In Chapter VIII, dealing with Movement responses, Beck duly stresses the subjective and objective difficulties in verifying M responses. He says about movement in geometric figures and single lines: 'I myself score such responses M as an act of faith in Rorschach and Oberholzer rather than from conviction based on validated findings'. He need not have relied on faith, had he considered such interpretations M responses only in persons who have perceived many other clearcut M's. With another less kinesthetic individual the same interpretation may be a definite F. This complication is apparently disliked by the author, nor would it fit into his neat rubrics. But here, too, Freud's *'Ça n'empèche pas d'exister'* holds.

Mutatis mutandis, the same is valid with regard to the Color responses, which are dealt with and listed in detail in Chapter IX. The author does not point out that the same interpretation of the same colored entity represents a pure Form with one subject, a Form color response with another subject, and even a Color form response with a third subject.

In Chapter X, devoted to the light determined responses, it appears comforting and convincing that the author differentiates only between the Vista, i.e., the three-dimensional, and the flat Grey interpretations. Grey, however, is a color, more specifically a color visibly composed of black and white. Why, then, substitute it for the Black white interpretations, which Oberholzer has already described and qualified as to their clinical significance in his paper on post traumatic conditions (1931), and recently in Dubois's book about the Aloris.

Thus far the author has adhered to Rorschach's original concepts. However, he has introduced changes concerning the factors as well as the testing procedure. The most striking one is that he has omitted Rorschach's Original answer, and wrongly so. In the reviewer's opinion no other factor reflects the education and background of a subject or hints at a neurosis as does the presence or absence of Original answers.

In Chapter VI Beck introduces a new factor Z, the Organization activity. Its justification is hard to challenge as the discussion of its clinical significance is apparently reserved for a second

volume. However, two objections can already be made. First, although Beck gives a list he omits the mode of derivation of the stated Organization values for the 10 figures. Secondly, Beck has already stated in his previous book, the Introduction, that *'Assoziationsbetrieb* is essentially organization activity'. In the present volume he also translates *Assoziationsbetrieb* as 'combining or organizing activity' as 'organization drive', or as 'organizing activity'. However, to associate and to organize are not the same; and the question arises whether this is not more than just a linguistic misunderstanding. The English translators of Rorschach's Psychodiagnostics consistently translate *Assoziationsbetrieb* as 'associative activity' which is acceptable.

As a third change Beck has modified the signature: Rorschach's Do becomes Hdx or Adx. The argument that anxiety rather than oligophrenia lies behind this reaction does not hold water. Did not Rorschach himself state that 'Do occur not only in oligophrenics but also in depressives and anxious subjects, as well as always in compulsives'. He could have added that they occur in subjects who do not see the forest for the trees. In other words they occur when an obviously specific form of inhibition of thought processes (*Denkhemmung*) is at work for whatever cause: stupidity, depression, anxiety or other factors.

With regard to the same Chapter, XV, the reviewer wishes to add that not only should the sex interpretations be separated from the human detail and listed separately, but likewise the anal interpretations.

So much for the author's modifications of test factors. Another of his modifications applies to the experimental procedure, namely the so-called inquiry, the repetition of the test in reverse in order to verify the entities and qualities of the single answers. Rorschach obviously did not consider such an inquiry necessary. Why should not the examiner, if any doubt arises, make the subject show the entity immediately after the response was given and induce him through neutral questions to verify or exclude the doubtful determinants? If, in a difficult response, the examiner's question should become too outspoken and thus risk a betrayal of possible determinants, one may postpone the clarification of this specific response until the end. But why, for this one instance, repeat the entire test? The immediate questioning, directly after a response is given, offers the decisive advantage of reliability, a reliability

which is lessened after a patient has gone through the entire test when he is likely to change his interpretations or even not to recognize them again or to see them in a different way. The last possibility, namely additional new interpretations, are explicitly disregarded even by Beck.

One more remark about the author's technique: In Chapter IV, on Scoring, he says: '. . . for permanent recording of these very rare as well as of the poorly outlined Dd the best method is to use a facsimile of the Rorschach test card'. The reviewer still considers tracing the more exact method for this purpose. The facsimiles leave out the most subtle details, and the fact that a Dd was seen may be much less decisive for the diagnosis than its specific type.

A technical review of a technical book necessarily sounds more critical than it actually is. It is to be hoped that the second volume will appear soon.

FREDERIC S. WEIL (NEW YORK)

UNCONSCIOUSNESS. By James Grier Miller. New York: John Wiley & Sons, Inc. 1942. 329 PP.

The author begins his treatise on unconsciousness with a regretful comment deploring the separation of clinic and laboratory in the field of psychology. The reasons are historic as well as psychological. In the middle of the last century, psychologists, interested primarily in the function of the so-called normal mind, succeeded in establishing independent chairs of psychology on the continent and subsequently in America. This was followed by complete separation of the laboratory and the clinic. Psychology became a fairly sterile branch of physiology and lost sight of its primary objective, that is, the study of the human psyche. This of necessity was taken over by psychiatry which, since it is a clinical science, naturally suffered as would any clinical science were it divorced from an objective and solid scientific background in its thinking and deductions. Then again, psychology is interested in the mind in general, whereas the clinician is primarily interested in the individual.

The academic psychologists are essentially sceptics. The clinicians on the other hand are loose thinkers. The psychologists felt that they were on the right track because they were able to introduce the experimental method into the study of the mind but they

forgot that they never really studied the mind but only isolated functions or faculties. To be sure, some of the newer schools of psychology have tried to correct this fallacy. Of late there has been an earnest attempt on the part of the laboratory to meet the problems of the clinician. There is no question but that it is high time for the clinician and laboratory to work more effectively together. The present volume is an illustration of such a collaboration.

The author finds that there are sixteen different meanings of the word 'unconscious'. The various differentiations are documented by case material from current neuropsychiatric literature. In analyzing the various states of unconsciousness, he points out that they all have in common the psychological fact that they interfere with the vigilance of the various levels of the central nervous system. The author discusses various clinical problems such as unconsciousness in daily life, in sleeping, in hypnosis, in dreams and in anæsthesia.

The various other types of unconsciousness are discussed from the neurophysiological and the clinical points of view. The author finds that dissociation is concerned with levels of attention. One process goes on at the focus, the other at the periphery. The French clinicians have demonstrated that human beings can do two or more things at once, each independent of the other and not necessarily connected even in memory. Hypnosis then is a state in which the patient for the time being is entirely focused on the hynotist with the rest of the world completely dissociated.

A whole chapter is devoted to subliminal or sub-threshold unconsciousness (what is more commonly called by the clinicians, the unconscious). Reviewing our knowledge of the unconscious, the author finds that it can be well summarized by a footnote in one of Freud's discussions on unconsciousness in the Psychopathology of Everyday Life. Memory is alterative as evidenced by the fact that condensation and distortion occur, traces grow indefinite and merge into each other.

In the last chapter, the author presents a hypothetical case of a young interne's day in a busy general hospital. The account is somewhat humorous as the poor interne seems to be doing the work of twenty men and is full of all sorts of ideas. The fine blending of conscious and unconscious factors in every-day life is well illustrated by the presentation. Miller finds that the differ-

entiating point of the various stages of unconsciousness depends upon the quality of awareness.

One ought to be very grateful to the author for the collecting of an extraordinary amount of material bearing on the subject of unconsciousness. It smacks a little of a doctoral thesis, is somewhat 'academic', but it nevertheless contains a great deal of valuable, well-coördinated information.

J. KASANIN (SAN FRANCISCO)

AFTEREFFECTS OF BRAIN INJURIES IN WAR. By Kurt Goldstein, M.D. New York: Grune & Stratton, 1942. 244 pp.

In this volume Dr. Kurt Goldstein has made available some of the invaluable experience gained through an unusual opportunity to observe and treat a large number of brain injuries in the first World War. He is excellently qualified and very ably presents the fruits of his experiences. In the war of 1914 to 1918 he examined about two thousand patients with skull and brain injuries caused by gunshot wounds. His experience in the study and treatment of a large percentage of these and most particularly of the ninety to one hundred cases which he had under continuous observation for approximately ten years is of the greatest importance. His source of information for this book includes detailed records of these patients, some of whom were observed for a few days and others for a few weeks following the injuries. The author has written many articles on the subject but this volume is based upon his entire studies of the past twenty years. It is fitting to note that his methods have stood the test of time and, with little adaptation, have been found the most successful approach to the problem.

In the two hundred and forty-four pages of the volume Dr. Goldstein has condensed a great amount of easily assimilated material. He has divided it into two parts, the first dealing with symptomatology and the second with treatment. Beginning with a brief statistical quotation of the lethal effects of penetrating wounds in the first World War, at which time ninety to ninety-six percent of men so injured died, he reminds us that the injuries then were mainly from gunshot and shrapnel, with wounds from bombing a rarity. He proceeds with a brief and concise review of general symptoms with generalizations on their evaluation with regard to severity, prognosis and the indications for therapy. He again emphasizes the necessity for coöperation be-

tween the neurosurgeon and the neurologist and the importance of regarding the behavior of the person as a whole. The neurologic symptoms and their origin, together with the observed mental changes, are reviewed and the value of laboratories for special psychological studies emphasized. He also presents a psychological examination outline with some stress upon the interpretation of the ergograph curves and the concrete labor tests or workshop method.

In the section devoted to treatment, he has some interesting comments on amnesic aphasias as well as other speech, writing, and calculation disturbances. The problems of social adjustments, choice of future vocation, improvement of working capacity, and a reminder that the responsibility for the evaluation of the usefulness of these persons for military service and civilian life lies with the physician, are adequately stressed. An extensive bibliography is appended.

While not an all-inclusive volume, this book provides an excellent starting point and can be exceedingly valuable to those who are being so abruptly exposed to the problems of war injuries.

CURTIS T. PROUT (WHITE PLAINS, NEW YORK)

THE VARIETIES OF TEMPERAMENT. A Psychology of Constitutional Differences. By W. H. Sheldon, Ph.D., M.D., with the collaboration of S. S. Stevens, Ph.D. New York: Harper & Brothers, 1942. 520 pp.

Dr. Sheldon wrote The Varieties of Human Physique in which he made a systematic study of human morphological differences. In The Varieties of Temperament he presents a 'constitutional psychology' and proposes that it supplement general psychology.

Some Theoretical Considerations (Chapter VIII) should be read by all practicing psychoanalysts because the qualifications of a constitutional psychologist are so well discussed and the juxtaposition of psychology, psychiatry, and psychoanalysis so well stated.

Although constitutional analysis and freudian analysis are not totally unrelated procedures, Sheldon, with respect for their different methods and terminologies, sees the two approaches as upward and downward extensions, respectively, of a continuum. He says that freudians start with consciousness and go as far (down) as they can, whereas constitutional psychologists start with the solid

bone and flesh of the individual and go as far (up) as they can. When these two procedures are united, excellent results can be obtained; but it would appear from the text that as the downward and upward orbits impinge, brilliant sparks fly out. This is actually no detraction from the magnificent quality and vision of the work. The authors seem to find some pleasurable escape from their impressive but scientifically shackling numericals and correlation boundaries and to poke condescendingly in their upward flight at psychoanalysis. For instance, in two examples of The 4–6–1's (p. 355) whose rarity is marked and whose physiques are extremely massive and powerful, it seems significant that though both are Jewish and medical school graduates, one is a successful psychoanalyst and the other an institutionalized manic-depressive! Elsewhere, after a delightful swipe at the 'halo effect' in psychological ratings, it is claimed that psychoanalysis is a good experience for anybody, especially if carried out in the spirit of whimsical good humor and sympathetic objectivity, 'as one would watch the courting of sparrows', but that a rich background of sexual experience appears to exert about the same effect, *in those who can assimilate it*. 'Both psychoanalysis and overt sexuality are seen sometimes to coarsen the ordinary person, to render him more obnoxiously aggressive (if his second component predominates), and more crassly sophisticated.'

As the authors go higher in their upward swing and psychoanalysts, going downward, are hailed in passing, they are pleased to reveal that the constitutional analyst, sworn to total analyses, is able 'to effect a kind of "pincers movement" and the efficiency of the analytic attack should be enhanced'. With verbal pincers at hand, 'the problem of synthesis lies on beyond'. Sheldon claims to have merely presented a neglected side of the 'constitutional factor' picture, without which a general psychology 'seems fatuous or anomalous'.

Sheldon admits that there still exist restricting omissions in the data related to the fields of endocrinology and physiology. However, three types of temperament have been classified on the basis of endomorphy, mesomorphy, and ectomorphy. They are viscerotonia, somatotonia, and cerebrotonia. In the viscerotonic there is earthiness and realism in abundance. With the somatotonic all is coördinated and conquering. Their hell is inaction and noiselessness. The cerebrotonic (in many ways Jung's introvert)

are neurodermatitic, apprehensive and tense with marked eroticism. Their blood pressure is low and labile and their digestive disturbances are functional. They are tired, experience thermal instability and the basic metabolic rate is high. As to passports for the three, the open face is the somatotonic; the amiable is the viscerotonic; and the face of the cerebrotonic does not qualify for a passport at all. The viscerotonic wears a 'lean danger sign which arouses universal suspicion'.

Deeper patterns of individual personality and the dusky problems of constitutional predisposition to disease (the psychology of constitutional differences) are but two of many features that this work offers by way of stimulation and inspiration for further investigation and interpretation. Basic data on two hundred young men are given and the relationship between constitution, achievement and adjustment is shown rather confidently. Appendices summarize much of the data and also include The Wisconsin Scale of Radicalism and Conservatism and The Chicago Scale of Mental Growth, neither one of which has been previously published. Both scales can be used in self-rating and both are well worth studying.

This book is authoritative, provocative, and splendid. It is well written and interspersed with enough vitality of expression to make it exceptionally choice reading. As a scientific contribution to progressive research it heads the list and must be read to be really appreciated.

H. E. CHAMBERLAIN (SACRAMENTO)

INTELLIGENCE IN MENTAL DISORDER. By Anne Roe and David Shakow. New York: Annals of the New York Academy of Sciences. Vol. XLII, Art. 4, 1942, pp. 361–490.

This monograph presents an exhaustive study based on the results of Stanford-Binet examinations given to 827 patients at the Worcester State Hospital during the years 1929 to 1933. The study includes an attempt to determine (a) the general test level of various diagnostic groups at the hospital and (b) the relative performance of the different groups in specific items in the test. Extraneous factors which might modify the results, such as disparities in age, educational level or occupation, were excluded by selecting groups of individuals as closely alike as possible in these respects; this left the diagnostic factor the essential criterion.

The material is presented from three standpoints.

(1) Comparison of representative and nonrepresentative test performances within the various diagnostic groups. Representativeness is judged by the degree of accessibility and coöperation that is present in the subjects being investigated. Elements that affect representativeness are effort, interest, confidence, temporary psychotic episodes or emotional disturbances, physical illness or poor test conditions. The diagnostic groups studied on the basis of the dichotomy of representativeness or nonrepresentativeness were: general paresis; feeblemindedness with psychosis; paranoid, hebephrenic, catatonic and unclassified dementia præcox; manic depressive psychosis; psychopathic personality with psychoses, psychopathic personality without psychoses. The not particularly surprising conclusion established by this phase of the study is that the patients who are accessible and coöperative perform better in the tests than those who are not. Where such a difference does not obtain, as in feeblemindedness with psychosis, it is ascribed to the fact that in feeblemindedness it is hard to distinguish between unresponsiveness due to uncoöperativeness and unresponsiveness due to stupidity. In addition to the comparison of the two groups on their achievement in the total test, the performance of each group with respect to specific items in the test is indicated by various tables.

(2) Comparison between the State Hospital population, grouped by diagnosis, and a normal group. In general, the severer the psychosis the lower is the performance level. The results were lower than normal in general paresis, chronic alcoholism with psychosis, paranoid and hebephrenic dementia præcox. Chronic alcoholism without psychosis compared favorably with the normal group; as did catatonic and simple dementia præcox, manic depressive psychosis, psychopathic personality with or without psychosis, paranoid conditions. The psychoneurotic group yielded findings slightly higher than the normal, in contrast to the reports of other observers regarding this point. Here, too, a further breakdown of the test results with regard to performance in special functions is afforded. For example, in general paresis it was found that conceptual thinking and immediate memory are seriously impaired, while vocabulary and remote memory are least affected.

(3) Comparison between and among various diagnostic groups.

In the alcoholic group there was no significant difference in performance between chronic alcoholism with psychosis, chronic alcoholism without psychosis and acute alcoholic psychosis. The same holds true for psychopathic personality with and without psychosis, for paranoid dementia præcox and paranoid conditions, for psychopathic personality without psychosis and psychoneuroses, for catatonic dementia præcox and manic depressive psychosis. Feeblemindedness without psychosis yields higher results than feeblemindedness with psychosis. Psychosis, when it has any specific effect, seems particularly to disturb conceptual thinking. The general paretic process affects intellectual functioning much more profoundly than the alcoholic process; in paretics old learning is least and new learning is most disturbed. In the several dementia præcox groups, the hebephrenic performs at a much lower level than the catatonic and paranoid types.

The monograph contains a formidable amount of material, classified from every conceivable angle. It is implemented with numerous tables, graphs and figures. The authors appreciate the difficulty of their undertaking, for they state: 'In a study dealing with so many variables in so many different groups, it is difficult to keep from becoming lost in a morass of details, especially as many of the observed facts seem at first glance to be isolated ones, not fitting into any general pattern'. If the reviewer can consider his own reactions as representative, this monograph will not lend itself to enthusiastic reading by a clinical psychiatrist. It may appeal to the professional psychologist who relishes statistical compilations of vital material.

WILLIAM NEEDLES (NEW YORK)

HANDWRITING ANALYSIS. A Series of Scales for Evaluating the Dynamic Aspects of Handwriting. By Thea Stein Lewinson and Joseph Zubin. New York: King's Crown Press, 1942. 147 pp.

During the last three years a constantly growing interest in the possibilities of handwriting analysis has developed in this country. It is manifesting itself not only through an increasing number of popular books and magazine articles but also through reports on validation experiments in scientific journals. Ten years have elapsed since Gordon W. Allport and Philip E. Vernon expressed themselves definitely, if cautiously, in favor of graphology in their Studies in Expressive Movement, but until very recently all has

been quiet in this field. Now it appears as if we were in for a veritable flood of literature purporting to teach every able-brained person how to read a man's character from his handwriting. Scientific research cannot be expected to counterbalance this expansion. Instead, a severe statistical reaction-formation against the fascination of easy character reading is certain to assert itself on the part of academic psychology. Pretentious unscientific claims will then reaffirm themselves all the more lustily.

In this situation we should welcome the association of Miss Lewinson, a graphologist with a good reputation as a practitioner, with Mr. Zubin, research psychologist at the New York State Psychiatric Institute. Since it is teamwork of this kind which can eventually bridge the gap between the lofty claims of graphology and the scepticism of academic psychology, we regret that the authors confined themselves to such a limited program. Their book contains two main parts of unequal length. In the much longer first part, scales for the measurement of certain handwriting features are described, and the interpretative value of these features is presented in a perfunctory fashion in the second part under the name of 'working hypotheses'. Both the selection of the relevant handwriting features and their psychological interpretations are admittedly based on the graphological system of Ludwig Klages. In the authors' treatment both parts are entirely unconnected since they do not reproduce the cardinal part of Klages' theory: the assumption of a psychomotoric component *(Antriebserlebnis)* in all psychological phenomena. For this they substitute general references to the concepts of expressive movement and symbolism, leaving the reader with two incongruent pieces of doctrine each of which thus becomes still more arbitrary and dogmatic than it was in Klages' original context.

The painfully elaborate definitions of the various handwriting features and the truly pedantic accuracy of the measuring procedures leave the reader completely in the dark as to why just those features should be significant from a psychological point of view. On the other hand, the doctrinaire presentation of the characterological meanings in Miss Lewinson's special chapter is not amended by calling these interpretations 'working hypotheses'. The authors admit (Miss Lewinson reluctantly, Mr. Zubin willingly) that sufficient empirical evidence to substantiate them is not yet available. However, this deficiency does not make them work-

ing hypotheses. These interpretations have never been used as a basis for research in the realistic spirit of an empirical science. Indeed, it is hard to see how Miss Lewinson can call the master's deductions from his general metaphysical principles 'working hypotheses'.

One attempt is made in the book to establish handwriting analysis on a new fundament. According to the authors, every one of the twenty-two handwriting features (e.g., size, slant, width) is to be measured on a scale reaching from extreme 'contraction' (e.g., smallness of the letters) to extreme 'release' (e.g., largeness of the letters). The middle values on these scales are considered to represent 'rhythmic balance' and negative interpretive significance is connected throughout with any deviation from these standard values. Why this should be so is not explained. The statistician would naturally rejoice over the symmetry of this perfection when he actually discovers it somewhere, but he would not expect to find it in a gestalt such as handwriting, much less would he postulate it. At this point of their book it becomes obvious that the authors are involved in wishful theorizing for they require normal handwriting, if not rhythmically balanced, to have at least one and the same value of the contraction tendency for all of the twenty-two handwriting features. This assumption is so much at variance with the facts that they subsequently reduce it to 'one or two values'. If no single pair of values of the contraction tendency can be found to fit a given handwriting, the authors take it as an indication of a personality disturbance. It is difficult to understand how they could blind themselves to the fact that handwriting with only one or two values of the contraction tendency, as defined by them, is a rare exception and that their basic assumption immediately leads into absurd consequences.

This reviewer is inclined to infer from the incoherence and formalism of the book, that the two authors found it impossible to agree between themselves on the material issues of handwriting analysis. The discrepancy between an uncontrollable intuitive approach and a blind statistical approach to the phenomenon of handwriting, the very contradiction the authors set out to resolve, stands out blatantly as the weakness of their own effort. Thus the microcosm of their authorship team reflects after a fashion the general situation of graphology with its antagonism between the scholar's scepticism and the practitioner's belief. Indirectly, the

authors have tried to anticipate criticism of this kind with the claim that their measuring scales retain their value if used in connection with an interpretive system different from that of Klages. The trust in this sort of objectivity is sheer naïveté. Without an understanding of the problems of psychomotility it does not even make sense to measure any features of the traces which the writing movements leave on the paper. The authors pay lip service to the relevance of the concepts of 'expressive movement' and 'gestalt' to their problem, but they have entirely neglected them in their actual work. Not even so fundamental a factor as the speed of the writing movement has been included among their twenty-two handwriting features.

The psychoanalytic point of view does not predispose the student in favor of graphology. Neither the theoretical interest in psychogenesis nor the practical interest in psychotherapy would support the concern with a psychological method which is, at best, purely diagnostic in nature. The psychoanalyst is furthermore inclined to believe that remnants of magic thinking and desires of omniscience play a rôle in the motivation of graphologists. On the other hand, he would be less afraid than others of accepting manifestations of 'irrationality' in human beings. He would not be surprised to learn that the activity of writing offers a good many opportunities for both the open manifestation and symbolic expression of various personality constellations and disturbances. He would doubt, however, whether these handwriting symptoms are so uniform among individuals and at the same time specific enough in their characterological significance to allow of interpretation without a knowledge of the writing individual's case history.

It seems that in this situation progress could be made only through statistical validation of the graphological diagnosis of personality traits, in a field where the predictive value of handwriting analysis could be compared with that of standard tests or other diagnostic methods of proved merits. It is regrettable that the authors have not turned their efforts in that direction.

WALTER W. MARSEILLE (CHICAGO)

MARK TWAIN AT WORK. By Bernard DeVoto. Cambridge: Harvard University Press, 1942. 144 pp.

Bernard DeVoto, custodian since 1938 of the unpublished Mark Twain papers, publishes the first results of his studies of Mark

Twain's ways and habits of artistic creation. The book may have been primarily intended for the literary specialist, but the psychoanalyst will be interested in many details hitherto unknown. The first essay is about Tom Sawyer's immortal daydreams and includes the first publication of a preliminary sketch, Boy's Manuscript, from which it later grew to full literary life. Similar material forms the second essay, giving extremely interesting manuscript pages from Mark Twain's notes when he started to write the adventures of Huckleberry Finn.

The third essay, The Symbols of Despair, is the most fascinating for the analyst. Here DeVoto shows rare insight in seeing in Mark Twain's art an expression of a national experience and the formulation of the American dream, as well as a highly personal attempt at artistic working through of a personal tragedy which culminates in the story of The Mysterious Stranger. The dream framework, the mood of mystery and terror, the ill-fated family, the confusion of dream and reality, all come to uncanny life in the manuscript called The Great Dark. That DeVoto is unusually competent to write about the interrelation between the collective unconscious and the individual is known to psychoanalysts through DeVoto's paper, Freud in American Literature (This QUARTERLY, IX, 1940, p. 263).

MARTIN GROTJAHN (CHICAGO)

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The Body Image in Dreams. Paul Schilder. Psa. Rev., XXIX, 1942, pp. 113–126.

Edith Weigert

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ABSTRACTS

The Body Image in Dreams. Paul Schilder. Psa. Rev., XXIX, 1942, pp. 113–126.

Schilder complains that dream interpretation has been comparatively neglected in recent psychoanalytic literature, and further that the experiences which he summarized in the concept of body image have not been scientifically elaborated. Psychoanalysis is concerned with the symbolic representations of the genital organs and erogenous zones as they occur in dream language. Schilder points out that the awareness of the dreamer's own body and its relation to other bodies is also depicted in dreams—not only parts of the body, but the idea of the total body is always present. The body image frequently enters the manifest dream directly, without symbolic disguise. It may be an adult body image or that of an earlier stage of development with infantile attributes. Concern about body integrity is a frequent motive for the body image in the dream.

EDITH WEIGERT

A Psychomotor Sequence (Abreaction and Catharsis). Arthur N. Foxe. Psa. Rev., XXIX, 1942, pp. 127–130.

The interpretation of 'anxiety equivalents' as such, and references to the past, relaxed a patient's tension, changed her whole physical attitude, and made her experience a hate which had been unconscious.

OTTO FENICHEL

The Origin and Function of Culture. Géza Róheim. Psa. Rev., XXIX, 1942, pp. 131–164.

Freud has drawn a closer analogy, not between the primitive person as an individual and the neurotic, but between the dynamics and structure of primitive cultures and individual neurosis as found in our own culture. In every primitive tribe, the medicine man stands in the center of society and is usually neurotic or psychotic, or at least his art is based on the same mechanisms as those found in a neurosis or psychosis in our culture. Human groups are actuated by their group ideals and these are always based on the infantile situation. Culture, according to Róheim, is due to retardation, that is to a slowing down of the process of growth, to a prolongation of the infantile situation. Primitive cultures originate as a defense mechanism against certain libidinal dangers of specific infantile situations. It is the prolongation of infancy that gives the key to the specific aspects of human nature whereby mankind is differentiated from other animals.

MARTIN GROTJAHN

Three Psychiatric Stories from Rabbinic Lore. Solomon W. Freehoff. Psa. Rev., XXIX, 1942, pp. 185–187.

In these three stories rabbis use certain psychotherapeutic devices to cure personality disturbances. In one case the uncovering of a sense of guilt was the therapeutic agent; in another, the reality situation is altered; in the third,

a magic amulet cures by suggestion. The stories demonstrate the rabbis' ingenuity rather than their psychiatric insight.

RALPH R. GREENSON

Psychological Aspects of the Fantasy of Snow White and the Seven Dwarfs. A. S. Macquisten and R. W. Pickford. Psa. Rev., XXIX, 1942, pp. 233–252.

Snow White is the fairy tale of an exceedingly lovable child who is first very much wished for by her mother and then hated, persecuted, and finally killed by a wicked stepmother; but her loveliness and her innocence command miracles which bring her final rehabilitation and justice. This is the manifest content of the tale. Along with it goes an abundance of symbolism which allows a variety of interpretations of which the authors present only a certain group.

The story, they point out, is chiefly concerned with the relationships of a mother and daughter, from the child's birth until her development into womanhood, and the chief villain of the piece is their mutual sexual jealousy. The father, conspicuously absent in the text, is found transformed into other figures and symbols, e.g., the huntsman and the dwarfs. The threatened killing by the huntsman is interpreted as a sexual attack by the father, which in turn is a projection in the form of an imagined retaliation for Snow White's impulses of hatred and anger toward the parents. The attacks on Snow White by the stepmother are likewise interpreted as fantasies of retaliation for the child's hatred of the mother and for her unconscious wish to displace the mother in the father's affections. The amazed reader is told that Snow White continues to be aggressive and destructive to the end.

The stressing of the masochistic theme as an outgrowth of œdipal aggression appears arbitrary and unwarranted by the material. The point of view of the authors is an example of a widespread misconception of masochism.

BERNHARD BERLINER

Psychoanalysis of Psychoses. I. Errors and How to Avoid Them. Paul Federn. Psychiatric Quarterly, XVII, 1943, pp. 3–19.

This is the first of a series of three papers on the psychoanalysis of psychoses. It will be followed by two more entitled Transference and The Psychoanalytic Process.

The author collaborated with Freud from the beginnings of psychoanalysis and took an early interest in the psychoanalytic treatment of psychoses, especially of schizophrenia. He gives an impressively honest account of the many errors and failures in his attempts to combat the severest diseases at a time when most analysts preferred to devote their therapy exclusively to neuroses. The American reader should keep in mind that most of the cases reported by the author concern psychotic processes rather than psychotic episodes. Otherwise some of the author's technical advice may be misunderstood.

The author is well known for his rich clinical experience. He had the benefit of starting his research work at a time when every new piece of knowledge was the result of repeated personal observation, and no means of acquiring knowledge existed other than hard clinical work. Thus his paper breathes that empiristic spirit which is so frequently replaced by a more rationalistic attitude in the younger scholar of psychoanalysis. It contains valuable observations on such difficult points as the early diagnosis of psychoses,

postpsychotic treatment, prognosis, and the interplay of psychosis and neurosis.

In his concluding remarks, Federn makes an appeal in favor of lay analysis which should provoke thought in all those interested in effective mental hygiene.

KURT R. EISSLER

Dissociated Personality: A Case Report. Samuel Lipton. Psychiatric Quarterly, XVII, 1943, pp. 35–56

A twenty-five-year-old married woman suffered from repeated attacks of amnesia. Precipitating factors were anxiety over a thyroidectomy and the commitment of her father to the state hospital because he had threatened to cut his children's throats.

The case first was diagnosed as hysterical amnesia with conversion symptoms. Psychotherapy was combined with hypnosis during amnesic attacks which yielded repressed and suppressed incestuous material concerning her father and brother. The patient reacted with suicidal threats and developed two distinctly different, alternating personalities: the primary one characterized by severe depression and the secondary by destructive and assaultive behavior with visual and auditory hallucinations about her brother. Incidental investigation into her history showed earlier traces of dissociation.

Progressive manifestations of schizophrenia indicated insulin therapy. After fifty-nine treatments and forty-five comas some improvement was noticeable and the dissociation disappeared, but the patient showed no insight and had again forgotten much of her history.

MARGRIT MUNK

An Interpretation of Anti-Semitism. G. Davidson. Psychiatric Quarterly, XVII, 1943, pp. 123–134.

After a short summary of the history of the Jews and of anti-Semitism, and after explaining that unconscious motives alone can be decisive in this history, Davidson proposes his own theory. This theory is simple but in no way convincing. The old conflict between patriarchy and matriarchy is at work between anti-Semites and Jews. The Jews 'remind' the anti-Semite 'continuously of his matriarchal dependence'. Matriarchal reminders are still effective in the unconscious of the anti-Semite, and he projects them on, and persecutes them in the Jews.

It is certainly correct that the Jews have preserved many archaic trends, and that this circumstance makes them apt objects of projection. But it is difficult to say why among these archaic trends the 'matriarchal' ones should be paramount. Matriarchal trends are mostly very weak and repressed in Jewish tradition, covered by an excessively stressed patriarchy. It is to be regretted that the author seems not to know some of the previously published psychoanalytic papers on anti-Semitism.

OTTO FENICHEL

Consideration of Results with Psychoanalytic Therapy. C. P. Oberndorf. Amer. J. of Psychiatry, XCIX, 1942, pp. 374–381.

Reports of treatment from psychoanalytic sources presented in statistical form indicate that approximately sixty per cent of all cases were considered recovered or improved. This percentage closely approximates that reported from insti-

tutes where intensive psychoanalysis had not been used. It may well have been an error to report such immensurables as psychoneurotic situations by means of statistics. Strikingly satisfactory results can be obtained by brief treatment conducted on strictly psychoanalytic lines. Two case reports of such short treatment are given. The question arises whether, when there is too great or too deep a preoccupation with the unconscious, this does not retard synthesis between conscience and primitive drives. Lengthy and deep analyses are today most in favor, but there has been no investigation to correlate the permanency and quality of result with the length and/or depth of treatment. The tapering off of treatment appears valuable especially in borderline and psychotic cases. Anxiety neurosis and conversion hysteria react most favorably to psychoanalytic treatment; the intellectual narcissist and the individual who recedes into deep depression or expands into manic hyperactivity when faced with analytic revelations, reacts least favorably. Cases who escape hospitalization because of their analyses far outnumber those who require hospitalization after analysis.

While control of the younger analysts might reveal certain errors due to inexperience, the older analyst should review his analytic cases from time to time with other analysts in order to clarify certain rigid or fixed tendencies which he may have developed. It is hoped that such a technique will shorten analyses which run for two or more years.

Possibly a general overenthusiasm thirty years ago may account for some of the present incertitudes. One of Freud's epigrams seems apt at this moment: 'If we cannot see clearly, let us at least see what is unclear clearly'.

MARTIN GROTJAHN

What Unemployment Does to People. Sol Wiener Ginsburg. Amer. J. of Psychiatry, XCIX, 1942, pp. 439–446.

This psychiatric investigation of one hundred eighty families was undertaken to determine the effects of a prolonged period of unemployment on 'normal' people. The procedure consisted of interviews and home visits.

The families selected were of a low income group, politically conservative and, as far as could be established, free from emotional tensions. A definite age group was chosen for physical and psychological reasons.

It was found that the emotional effect of unemployment was traumatic in character, comparable to the loss of love which a rejected child feels. The first reaction was usually fear and bewilderment which turned into discouragement, defeat, and a loss of self-confidence.

The only evidence of protest was manifested in a changed religious attitude in some of the clients. No regressive behavior could be observed nor was there an increase in drinking or crime, with the possible exception of occasional petty cheating which afforded some ego gratification. A protective layer of 'not thinking' seemed to have developed as a defense reaction against reality.

MARGRIT MUNK

Anorexia Nervosa. Report of a Case. Sandor Lorand. Psychosomatic Med., V, 1943, pp. 282–292.

Lorand's patient, who suffered from severe anorexia nervosa, felt herself to be an unwanted child. Her feeling of not belonging caused disturbances

in the development of her superego and ego. Her superego was extremely severe and consequently her ego identifications became difficult, which resulted in a weak ego structure. Puberty was characterized by vivid and painful revivals of infantile experiences with mother and father. Although anorexia itself should be classified as a conversion symptom, it is as a rule connected with rather serious depressions and thus becomes the expression of an intense wish to die. Food implies instinctual gratification, thought of in terms of early fantasies of impregnation. The denial of adulthood is due to the patient's constant preoccupation with the conflicts surrounding food.

MARTIN GROTJAHN

Hitler's Imagery and German Youth. Erik Homburger Erikson. Psychiatry, V, 1942, pp. 475–493.

Germany is an experienced myth maker. She believes in a metaphysical uniqueness which destines her either to be supreme or to vanish. The German people have always been divided against themselves, one part aspiring to spiritual, the other to military supremacy. The author's main aim is to analyze the common symbols that make all Germans one people and one danger. This analysis is done with such outstanding clarity and with such admirable methodology, that a detailed review is indicated.

Adolph Hitler's childhood, for instance, is one representative expression of German attitudes and symbols. Like a primitive medicine man, Hitler knows how to exploit his hysteria and how to represent with it something which lives in every German listener and reader. It is the tune, not the man, which the author analyzes.

The striking use of parental images in *Mein Kampf* constitutes a neurotic confession and at the same time a shrewd and seductive propaganda. It is significant that the German father essentially lacks a true inner authority, an authority which stems only from an integration of cultural ideal and educational method. The German (and Hitler's) father suffers from an eternally bad conscience for having sacrificed genius for mammon. The parallel split between individualistic rebellion and obedient citizenship is a strong factor in the political immaturity of the German. Hitler's person and his very personal development fits a universal latent conflict so well, that a crisis in the life of the German nation made it acceptable as a representative position. Hitler represents an adolescent who never gave in. He is a glorified older brother. Into this fits his ambivalent attitude towards his mother. He is always a lonely man, fighting and pleasing superhuman mother-figures.

The German geographical situation explains the vacillation of German character between suggestibility and defensive stubbornness. The German people are open to suggestion and foreign influence, against which they have no natural frontiers. As a defense against this weakness they develop their national stubbornness. To be freed from foreign values seems for the tormented German like real freedom. What is often considered as two different Germanys grows out of the burning spiritual ambition to fight a morbid suggestibility and a deep insecurity. The German with his spiritual ambition, the 'citizen of the world', is a brother and counterpart of the narrow-minded nationalistic German. They both deny the same conflict in different ways.

It was felt that German anti-Semitism was possible only because of the

German's lack of insight into his own 'Jewish' inclinations: irrational pacifism and hatred of authority. Hitler's anti-Semitism is clearly based on the adolescent antithesis of ape man and superman, and his imagery, common and monomanic as it seems, reflects a typical aspect of German fantasy life. The German soldier is the collective expression of everything that makes for synthesis in the German national character; he represents the spiritualization of what is German. The army represents the only politically mature institution in Germany, replacing Germany's lacking national frontiers. The *Blitzkrieg* is not only a technical feat, but also a sweeping solution for and salvation of the traumatized German mind. To give the German's flight from himself daring mechanical precision and military success: this meant to make a truly German history. In this way Hitler gains a terriffic power over German youth. He uses the motto, 'Youth shapes its own destiny.'

It will be one of the functions of psychology to recognize in human motivation those archaic and infantile residues which are subject to misuse by demagogic adventurers.

MARTIN GROTJAHN

Evolution of the Neurotic Present from the Traumatic Past. Bernard S. Robbins. Psychiatry, V, 1942, pp. 537–542.

The course of scientific development is distinguished by the collection of facts and the creation of theories to explain these facts. Neither the collection of facts alone nor the spinning of theories alone is science. Freud lifted functional psychiatry, the last of the medical fields to be so converted, from mysticism to science. Now, however, psychoanalysis, as Robbins sees it, must be regarded as unprogressive and anti-evolutionary. In psychoanalysis is found 'the notion of the past adhered to as a fully formed body lying dormant, dissociated or encapsulated somewhere in the psyche, continuing to live in the present without change'. This misconception of psychic life is due to the misinterpretation of two clinical observations: the association of a painful affect usually recalls an earlier painful episode and the neurotic patient has to repeat painful episodes.

The author's opinion that Freud looked at the neurotic phenomena as a literal repetition of events from childhood history is a peculiar misunderstanding. Freud's writings make it quite clear that the patient's reactions are not *only* determined by new stimuli and the motivating influence of past experiences, but *also* by the repressed impulses which are constantly striving for expression and discharge. Because of the return of the repressed, or the drive of the repressed for discharge, the patient is inhibited in understanding the difference between the present and the past and his reactions assume the character of rigid patterns.

MARTIN GROTJAHN

Group Emotion and Leadership. Fritz Redl. Psychiatry, V, 1942, pp. 573–596.

Freud's paper, Mass Psychology and the Psychoanalysis of the Ego (1921), has influenced psychoanalytic literature both by the methodological equipment used and the material to which it is applied. Redl's investigation supplements Freud's study by utilizing the methodological equipment developed since 1921. It applies these methods to those group observations which could be made

in practical work with children and adolescents in school and camp situations.

Freud's term 'leader' is for good reasons substituted by the term 'central person', meaning the person around whom the group formation crystallizes. The significance of the central person for the member of the group consists, according to Freud's original views, in the fact that this person functions as the superego of the group. The author states that this is by no means the only function which the central person may assume and describes (with illustrative case material) the different group formations and situations:

(1) The central person as an object of identification
  (a) on the basis of love
    1. incorporation into conscience ('The Patriarch')
    2. incorporation into the ego ideal ('The Leader')
  (b) on the basis of fear
    identification with the aggressor ('The Tyrant')
(2) The central person as an object of drives
  (a) as an object of love drives
  (b) as an object of aggressive drives
(3) The central person as an ego support
  (a) providing means for drive satisfaction ('The Organizer')
  (b) dissolving conflict situations through guilt-anxiety assuagement ('The Seducer', 'The Hero', 'The Bad Influence', 'The Good Example')

In the chapter, Application to Education, many extremely interesting and stimulating points are mentioned: the importance of 'secondary emotions' which are created by the group situation; the importance of the specific group in its specific influence upon the individual; the relation of different group formations to different age groups.

Two more theoretical considerations take up the last part of this paper. The first one concerns the 'exculpation magics through the initiatory act'. If the central person performs a forbidden act first, the member of the group feels not at all, or less guilty. This is rooted in the fantasy of the Hero, who performs what the others have been longing for, taking the guilt and the expected punishment on his shoulders. As Sachs pointed out, this function of 'magic exculpation' is of basic importance in the psychology of artistic creation. The second theoretical point remains dark and unconvincing. It is a differentiation between the 'primary identification' (Freud) and a mechanism called by the author the 'infectiousness of the unconflicted over the conflicted personality constellation'. This 'special conception of the repetition compulsion' is found to work better than Freud's original views. It does not become clear as to why three basic factors do not explain the same situation quite sufficiently: the periodicity of the instincts, the tendency of the repressed to insist upon discharge, and the tendency of every organism to achieve belated mastery of events which could not be mastered at once.

MARTIN GROTJAHN

Metapsychology of Morale. Richard Sterba. Bulletin of the Menninger Clinic, VII, 1943, p. 69.

In investigating the metapsychology of morale, Sterba sees the most important factor in the quantitative relation between egotism and the individual's participation in the aims and interests of the group. Morale, though very neces-

sary and in the service of progressive forces, is psychologically a regressive phenomenon. Its components are: 1. Identification with the leader and co-members of the group. 2. Common hatred and the greater possibility for its discharge. 3. A transformation of the superego under the influence of the leader. 4. Narcissistic gratification due to feelings of infantile omnipotence. Sterba finally suggests that one can influence morale by manipulating the quantity of emotional gratification.

RALPH R. GREENSON

Psychological Testing Number. Bulletin of the Menninger Clinic, VII, 1943, No. 3.

This issue of the Menninger Bulletin is devoted to various psychological tests and comparative studies showing the close interrelationship between such tests and clinical findings. Those tests are particularly significant which gave clues to early psychotic manifestations in cases where ordinary routine clinical examinations would have been negative. There are many interesting pictures and diagrams.

RALPH R. GREENSON

The Military Psychiatrist. Lt. Col. William C. Menninger, M.C. Bulletin of the Menninger Clinic, VII, 1943, No. 4.

In this article, Lt. Col. Menninger points out the specific problems and responsibilities of the military psychiatrist. He has to adjust himself to the fact that the army is not a treatment method nor a social agency. It is his job to get the soldier back to duty as quickly as possible or to return him to civilian life. Thus, early diagnosis and short therapy with the limited facilities at hand are his chief aims. The author demonstrates how it is possible to do scientific work despite the many necessary restrictions imposed by military organization.

RALPH R. GREENSON

The Treatment of the Psychoneuroses of War. Robert P. Knight. Bulletin of the Menninger Clinic, VII, 1943, No. 4.

This paper is a very clear, short and general review of the war neuroses. The general nature of these disturbances and the necessity for immediate treatment near combat zones is stressed. There are statistics on the different types of cases and an outline for treating cases in combat zones and after evacuation.

RALPH R. GREENSON

Anthropological Techniques in War Psychology. Margaret Mead. Bulletin of the Menninger Clinic, VII, 1943, No. 4.

In this short paper, Margaret Mead gives a general outline of how anthropological techniques can be of immediate military importance in combat and psychological warfare. She points out that whereas the military takes great pains in determining what kind of military training our enemies have undergone, it has neglected studying the early childhood influences of these peoples. The author further suggests that the use of these methods would be excellent preparation for personnel working with problems of postwar relief, reconstruction and international relations.

RALPH R. GREENSON

About the Fascinating Effect of the Narcissistic Personality. Christine Olden. Amer. Imago, II, 1941, No. 4, pp. 347–356.

The fascinating effect of the narcissistic personality arises from the longing of his followers to find an omnipotence outside of themselves to which they may submit, or rather in which they may participate. The relationship between the narcissistic personality and his follower is the same as that between the hypnotist and his object—a remobilization of the archaic relation between the little child and its parents whom it believes to be omnipotent. To be loved and protected by them affords both sexual and narcissistic satisfaction. Persons with oral fixations, whose regulation of self-esteem functions according to primitive patterns, are especially inclined to develop this form of longing. The same holds true for frustrated persons in general who feel helpless and therefore long for the protectors of the past—as the pious finds the omnipotent parents again in his god. All this is important for the psychology of authority in general. An interesting case history illustrates these theses.

OTTO FENICHEL

Surrealism as Symptom. Efraim M. Rosenzweig. Amer. Imago, II, 1941, No. 4.

The antecedent of surrealism was futurism, which started in Italy about 1910 as a rebellion 'against the tyranny of the words "Harmony" and "Good Taste" '. A special variation is Dadaism, whose object was 'to spit in the eyes of the world'. Surrealism got new energy after the first world war and used psychoanalysis to reënforce with authority the assault upon all forms of restraint. Surrealism is Dadaism grown to cunning maturity. It is one symptom of the great contemporary rebellion from which Naziism grew as another.

MARTIN GROTJAHN

The Covenant of Gangsters. Ernst Kris. J. of Criminal Psychopathology, IV, 1943, pp. 445–458.

'The promise of loot, the description of retaliation to be meted out by society, and the threat of punishment for attempts at betrayal', are the means by which gangsters tie their wavering associates to themselves. The Nazis use the same methods on the German people. It is true that promises in case of victory, threats in case of defeat, and punishment for treason are means which are used by any government at war. However, the Nazis use them in a different way. 'German leaders rely upon participation in crime as a powerful factor of group unification.'

Kris investigates in detail how the German leaders methodically push their subjects into guilt, and how the annihilation of the Jews is a special means of creating participation in crime. 'The annihilation of the Jewish race would spell disaster to the Germans should they be defeated. Dr. Goebbels summarizes his point in these terms: "If only because of the Jews, we must win this war".' (Kris asserts that this is not the only reason for Nazi anti-Semitism.) 'The German leaders treat the German people as accomplices because they believe that the battle which lies ahead is best fought by a people which has lost faith in any alternatives.'

OTTO FENICHEL

Psychotherapy of the Adult Criminal. Ralph Brancale. J. of Criminal Psychopathology, IV, 1943, pp. 472–484.

Although the author seems to have some psychoanalytic leaning, his approach to a more dynamic conception of crime remains on relatively superficial levels. Brancale is aware of the inadequacy of our present day penal system and suggests further study and research. He makes an attempt to outline some of the most important problems and character types. However, there is no genuine insight into the dynamics of the problems and there is a total disregard for the significance of economic factors. The author does not refer to other writings on the subject and there is no bibliography.

RALPH R. GREENSON

Compulsion Factors in Exhibitionism. May E. Romm. J. of Criminal Psychopathology, III, 1942, pp. 585–597.

The psychoanalysis of an exhibitionist, who after four and a half months of treatment got himself rearrested in order to escape further analysis, is extensively reported. A remarkable fact is that a younger brother had once been sentenced for the same perversion. The case illustrates very well the commonly recognized features of exhibitionism—feelings of doubt about one's own masculinity and strongly developed voyeurism. The meaning of the perverse act is shown to be a denial of the fear of castration related to an unconscious guilt feeling and at the same time a search for the 'perfectly complete woman'. Unfortunately, the short period of analysis did not allow a profound understanding of the childhood relation with the mother who, as one often finds in the history of exhibitionists, was a highly dominant and sexually seductive person.

CAREL VAN DER HEIDE

Esophageal Spasm. William B. Faulkner, Jr. J. Nervous and Mental Disease, XCIII, 1941, pp. 713–715.

A male patient, aged thirty-one, had transient difficulty in swallowing for seven months. Physical and x-ray examination were negative. Esophagoscopic examination revealed alternating changes from spasm to relaxation concomitant with depressing or pleasurable thoughts. The patient had a history of neurotic conflicts.

KURT R. EISSLER

Hypnotic Suggestion: Its Dynamics, Indications and Limitations in the Therapy of Neuroses. Sandor Lorand. J. of Nervous and Mental Disease, XCIV, 1941, pp. 64–75.

The psychodynamics underlying hypnosis are investigated. Although hypnosis is increasingly used, there has been no advance in the knowledge of its theoretical background since Freud's and Ferenczi's contributions. Hypnotism is still considered as quackery by many, and among the factors responsible for this is the attitude of those who apply it. The hypnotist still wants to be surrounded by mystery, not only in order to support the treatment, but also for subjective narcissistic reasons. The author suggests a technique which one might call 'rational' hypnosis in which the patient is given information about the basic mechanisms underlying his hypnotic state. This would amount to an analysis of the transference. The courses of two hypnotic treatments

are compared: in one, any discussion of the patient's relationship to the hypnotist was carefully avoided; subsequent analysis showed this to have been the stumbling block to permanent recovery. In the other case, every effort was made to bring the transference relationship inherent in the hypnotic treatment to the patient's consciousness. The author was satisfied with the therapeutic success in this case.

KURT R. EISSLER

Psychopathological Disorders in the Mother. Mabel Huschka. J. of Nervous and Mental Disease, XCIV, 1941, pp. 76–83.

Of a large group of problem children, 41.6 per cent had mothers suffering from severe neuroses. The author avoids classifying the mechanisms in the mothers because she does not want to run the risk of superficial evaluation. The resistance to treatment in these mothers was extreme. Their children served as objects of projection and there was, of course, an intimate connection between the child's and the mother's difficulties. The psychiatrist should not leave the investigation and therapy of the mother-child relationship to the psychologist and social worker. The great importance of this problem to mental hygiene is pointed out.

KURT R. EISSLER

National and International Difficulties—A Suggested National Program for Alleviation. Margaret E. Fries. Amer. J. of Orthopsychiatry, XI, 1941, pp. 562–574.

Dr. Fries begins by remarking that those individuals or nations who can think with relative objectivity have the advantage over their opponents. Widespread knowledge of human motivations can give us such an advantage in the present war. The remainder of the paper summarizes the author's beliefs about Fascism, frustration, and preventive mental hygiene. Poverty and emotional conflicts predispose to a regression to infantile dependence and sadism. In dictatorships this regressive tendency is exploited and the activity of the individual's superego is short-circuited, the dictator becoming a national superego. The author analyzed an Austrian youth who demonstrated this mechanism. He utilized the aggression which was released by his Youth Organization to support his unresolved œdipus hostility toward his father, who was a policeman. Rejected children who must constantly repress hostility to their parents find special comfort in the omnipotent father-dictator to whom even their parents must bow. This fact accounts for the frequency with which children denounce their parents to the authorities in Fascist countries. Similar impulses such as precœdipal aggression, lust for power, and wishful fantasy motivate fifth columnists. The author recommends a national education program exposing such conscious and unconscious motives as a means for combatting fifth column activities.

Frustration in early life, through its effect on emotional development, helps to form adult attitudes to national and international affairs. The way in which a child reacts to frustration is determined at birth but can be modified by the environment. Hence, in order to assess accurately an individual's behavior, the total situation must be examined. For example, the cradleboard used by the Navaho Indians appears at first sight to be a very frustrating instrument. Actually, the tight binding gives the child a feeling of security and, when propped against a tree, he is able to take a larger part in the family life than his white brother who lies on his back in a crib.

Dr. Fries then outlines a comprehensive program for the prevention of crime, neurosis, psychosis, and national and international difficulties. Her main objective is the continuous supervision of the child's development from the prenatal period onward by teams consisting of psychiatrically trained obstetricians, internists, pediatricians, and social workers, working in a clinic set-up in close coöperation with school authorities, social agencies, and recreational services. The results of such an experimental project conducted for the past nine years indicate that no single factor determines whether or not the child will develop into a well-adjusted adult. Rather, the formative vectors result from the interaction between congenital, environmental and sociological forces. The most important single determinant is the relationship between the congenital activity pattern of the baby and the amount of frustration he has to endure from the parents. The author has shown that such a program favorably affects not only the children supervised but also the supervisors. They, in turn, Dr. Fries believes, through graphic presentation of their findings to lay groups, might well enable everyone to move more rapidly toward our immediate goal, namely the acceptance of reality.

While the author's program sounds a bit Utopian, there is no denying the validity of her experimental findings.

A. H. VANDER VEER

A Delinquent Adolescent. Margaret Mitchell. The Family, J. of Social Case Work, XXV, 1944, pp. 83–88.

The delinquent behavior of a seventeen-year-old girl—aggressiveness and defiance, neglect of personal appearance, refusal to work, disappearance from home for long periods of time, sexual activities—was based on a complete lack of libidinal satisfactions throughout childhood. Her parents were divorced when she was three years old and her unloving, preoccupied mother remarried a man with a younger daughter when she was seven years old. Her resultant hostilitiy created a deep-seated sense of guilt and a need for punishment.

Case work interviews with the psychoanalytically understanding author showed the patient that the pattern of her delinquent behavior consisted in unsuccessful attempts at compensating for her libidinal frustrations and in an unconscious need for punishment. A careful handling of this need, together with foster home placement, proved successful.

MARGRIT MUNK

A Recent Epidemic of Hysteria in a Louisiana High School. Edgar A. Schuler and Vernon J. Parenton. J. of Social Psychology, XVII, 1943, pp. 221–235.

The participants in this epidemic were girls ranging in age from sixteen to eighteen who were considered intelligent members of their school. Their symptoms consisted in involuntary contractions of their diaphragms, of their head and neck muscles, and in crying spells. The symptoms first appeared in a girl who was outstanding both as a social and academic leader and as an athlete, but who had an aversion to dancing. Her attack was precipitated by a series of disappointments: failure to be elected to a position of honor in connection with a school carnival and the loss of the attentions of a prominent senior boy, a good dancer, to an attractive newcomer who was also a skilful tap dancer. The hysterical attack became known throughout the school without immediate consequences.

Some weeks later, Mardi Gras was celebrated shortly after the school carnival and there was much dancing and excitement. Two days afterwards, several girls manifested motor symptoms similar to those of the first case, while others suffered from attacks of fearful crying. Some upset parents who came to claim their children, combined with the curiosity and anxiety of the pupils, created such a confusion and panic that school had to be dismissed for the day.

MARGRIT MUNK

Psychological Sidelights on Andreas Vesalius. Gregory Zilboorg. Bull. of the History of Medicine, XIV, 1943, pp. 562–575.

Andreas Vesalius rose to unprecedented heights of scientific achievement between the ages of twenty-two and twenty-nine. In the subsequent twenty years he lived an almost sterile life scientifically, and finally died as suddenly as did his career twenty years before. It is the author's assumption that Vesalius—taciturn, melancholic, unpredictable, spirtually sick and morose—suffered from a chronic depressive condition, which must have started between 1543 and 1544. His pathological infantile and adolescent drives, which were the cause of his failure in his personal life, made it possible for him to serve the scientific revolution and humanitarian trends of the Renaissance. This predisposition was, therefore, pathological from the individual, but not from the historical point of view.

MARTIN GROTJAHN

Observations on the Yurok—Childhood and World Image. Erik Homburger Erikson. University of California Publications in American Archeology and Ethnology, XXXV, 1943, No. 10.

As in his previous study of the Sioux, Erik Homburger Erikson again succeeds in showing how the conditions of production in a given culture create certain individual character structures through the medium of traditional education. He shows especially how the world image is determined by a projection of body sensations and how the typical body sensations in their turn are determined by the conditions of production and education. The Sioux baby is nursed long and generously enough to acquire a basic feeling of being loved and provided for. In contrast to Sioux training, the Yurok child is weaned early, well before the child is one year old, at a time when his teeth develop and he begins his attempts at locomotion. The mother's attitude toward the baby is well expressed in certain rituals she has to follow during pregnancy and which are intended to prevent the baby from resting 'too comfortably against the mother's spine'. One pronounced character trait of the Yurok is his nostalgia. In their myth the father god created the world by crying. Yurok songs seem to be cries of hunger and helplessness, of desire and longing, intermingled with 'hallucinatory wish fulfilment'—quite different from the martial cries of the Sioux. The Yurok child is taught to choose food carefully, to avoid contamination, to chew slowly and eventually to develop a craving for wealth. The tribal life centers around the life of the salmon, which the Indian sees only at the time of its seasonal run up the river. As far as the Yurok knows, this strange animal never eats; its sexual activity leads to loss of strength and death. It is sent for its yearly run by the father 'beyond the ocean'. By means of a truly wise system, the Yurok manages a miracle: to eat his salmon, and have it the next year, too.

The paper is well written, and the observations are brought to the reader vividly and convincingly. Many problems, of course, remain unsolved, and many others, which would be of great interest to analysts, are scarcely touched upon. It is striking that the factual importance of genital sexuality in the Yurok life and its theoretical importance in the interpretation of the culture is underestimated in favor of the predominant pregenital orientation.

MARTIN GROTJAHN

Georg Christoph Lichtenberg: An Eighteenth Century Pioneer of Semantics. Richard D. Loewenberg. Etcetera, a Review of General Semantics, I, Winter 1943–44, pp. 99–104.

In this paper Loewenberg expresses his great admiration for Lichtenberg, about whom Goethe said: 'Where he makes a joke, a problem lies hidden'. Translating some of his wonderful aphorisms, he throws light on Lichtenberg as a forerunner of semanticists.

'Therefore, I have often wished that there existed a language in which an error could not be said, or where every boner against truth would be also a grammatical error.'

'If only one could educate children to that point where everything that is vague or indistinct would be entirely unintelligible to them'.

It is my fond hope that Lichtenberg is not quite as forgotten as the author believes. He is at least immortalized for psychoanalysts in Freud's frequent quotations from him.

OTTO FENICHEL

La 'serpente emplumada'. Psicoanálisis de la religion maya-azteca y del sacrificio humano. (The Plumed Serpent. Psychoanalysis of the Mayan-Aztec Religion of Human Sacrifice.) Celes Ernesto Carcamo. Revista de Psicoanálisis (Buenos Aires), I, 1943, pp. 5–38.

The serpent is generally interpreted as a masculine symbol. A comparative study of old American religions, however, shows that serpents under certain circumstances may have a special feminine significance. The old Mexican goddess Coatlicue is represented as a woman, dressed in a skirt fashioned of snakes, with two snakes on her head and with feet in the shape of claws. Coatlicue represents a phallic mother who arouses affection and disgust simultaneously. The feathers with which she is adorned represent the fertilizing wind or lightning.

The feathered serpent has a hermaphroditic character: by continually fertilizing and giving birth to herself, she represents the realization of a wish of the human unconscious.

Among the Aztec gods, Quetzalcoatl symbolizes all the instincts of life, as opposed to Tezcatlipoca, who represents death. The whole sadism of the primitive people was expressed in the ritual sacrifices which were brought to these gods. The victim was tortured in a very complicated manner until the heart was eventually torn out of his chest. The sacrifice gratified different instinctual tendencies in a magical way: 1. hostility against the father, 2. guilt feelings because of this hostility, 3. atonement for incentuous wishes for the mother, 4. a longing to return to the mother's womb.

ANGEL GARMA

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Notes

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NOTES

The NEW YORK PSYCHOANALYTIC SOCIETY AND INSTITUTE, at its meeting on June 20th, elected the following officers: Leonard Blumgart, M.D., President; Sandor Lorand, M.D., Vice-President; Henry A. Bunker, M.D., Secretary; Z. Rita Parker, M.D., Treasurer.

The CHICAGO PSYCHOANALYTIC SOCIETY has elected the following officers for the year 1944–1945: Margaret W. Gerard, M.D., President; George W. Wilson, M.D., Vice-President; Maxwell Gitelson, M.D., Secretary-Treasurer.

At the recent scientific meetings of the TOPEKA PSYCHOANALYTIC SOCIETY the following papers were read: Phallic Character by Dr. Karl Menninger, and Introduction to a Discussion of Psychoanalytic Aspects of Rehabilitation by Dr. Ernst Lewy.

The ILLINOIS PSYCHIATRIC SOCIETY, at its annual meeting held May 6, 1944, elected the following officers for the year 1944–1945: Dr. David Slight, President; Dr. Joseph Luhan, Vice-President; Dr. Frances Hannett, Secretary-Treasurer; Dr. Clarence A. Neymann and Dr. Rudolph G. Novick, Councilors.

The PENNSYLVANIA PSYCHIATRIC SOCIETY held its Sixth Annual Dinner Meeting at Pittsburgh on September 21, 1944. Ralph L. Hill, M.D. presided. James M. Henninger, Commander (MC) U.S.N.R., spoke on Navy Psychiatry with Particular Reference to the South Pacific. Baldwin L. Keyes, Lieutenant Colonel, (MC) U.S.A., spoke on Psychiatry in the Middle East. The following officers were elected: George W. Smeltz, M.D., President; Kenneth E. Appel, M.D., President-Elect; LeRoy M. A. Maeder, Secretary-Treasurer; Frederick H. Allen, M.D., Roy W. Goshorn, M.D., Ralph L. Hill, M.D., Harry M. Little, M.D., Councilors; Harry F. Hoffman, M.D., Auditor.

The Department of Psychiatry of MOUNT ZION HOSPITAL OF SAN FRANCISCO announces the opening of a Psychiatric Rehabilitation Clinic for the treatment of ex-servicemen and women discharged from the armed forces because of neuropsychiatric disabilities. The staff will consist of Dr. J. Kasanin, Director; Dr. Emmanuel Windholz, Chief Psychiatrist; Miss Charl Rhode, Chief Psychiatric Social Worker, and a corps of volunteer psychiatrists and psychiatric social workers. The project was made possible by a grant from the Columbia Foundation of San Francisco.

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