The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

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To cite this article: Otto Fenichel (1946) Some Remarks on Freud's Place in the History of Science, The Psychoanalytic Quarterly, 15:3, 279-284, DOI: 10.1080/21674086.1946.11925644

To link to this article: https://doi.org/10.1080/21674086.1946.11925644

SOME REMARKS ON FREUD'S PLACE IN THE HISTORY OF SCIENCE

BY OTTO FENICHEL.

In 1917 Freud published a short paper entitled, One of the Difficulties of Psychoanalysis.[1] In it he wrote that psychoanalysis tends to arouse an affective prejudice, with the result that whoever hears about it is 'less inclined to believe in it or take an interest in it'. After explaining the force of narcissism in human beings, he discussed how the discoveries of psychoanalysis wounded narcissistic self-esteem. The discovery of the unconscious revealed 'that the ego is not master in its own house'; moreover, the statement that mental life is primarily unconscious was 'not affirmed by psychoanalysis on an abstract basis, but has been demonstrated in matters that touch every individual personally and force him to take up some attitude towards these problems'. Freud compares this narcissistic humiliation to two other similar humiliations man has suffered as a result of the development of scientific knowledge: the cosmological humiliation for which Copernicus was responsible when he proved that the earth is not the center of the universe, and the biological humiliation caused by Darwin when he showed that man is an animal like all other animals.

When one who has devoted his life to the practice and the further development of Freud's ideas attempts to evaluate what among his contributions is essential to human knowledge, he is so overwhelmed by the abundance of new concepts Freud introduced that he is at first inclined to give up the task. It is at this point that Freud's One of the Difficulties of Psychoanalysis comes to one's assistance. It describes a special 'difficulty' of psychoanalysis. It must be the principal merit of psychoanalysis to have overcome this difficulty. This is a consequence not alone of the discovery of the unconscious but more, the mode of thinking that made this discovery possible—the decisive step beyond those narcissistic prejudices which

[1] Freud: Coll. Papers, IV, pp. 347–356.

sober research into reality has taken. Psychoanalysis has made possible nothing less than this: to see a half of reality—the data of mental life—not more or less as we should like to see it, but with the same objectivity with which physics, chemistry and biology have long since viewed phenomena in their respective fields. An attitude that has long been accepted as a matter of course in these sciences has been attained in the field of psychology. A certain displeasure in the individual ('science grays the many-colored pattern of life') is overcome, and the practical advantages offered by scientific knowledge—the potentialities of prognosis and technique—gained.

Psychoanalysis as a dynamic science takes its point of departure from the description of mental phenomena, and views the observed phenomena as the result of a hidden play of forces. Its interpretative aspect is no different from other sciences which aim to discover hidden structural connections. As a genetic psychology, it seeks also to determine their historical development so that the structure may be viewed as the finished product of such development. Consequently, 'morphological' and 'historical' points of view play a fundamental rôle in psychoanalysis, but they do not delimit the scope of psychoanalytic knowledge. Psychoanalysis is not only concerned with life histories; its aim is, in addition, to compare the course of many life histories and many mental phenomena in an attempt to discover the *general laws* governing mental life. It seeks to comprehend laws governing mental functions as a special case of the function of life in general, just as the biological sciences comprehend other life functions. Although Freud's metapsychology may in time be supplemented or altered, the insight psychoanalysis has given us into such general laws is, indeed, considerable.

Freud was not the first to consider the field of psychology from a scientific point of view. There were scientific psychologies before him, and others exist today. But compared to 'philosophical' psychologies, scientific psychologies have always been in the minority and have been able only to consider disparate functions and action. An understanding of the multi-

plicity of everyday human mental life based on natural science, really only began with psychoanalysis.

For centuries psychology was considered a special field of speculative philosophy, far removed from sober empiricism. If one considers the more or less metaphysical questions that were held to be of paramount importance, one easily recognizes that the problems discussed originated in theology. They reflected the antitheses, 'body' and 'soul', 'human' and 'divine', 'natural' and 'supernatural'. Psychoanalysis, which overcame these prejudices, gave us also the means to understand them. It explained not only the narcissism which is humiliated because man realizes he is not master in his own house, but also 'magical thinking' which is closely related to this narcissism. Magical thinking, it is true, has played in the remote history of human thought a significant rôle in furthering adaptation to reality. Nevertheless we know that it later tended entirely to replace realistic thinking wherever such thinking would have led to consequences painful to man's self-esteem.

Gradually, scientific thinking has gained ground over religio-magical thinking. The natural sciences, originating and evolving at definite periods in the development of human society (from technical necessity), have had to overcome the most violent and stubborn resistances in their striving to describe and to explain natural phenomena. These resistances in different sciences find varying degrees of intensity of expression. One need only compare any issue of a clinical journal with one devoted to chemistry or physics to find evidences of this variation. The influence of magic is everywhere more in evidence in medicine than in the so-called pure sciences. The traditions of medicine stem from the activity of medicine men and priests; further, psychiatry is not only the youngest branches of the magic-imbued science of medicine, but also the one most saturated with magic. It deals with facts which until recently were closed to the scientist and accessible only to the priest. The resistance to science increases in proportion to the approach of the subject matter of the science to the intimate concerns of men. Not so long ago the pathologist was forbidden to dis-

sect the human body. Human pathology and physiology finally freed, magic nevertheless persisted in the realm of mental research. Here causality and quantity were not conceded to exist; one was supposed to meditate and to feel reverent. In all such psychologies there is a remnant of belief in the immortality of the soul.

A glance at the history of science teaches us that the process of overcoming magic has been a devious one. There have been advances and retreats. The fluctuations in the struggle between the reality principle and magic seem to have been dependent upon other historical conditions that are far more complicated. They can only be understood through sociology, by a study of conflicting groups and interests in society.

In scientific and historical evaluations of psychoanalysis, one often hears two opposite opinions. Some say that Freud is a confirmed materialist who strives to shut off the living stream of mental phenomena in rigid categories. There are also those who say that, at a period when the natural sciences were at the height of their development, his contribution consisted of once again forcing recognition of the irrational, the psychogenic, against the prevalent overestimation of rationalism; that he thereby revealed the limitations of 'materialistic medicine' which for example had been baffled by the phenomenon of hysteria. How can this contradiction be explained?

The golden days of medicine, epitomized by the name of Virchow, simply did not include the total human being in its researches. The neglect of psychology indicates nothing other than that progress in scientific thinking was purchased at the price of letting one entire realm of nature—the mind—remain a reservation for religion and magical thinking. The physical scientists were unconscious mystics in the mental sphere.

The contradiction in the scientific historical evaluation of Freud's work is resolved by recognizing that he accomplished two things at the same time: by opposing pseudomaterialism and by strongly emphasizing the existence of a mental sphere and the inadequacy of the physical sciences in dealing with psychopathology and the psychological aspects of life, he won

this terrain for science. It is agreed too that Freud gave the 'subjective factor', the 'irrational', its just due. I believe that Freud's discovery clearly reveals the spirit of that broad cultural trend which proclaimed as its ideal the primacy of reason over religious prejudice, and the unbiased investigation of reality. What had previously been considered sacred and untouchable might now be touched because the very validity of such taboos had been denied. The absolute 'ideals' made known to us through revelation were likewise brought down to earth and examined as manifestations of the workings of men's minds. Despite the distance between Freud and Virchow, they had much in common. Freud investigated the mental world with the same scientific courage that Virchow applied to the physical. That meant rebellion against the prejudices that had prevailed up to that time. It represents the same spirit of liberal thinking in science that in ethics proclaimed 'the rights of man'.

The objection may be raised that such a statement is a one-sided presentation of psychoanalysis. Does not this science contain a great deal of mysticism, or at least of the mystic tradition? Did it not develop from hypnotism, derived in turn from Mesmerism? Is not, furthermore, 'mental healing' a variety of magic? Certainly it has descended directly from magical methods. But psychoanalysis, despite its background of magical thinking, has transformed magic into a natural science. Its object, not its method, is irrational. We know that in every phase of mental development rudiments of earlier phases persist, and it would not be difficult to find many echoes of magic in the theory and the practice of psychoanalysis. This would not be difficult in any branch of medicine. Psychoanalysis will always retain certain historical traces of magical thinking. And wherever in psychoanalysis there is encountered a resurgence of recessive theorizing, one can be sure that mystical rudiments are pushing to the surface at the expense of the scientific elements.

To what extent this holds true depends upon social conditions. There is no doubt that despite the great resistance to his discoveries that Freud encountered, his daring nevertheless

accorded with the current trend of the preponderance of reason in thinking which was a general trend fifty years ago. No doubt today, contrariwise, there is a swing away from the 'rational' to the 'ideal'. Such a tendency comes to expression in psychoanalysis early in its history because this science was delivered from magical thinking far later than any other science.

Scientific psychology explains mental phenomena as the result of primitive bodily needs developed in the course of biological development and therefore changeable (the instincts), and, in addition, as the operation of environment on these instincts. There is no place for a third factor such as an immanent principle of perfection. To psychoanalysis, therefore, all 'ideals' are human ideas whose origin can be explained by the interplay of instincts and environment. Every trend of thought which required ideals that savor of the beyond, the absolute, and that exclude all criticism, must be inimical to scientific psychology and must lead to a reversion to magical thinking.

In seeking to implement his practical needs as a physician treating hysterics, Freud discovered and developed the science of psychology. Compared to this fact the therapeutic application of psychoanalysis pales into insignificance. Social conditions make the direct therapeutic efforts of psychoanalysis inadequate in comparison with the extent of neurotic misery in our day.

Psychoanalysts can do no better than to follow Freud's example.

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ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Masochism in Paranoia

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To cite this article: Robert C. Bar (1946) Masochism in Paranoia, The Psychoanalytic Quarterly, 15:3, 285-301, DOI: 10.1080/21674086.1946.11925645

To link to this article: https://doi.org/10.1080/21674086.1946.11925645

MASOCHISM IN PARANOIA

BY ROBERT C. BAK, M.D. (NEW YORK)

Until the works of Ferenczi *(1)* and Freud gave us essential insight into paranoia, Kraepelin's point of view dominated. Kraepelin gave the classic description, delineating the symptom complex, and the bulk of the ensuing research attempted to isolate paranoia as a disease entity. With the separation of the paraphrenias from dementia præcox, the sole two remaining clinical forms of sensitive paranoia were the paranoia of jealousy and litigious paranoia. Most investigators held that the psychosis was characterogenic, originating in a specific paranoid constitution, which manifested itself in certain personality traits. The psychosis was supposed to develop under the influence of certain experiences as an exaggeration of the underlying constitution. Among the precipitating experiences were particularly emphasized injuries to the ego, such as slights, frustrated ambitions, injustices.

Freud *(2)* emerged with his brilliant genetic theory of paranoia, demonstrated by means of Schreber's autobiography. Essentially this theory states that in paranoia the ego sets up defenses against homosexuality, from which there results a regression from sublimated homosexuality to narcissism. The libido is withdrawn from the loved person, the homosexual trend ('I love him') is denied and turned into its opposite ('I hate him'), and the hatred is then projected ('because he persecutes me'). Projection undoes the withdrawal. The subsequent formation of delusions is a work of reconstruction, which carries the libido back to the object, but with a negative prefix. This ingenious theory seemed applicable to the various clinical forms of paranoia.

Clinical psychiatry took over elements of Freud's theory but in an attenuated form. Schulte *(3)* developed the 'we' theory of paranoia, translating the idea of reconstruction into Gestalt

Read before the New York Psychoanalytic Society on June 19, 1945.

terminology. He stated that the paranoiac regains contact with the group in his delusional relations, thus 'closing the wound' of isolation. Cameron *(4)* recently, and similarly, attributed paranoid delusions to a defective development of rôle-taking and a relative inadequacy in social perspectives. In place of projection and reconstruction he introduced the concept of 'pseudo-community', organized by the paranoiac's reaction to his own preoccupations out of fragments of the social behavior of others. Mayer-Gross *(5)*, paraphrasing the idea of libido withdrawal, derived persecutory delusions from the 'cooling of sympathetic emotions', which are then projected on the outside world. Kretschmer *(6)* in his study of the *'sensitive Beziehungswahn'* stressed the sexual ethical conflict as the main factor, and derived the paranoid reaction from the interplay of character and environment: a weak sexual endowment is manifested in an 'uncertainty of instinctual drives', while psychical trauma and exhaustion serve as precipitating factors.

In psychoanalytic circles at the time of Freud's paper on Schreber, interest was mainly focused on libidinal trends and the defense against them; hence, the discovery of the rôle of homosexuality was of enormous significance for an understanding of paranoia. To this emphasis, perhaps, may be due the inadequate answer to the main and specific question, namely, why the beloved person should be transformed into a persecutor.

Stärcke *(7)* and van Ophuijsen *(8)* attempted to explain this particular vicissitude of the homosexual trend. In their valuable contributions, still dominated by the reigning interest in phases of libido development, they upheld the view that the original persecutor is the scybalum, and that the delusions of persecution are derived mainly by elaboration and symbolizations of anal sensations. But this addition to the homosexual aspect did not provide sufficient clarification.

Another factor had to be considered. The enormous rôle played by aggression in paranoia could not elude Freud very long *(9)*. In the Ego and the Id, discussing the duality of instincts, he stated that the paranoiac does not directly trans-

form the personal relationship from love into hate. From the start there is present an ambivalence; the transformation takes place by a reactive shifting of cathexis. The quantity of energy withdrawn from erotic trends is added to the hostile impulses.

This new important point clarified the second defensive step of the ego in paranoia. The first step is the withdrawal of love as a defense against the sexual wish. Reënforcement of hostility by the liberated energy constitutes the second step, and this second step accounts for the hatred felt for the previously loved person. The way in which this hatred is rationalized and nourished by interpretations of other persons' unconscious wishes was illuminated earlier by Freud in the article, Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality *(10)*. But hatred and hostility are not by any means paranoia. Therefore it seemed that somewhere in the third step of Freud's scheme, that of the projection of the aggression, lay the secret of persecutory delusional formation.

Klein *(11)*, who refers also to Róheim's *(12)* findings, believes that the fixation point of paranoia lies in the period of maximal sadism, during which the mother's body is attacked by means of dangerous and poisonous excreta. The delusions of persecution are supposed to arise from the anxiety attached to these attacks.

Nunberg *(13)* in his much quoted paper, Homosexuality, Magic and Aggression, gives us a profound hint in a somewhat different direction. He describes a particular type of homosexual, in whom the sexual act satisfies simultaneously both aggressive and libidinal impulses. In this type the ego ideal is projected onto the love object, which then receives sadistic treatment in the sexual act. In paranoia the sadism is turned largely into its opposite, into masochism. This paper, following a somewhat similar line of thought, will corroborate Nunberg's view.

The patient, a man of thirty-seven, began his analysis after an acute anxiety state with depression, for which he had spent four weeks in a hospital. He improved considerably but felt the need of further help to get at the cause of his acute break-

down. A few weeks prior to his hospitalization, he had become apprehensive about his relations with his fiancée. As the wedding day approached, although he was intensely desirous of being married, his anxiety mounted. He started to examine his penis and to worry about his ordinarily well-functioning potency. With increasing panic he observed a slackening of his mental faculties. He felt as if a catastrophe impended, as if he were sitting on a volcano whose eruption would sweep him away. At this point he asked for psychiatric help and was hospitalized.

In the hospital he was preoccupied mainly with three topics. In the first place he thought that he had lost his mind, which seemed proved to him by his own difficulty in thinking and by his suicidal impulses. Second, he thought he was incapable of getting married; this it was which made him think of suicide as the only way of avoiding the prospect of remaining a bachelor and leading 'a lonely, horrid, hideous existence'. Third, he feared his nervous breakdown would be interpreted by people to be the result of some sexual aberration, and that they might spread gossip about him in this connection. This was his first definitely paranoid idea, which later turned out to be related to childhood experiences of 'being buggered' (anal intercourse).

Early in his treatment it became evident that the patient's main difficulty lay in his relation to men. Among women he was successful, especially in sexual relations, yet he had not developed any emotional tie up to the time of his engagement. His life was void of male friendships. His contacts were mainly restricted to the professional field, but even these relations proved to be very fragile. Previous to and during treatment, he got into states of anxiety which ran according to a more or less similar pattern. In most instances, he felt slighted by either of his older superiors, or by one of his rivals with whom he had had pleasant relations prior to the conflict; or he felt as though some injustice was inflicted upon him. A variation of these feelings occurred when he tried to get out of a situation in which he felt some obligation. The feeling that something was expected of him was experienced as something

forced upon him. He was afraid he might be taken advantage of, 'used' and 'reduced to a mere tool'.

During a short absence from treatment he went through a typical episode which he communicated to me in a letter that gives insight into the structure and course of such a conflict.

'I am writing you regarding the recurrence of my troubles. Their cause is concerned with some of my personal relationships which are in reality getting out of hand. I realize that I am abnormally conscious of and concerned with these matters. But, this consciousness and concern is part of the cycle of wanting good personal relations, of being conscious of their status, of anxiety about them and of deterioration in them, partly because of the concern.

'A month ago, I moved to another building. The people were unfriendly and made no welcome and while I made some efforts to cultivate several members, I was not very successful. As a result of a strained feeling I refused to attend two of their private parties and that seems to have facilitated their resentment (which I feel, whether it exists or not). And during the course of a drinking bout indulged in by one of them, some quite serious indignities were inflicted on all members including me.

'The indignities as such are a minor problem. However, other reactions are much more disturbing and are making me seriously consider drastic measures. The main reactions are: sleeplessness, marked tension and much the same feeling of "sitting on a volcano" which I have described to you. In addition, I feel ill at ease with people, noncommunicative, and the anxiety, which is apparently detectable, spoils relationships with people with whom I had previously made a considerable favorable contact.

'The fear that I feel has been tremendous too, and is probably greater than I've experienced for eighteen months. As far as I can analyze it, the fear comes from the idea that I'll eventually have *to batter and beat one or more people—or be battered and beaten.*[1] Some of it is from the feeling that I'll get into a physical combat and will be disgraced and "talked about" by other members of the community—dis-

[1] Italics mine.

graced because of "starting a fight" (if I win), or because of getting a licking (if I lose). Some of these aspects have tortured me day and night for a week and that means that it has been more distressing than any situation since before I stopped seeing you regularly. If one feature is most disturbing, it is the fear which may be noticeable to others and thus tends (because of that) to cause more panic.

'At times like last night, I become almost panic-stricken when my mind "runs away" with all sorts of paranoid ideas. It would not be possible to name all of these, but most of them have to do with suspicion of conspiracies against me. I am moderately sure (during saner moments) that there are no conspiracies other than perhaps some small talk between the two people whom I dislike and distrust the most. I seriously suspect them of it, however, whether or not it is true.'

The scene of 'indignities' referred to in the letter were truly remarkable. The patient remained seated, motionless while a drunken, boisterous person spilled beer around the room, challenging him to fight, spilling beer on him, making him soaking wet. He could neither protest nor leave. He sat there in a kind of paralyzed fascination, waiting for the assault. Only later was he overwhelmed by a desire to 'split that man's head, and ruining the reputation of the whole place in case he was not rehabilitated'.

The conflict with one individual tended to include the group of which the individual was a member (Jews, Catholics, or various nationalities). When precipitated by the transference, as a 'transitive transference' reaction *(14)* only the conflict with the group became conscious. Thus, at one time the patient felt particularly slighted by taxi drivers. They were impolite, they cut in front of him, bumped into his car, pushed him out of their way; furthermore, sailors spat in front of him, salesmen 'threw the change' in his face. He was fairly convinced in these phases that these were not chance happenings, but that they were directed against him. The reaction to these experiences was impulses of violence 'against the inferior mob or race', anxiety about them, and the desire to flee. He was on

the way to developing the paranoiac pattern of the 'haunted man' whose fate is fleeing from one city to another.

Further clinical details which confirm the diagnosis of paranoia are omitted: systematization, excessive vulnerability, traces of megalomania, marked tendency to projection, ideas of reference and persecution, and litigious fantasies.

There is in the patient's history an organic factor that shaped his entire future. He was born with hypospadias. This seems to have remained unnoticed until the age of five, when he entered school. He became conspicuous through his urination: 'He can piss through a nut-hole', the boys teased him. His first name was distorted into a nickname similar to one of the vulgar expressions for the penis. They also changed his name into that of a woman. The vague notion that something was wrong became certainty when his mother said to him from an adjoining room, 'You are not quite like other boys', but avoided further explanation. The fact that she did not tell him made her appear guilty. At about the same age he agreed with his younger brother to mutual fellatio, which he performed. When the brother's turn came, he refused. This, he reasoned, occurred because his penis was unattractive. His enuresis was ridiculed by his brother and his parents. The ardent desire to be 'one of the boys', and his ostracism from the group became early realities. His envy of other boys and his hostility against them were vividly remembered. Later he heard that he was taken by his mother to several doctors, and that they might have operated on him.

He frequently examined his penis, found some scars on it, and thought they might have been caused by circumcision or by some other kind of operation. Up to an adult age, he could not decide whether the missing part of his foreskin was congenital or surgical.

A remarkable fantasy at the age of nine relates to this problem. It is probably a retrograde projection. In the fantasy he is not a child of his parents but the product of an experiment, the result of some chemical concoction. He thought he

would have to go through further experiments and ordeals and probably come to a terrible end.

During puberty he became concerned with the relative enlargement of the glans penis and thought this might cause difficulty in withdrawing his penis from the vagina. From his first sexual intercourse with a prostitute he contracted gonorrhœa requiring long and painful treatments. The idea of injury done by women to the penis was thus confirmed. The evil rôle of women was represented in the dream:

> 'I was incarcerated in a sort of prison. A great many people were making efforts to get me out. I finally got out. You were standing in the background.'

Before the dream he had been pondering whether he should give up his affair with his current girl, a divorcee. The associations led through the links *carnis,* flesh, vulva to a memory which he was hesitant about confiding. 'It's too base and cruel', he said. As a boy of four or five he was playing with another child when they saw two dogs stuck together in coitus. They did not know quite what it was, and they chased the dogs with sticks toward a barbed-wire fence. The dogs became entangled in the barbed wire and hung suspended on the fence, their skins torn by the wire. He then got the vague idea that the dog's penis was cut off and that the bitch ran away with the male's penis inside of her.

Why he should discontinue his friendship with the divorcee became clear only later. Separation in time from her husband was not sufficient. He could not escape the feeling that the penis of the former husband was left in the wife's vagina. He had been told by his mother as a youngster that only a first marriage counts in heaven. He then visualized the second husband, roaming alone, lonely, having no place anywhere.

The notion persisted in the unconscious that woman inflicts injury on the man's penis, can tear it off and harbor it in the vagina. In the act of marriage not only his name but the man's penis is bestowed. The mother possesses the father's penis, and has power to destroy it.

The mother's treatment of the boy was total rejection. He felt he had been reared without any love at all. He could not recall any token of affection from his mother, no memory of caressing or tenderness. By contrast, the remembrance of a maid clasping him to her bosom, and the attendant feeling of her softness and warmth stood out in relief in his memory. The mother was no protection for him from his father; they presented a common front and participated in punishing the child. 'Wait until father comes home' was her repetitive admonition. Being the eldest, he saw the arrival of six children, one every second year.

Whatever the 'constitutional predisposition', the hypospadias more than paved the way to a preponderantly negative œdipus. The feminine component of his bisexuality was supplemented by his mother's harsh treatment, and by his fantasy of her threatening image. The convergence of these factors resulted in an identification with the castrating parent, the aggressive, phallic mother.

He turned to his father to be loved and appreciated by him. The father was a withdrawn, cold, strict, hard-working farmer. It was impossible to get in his good graces. The patient remembered often, with tears, how unappreciative his father was of him. As a child of six, he was helping his father gather hay. He worked diligently the whole day, and driving home from the fields he asked his father if his work that day was worth fifty cents, and if so whether he could have it. The father ignored him completely. He pleaded, and finally in desperation asked if his work was worth at least a nickel. His father brushed him off as before. The emotional cathexis of these memories was tremendous. Not being loved, and particularly not having had any physical contact as a token of love, caused him a great deal of suffering. He felt very much moved when a neighbor's son put his arms around him. He felt a strong desire to go hand in hand with his father and for many years resented that the father did not play with him and did not teach him to fight. 'Together with father' he would have been strong, powerful, and a member of the male group. But

instead of the close relationship and gentle physical contact he was beaten by the father for the slightest mischief. If he got into a fight with his brothers, which they started, he was nevertheless beaten by his father, being told he was older and should know better. Sometimes he waited for hours in a cold sweat for the threatened beating. The beatings, with a stick, were ruthlessly sadistic. He was always found to be in the wrong and was never exonerated. He fantasied though, with great clarity, picking up a shovel, or getting hold of the stick and attacking his father. After one beating he vowed that when he grew up he would beat up his father.

Such powerful aggression in this helpless boy, who craved for love and physical affection, intensified his ambivalence. One part of the aggression remained in fantasy, and developed into manifold sadistic reveries. He daydreamed, for instance, that women were stationed in stalls like racing horses. Every woman was set and alert, bent forward on her toes in the stall. The patient, the boss, was beating them using his penis as a rod. He remembered a beating in the fields, his father starting back for the house, his being left behind overwhelmed by rage and sorrow, the idea flashing through his mind, 'Now he is going back to the house to screw mother'. The patient advanced the theory that his father 'was taking something out on him' at that time. There must have been a 'lack of sexual synchronization between my parents'. He recalled vaguely that his father had some sort of 'nervous breakdown' about that time. We have noted that 'nervous breakdown' was linked in the patient's mind to sexual (anal) aberration. It becomes obvious that in the unconscious the experience of being beaten by the father became libidinized into being sexually abused by him. The yearning for affection was regressively debased into masochistic degradation. In the masochistic act, part of the sadism took a circuitous path to gratification. During prostatic treatment the patient dreamed:

> 'I am going to the doctor for treatment. He looks like a debonair Frenchman, with a goatee. He could be a psychiatrist. The doctor starts to finger my anus, then it seems to

change to intercourse. Finally I find myself dancing around in the room like a witch with a broomstick in my arse.'

To get hold of the father's stick, to castrate him, is achieved when anally he incorporates the father's penis, playing the part of the castrating woman, ultimately the rôle of the phallic mother. The patient's pugnacity and his lifelong preoccupation with preparing himself for physical fights by 'jiu-jitsu' lessons and 'commando training' also become understandable.

The constellation in which the paranoid reaction originates, as we know from Freud, is homosexuality. One of the prominent strivings in our patient had been the ambition to be recognized, appreciated and loved by important, outstanding men. The infantile desire to gain the father's recognition was never abandoned. Before the acute phase of his illness he dreamed that he went home, resolved the differences with his father, and at the final reconciliation they both wept. In his daydreams he became the favorite son as a reward for his successes and achievements. Fulfilment of the ego ideal, and being loved according to this ideal, is a sublimation which binds large quantities of homosexual and narcissistic libido. We know, however, that relationships on this basis prove to be very fragile, undermined as they are by strong ambivalence.

In such an unstable psychological structure economic changes in the ego or in the id result in a threat to the ego, and put the ego's defenses in action. An increase in homosexual libido may be due to biological or to situational factors (seduction, frustration); however, a greater rôle seems to be played in the further development by injuries inflicted directly upon the ego. Slights, frustrations, and disappointments reverse sublimations and liberate homosexual libido *(15)*: 'You are not a man. You should be treated as a woman.' The failure of sublimation and the direct threat of castration lead to a retreat from phallic activity and induce a masochistic regression (homosexuality) where, according to the phallic and anal-sadistic organization, the desires to be castrated, beaten, and anally abused are reactivated.

A dream illustrates this point:

> 'Hitler, Mussolini, and Hirohito are about to be executed, but Hirohito cannot be found. I offer to replace him. The execution looks like a decapitation. I put my head on the scaffold; they separate the scalp from my skull, and push a knife into the back of my head.'

Through masochistic identification he could become the father, the powerful and loved enemy. The price he had to pay was castration (circumcision and anal intercourse).

This regression from sublimated homosexuality to masochism is an essential feature of the paranoid reaction, and constitutes the *first* defensive action of the ego. The withdrawal of love that follows is the *second* step in the defense through which the ego protects itself from the masochistic threat coming from the id. Alienation, feelings of estrangement, detachment from the previously beloved person, and free floating anxiety are the clinical corollaries of this stage. The *third* step is an increase of hostility, hatred of the love object, and the appearance of sadistic fantasies. In making the transition from love to hate the ego makes use of the displaceable energies contained in the originally ambivalent attitude. Sadism then fulfils several functions: the ego succeeds in turning passivity into activity and exploiting it as a countercathexis against masochism; furthermore, it reënforces the ego feelings (male attitude), and represents a recathexis of phallic activity. At this point mastery of the increased sadism is the primary task of the ego. That it fails is due to the interplay of several factors: weakness of the ego, masochistic fixation, and castration anxiety. The ego has to get rid of the increased tension and of the feelings of isolation, and this it manages by projecting a part of the sadism. The projection of sadism then would be the *fourth* step of defense. It is 'the paranoid mechanism proper', and it is a restitution. Projection is possible partly through the unconscious hostility of the actual and past participants and runs according to this preordained path. *In the projection of the sadism the masochism is bound to return.* The patient's preoccupation with precipitating a 'physical showdown' (being assaulted) and its ramified delusional elabora-

tions, as being mistreated, injured, and persecuted, gratify the original masochistic desires of castration, beating, and abuse by the father. The delusion is a return of the repressed, and *paranoia is delusional masochism.*

The ego aligns itself on the side of sadism. Masochism (id) serves to reëstablish object cathexis and to hinder further 'defusion'. The antagonistic hypercathexis of the two psychic agencies is an attempt to achieve equilibrium. Depending on economic factors, the outcome may be flight, murder, suicide, or subsiding of the tension and cessation of the attack. Megalomania seems to be a later development when quantities of masochistic cathexis are further withdrawn.

Omitting the individual persecutory mechanism, let us examine briefly another characteristic feature of paranoia, that of an expanding, generalized persecution by a group. The answer may be found in the family constellation, perhaps more specifically in a vicissitude of sibling rivalry. The infantile prototype of this cohesive, hostile group may be traced in the fused image of the parents, their 'common front', representing the image of the phallic mother. This concept is later widened and includes the group of siblings. In the course of development these concepts in the ego ideal are further extended but seem to preserve their fused character and highly ambivalent cathexis. By regression they undergo a masochistic transformation to which can be applied Freud's *(16)* formulation in a modified version: 'My father loves me, I am the favorite, and he beats my brothers'. The libidinal and sadistic impulse after having undergone masochistic transformation is: 'My father beats me; I am hated; they all want to beat me', and this masochistic turn seems to correspond to reality. The love object, the father, was the original persecutor. The family was aligned against the patient in a 'common front'. His schoolmates ridiculed him. He was not accepted in fraternities, and his religious group was looked down on. Here we meet some of the real elements in delusion to which Freud referred in one of his last papers, Constructions in Analysis. True, to a large extent,

the patient brought it on himself; but the paranoiac is not infrequently a person who has been persecuted in his past.

The sociological significance of this type of personality is well known. Our patient also turns violently against underprivileged minority groups. But once, when he witnessed a scene in which a fragile, small, Jewish-looking man was threatened with beating, he suddenly felt as if he himself were Jewish. He identifies himself with the persecuted minority on the basis of his history and on the basis of his masochistic propensity. In releasing his sadism against these groups, he not only defends himself against his own masochism, but realizes the beating fantasy through dramatization.

To what extent have these observations general validity in relation to paranoia? This case history is selected from a vast number of clinical experiences in the study of paranoid psychoses and from the analyses of paranoid personalities. We are indebted for the subtle and thorough analysis of a case of paranoia to Ruth Mack Brunswick *(17)*. In addition to this we are in possession of the full infantile history of this patient described in Freud's *(18)* inimitable way in the 'Wolf-man', in The History of an Infantile Neurosis, and this patient's later paranoid condition, observed by Brunswick.

The paranoia that started about twelve years after the analysis with Freud centered around a hypochondriac idea. The patient felt that his nose was swollen and disfigured by a scar due to operations that were performed on it by a dermatologist (who was a substitute for Freud). He felt crippled, and ruined for life, and claimed that 'he could not go on living that way', thereby repeating his mother's words which were related to her abdominal illness. The injury to the nose was originally self-inflicted and only later treated by the dermatologist. Brunswick stated:

'The patient's failure to be satisfied by his self-castration reveals a motive beyond the usual masochistic one of guilt, which, regardless of the perpetrator, would be satisfied by the act itself. The further motive is, of course, the libidinal one, the desire for castration at the hands of the father as an expres-

sion in anal-sadistic language of that father's love.' In discussing the patient's change of character, Brunswick relates it to the 'irritable and aggressive' period of childhood. 'Behind his tempers lay the masochistic desire for punishment at the hands of the father; but the outward form of his character was at that time sadistic. . . . In the present character change, the same regression to the anal-sadistic or masochistic level was present, but the rôle of the patient was passive. He was tormented and abused, instead of being the tormentor.' About the hypochondriac idea Brunswick wrote: 'The [childhood] fantasy of being beaten on the penis was reflected in the delusion of being injured on the nose by X [the dermatologist]'. There are many more masochistic elements in the case history, but still in the final analysis they are deprived of their due rôle. Brunswick derives the loss of psychic equilibrium in the patient from the flaring up of his love for the fatally ill Freud (father). This love represents a danger of castration, the love then is repressed and turned into hostility and has to be projected. It is true that the sight of the fatally ill Freud stirred up in the patient his old compassion for his father. In his childhood the sight of his sick father in a sanitarium became the prototype for his compassion for cripples, beggars, poor, and consumptive people, in whose presence he had to breathe noisily so as not to become like them. It was one of his defenses against identification with the castrated father.

We must add only some emphasis to Brunswick's analysis. Love for the ill Freud (father), which had the unconscious implication of the patient's being a 'woman', underwent regressive change into being castrated and beaten. *The homosexual object choice regressed into masochistic identification. We think that this form of regression constitutes the prerequisite of a paranoid development,* and the subsequent course in this patient also supports this assumption. In his hypochondria he consistently manœuvred to bring about his castration and at the same time defended himself against it by aggressive and litigious fantasies. This was the repetition of the sado-masochistic phase of his childhood, to which he had been thrown

back partly because of a threat of castration. At that time he had been a tormentor of animals and men, but, at the same time, he indulged in fantasies of boys being beaten, and especially of being beaten on the penis. In a variation of these fantasies, 'the Czarevitch . . . is shut up in a room (the wardrobe) and beaten'. The Czarevitch was evidently himself. As we know, in hypochondriac and persecutory delusions, these fantasies find renewed expression.

A vast number of questions remains unanswered. The primary aim of this presentation has been to demonstrate the crucial rôle that masochism plays in the paranoid mechanism. In his paper, 'A Child Is Being Beaten', referring to the masochistic beating fantasies, Freud wrote:

'People who harbor fantasies of this kind develop a special sensitiveness and irritability towards anyone whom they can put among the class of fathers. They allow themselves to be easily offended by a person of this kind, and in that way (to their own sorrow and cost) bring about the realization of the imagined situation of being beaten by their father. I should not be surprised if it were one day possible to prove that the same fantasy is the basis of the delusional litigiousness of paranoia.'

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

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To cite this article: Melitta Sperling (1946) Psychoanalytic Study of Ulcerative Colitis in Children, The Psychoanalytic Quarterly, 15:3, 302-329, DOI: 10.1080/21674086.1946.11925646

To link to this article: https://doi.org/10.1080/21674086.1946.11925646

Published online: 11 Dec 2017.

PSYCHOANALYTIC STUDY OF ULCERATIVE COLITIS IN CHILDREN

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The importance of psychogenic factors in ulcerative colitis has been emphasized in recent years by several investigators. Cecil D. Murray first demonstrated that there exists a definite relationship between emotional disturbance and the onset of bloody diarrhœa; also he expressed the opinion that this disease tended to occur in a definite type of personality, characterized by emotional immaturity that shows itself in lifelong dependence upon parents, and in sexual maladjustment. His impressions have been confirmed in a number of case reports by A. J. Sullivan and E. R. Cullinan and others. In a personality study of forty patients, E. Wittkower could show that ulcerative colitis is a disease of the mentally ill. Almost all the patients showed character disorders, clinical neurosis, or psychosis. In his opinion, similar precipitating events would not lead to this symptom in other individuals.

Although a great deal of psychoanalytic study has been made of gastrointestinal disturbances, especially by Alexander and his coworkers, there exists very little analytic literature on ulcerative colitis. A case history published by G. E. Daniels on the treatment of a patient with ulcerative colitis and depression confirms my observations.

Although emotional disturbance as a precipitating and constant factor in the etiology of ulcerative colitis has been stressed by all investigators, the cause and nature of this illness have remained unknown.

CASE 1

Robert was first seen by me after he had been ill with ulcerative colitis for more than one year. He had developed colitis when he was about six years old, a few weeks after he had started school. Attempting to place him in kindergarten when he was

five years old, Robert became terrified, refused to stay, and his mother had to have him withdrawn.

Robert, aged seven, had two sisters, twelve and fourteen years old. While the girls had presented no difficulties, he had been a difficult child from birth. He was, indeed, a problem to his mother even before he was born. She had to spend almost all of the first three months of this pregnancy in bed, and when she was six months pregnant her whole body became swollen. She had not wanted Robert nor, in fact, any children, but she had never done anything to get rid of them. Her husband, who at that time had lost his father, insisted on trying to have a boy to whom he could give his father's name.

Robert is described as having been a very irritable and stubborn baby. He was a very fearful child, much more demanding than his sisters had been, and he had frequent tantrums. The father was 'always more demonstrative' with the boy than the mother, and left all the disciplining or punishment to her. Robert always became extremely moody whenever he was punished. His mother was very defensive about the rôle that she might be playing in the child's illness, and wanted repeatedly to be reassured that she had not contributed to his illness by mismanagement.

I first saw Robert in a pediatric ward to which he had been admitted the fourth time since the onset of his illness more than a year previous. He had been treated with several courses of sulfonamides, high protein diets, low residue and gelatine diets, cod-liver oil, enemas, vitamins, liver extracts, and finally he was taken off all milk and milk products. He would improve spontaneously and then have another attack of bloody diarrhœa, cramps and fever. He required frequent transfusions. An x-ray examination revealed loss of haustrations with ulcerations of the large bowel. Bacteriological studies of material taken directly from the colon were negative for pathogenic organisms.

At the time treatment began, he was acutely ill, weighed about thirty-nine pounds, had bloody diarrhœa, abdominal cramps, and temperature up to 106. He was described in the

hospital as a moody, irritable, uncommunicative child, interested only in his diet and his stools. He never engaged spontaneously in conversation, and answered mostly in monosyllables. Whenever his mother visited him in the hospital, he demanded that she go immediately and buy him crackers or peanuts. If she refused he would begin to cry, complain of cramps and sit on the bedpan.

In my first contact with him, he regarded me very suspiciously and reserved judgment. When I told him that I could very well understand how he felt in the hospital, helplessly exposed to the nurses and doctors who did not give him the things he wanted, his face lighted. I told him that I could help him to get the things he wanted, and that this would help him to get well much faster, and I gave him the feeling I understood how lonely he felt in his futile struggle against everybody. The first thing he wanted me to bring him was a horn. It gave him great satisfaction to use this horn to annoy the other children and the nurses in the ward. He readily accepted my suggestion that he express his anger in some acceptable way, such as tearing up paper. He asked for scissors to cut up cardboard. He told me a dream the second time I saw him: 'The bed next to me was empty and the boy in it had disappeared'. He told me he had been very angry with this boy who teased him. Robert quickly accepted me as a valuable accomplice in getting him concessions. He ate much better when a number of previously forbidden foods were added to his very rigid diet. After four weeks during which he was brought in a wheelchair to me in the clinic twice a week, his general condition had improved somewhat. He was still running a high temperature and had bloody stools. He became more and more insistent upon going home and sought my aid in persuading his mother who was frightened at the mere mention of taking him home. After talking to his mother to prepare her, Robert was discharged from the hospital having first been given a blood transfusion. He weighed about forty-nine pounds, his temperature ranged to 103, and the bloody diarrhœa continued. He was to be brought to the clinic twice

a week, and his mother agreed to come whenever it was necessary to discuss the situation with her.

At home there was constant fighting about food between Robert and his mother who threatened repeatedly to send him back to the hospital. It was difficult to persuade her that it was better to let him have the food that he desired, especially since his cravings were for pickled herring and smoked salmon for breakfast, and all kinds of delicacies during the day. He complained that the things his mother cooked did not taste right; that whenever she turned on the gas there was a bad odor in the house. After three weeks he began to improve gradually. His weight increased, his temperature remained almost normal during the day, rising during the night, and the frequency of his stools decreased. It was evident that despite her knowledge that food did not cause the diarrhœa, Robert's mother used it as a threat to return the child to the hospital from her need to have him away from home. He was up for long stretches of time during the night with frequent bowel movements which roused him from bad dreams. In these dreams he would find himself at the hospital being given injections, being tortured by Japs, or killing Japs himself.

> 'I was lost on the street and I looked for a car. There was only an ambulance. I asked the man to drive. He didn't know where to drive to take me out of the place where I was lost. I drove and crashed.'

This dream he related one day when he was brought to the clinic having fallen out of bed and hurt himself during the night, at which his mother told him he would have to be hospitalized. He came in crying, frightened that he would have to remain. I told him that because he felt that he could not stand the suspense of impending hospitalization any longer, he had tried in his dream to put an end to the suspense. He was able to understand that his falling out of bed was the result of his unconscious decision to end an intolerable situation. My reassurance that I would keep him out of the hospital calmed him considerably.

In a discussion with his parents the same day, the father blamed the mother for making Robert sick, and she in turn blamed him for spoiling the child, complaining she could not 'go on any longer', that she could not manage Robert with his father in the house, and that one of them had to leave. Her very ambivalent attitude towards Robert had to be resolved if his treatment was to be successful.

The boy improved steadily. He gained sixteen pounds during the first three months at home although he had had measles. His temperature returned to normal, with occasional elevation in the evening and during the night. Blood disappeared from his stools. He gained control of his bowel movements during the day, but awoke frequently at night and had to run to the bathroom. His father's employer, who had donated blood for Robert in the hospital several times, arranged with me that I see Robert once a week in my office in addition to the two times that I saw him in the clinic.

In play analysis, Robert acted out his sadistic impulses towards his parents. With clay, for instance, he would make one figure and put it on top of another figure; then he would dismember the first figure, tearing off the head and extremities, then squashing the clay and throwing the whole thing away. This was his conception of parental intercourse. In this connection it transpired that Robert had been sleeping in his parents' bed since he was an infant. The parents had intercourse freely in his presence assuming that he was asleep but without bothering to make sure. At about the age of two he became unmanageable, would break windows, throw things and have frequent temper tantrums. On many occasions, especially during the night, he would soil himself. His nightmares, frequent awakenings at night and running to the bathroom had a direct connection with observation of parental intercourse, and represented his reactions to these experiences. In this manner he managed to keep his parents awake, to separate them, and so prevent intimacy between them. He would either take his mother's place with his father or preferably kept his father busy emptying the bedpan.

'I dreamed I was a pig. A man chopped off his neck. They wanted to eat it but the pig was still walking with his neck chopped off.'

'I was sleeping in my bed and all of a sudden I woke up and I saw a big rat coming towards me. I got very afraid and started to run away. I jumped out of the window and I climbed up a tree. The big rat with a big mouth and long ears and popping eyes started to climb after me and wanted to eat me up.'

This was a nightmare from which he awoke with fear and diarrhœa. On the basis of previous similar material, we connected it with his own impulse to devour whenever he was very angry. To the question with whom he was so angry that he was afraid of his own oral aggression, he laughed and said, 'I won't say it'. Asked to say what he was thinking, he replied, 'This time it is my father and not my mother'. At this time he was sleeping with his father. We had discussed with him and with his mother a change in sleeping arrangements. Robert was to sleep alone but he was resistent at that time to give up sleeping with his father. It was apparent that Robert was working out the œdipus on an oral sadistic level. His mother's observation that the child had begun to masturbate, which he had not done before, could therefore be considered as progress in his development.

The change in his behavior during this phase of treatment was very striking. While a few weeks before he had been afraid to touch playthings, he was now breaking or tearing whatever he played with. With clay he would frequently make animals which bit him. He would then squash or break them to pieces. At home this aggressive behavior was creating difficulties. He became extremely demanding, had temper tantrums, was destructive, and threw knives, especially at his older sister (mother substitute). While analysis enabled him to give expression to his aggressive impulses, thereby making his physical symptoms unnecessary, Robert now repeated his earlier behavior when only by means of temper tantrums could he get his way. Although his mother punished him by beatings

and deprivations, he would provoke her to outbursts of violent temper—satisfying to him because it proved to him that he was stronger than she; besides, he could induce his father to indulge him and derive much gratification from playing one parent against the other.

Since his ability to tolerate tension was still very limited, he was almost in a constant temper tantrum. In his illness, a reaction to a traumatic situation (starting in school, separation from mother, hospitalization), he had regressed to the level of oral sadistic fixation, partly relieving his feelings of complete helplessness and extreme fury by oral sadistic incorporation of the frustrating object, and anal elimination of this incorporated object—but at the price of his own physical destruction.

Since this phase of the analysis represented repetition of early infantile behavior, it was essential to guide mother and child through this period of retraining in a more successful way than had originally been done. His uncontrolled behavior demonstrated that he really never had received adequate training by his parents who were emotionally immature with great difficulties in controlling their own emotions. While the mother usually became very angry, the father tended to be more detached with an impulsive need to run away when the situation became difficult, or to indulge himself and Robert in a very childish way. The father, to whom I had suggested psychiatric treatment, could not accept this idea, and the mother, who was working with me, because of her own limitations and ambivalence, was not too helpful, so that the task of adaptation was left to the child.

One day Robert and his mother arrived at the clinic, both very excited. In a fit of temper he had broken dishes at home, thrown a knife at his sister, and threatened to break everything in the house. All that his mother could do was to threaten to give him away. I discussed his behavior with him, showing him that he was endangering others and getting himself into trouble. His answer was: 'I'm not afraid of anybody. I'm even stronger than a cop; and no one can do anything to me.' I told him he was getting me into trouble too because I, after

all, was responsible, having asked his mother to take him home and keep him. Since his mother was incapable of doing it, I had to teach him the fundamental restrictions and rewards of social behavior. Robert understood that I was serious, that he could not afford to lose me, and that he would have to control his aggressive impulses. After the interview, the social worker found him sitting on the curb, refusing to go home with his mother. The mother, in the presence of the social worker, spoke to him in endearing tones and promised to buy him a toy, but he refused to go with her, saying that he would wait and go home with me to live, showing clearly his need for security and a firm, consistent attitude. With much work, the mother was made aware of her ambivalence. She came to understand that she wanted to prove that Robert was impossible and could not be kept at home, and that instead of encouraging temper tantrums, countered by threats, she would have to be firm and consistent in her attitudes in order to help him gain control of himself. This change in the mother's attitude had an amazing effect on the boy whose reaction altered very considerably in every respect. From enjoying his parents' quarreling about him and the urge to separate them, he now began to show concern about them, at times even assuming the rôle of mediator. His father had difficulty with his work, became upset about it and quarreled with his wife. Robert insisted that his father come to talk to me about it. Previously he had squandered money he got on candy and toys; he began to save, and took pride in doing so. He showed a new interest in books and stories and drawing with color and crayons. He became interested in other children made friends, and played outdoors with them.

His physical symptoms had disappeared, and plans were made for him to go to the country with his mother while I went on vacation. When I returned from my vacation, I learned that he had had a relapse while away with his mother. He had been acutely ill for two weeks with vomiting, bloody diarrhœa and high temperature. His vomiting was so severe that he could hardly retain any food. The pediatrician who

examined him advised immediate hospitalization and blood transfusions. Robert was desperate and implored me to keep him out of the hospital. Although I had prepared him before I left for my vacation, his attack represented his reaction to my leaving him. He complained that he had felt very unhappy in the country, and that he could not get along with his mother. He seemed to understand my interpretation that 'Little Robert' (as we spoke of his unconscious impulses) had been so furious at me for deserting him that he wanted to destroy me and in this way destroy himself. He said, 'I know what you're telling me; I promise I'll stop it. I'll make him stop it if you keep me out of the hospital.' With this agreement, Robert went home. After a few days his mother telephoned me to say he had stopped vomiting, his temperature had dropped, and the bloody diarrhœa had disappeared. He was eating well and improving rapidly.

Treatment was resumed at the clinic once a week. Robert started school, did well, which was the more remarkable since he had shown very little interest in intellectual activities during his illness or before it. Our contacts became more infrequent but I continued to see him once every month or two because I felt that he needed support since the family situation had remained almost unchanged. His father had increasing difficulties with his employment (a displacement of the marital difficulty) and conceived the idea of leaving home and taking work out of town. For a time Robert took this situation very well. When I discussed the problem with him, wondering how he would manage without his father, he said, 'I told him to go and I'll show you that I won't get sick. And besides he got me a puppy.'

The father came to visit the family every other week end. After a few weeks, the child showed a peculiar reaction to his father's leaving when the week end was over. He became restless, looked at the clock, and developed a temperature of 102 to 103 which would last for a day or two without any other symptoms. When his father came home for the New Year's week end, Robert was more than usually excited. On New

Year's Day, when his father was to leave, he became very restless, kept looking at the clock, and began to run to the bathroom. But there was no bloody diarrhœa. He developed a temperature of about 104 with no other symptom. His father decided to remain at home (he told me he preferred not to go back).

In an interview with Robert it transpired he had had an agreement with his father that he might keep his job away from home until the end of the year; and Robert felt that he had kept his part of the bargain. Although the family remained a very unsatisfactory one, he did not have a recurrence of ulcerative colitis, but reacted to the difficult environment with the peculiar symptom of elevated temperature for which no organic explanation was found.

At present he is doing very well, attending school, and has become an enthusiastic collector of stamps. His weight is seventy-six pounds which is about double his weight when treatment began. He has made an excellent social and intellectual adjustment during the past two years.

CASE II

Barbara was seven and a half years old when she developed ulcerative colitis. She first began to complain about cramps and diarrhœa shortly after her father was inducted into the army. She was put immediately on a diet. Her stools became bloody and, developing an elevation of temperature, she was admitted to the hospital. Medical and proctoscopic examinations, x-ray and laboratory tests established the diagnosis of nonspecific ulcerative colitis.

Barbara had one brother, four years her junior. He was described as a friendly and 'outgoing' boy. Barbara never smiled. She had had a much closer relationship with her father than with her mother and his leaving her was obviously a psychic trauma. Shortly after her father's induction, her mother went to work and Barbara was left to herself. She was described by her mother as being a very moody, 'bossy',

and sensitive child. The mother had been very strict in her upbringing of Barbara, adhering strictly to 'rules' and letting her cry for hours. She had trained her very early and put much stress upon cleanliness. She was openly dissatisfied with her daughter, complaining that she displayed all the unpleasant characteristics of her husband's family which she hated intensely. She was determined not to let Barbara grow up to be like this family. Barbara had always been afraid of her mother and used to shrink whenever she came near her.

In my first interview in the hospital ward Barbara told me a dream she had had the night before she was to go to the hospital in which her entire family was killed by a witch. She felt completely helpless and unhappy in the hospital. She wanted to go home but feared her mother would refuse while she was ill. As I was to leave for my vacation, arrangement was made to have the child remain in the hospital until my return. Instead the child was discharged, and after two days at home was taken, acutely ill, to another hospital where she remained for three months. Her condition became much worse, she had no control over her bowels and soiled herself in bed. During the first ten days she did not take any food. She ran a high temperature to 106 and had bloody diarrhœa. She refused to see her mother. Her father was given an emergency furlough to visit her.

When her condition improved somewhat, but still having fever and bloody diarrhœa, she was discharged and referred to our psychiatric clinic for treatment. Barbara was very suspicious of me and feared that I might talk to her mother about her. It soon became apparent that she was very much afraid of and angry with her mother whom she blamed for having sent her father away. She reproached her mother for not having cried when her father left, and after his furlough she was quoted by her mother as saying, 'No one even cries for daddy. I am the only one.' Barbara had always felt protected by her father and when he left she was left entirely and helplessly in her mother's power. In addition to the projection of her own unconscious hostility towards her mother, there was justi-

fication in reality for Barbara's feelings. Her mother was very ambivalent towards her and, at the time, besides working and being 'wrapped up in herself', she was interested in another man. Meanwhile Barbara was transferring some of the feelings she had for her mother to me. This may be illustrated by a dream she had when her father had just left.

> There are soldiers and sailors in line. She asks me, 'What's that all about?' I say I do not know. She asks her mother and her mother does not know either. Then she asks her mother's friend (the only person for whom Barbara had friendly feelings at the time), and the friend tells her that these soldiers are on a furlough and will not have to go back. Then she vomits and I say to her that she will have to come to the hospital for a couple of days. She stays five days, goes home, and vomits again; then I tell her she will have to come to the clinic.

It was possible to convince Barbara of her resentment, anger, and frustration, and simultaneously the symptoms of colitis began to diminish. The development of intermediary symptoms consisting of facial tics and blinking of the eyelids were reported by her mother as having existed previous to the onset of the colitis.

Barbara was now doing well. She gained about sixteen pounds in weight, had no diarrhœa, no elevation of temperature, was going to school, and was fairly happy, perhaps happier than she had ever been before. In the meantime her father had been discharged from the army, and treatment was discontinued after about five months.

Two months later, her mother called to say that Barbara was very ill, had a high temperature, was complaining of pain in her knee, and had bloody diarrhœa. This was almost exactly one year after the onset of her illness, just preceded her brother's birthday and also, as we learned later, shortly after her best and only friend had moved away from the neighborhood. She appeared to be very ill, and she was much afraid that her mother would send her to the hospital. She told me (confirmed by her mother) she had squeezed a turtle, belong-

ing to her brother, so that a greenish liquid oozed, to which she referred as 'the guts coming out'; then, apparently in a quite sadistic manner, she had dismembered the turtle, put stones on it, and buried it. Barbara was so sick that she could neither be kept at home nor brought to the office, and she was admitted to the hospital with the understanding that I would see her there. At the hospital she proved herself to be a very disagreeable patient about whom both the nurses and the doctors complained.

In the ward she began immediately to tell me how unhappy she was and beg to be allowed to go home. When I said that 'little Barbara' (as we spoke of her unconscious impulses) was responsible for her plight because she was so angry that in her attempt to 'get even' with everybody she did not care what happened to 'big Barbara', the child screamed, 'Stop it! Stop it!' She writhed and called for a bedpan. While sitting on the bedpan, straining to defæcate, I continued to talk of her rage and destructiveness, adding that she now included me in her anger because I was telling her these things.

I now reassured her that I could and would help her if she wanted me to, and if she herself would fight 'little Barbara'. She became calm and we parted with my promise to get her some concessions in the matter of food and other liberties in the ward. When next I saw her she was much quieter and an arrangement was made, with her approval, that she be taken in a wheelchair to the clinic to see me regularly twice a week. She was running a high temperature, despite sulfonamide medication, was very weak, and was receiving blood transfusions regularly. She had blood diarrhœa, severe anorexia, and had lost much weight. There was a question of a complicating rheumatic fever because of pain in her knees and wrists and swelling of her wrists and fingers. All laboratory examinations including electrocardiograph and repeated sedimentation rates were negative. Proctoscopic examinations revealed an extensive ulcerative process in the colon.

I promised Barbara, regardless of her fever, to let her go home as soon as she could walk. One day when she was wheeled

into my office, she got up from the wheelchair and staggered to a chair, looking at me triumphantly. I felt obliged to say that although she had 'walked', she was still not well enough to go home. She flew into a rage, screamed and shouted, 'You're a witch. I wish you were dead!' and then began to cry. That I remained calm and described to her her feelings impressed her strongly. I said we both wanted to get her out of the hospital permanently but that this was not yet possible. I explained further that I would have to prepare her mother to make certain that she not only would take her home but would be willing to keep her there and bring her to me for treatment. Barbara's gloomy face lit up and I had the feeling that for the first time she accepted me as an ally. The subsequent change in her condition, and especially in her prevailing mood, was striking. She began to eat, the diarrhœa stopped, and her temperature began to drop. An x-ray of the bowels repeated before her discharge showed no changes.

Barbara came to see me several times at my office. The colitis symptoms disappeared entirely. She still had some pain and swelling in her wrists and fingers for which she received salicylates. She was playing with children and enjoying excursions to a beach. On my return from a holiday of one month, I learned that she had been well, was starting school, and planned to attend a dancing school.

One month later her mother called to tell me that Barbara was very sick. She was complaining of abdominal cramps, had bloody diarrhœa and elevation of temperature. It later transpired that the mother had disposed of Barbara's dog which had been bought for her after her discharge from the hospital. Although the mother thorougly disliked dogs, she had promised Barbara when she was acutely ill in the hospital to get her one when she came home (unconsciously she did not expect Barbara ever to come home).

Barbara was carried wrapped in blankets to my office by her father. She began immediately to tell me how much she hated her brother. She had asked her mother to remove him from the house. She could not sleep in the same room with him.

When it became clear that 'little Barbara' wanted to destroy Jim Barbara began to complain about her aching knee and lay down on the couch. She was afraid to fall asleep with Jim in the room because she feared what she might do to him in her sleep. The pains of which she was complaining had to do with 'little Barbara's' wish to break Jim's bones, much as she had dismembered the turtle. I reassured her by telling her that she could not cause anything to happen to Jim just by wishing it, and that she therefore did not have to punish herself by becoming sick. Jim after all, I said, was running around playing happily while she was sick. She retorted, 'But he does have sore throats'. For her, the destruction of Jim was an accomplished fact, justifying her sickness. Her fantasy of omnipotence caused Barbara to wonder why her mother never got sick; however, periodically she would keep her mother up nights and upset her during the day, finally getting the satisfaction of hearing her mother complain that she would collapse soon, and that she was so dizzy she could hardly stand on her feet. After the session, as Barbara walked without aid out of my office, she asked me not to laugh at the way she walked. It was a peculiar kind of zigzag gait. Next morning her mother called and told me in amazement that Barbara had got up in the morning, dressed herself, was walking around without complaints.

This phase of the analysis is reported in more detail first, because it lends itself to a clear understanding of the mechanisms involved in the production and dissolution of somatic symptoms; second, because the initial reaction to interpretation, as in this particular interview, brought on an immediate disappearance of all the symptoms (fever, bloody diarrhœa, pain, swelling, sleeplessness, and anorexia)—an effect comparable to the effect of surgery in an acute surgical condition. Unfortunately it does not give the same lasting results until this understanding has become an integrated part of the child's personality.

Barbara's reaction to frustration with rage quickly followed by somatic conversions can be best illustrated by an episode. She came for the first appointment after her discharge from the

hospital to the clinic where, having to wait for me, she saw two patients admitted to my office before her. She was moody and uncommunicative and, although realizing that she was angry with me for keeping her waiting, I was unable to devote sufficient time then to analyze her feelings. That afternoon her mother called me to tell me that while Barbara had been quite well that morning, she had returned from the clinic very much upset, complaining of stomach ache, having bloody diarrhœa, vomiting, and repeating, 'I don't care what happens to me'.

When I next saw Barbara she looked very ill, had to be carried by her father, and she was trembling. I interpreted to her her reaction of disappointment in me, indicating that she must have been very angry with me. This she confirmed, telling me that the fact that I saw other patients before her proved to her that I did not care for her. This discussion had a very beneficial influence on her. She left feeling and looking much better. She got up next day and again the physical symptoms disappeared.

At the next session Barbara complained of difficulty in chewing her lamb chop. She then related that she often had to get up at night and have her mother sleep with her. To my question, 'So that mother cannot sleep with father?' she replied, '"Little Barbara" gets angry when they sleep together. She doesn't want them to be so close.' Once, when she got up at night, she 'saw what they did together'. 'Mother was on top of him', she said. Barbara then spoke of an occasion when in play the boys took pictures of the girls' genitals with toy cameras. She said her brother calls his penis 'cookie', that he doesn't like it and wants to cut it off. 'He even tried to do so today. Father tells him it will fall off if he touches it. It can't fall off, can it?' she asked. 'He says he doesn't want it. He wants mine', she continued, 'he wants to urinate on me when he plays with it'. Barbara was covering up her penis envy by denying it. 'Some girls would like to have it', I ventured. She replied, 'I know a girl; she's in the hospital because she wants

to be a boy and urinate like a boy. My cousin wants to be a girl. He puts my dresses on.'

I suggested, 'Sometimes a dream can wake you up'. She said, 'I had a dream last night and I woke up. I saw 'little Barbara' and she looked just like me. She worked on Jim but then she also worked on me. She said something—I don't remember what.' 'What does this mean, "she worked" on you?', I asked. 'She broke his bones—no, she cracked his bones. But then she cracked mine too. I woke up and I had to go to the bathroom.'

Barbara had the habit of cracking her finger joints. She said she liked the noise of it. 'A little girl showed me how to do it when I was four years old [her age when her brother was born]. She had to have both her hands bandaged up.' While speaking, she alternately cracked her fingers and pulled at the bandage that covered a little sore on her knee.

During this period Barbara revealed her fantasies about pregnancy, childbirth, and intercourse. Her predominant fantasy of impregnation was an oral one. Mother gets the baby by eating a certain food that father gives her. Birth was conceived as an act of defæcation. Barbara had a ritual for undressing, a defense against exhibitionism: the doors had to be locked, the shades down, and no one was permitted to enter the room, especially her brother. Suddenly, on occasion, she would appear almost nude, especially when a certain male friend of the family was visiting. Later she became very casual about these things, abandoned the dressing ceremonial and behaved quite naturally, although for a long time she preferred to wear slacks instead of dresses.

Barbara called me, crying into the telephone, 'I can't stand Jim. Take him away.' When I saw her she said, 'Jim did disappear, but only for one night'. Reminding her that she wanted to have Jim out of her way completely, she laughed hysterically, cracking her fingers. She asked, 'Can you keep a secret? You know, I'm really scared of her [little Barbara]. I'm afraid to fall asleep. I feel choked when my mother wants to put on my hat and tie the ribbon. I'm even scared to do it myself.' After a pause she said, 'That's what she wants to do',

and she made a movement with her hands like squeezing or choking. 'She wants to make mush out of him. I just don't sleep. I keep on going to the bathroom but I don't always have a bowel movement although I try.'

Although her condition had improved considerably, when she next came she was carried by her father like a baby, and was scolding and criticizing him for not handling her carefully enough. The moment he had left the room she said proudly, 'How often do you think I got up last night? Ten times! And I made sure everybody was disturbed.' Asked why she continued to employ this method of keeping her parents separated, she said, 'Mother doesn't want to sleep with him anyhow. He's kicking her; so she sleeps with me.' At the end of the session, she first agreed to walk out by herself but then complained of stomach ache. After some discussion, she said, 'I'll make her walk', and she did.

At the next visit Barbara walked into my office with a staggering gait. She volunteered, 'You know "little Barbara" doesn't want me to walk; but I am fighting her. When I want to walk stairs she wants me to fall. That's why I have to hold on to the banister. I'd rather not walk stairs at all.' Her mother said that Barbara was afraid of climbing stairs.

As Barbara improved, her mother became more and more impatient to get her out of the house and off to school. To this Barbara reacted with a compulsive need to cling to her mother whom she simply would not let out of her sight. Sensing the hostile, aggressive impulse in this behavior, and resenting it, the mother in turn reacted sadistically, thus creating a vicious cycle. In addition, the analytic therapy was releasing her aggressive impulses which was essential for her physical improvement, and these encountered great opposition from her mother who began to feel that she could not endure the situation any longer.

Soon a telephone call came from the mother stating Barbara was sick, had an abscess of her foot and high temperature, treated with penicillin. At this point it was deemed necessary that the mother be given some understanding of her own

destructive impulses towards Barbara, and of the effects of the reciprocally hostile, unconscious rapport between her and the child. It was essential to try to enlist the mother's aid in helping her daughter develop a sense of confidence and trust which she had so far not been given the opportunity to develop. Only if she could feel more secure with her mother could she develop emotionally and learn to tolerate psychic tensions instead of discharging them in a neurotic way.

In this interview Barbara's mother was sufficiently ambivalent and guilty that she could hardly face me. She said, 'I have done everything but it doesn't help. Everybody says there is no hope for the child. Aren't you giving up? Barbara said to me today, "You are not a mother. You are a nurse." I said, "Don't I do everything for you?" and Barbara answered, "A mother doesn't do these things. Nurses do." [Barbara hated nurses intensely.] The other night, when I was looking at Barbara, my husband said, "Why are you looking at her like that? You think it would be better if she were dead!" '

I continued to see the mother while the child was confined in bed. Barbara's behavior, as described by her mother, was very characteristic. She made a great fuss when the wound was dressed, and the doctor could examine her only by force. She always wanted to look at her foot, asking frequently whether it would leave a permanent deformity and whether she would ever be able to walk again. This illness was her solution of the conflict whether to remain a baby and cling to her mother, or to grow up and go to school.

Besides cracking her fingers, Barbara also had the habits of biting and picking her nails and pulling at her skin and scabs. Such habits are well-known expressions of strong unconscious sadism. The infection of her foot she had acquired by picking and scratching. She wanted to think this infection was 'accidental' but her doubtful questioning about whether 'little Barbara' could bring on such a thing gave proof that she had some vague awareness of the deep and hidden ways in which her unconscious was working.

Over two weeks later, Barbara was carried into my office, her

leg still swollen and bandaged. She looked very pale and ill. 'I'm afraid', she said, 'I want to get well but I'm afraid "little Barbara" won't let me'. Then she asked, pointing to a plant in the room, 'When is that plant going to die? Before, I wanted to be sick; then I could be like a baby, but now Mommy says she can't lock herself up with me and she can't sleep with me.' 'The more reason', I said, 'for "little Barbara" to be angry with mother'. 'Yes', she said, 'I had a big fight with her. I called her names and tore her dress. She had to change it before we came here.'

A week later her mother called to tell me that the child was behaving surprisingly well and had improved physically. She quoted her as saying repeatedly, 'I want to get well and go to school like other children', and she was also eating much better.

Barbara looked much better and offered to let me take the bandage off her leg to look at it when I next saw her. She told with satisfaction that her brother had an infection of his finger and he could neither use her typewriter nor play with her things. 'Perhaps he will have to be cut', she said, 'I would like to cut him to pieces. But mother wouldn't let me.' With satisfaction she reported the many times she had awakened her mother at night. She was quite conscious of her sadistic behavior: 'I scratched my father on his face. He has to pull away from me.' She continued to be very jealous of her father and resentful of his attentions to her mother. After talking pleasantly in my office, just after she had been carried out by her father there was a loud outcry. It was Barbara shouting at her father for not being careful with her.

Barbara was improved and she had temperature only occasionally. Her parents were now convinced that her illnesses, including the colitis, were emotional in origin. The mother approached me with the request that I see her daughter three times a week until she was ready for school.

During the succeeding weeks Barbara learned further to understand her needs, her conflicts, and also her defenses. She was growing up almost visibly. One day she came in saying jokingly, 'I am a big girl now. I am eating by myself and I am

also sleeping at night now.' She had, until recently, been disturbed at night, sometimes talking to herself in her sleep, once being overheard by her mother saying repeatedly, 'It's got to be done. It's got to be done.' She was much more pleasant and friendly than ever before, and her mother was pleased with her conduct. The mother did not understand what had wrought the change and felt it had to do with something I discussed with Barbara. The degree of the mother's acquired insight into her daughter's continuous emotional struggles was remarkable. For instance, when Barbara whose foot was still bandaged but much better said, 'I want to walk', her mother replied, 'All right'. When Barbara objected, 'But I can't', her mother said, 'Then don't walk', whereupon Barbara began to cry, 'But I want to walk'. Formerly the mother would have become very angry and have screamed at her, 'Leave me alone'. Barbara, of course, was looking for the opportunity to externalize her conflicts, so that instead of having to fight 'little Barbara' she might have a fight with her mother. The mother, better than ever before, was still sufficiently ambivalent to ask such questions as, 'Will Barbara ever really change? I don't mean the colitis. You know what I mean. She is just like his whole family' (the father's family which she considers 'crazy'). She worried no less about Barbara when she was doing well, fearing a relapse as if she could not believe the child could so remain, or, unconsciously, not wanting her to be well.

Barbara had never been as pleasant as she now was. She helped with housework and one day surprised her mother by making breakfast for her who commented, 'I didn't know she had it in her'. She became protective of her brother and started to play with him. When he became sick Barbara said to her mother, 'You know, mother, "little Barbara" thinks that she made Jim sick. Isn't that silly?' Visiting a family towards whose little daughter Barbara had previously been very hostile and assaultive, the little girl hit her in the face. The mother of the little girl wanted to punish her daughter. Barbara said,

'Don't hit her. She's only a little girl. And you don't make her better by hitting her.'

In discussing her return to school, she was frankly frightened. Having missed almost two full terms of school, there was some justification for her apprehension that she could not compete with other children. Immediately after she came home from her first day at school, she called me to break the news. She was in a complicated emotional state, torn between her resentment towards her mother who was urging her to return to school, and her wish to break this dependence. The mother, as usual whenever the child improved, became irritable and knew 'something was going to happen'. The tension grew and one day when the mother insisted that she stay home from school because of a cold, Barbara flew into a rage accusing her mother of wanting her to be sick and threatening to 'get even with her'. She took food, demanding that her mother look on while she took one bite and crumbled the rest. If her mother started to leave the room, she would either hold her or run after her. She threatened her with a recurrence of an attack of ulcerative colitis, and that she would make her mother empty the bedpan for her. Although she was up all night with the bedpan at her side, she could not produce bloody diarrhœa nor any of the other symptoms of ulcerative colitis, but had only one formed stool in twenty-four hours. For the first time she displayed severe anxiety, screaming that she was going blind. She developed a swelling of the previously infected foot, and when I saw her again she was bandaged and had to be carried in. She looked very fearful and began to cry and call for her mother. I called her mother in and Barbara held on to her hand in a phobic manner. I said, 'You are afraid to lose your mother'. Barbara nodded her head. It became clear to her that she had to hold on to her mother physically in order to protect her from her own death wishes. Barbara then permitted her mother to leave the room. She described her fear of the destructive impulses she felt towards mother and brother, understanding that because it was impossible to achieve them or get rid of them, she was releasing the destructive anger against herself. She had

been up for several nights listening for noises from the parental bedroom. She was reliving the trauma of Jim's birth. 'And worst of all', she added, 'he was a boy'. When she left she was composed, almost cheerful.

To reassure her I had stated to her that she had no need to fear 'little Barbara' since she could not give her bloody stools any more. She had a single bloody stool that day after she returned home from the visit. The interpretation to her of this symptom as a transference reaction she understood very well. She said, 'You see you said I don't have to be afraid of "little Barbara" any more'.

She avoided looking at her foot and refused to let me see it. In our last session, while discussing her destructive impulses, I suggested that her sore leg seemed to represent Jim whom she wished to destroy like that. She became anxious and pleaded, 'Don't let me do that!'

The physician who treated her foot advised hospitalization because he suspected an osteomyelitis. With this Barbara complied in a reasonable and sensible way. The x-ray examination did not show any bone pathology, and the ulcer cleared quickly with penicillin. When I visited her in the hospital she said, ' "Little Barbara" doesn't have much to do with this now. She only started it.'

CONCLUSIONS

In these and other similar cases from which conclusions are drawn, we found an extremely ambivalent mother who subjected her child to very early and deep frustration. All these mothers showed strong unconscious destructive impulses towards the child with a wish to rid themselves of it, rationalized in every case by the opinion that the child would do better away from home. To such ambivalent and therefore inconsistent mothers the children reacted with hostile attachment and an intense need to hold on to the position of a baby with extremely strong oral and anal sadistic tendencies. All these children showed a fixation on an oral sadistic level

due to early frustration. The personality of these children is characterized by an extreme inability to tolerate any psychic tension. Failure in resolving the œdipus and in achieving a genital level of development leads to pregenital regression.

The symptoms, eating difficulties, vomiting, stomach ache, and diarrhœa are very common in children as a neurotic reaction to disappointments and frustrations and are somatic expressions both of the child's inability to control the situation, and a defense against and release of painful psychic tensions. The difference between such cases and those who develop ulcerative colitis shows itself in the initial phases and especially in the attitude of the child towards the illness. In ulcerative colitis the complete absorption of the child in the illness and the symptoms are striking and indicative of a narcissistic orientation. The bleeding occurs quite early in the illness and that differentiates, not only somatically but also psychologically, such cases from all other psychogenic forms of diarrhœa. One gains the impression that the amount of bleeding can be determined by the individual child. There is no ulceration in the initial phases, proctoscopic examinations revealing a diffuse inflammation and œdema of the mucous membrane with transudation of blood. Later, after a number of recurrences, a secondary ulceration takes place. I observed in many instances, by comparing the proctoscopic findings upon discharge and readmission, that the inflammation had subsided while the child was at home, increased during hospital residence, and cleared after a second discharge from the hospital. This confirms my impression that hospitalization represented a traumatic experience to which these children reacted in a specific way. It disrupted their narcissistic equilibrium. They could accept such an environment only after they had decided that they could live again, so to speak. The corresponding reaction of the mothers was guilt and anxiety as their unconscious wish to get rid of the child was fulfilled. To the child it meant loss of the mother and being helplessly left to destruction, a fate which could be avoided only by setting into motion the archaic mechanism of oral sadistic incorporation of the needed object

with all the destructive somatic consequences of the defense mechanisms.

These children are in a state of permanent frustration that results in a state of unconscious rage with an irresistible urge for immediate discharge. The slightest additional frustrations such as medical procedures and dietary restrictions provoke exaggerated reactions. The destruction and elimination of the object through the mucosa of the colon (bleeding) would seem to be the specific mechanism in ulcerative colitis. As the object is incorporated sadistically, it is a hostile inner danger and has to be eliminated immediately. The fæces and blood (in severe attacks, only blood and mucus) represent the devaluated and dangerous objects. In all cases with much bleeding, observed and analyzed, it appeared as if the quantity of blood was directly proportional to the intensity of unconscious rage (oral and anal sadism) present at the time. Although essentially it is the degree of regression that differentiates ulcerative colitis from conversion hysteria and mucous colitis, I believe that it is the quantity of sadism that perhaps determines the depths of the regression itself.

The severe form of ulcerative colitis shows great resemblance in behavior, personality structure and dynamics to melancholia, and seems to represent the somatic dramatization of the same conflict, with relatively little mental pain, that in depression is expressed psychologically. Wittkower states, 'Sometimes the patients notice a decline of the mental symptoms during the period of the increased bodily symptoms'. Similarly in Daniels' case, with a decline of the physical symptoms the patient developed depression with strong suicidal tendencies. Cullinan writes, 'There are few diseases in which a patient may become so ill and emaciated and yet recover'.

It is a known fact that sometimes a severe depression clears up when the patient becomes physically sick or suffers a great physical loss. Like depression, ulcerative colitis is a process aimed at reparation. But because the introjected object becomes part of the patient, the outcome will depend upon the quantity and quality of the sadism that now is turned within

towards the introjected object. Only after the sadism has been satisfied and has been exhausted or changed by treatment can the individual recover. This perhaps explains the spontaneous recoveries in depression and in ulcerative colitis, and also why some cases of depression inevitably end with suicide, and the fatal cases of ulcerative colitis.

While in depression the ego is attacked by the superego, in ulcerative colitis the organism is attacked by the aggressively incorporated object and tries to free itself by immediate discharge anally. The gnawing of the conscience in depression is represented in ulcerative colitis by abdominal pain and bleeding. These observations of sadistic devouring tendencies employed in the service of the ego as an act of self-preservation, but at the same time detrimental to the physical economy, are in accordance with Simmel's concept of a primary gastrointestinal libido organization, the prototype of all pregenital libido strivings. Psychodynamically, ulcerative colitis is an organ neurosis with pregenital conversion symptoms. The choice of the organ is determined by oral and anal fixations, the colon being the eliminatory organ. The anorexia, vomiting, abdominal pain, diarrhœa and bleeding represent expressions of and defenses against aggressive incorporation of the frustrating object.

Since psychoanalysis is difficult in these cases and has to include the mother, prophylaxis would be the best treatment. Prophylaxis in such cases should start with the treatment of the mother, or even better, with the prospective mother.

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

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To cite this article: Edith Jacobson (1946) A Case of Sterility, The Psychoanalytic Quarterly, 15:3, 330-350, DOI: 10.1080/21674086.1946.11925647

To link to this article: https://doi.org/10.1080/21674086.1946.11925647

A CASE OF STERILITY

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In September 1941 Sylvia, a married woman of thirty-five, came to analysis in a state of acute neurotic depression. Her first account of the reasons for her depression was that during her ten years of marital life she had failed to become pregnant. The cause of her sterility was apparently ovarian deficiency. After two years of regular periods, her menstruation had suddenly stopped at the age of sixteen and for about nineteen years she had been amenorrhœic. Medical treatment had failed to reinstate her menstrual cycle.

In the summer of 1941 Sylvia had attempted to adopt a seven-month-old girl through an adoption agency which informed me that when she saw the child for the first time she displayed conspicuously ambivalent behavior marked by apparent disappointment. During the trial period preceding the legal adoption, the agency's social worker noticed in Sylvia an increasing feeling of insecurity, anxiety, doubt and depression coupled with a compulsive behavior in the handling of the baby, who quickly changed from a happy, into a disturbed, anxious child. After ten weeks of growing difficulties, Sylvia went to the hospital for a hemorrhoidectomy, first bringing the baby to the agency and asking them to keep it in a nursery home during her hospital stay. At the same time she expressed serious doubts about keeping it, whereupon the agency decided to take the child back. Sylvia reacted to her failure with such a severe depression that the consultant psychiatrist of the agency recommended analytic treatment. Sylvia interpreted the suggestion as a vague promise of another baby should she be cured.

The physical appearance of the patient betrayed at first sight definite glandular disturbances. She looked very much underweight, exceedingly frail and childlike; her boyish figure lacked female roundings, her breasts were small, her legs, shoulders and arms very skinny. According to her, she had

been a healthy but undernourished, ænemic and homely child up to the age of fourteen. Then she began to menstruate, developing quickly and blooming suddenly. Her periods lasted nine to eleven days with a heavy flow. Within two years her weight increased from less than a hundred pounds to a hundred and sixteen. In her sixteenth year she began to worry about getting too fat and she made up her mind to go on a diet. Working hard that summer, she lost weight quickly. At the end of the summer she went to the mountains for vacation where, in the middle of her menstrual cycle she stained and then did not menstruate again for the next six months. Subsequently, under a doctor's care, she gained weight and menstruated once, only to stop treatment immediately, relapse to her old condition, half consciously wishing not to get well again. From that time on she was amenorrhœic. The next years, up to the age of twenty, witnessed an ever growing struggle against a constant compelling wish to force her weight down. She dropped to ninety pounds, looked 'ghostly', felt easily tired and exhausted, and suffered from severe headaches. She was nevertheless able to work on and off throughout this time.

At twenty she received insulin treatment for her anorexia and gastrointestinal disturbances and gained about fifteen pounds, whereupon she promptly stopped treatment and suffered a relapse.

At twenty-four Sylvia married after having told her fiancé about her amenorrhœa. He did not mind as he was not anxious to have children. Nevertheless in 1939, at thirty-three, her bad physical condition as well as her own growing desire to have a child caused her to make another serious effort to be cured. Her gynecologist examined her thoroughly and found:

> Height 63 inches, weight 87½ lbs., extremely emaciated, pulse rate 66, breasts normal size, nipples inverted, hair distribution normal. Vaginal examination: reveals atrophic uterus and vagina, adnexa not palpable. Basal metabolism —42. Hormone analysis of urine fails to show any excretion of estrogene.

In view of these findings the gynecologist made a tentative diagnosis of Simmonds Cachexia and put her on thyroid and estrogenic therapy. Within some months her breasts became tender and larger, her weight increased, and vaginal smear showed 'evidences of local effect'. Endometrial biopsy revealed a few proliferative glands. After half a year of treatment, monthly injections of estrogen (100,000 Rat Units) were followed by a one-day flow. B.M.R. was by that time −31. In 1940 Sylvia was placed on stilbestrol, again monthly, which induced a short flow three times. As two years of effort did not result in pregnancy, Sylvia tired of the treatment and gradually gave it up. She became amenorrhœic again and made no further attempt to get well. Her physical condition relapsed to what it had been before but did not get worse, disproving the diagnosis of Simmonds disease.

At the beginning of her analysis Sylvia was sent for another clinical check-up. She showed signs and symptoms of general hormonal deficiency.

> Blood pressure 90/70, pulse rate 64, B.M.R. −20, blood sugar 96. Uterus small and atrophic. Endometrial biopsy: small fragments of endometrium, atrophic non-functioning endometrial cells.

As to the precise nature of her condition, the internist as well as the gynecologist felt at a loss. Nor did they advise further treatment of her infertility, since they did not regard it as promising. They prescribed thyroid and an enriched diet to improve her general health.

What the clinicians failed to accomplish, analysis achieved. After some months of treatment, the patient began to eat better and to gain weight. Her figure changed rapidly and developed feminine contours. Her breasts grew larger, the inverted nipples became normal. After six months of treatment Sylvia felt ready to adopt another baby and got in touch with the agency. She was advised to wait until the analysis was complete or at least in its final stage. But in the eighth month of her analysis Sylvia became pregnant without having

previously menstruated. Her condition was detected by the analyst in the fourth month of her pregnancy and confirmed by her gynecologist. After an uneventful pregnancy she delivered a healthy baby, a girl, who is now three years old. The analysis, although by no means finished, was interrupted shortly before delivery. It was not continued because Sylvia was too happy to feel the need of further treatment. There have been some interviews since which helped her over some current neurotic conflicts. They revealed further amazing features of the case which will be reported at the end of the paper.

Sylvia is the child of a poor, lower east side, Jewish immigrant family. She is the fourth of eight children: three older sisters, another sister only fourteen months her junior, and three younger brothers, one of whom died at the age of one and a half when she was eleven years old. Her father was a soft, quiet man, her mother a domineering and compulsive woman who combined Jewish matriarchal attitudes with the compulsive traits of the German *Hausfrau*. She suffered from the yoke of poverty and took it out on her noisy crowd of children. They were brought up with overstrictness and imbued with puritanical standards of moral conduct. The mother scolded and spanked the children constantly and prodded them by playing off one child against the other. Consequently the siblings, particularly the girls, were in constant open competition. All of them were as highly excitable as their mother. Violent quarrels alternated with exaggerated expressions of love as the sisters loved, envied and fought each other in turns. Sylvia was the most ambitious one both at home and in school, and later with regard to a career and to social and cultural achievements.

As stated above, Sylvia's psychosomatic syndrome developed in her sixteenth year. The preceding period had been one of intense ambivalence towards her family. At prepuberty she had gone through a period of submissiveness and overcompliance. With the beginning of adolescence, however, she had felt a growing resentment because of the material and spiritual

poverty of her home. Her rebellion against her parents and her religion was so overpowering that she would sometimes burst out saying to herself: 'I hate Mama, I hate Papa, I hate God'. It was at this time that she began to diet. At the age of fifteen and a half her inner protest eventually found an outlet in a secret hectic romance with a Gentile boy, Alfred. She had met him on a job which she took in order to escape from the intolerable family situation. Alfred represented all the ideals she missed in her family and concomitantly everything they would despise and reject. Her love for the 'Gentile' filled her with deep guilt feelings but she could not make herself give him up. It was at this time that she suddenly lost so much weight and, at the end of an exciting summer during which she struggled with increasing sexual temptations, that she became amenorrhœic.

In the fall Sylvia tried to gain her father's consent to change her school course to one of college preparation. She met with violent family resistance, particularly from her sisters who did not want her to get a college education which they themselves had not received, and to which they thought only the brothers were entitled. There were endless family discussions—usually at dinner—about her selfishness which started her leaving the table demonstratively without eating. Nevertheless Sylvia was finally permitted to go to college. Studying hard helped her to suppress her passion for Alfred whom she gave up, at least temporarily. Her fasting habits—a half-conscious spiteful demonstration that she was not 'hogging' the family fortune for her education—became more and more pathological. Sometimes, when she came home from college, she would, instead of taking food from the frigidaire, pick up discarded food from the garbage can.

After about one year, Sylvia's craving for Alfred grew so strong that she again took up the relationship. What developed now, in her eighteenth year, was a passionate sexual affair which eventually led to intercourse, whereupon Sylvia, overwhelmed by guilt, definitely left him. In fact, she was so disturbed by this experience that for the next few years she gave

up boys entirely and devoted herself exclusively to her studies.

After graduating from college, she met her present husband, Eddy, a Jewish boy whom her parents liked and accepted. His soft, quiet personality resembled that of her father and her brothers. By this time her rebellion against her family had again changed to compliance with their wishes, a compliance which only occasionally gave way to sudden violent outbursts of hostility. Sylvia broke off her engagement to Eddy several times—whenever 'he showed too much sexual desire'. At long last they were married. Their relationship, though warm and affectionate, involved many conflicts: she did not regard Eddy as 'manly' enough or as sexually attractive as Alfred. She felt disappointed in his professional career and his cultural and intellectual interests. During her married life she repeatedly fell in love with other men—always Gentiles and her superiors—whom she met at work, but she was never physically unfaithful to her husband. While she was not sexually frigid with her husband, she had to overcome a resistance against intercourse, and compulsive thoughts of her everyday duties would often interfere with her enjoyment. Since Eddy did not like her to work, she was tempted just to stay at home and let herself be taken care of, but at the same time his resistance against her career frustrated and angered her as it reminded her of the attitude of her family years ago. She also resented his indifference towards her sterility which indicated to her that he did not expect her to be a mature woman and a mother. Her own attitude fluctated between periods of intense longing for a career and times when she craved a baby. In between these waves of opposing desires she retreated into a sickly baby existence with Eddy mothering her. After her definite failure under medical and gynecological treatment in 1940, her craving for a child grew until Eddy at last let himself be persuaded to adopt one.

The agency's statements anent Sylvia's difficulties when adopting Gracy have been briefly reported above. Her own account revolved around complications caused by her maternal aunt, who had helped her care for the baby. There had been a

secret struggle between them over the possession of the child in which Sylvia had felt herself defeated. The aunt's eagerness to help Sylvia was explained by the fact that she had once given away her own illegitimate child for adoption. Sylvia correctly interpreted her aunt's possessiveness toward Gracy as a desire to retalitate for, and make up for the loss of her own child. Her sensitiveness toward her aunt's unconscious attitudes was due to her own complementary conscious and unconscious conflicts.

Sylvia had felt very guilty toward Gracy's mother because she regarded adoption as 'grasping a baby from the real mother' who had earned it by undergoing the risk and sufferings of pregnancy and childbirth. These guilt feelings, which she transferred from Gracy's mother to her aunt, made her unable to accept the legitimate possession of the child. In the presence of her aunt she felt incapacitated and became awkward in handling the baby, particularly under the critical observation of the social worker. In analysis the unconscious motives of Sylvia's neurotic reactions to adoption were soon brought to discussion in connection with the following dream:

> Sylvia saw her sister-in-law, Freda, and a child, both apparently sick, lying on two thick grass ropes like two beds. When she leaned first on the child, then on Freda, the child got well. She thought if Freda—who now appeared to be her oldest sister, Helen—would also get well, she would go to the movies.

The complete analysis of the dream cannot be related. It will be sufficient to state that her associations revealed that the ropes represented the sufferings and ties of motherhood, whereas the movies symbolized freedom and pleasure.

The meaning of the word 'grass' in the dream was clarified by another dream which opened the road to a deeper understanding of her guilt problems. This was a dream about 'grasberries'. The word, a distortion of raspberries, was a contraction of 'grasping' and 'berries'. 'Grasping' referred to grasping the child from the real mother; 'berries', standing for

'cherries', was associated with an incident which had occurred after she began to have closer physical relations with Alfred. Arriving home after a secret date, she had seen a dish full of cherries on the table and had eaten them all. Afterwards, feeling guilty out of all proportion for being so greedy, Sylvia began consciously to starve herself as a self-inflicted punishment. Analysis of this incident made clear that eating cherries had symbolized her secret sexual sins, for which she had to atone by fasting. She had expected her lover to take her 'cherry' and to give her a baby in return. The displacement of her sexual desire onto food indicated an intense oral problem at the bottom of her sexual conflicts.

In connection with her sister Helen, Sylvia remembered two disturbing scenes. The first was one in which Helen, who had worked hard to become an actress, fainted one night backstage from overfatigue. (Later on Helen sacrificed her career to marry her lover.) The second scene was a visit to the hospital when Helen had become ill with kidney trouble during her first pregnancy. On that occasion Helen had offered Sylvia her child in the event that she should die. Sylvia reacted first with shock, then with sudden elation because she felt 'protected from the dangers of pregnancy and free to make a career'.

Analysis of the hospital scene brought out Sylvia's envy, first of Helen's career and later of Helen's pregnancy. Helen's offer had stirred up her most sinful unconscious thoughts: either Helen and her baby might die, or through Helen's death she might get a baby without taking the risk of pregnancy or childbirth. Hence her leaning on Freda (Helen) and the child in the dream expresses her need to atone for her bad wishes by rescuing mother and child from sickness and death.

While these experiences with Helen account for Sylvia's unrealistic reactions towards adoption and towards her aunt, yet her ambivalent relationship to both her aunt and Helen cover up and repeat her earlier conflicts with her mother.

Sylvia had been nursed by her mother 'to avoid pregnancy' but was weaned earlier than the other siblings because the mother did not have sufficient milk, and she consequently

refused to give up her bottle until she was five years old. Until the time of her marriage she made sucking movements before falling asleep at night. She also wet her bed up to the age of five, and at four or five suffered from nightmares in which she smeared fæces on the furniture. Her resistance against growing up arose from her jealousy of Mary, the sister who had been born only fourteen months after her. Her mother often told, as a 'funny story', how Sylvia had, over a long period, crept to Mary's crib every night, snatched away the milk bottle and drunk it herself, not knowing that her mother regularly provided another bottle for the baby. When Mary later developed a squint which had to be operated on, Sylvia thought it was her fault. Since there was hardly ever sufficient food at home for so many children, the interest of the whole family revolved around food and money problems, and Sylvia's oral envy and craving for food were kept alive during her whole childhood by the poverty of her family. She was undernourished and ænemic until puberty.

Between five and six, Sylvia outgrew her baby behavior sufficiently to go to kindergarten where she was attended by an understanding teacher whom she fantasied to be her mother. There she also met little Gentile boys who were better dressed and were allowed more liberties than she. Her envy switched from Mary to these boys, from the milk bottle to the male genital, and she soon began sexual games with her new playmates, mostly mutual exhibition. Her jealousy of boys was at this time greatly increased by the birth of another child, a boy, when she was five and a half. Since this was the first boy after five sisters, her parents were overjoyed and spoiled the baby accordingly. Sylvia remembered how frightened she had been by his circumcision which she had witnessed. This experience started anxious fantasies about herself having been subjected to a similar operation as punishment for her sexual play with boys, which were followed by daydreams in which she herself was a boy. Characteristic of the intensity of her oral fixation was her belief that boys grew a penis because they got more and better food. For years she tried to urinate standing

and later developed ambitious masculine fantasies of great achievements for which she would be loved and praised by an ideal mother who had adopted her. Her wonderful daydreams would often suddenly give way to the realization that she was nothing but a poor, untidy little girl, the least worthy of all her sisters. During her school years she became more and more aware of the difference between the physically strong, neat, nicely dressed Gentile boys at school, and the dirty, undernourished, circumcised Jewish boys in her poor home section, who were no better than she herself. Here was the source of her preference for Alfred, her Gentile lover, as against Eddy, her Jewish husband, whose superiority she had never been able to accept. Analysis of her relationship with Eddy uncovered her repressed hostility and her fears of men. Castrative impulses towards her husband, as a substitute for her father and brothers (a second brother was born later) became conscious when she remembered having frequently pulled hard at the genitals of the little brothers in her care. She confessed that she had been disappointed but at the same time relieved to get a *girl* from the agency because she had been afraid that a little boy might have tempted her to play with and hurt his genital.

During Sylvia's tenth year a most traumatic important period in her life was ushered in by her mother becoming pregnant once more. Her relationship to her father, which previously had been overshadowed by her powerful longing for a good mother, now came to the fore. She became preoccupied with the sexual activities of her parents and the problems of pregnancy and childbirth. Influenced by her mother's open rejection of sex and pregnancy—she had, for instance, overheard her mother say to a neighbor that children were a curse not a blessing—and by many primal scene experiences throughout the years, she developed various sado-masochistic concepts of intercourse and childbirth, with corresponding severe anxieties. A series of dreams and fantasies, however, again showed the predominance of her orality. Her most cherished sexual fantasy was that pregnancy is caused by the woman eating something

from the man's genital. In the same way in which she had once replaced her craving for the bottle by the wish to grow a penis, she now at the age of ten switched her envy from the male genital to the pregnancy of her mother. Sylvia remembered believing at this time that she who had never possessed a doll would get one now for her tenth birthday. She was extremely disappointed and resentful when her wish was not fulfilled. Her envy and hostility towards her pregnant mother were expressed in a dream revealing unconscious fantasies that in delivery her mother's abdomen might explode like a bomb, her mother would die from the explosion and she would get the baby.

The explosion of the bomb symbolized her unconscious masochistic anal concept of delivery. Her associations showed that the hemorrhoid operation, which she had used as pretense behind which she could return the adopted child, had the unconscious meaning of a delivery, with the loss of the child inflicted upon herself as atonement for what she had wished would happen to her mother.

When this child, a boy named Martin, was born, Sylvia attached herself closely to him and took over his care completely. Evincing severe guilt feelings, she told how at that time—like her aunt later on—she went into violent competition with her mother by usurping the domestic work as well as the newborn baby—all under the guise of eager helpfulness.

She was proud and happy when her father praised her above the other girls for her domestic virtues and her maternal care of the younger brothers. Underneath, however, she felt much ashamed of his praise which she felt she deserved all the less because of her above-mentioned attacks on their genitals.

When Martin was one and a half years old he died accidentally. He had cut his finger by breaking his milk bottle. The sight of his bleeding finger, fusing with her recollection of the other brother's circumcised bleeding genital, shocked her profoundly as it stirred up her castration impulses and fears. Her mother took the bleeding child to a doctor who gave him an anæsthetic under which he suddenly died.

Sylvia was sitting at home knitting when her mother rushed in screaming, holding the dead child in her arms. There was a terrible family scene. Her mother immediately went into a depression which lasted several months until she again became pregnant. For days Sylvia refused to believe that the baby was dead. She suffered from conscious guilt feelings which were displaced onto the following incident: a neighbor had given her ten cents to call up her father and tell him the bad news and Sylvia kept the nickel change for herself. She could never forgive herself for having been greedy enough to think of money when her baby brother had just died.

Why she regarded her little crime so sinful became clear when Sylvia told of another recollection from the mourning period. When her mother lay in bed, quiet and weak for once, Sylvia remembered having thought in fleeting happy moments that now there was peace and one child less to demand food, care and attention. This memory made conscious earlier death wishes against her sibling rivals, which she had suppressed by overattachment to the younger children: Mary, the least talented and least pretty of the girls, clung to her so much that Sylvia felt as if she had wronged and deserted her when she began her first love affair. After Martin's death she developed such a reactive excessive love for the next born brother that her husband is still jealous of him.

A summary of the development of Sylvia's neurosis might begin with the fact that, despite her traumatic childhood history, she still *appears* to be a rather normal little girl at prepuberty, a little girl trying to gain her father's love by being a good helpful child, eager to mother the younger children. However, because of her tremendous ambivalence originating in early babyhood and frustration, she is skating on thin ice. Since her major conflicts involve her mother and the children born after her, the tragic accident and death of Martin with the ensuing depressive collpase of her mother brings her development in a normal direction to a sharp halt. Her hostile actions against her rivals—incited by her tremendous envy—all

appear to her to have had damaging effects: she felt responsible for Mary's squint as well as for the circumcision of the next brother born. The feeling of responsibility and guilt culminates in the nightmare of Martin's accident and death and her mother's ensuing sickness: the worst of her evil wishes come true to punish her for all her sins.

Overburdened with feelings of unworthiness, the little girl tries to atone first by becoming quiet and overobedient at home and in school and overdevoted to the next baby brother. But with the onset of menstruation her compulsive reaction-formations break down completely under the pressure of increasing instinctual demands and too strict prohibitions at home. At this point she escapes from the frustrating family atmosphere, which is saturated with conflicts, first into jobs and later into her secret love affair. This is a precise repetition of her flight as a child of four into nursery school and sexual play with Gentile boys. Consequently she becomes entangled in an even more intense guilt problem which she cannot solve but by the development of a neurosis.

Her symptoms begin insidiously with her going on a diet to counteract her sudden gain in weight which had stirred up unconscious pregnancy fantasies as well as her deeper oral problems. With increasing sexual temptation her dieting develops into compulsive fasting—a self-inflicted punishment for her sexual 'greed'. At the same time her slim boyish figure gratifies her masculine wishes which are regressively revived and used as defense against her sinful passion. Finally, in the deepest unconscious layer her self-starvation represents suicidal impulses, atonements for intense death wishes.

Her amenorrhœa, which sets in soon after her first kissing experience with Alfred, again is overdetermined: not menstruating is both an escape from femininity and being pregnant. The symptom thus concomitantly represents her fear of, and desire for impregnation. Her defensive masculine strivings find further expression in ambitious wishes for a college education and a career. On this road of escape Sylvia again meets with frustration in the forms of attacks by her family for

usurping the rights reserved for the boys. She pays for the resulting guilt from her underlying hostile competition with her brothers by practically starving herself but nevertheless insists on going to college and taking up her love relationship again.

This spiteful demand for instinctual gratification is characteristic of the patient. She is unable to renounce and ward off her instinctual demands, sexual as well as aggressive, for a sufficiently long time by reaction-formation or even by symptom formation. For years she indulged in sinful fantasies and actions, for which at the same time she atoned by fasting, chronic sickness and loss of her feminine functions. Even such a severe masochistic symptom as taking food from the garbage can is an extremely spiteful demonstration against the family.

It is only after her first sexual intercourse that Sylvia develops defenses strong enough to check her guilt laden strivings. She renounces love and sex, conforms with the life in her family, works hard but with little pleasure, and at last marries a man in compliance with her parents' wishes. Her marriage relationship combined with her physical ailments become a shelter from instinctual danger while at the same time they permit her to gratify the longings of babyhood: her husband behaves like a kind mother who loves and spoils her. Her repeated attempts to liberate herself and build up an active, mature life are doomed to collapse. Her reaction to her failure to adopt a baby duplicates that of her mother: she is deprived of the child and reacts to the loss with a depression.

This patient's illness raises manifold interesting problems. We will begin with some diagnostic questions. Apart from her psychosomatic syndrome, the picture is that of a psychoneurosis with pathological character development and symptom formation. There are definite compulsive traits in her personality and from time to time she developed transitory compulsive symptoms and obsessional ideas. In spite of the compulsive components of her neurosis, her behavior in analysis, her main defense mechanisms, her transference reactions and

her transitory symptom formation were all characteristic of a hysteria rather than a compulsion neurosis. Her childhood history likewise shows that she reached and never fully relinquished the genital stage of instinctual organization. Her depression was also of a hysterical type.

The leading symptoms of the patient—her eating disturbance and her endocrine deficiency with resulting sterility—belong to the field of psychosomatics. Fenichel,[1] in a recent attempt at a theoretical clarification of psychosomatic phenomena from the standpoint of psychoanalysis, emphasized the necessity of distinguishing clearly between psychosomatic and psychoneurotic disturbances. Unfortunately, the line of demarcation, though theoretically very important, cannot always be clearly drawn. This is also true in this case. It is hard to define to what extent the symptoms of the patient should be regarded as psychoneurotic, as psychosomatic, or as a mixture of both. As will be seen, they can be understood only by clarifying the interlocking relations between psychological and psychosomatic processes.

It is doubtful whether the eating disturbance of the patient at the time when she came to analysis should be diagnosed as psychosomatic—a chronic attitude towards food devoid of ideational content. This disturbance developed insidiously from conscious dieting into a typical neurotic symptom representing unconscious fantasies. In adolescence the patient fasted for some time because she had the 'compelling idea' of forcing her weight down; later her fasting habit appeared to turn into anorexia. It was the positive therapeutic reaction which suggested the presence of anorexia of the hysterical type: her lack of appetite and disgust for food, as well as her gastrointestinal disturbances, disappeared with amazing rapidity as soon as she understood the unconscious meaning of the symptoms.

Her amenorrhœa—at first certainly no more than a mild functional glandular disturbance—also had a specific symbolic meaning at the beginning, but within a few years she had acquired a

[1] Fenichel, Otto: *Nature and Classification of the So-Called Psychosomatic Phenomena.* This QUARTERLY, XIV, 1945, pp. 287–312.

severe polyglandular hormonal deficiency resulting in definite physical alterations, such as the change in her whole physique, the shrinking of her uterus, atrophy of the endometrium and sterility. Despite the quite hopeless prognosis accorded her by both clinicians and analyst, the patient, having gained weight, changed her whole physique and overcame her glandular deficiency enough to become pregnant. This is sufficient evidence for the assumption that her endocrine functions were secondarily deficient because of her chronic anorexia nervosa and recovered after its successful treatment.

Again however, the interacting relations between organ and psychoneurosis, but even more the leading rôle of the psychogenetic factors, must be considered. In previous years her anorexia had also been temporarily improved by physical treatment but without influence on her glandular system. Only after the psychic barriers against menstruation and pregnancy —her resistance against accepting her mature feminine rôle— were lifted did her ovarian cycle reappear. This underlines the advisability of psychotherapeutic treatment in such disturbances—a fact demonstrated several years ago by Schur and Medoci [2] in a number of clinical cases.

Returning to Fenichel's paper, in his classification of psychosomatic phenomena he distinguishes three groups from the libido-economic standpoint: (1) affect equivalents, (2) results of changes in the chemistry of the dammed-up person, (3) physical results of unconscious attitudes and behavior patterns. According to this classification the physical disturbances of the patient should be listed under the second and third group.

The next problem is the question of what determined the development of the patient's psychosomatic symptoms. Fenichel mentioned, of course, the importance of constitutional factors as well as the childhood history. There was in fact a tendency towards mild endocrine diseases, menstrual irregularities, spontaneous abortion and slight metabolic disturbances in the patient's family.

[2] Schur, Max and Medoci, C. V.: *Über Hypophysenvorderlappeninsuffizienz.* Wiener Archiv für innere Medizin, XXXI, 1937.

As to the childhood history, it may be that genetic perspectives are better able to shed light on the causes of psychosomatic symptom formation than classification from the libido-economic standpoint alone.

What is impressive in this patient is the enormous intensity of the pregenital anal, and in particular oral fixations, and the depth of the narcissistic regression. Again the constitutional element should not be forgotten. Her mother developed what was evidently a true melancholic depression which suggests a hereditary oral instinctual constitution. However, her early childhood experiences, i.e. the ambivalent, sadistic attitude of her mother, the early weaning, the arrival of another baby when the patient was only fourteen months old, his milk bottle, the permanent lack of sufficient food and the emphasis laid by the whole family on food and money, account sufficiently for the pathological aggressive orality of the patient. Other authors have pointed out the same genetic factors predisposing to anorexia nervosa and Lorand's[3] case resembles that of Sylvia in many features.

In view of her inheritance and her traumatic infancy and babyhood, the question may be raised as to why the patient did not fall ill with true melancholic depressions as did her mother with whose compulsiveness she had definitely identified herself. The answer to this may lie in the fact that Sylvia's father, though rarely at home, was a warm, soft, loving personality. The analysis showed that the patient could love him and identify herself with his kindness sufficiently to be protected from melancholic reactions, but not enough to find a substitute for the lack of mothering when she was a baby.

Considering all these genetic factors as well as the picture of Sylvia's present life as a married woman, it may be stated that her illness, though essentially hysteria, also represented a partial regression to a deeper infantile level than is common in a psychoneurosis though without reaching the depth of narcissistic regression which characterizes psychosis. This may have

[3] Lorand, Sandor: *Anorexia Nervosa: A Report of a Case.* Psychosomatic Med., V, 1943, No. 3.

predisposed her to disturbances overstepping the boundaries of psychoneurosis and expanding into the area of psychosomatics. A further interesting issue which can only be pointed out here is the question why in this case the pathological development starts with neurotic symptoms which rapidly turn into severe psychosomatic disturbances, while in other patients there is either psychosomatic or psychoneurotic symptom formations alone, while in still others psychosomatic symptoms become secondarily psychoneurotic, i.e., cathexed with unconscious fantasies.

Finally there is the problem of psychogenic sterility, a subject which has been in the center of interest during the last decade. In his article, Sterility in the Female,[4] a complete review of the literature on the subject of sterility, Kelley devotes one chapter to infertility caused by endocrine disturbances and another to sterility arising from psychosexual maladjustment and psychic conflict. In the latter he says that 'in anorexia nervosa, which is accompanied by marked changes in ovulation and the menstrual cycle, dietary, endocrine and directly psychic factors are actively interrelated'. These observations are in conformance with the impressions gained from this patient. No case of sterility is mentioned by Kelley in which psychotherapeutic treatment effected a cure.

That the therapeutic success was due to the analysis cannot, in my opinion, be doubted. Objections may be raised on the ground that many women suffering from sterility caused by an infantile uterus and ovarian deficiency spontaneously recover their ovarian function in the fourth decade of life and become pregnant. Cases have been described in the literature in which menstruation was reëstablished after ten years of amenorrhœa. The clinicians agreed, however, that in this case of severe and long lasting endocrine involvement the assumption of such a sudden coincidental spontaneous recovery had to be rejected.

Further questions may arise as to how the preceding

[4] Kelley, Kenneth: *Sterility in the Female.* Psychosomatic Med., IV, 1942, No. 2.

attempted adoption of a child might have had a bearing on the pregnancy occurring one year later. During recent years investigations have been begun on women who, having been sterile for years, become pregnant after adoption of a child. It is assumed that a therapeutic effect is brought about by an acceptance of femininity and motherhood inherent in adoption and frequently fostered by the encouragement and psychological support of the physicians and social workers of the adoption committees.

Orr [5] tells of a woman who became pregnant after deciding to adopt a child. Analysis of this patient and later of her husband showed how the decision to adopt a child broke a vicious psychological circle by creating legitimate reasons for the wife to quit her job, which in turn lessened her hostility towards her husband and helped her to accept her feminine rôle.

Such observations suggest that Sylvia's attempt to adopt a baby, though it failed, may have played a part in the positive therapeutic effect in so far as it may have prepared her for psychoanalytic treatment. Since the adoption was a failure resulting in a depressive breakdown, it is unlikely that it had a direct share in the therapeutic effect. Finally—and this fact holds against any objections—the improvement in the patient's symptoms during the course of her treatment up to the time of impregnation were observed as they followed step by step the steady progress made in her analysis.

One favorable factor must be mentioned, however, which life itself offered in support of her cure. During her analysis her youngest sister Mary, the object of her earliest and most profound envy and guilt, the only one of her sisters who had remained single, married and became pregnant. It can hardly be regarded as coincidental that Sylvia became pregnant one month after her sister, especially since the analytic material showed the enormous relief from guilt brought about by this fortunate circumstance. What must also be mentioned is

[5] Orr, Douglass W.: *Pregnancy Following the Decision to Adopt.* Psychosomatic Med., III, 1941, No. 4.

Sylvia's comparatively sound reaction when Mary had a miscarriage in her last month of pregnancy: she was at first disturbed but quickly regained her equilibrium. Two years later Mary again became pregnant and had a normal delivery.

During the past two years following the patient's delivery she came in for a series of interviews which cast some interesting sidelights on her problems.

Pregnancy and delivery were normal and without physical or psychological complications. She nursed her baby at first but soon had to wean it because of a mastitis. The striking parallel with her own infancy did not stop at this point. After some weeks the infant developed a lack of appetite which the pediatrician, without knowing anything of the mother's psychological history, diagnosed as anorexia nervosa.

Her interviews with the analyst helped her to a large extent to overcome the difficulties which seemed to be caused partly by an inherited tendency in the infant to oral complications, and partly by the neurotic attitude of the mother.

Some months after delivery the patient menstruated normally after which she became pregnant again despite precautions taken by her as well as by her husband. Since she refused to have a second child due to the fear of creating for her first child the same emotional complications from which she had suffered, she had an abortion. She then consulted several gynecologists for advice as to how to avoid another pregnancy. Although the couple took all available precautions Sylvia became pregnant a third time.

These amazing facts are evidence of the changes in her endocrine production which resulted in a period of high fertility following years of sterility.

After the patient had undergone a second abortion, she played with the idea of artificial sterilization which was advised by her gynecologist. A long discussion with her analyst failed to make her realize sufficiently the unconscious motives and psychological dangers of such a decision. Nor could she be convinced that further analysis was indicated and she left rather

determined to subject herself to this operation. After many months she once more consulted her analyst about certain difficulties with her child. On this occasion she reported that since the last interview she had given up the idea of artificial sterilization. However, her menstruation had again stopped, a fact which made her happy indeed because it definitely settled her problem. Her health in other respects was satisfactory. She felt rather well adjusted to her family situation and quite active and successful in writing articles on infant psychology for popular magazines. Despite the undeniable therapeutic success it appeared that her neurosis had the last word.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

A Depression Which Recurred Annually

To cite this article: (1946) A Depression Which Recurred Annually, The Psychoanalytic Quarterly, 15:3, 351-364, DOI: 10.1080/21674086.1946.11925648

To link to this article: https://doi.org/10.1080/21674086.1946.11925648

A DEPRESSION WHICH RECURRED ANNUALLY

BY GEORGE FRUMKES, COLONEL, M.C., A.U.S.

A thirty-year-old unmarried clerk was referred for treatment as he was recovering from a depression of a type he had had each year for the past ten years. Although he knew he would be better in the spring and summer, he wanted to be treated so that the depressions would not recur. They began in August or September and continued about six months. During the spring and summer he was overactive and too confident without excitement or unseemly behavior. After the recurrence of the first few cycles he was never free from the fear of the autumnal depression. This constant threat interfered with his freedom of action in his business and in his relationship with women.

The depressions were heralded by the observation that he was sweating excessively; then he felt vague anxiety, followed by the fear that he would not be able to do his work. Later, came feelings of unworthiness and inefficiency. He was convinced his work suffered because he was slow because he had to check his work four times and he dreaded anything new and avoided making decisions. He tried to evade as much work as possible without attracting attention, and he avoided contact with superiors and fellow workers. Despite the great effort it cost him he never missed a day's work. He felt he had no right to indulge himself. He was certain that his deficiencies were apparent to everyone. If he could have afforded to do so he would have remained in hiding in the South for six months. If criticized, he would suffer keenly and be incapable of defending himself. Praise or affection caused him suffering because he felt he was an imposter not deserving such consideration. There were no ideas of suicide. He was haunted by the fear, 'Suppose my immediate superior died; how would I be able to take over his work?'

He was especially uncomfortable in cold weather, but there was not a constant relationship between the depth of the depression and the drop in temperature. Certain signs foretold his recovery: he would take out his camera, make strokes as if he were playing tennis, and become interested in girls. In his overactive phase he was with as many as four girls a week, he was restless, prided himself on doing the work of three men and devised new office systems.

The patient was born of Russian Jewish parentage, in a small American town where his father was a poor tailor. Both the mother and the patient had to help in the store. He also helped his mother with the care of the children (a brother two years younger, and two sisters eight and ten years younger). During summer vacations he tried to find work to earn some extra money. He was a good student. He completed high school at sixteen, and a year later the family moved to New York where the father established another tailor shop and the patient completed a four-year course in accounting by attending classes at night.

He entered his place of employment as an office boy and was gradually promoted, becoming assistant to the head of one of the departments. His increases in salary were disappointingly small. He ardently desired to become rich and successful so that he could furnish his mother with a better apartment and little luxuries. He wanted to hear people say, 'That is what we expected of X'. Other firms paid twice as much salary for the work he was doing, but his employer hinted that positions with him were more secure because he did not lay off employees during business depressions. Since the patient feared the return of his illness, even in his most elated moods he was deterred from any serious attempt either to demand more salary or to seek it elsewhere.

He loved his mother whom he described as a warm-hearted person, a dutiful wife and a tender mother. He believed he was her favorite. She prepared the food he liked best and encouraged him to eat and to rest. Recently he had begun to resent her solicitude as a restriction of his freedom. In the

first interview the patient made a slip of the tongue, referring to his mother as his wife.

He regarded his father with dutiful but contemptuous indifference because he was ineffectual and could not support the family without the aid of the children; also he frequently lost his temper unreasonably. The mother once discussed with the patient the possibility that she would some day leave her husband and set up house with her son.

The patient tried to dismiss his younger brother with assumed indifference but it was soon apparent that he felt dislike and jealousy. Family anecdotes indicated his resentment of the new arrival. He had to give his toys to the brother, and he was expected to act more sensibly and to set a good example. The patient was conscientious, studious, always a good boy, did his school work at night, while the brother was relatively irresponsible and played more. The patient was too shy to approach girls. When he was sixteen years old he made the acquaintance of a shopkeeper's daughter, his first 'puppy' love. He arranged his newspaper delivery route to provide as many opportunities as possible to pass her store and to enter it on some pretext. He had never expressed his feelings to the girl but was on the point of doing so by showing her his watch, which he prized very highly and on whose case he had inscribed her name. It so happened that on just about this day his brother met the girl, won her favor, and then related how much this girl liked him. The patient was filled with secret disappointment and shame. He tried to forget about the girl, erased her name from his watch case. Far from complaining to his brother, he expressed his willingness to help the pair arrange meetings. Much later, when the brother was courting his fiancée, his behavior strongly provoked the patient's resentment, ostensibly because the brother's late and uncertain hours made the mother worry about him. Once the patient had fantasies of his brother having been killed. When the brother married, the main burden for support of the family fell to the patient. However, it would have been intolerable for him if the situation had been reversed and his brother had remained

home as the good son. Currently he was annoyed that the brother and his family should spend week ends at his home because it entailed excessive work for his mother.

He regarded his sisters as responsibilities and looked forward to their getting married. The elder was subject to recurring periods of irritability and lassitude. She had to be given a bedroom for herself while the patient slept in the living room with the prettier and more vivacious younger sister. He was surprised that I commented on this arrangement and insisted he never gave a thought to his sister's presence. In fact, he prided himself on his self-control; cold-bloodedness he called it. This confidence in his ability to keep his thoughts pure caused him to get into situations which occasioned ribald comment: the offer to apply a bandage to a girl's knee; sleeping in a room with four girls of whom two were in the bed with him. He prided himself on being able to be in such situations without getting an erection.

When he moved to New York he was incredibly naïve about sex. He had no conception of sexual intercourse or of how babies are born. He had never kissed a girl. He could not believe such intimacies were permitted. He had no friends from whom he could learn anything. His parents never mentioned sex, he did not discuss these matters with his brother, and his high school course did not include biology. He began to masturbate at about twelve. He considered it a unique vice. He had no recollection of any fantasies associated with it. Ejaculation frightened him. He thought he was losing a 'vital lubricating fluid'. He felt too guilty to speak of it and was especially ashamed that this practice contrasted so much to his reputation as a 'good boy'. He made resolutions to desist and would mark certain days, especially holidays, as a last date for the practice, but he continued to masturbate once or twice a week, usually in the toilet. It was a revelation to him at about the age of eighteen, from conversations with fellow students and the elevator boy, that there actually was a name for what he was doing. He surreptitiously looked up the new words in the public library and was especially anxious about

what harm he had done to himself. His feelings of guilt were appreciably lessened but continued to be excessive, especially when he was depressed.

He had occasion to meet girls through his college fraternity brothers and soon had an extensive acquaintanceship. After a time he kissed and 'petted', but he was certain that girls with whom he associated were virgins and therefore were inviolable. No girl he met entirely suited him even as a friend. He once made a list of about fifty names and classified the girls as to their desirable qualities, from which he created an ideal girl who might suit him.

At the age of twenty-three he had sexual intercourse for the first time in a brothel. Three years ago a physician gave him the telephone number of a prostitute with whom he had about seven satisfactory experiences in the course of two years. He begrudged the charge. Once he went to bed with a girl who worked in his office but he could not penetrate her hymen. She performed fellatio which he found pleasurable and exciting, especially 'when a nice girl did it'.

He regarded the sexual urge as a nuisance. It was too troublesome to arrange—telephone calls to be made, money to be spent, the bother of making an appointment, of obtaining the use of his brother's apartment; besides, when he had the urge he wanted immediate relief. The girls he knew were all virgins. Masturbation solved the problem so much more satisfactorily even though intercourse might be more pleasurable. Occasionally, on leaving a girl after midnight, he walked on a deserted street with his penis exposed. Sometimes he masturbated on the street. He consulted a psychiatrist who recommended intercourse.

He met a girl named J, who had an apartment of her own. One night he suggested that he sleep there and promised that he would make no advances. He kept his word, but on the next occasion they began to have sexual relations. The patient did not care much for the girl, but the arrangement was very convenient and he was following the doctor's orders, so he visited her every Friday. He complained that she interfered with his

sleep because she would not let him alone after intercourse. He chose Friday night because he did not have to work on Saturday. Even then the lack of sound sleep disturbed the next day's tennis game. The patient was disappointed when, despite his coöperation in following the doctor's prescription, his depression recurred the next fall. He consulted other doctors who told him he would have to uncover some forgotten memory and then he would be well. In these treatments he talked very little, never recovered memories and never dreamed.

During analysis his attitude was very detached. There were long silences interspersed with 'so'. He examined his hands, played with keys, and yawned. He displayed almost no emotion. He would telephone and say brusquely: 'I'm busy at the office. I can't make it tonight; will see you tomorrow', or he would come late for the hour. Once he hurried into the office, asked to use the telephone, and gave orders to his secretary. Hours were arranged so that he had either late appointments or appointments on his free days. When he was charged for an hour he had cancelled he became indignant. An unfair advantage was being taken of him. As further evidence of the analyst's lack of consideration, he cited that the analyst had not given him advice he sought about a furuncle on his ear. This was construed as evidence that the analyst was 'high-hat' or 'Park Avenue', refusing to demean himself with minor surgical matters and proved to him again that the world was unfriendly. He would bide his time and some day have his revenge, either by refusing to perform a service for the analyst or by performing a service to remind the analyst of his previous selfishness.

His armor of detachment was weakened by discussion of the day-to-day events and the interrelation of these events with his character and previous history. He said that the other doctors had dwelt almost exclusively on his sex life. He was especially impressed by the analysis of the relationship between his sense of guilt, his striving for perfection, masturbation, and his depression. These discussions often evoked emotion and led him to express the opinion that he was 'getting places'.

He felt as if he were understood. In the third month of analysis he brought his first dream.

> 'I was here and at the end of the visit I still wasn't finished, so you walked out with me for fifteen or twenty minutes and we talked. At the end you said you wished I would not waste your time since nothing I had to say was of any importance.'

He could not understand why he should have this dream since he had not seen me the previous day. He had telephoned fifteen minutes after the hour was to have begun to say he had been detained, and to ask if he should come. I said that if he started out immediately he would still have fifteen minutes of his time. He laughed and said, 'all right', but five minutes later he telephoned again to say he would see me the next day. His tone was curt.

'When you said I had fiften minutes I laughed. I thought, "You, too, Brutus". First my boss is nasty and then my doctor says, "You have fifteen minutes". I was angry. Later I though maybe you weren't just unreasonable or trying to make me pay for the hour but did it to get my reactions. I thought I'd wait until the end of the month to see if you would charge me, then I would argue. Yesterday for the first time I felt that my anger was normal. I don't have to be pushed around. I thought, "I don't give a damn". Why do you finish on the dot and not when I'm through talking. In the dream you were good to me. I want you to like me as a person. I want everyone to like me and do me favors just as I would do them for others. In the dream you put your arm around my shoulder. I've tried to make people like me. My pride has been hurt. I was going to ask you if you'd permit me to take a picture of you. I didn't mention it because you would think I was imposing.'

The manifest content of the first part of the dream was readily accepted by the patient as a wish fulfilment that I like him. This was connected with his expression of his long felt desire to find a man in a superior position whom he could admire and who would be benevolent to him (a good father).

The second part of the dream was interpreted as a justification for feeling hostile to me, as an excuse for aggression, or at least for a reserved attitude. He was encouraged to express his emotional reactions as they occurred and not to wait until they were obscured by his defense mechanisms, especially his attitude of detachment. He was told that aggression and reactions against it played a large part in the determination of his ideas, attitudes and symptoms.

His solicitude about injuring girls was connected with his almost forgotten resentment against those who had not offered him their favors in his youth. Despite his precautions he treated them with distrust and aggression. Sex he regarded as wrong. His sexual activity occurred in an atmosphere of fear, guilt and defiance. He had a dream in which he desired to have intercourse despite a fear that his penis would rot. He preferred that the personal relationship to his sexual partners remain minimal. His girl's loving remarks left him either cold or annoyed. It was a unique experience for him that he should desire intercourse with a specific girl and not feel that anyone would do. This experience seemed to frighten him because he prayed for forgiveness after masturbating on the night it occurred.

He said he wanted for a wife a girl with his mother's qualities. She had to be dependable and some one who herself did not have to be cared for. This was especially important when he considered his state during depressions. She had to be able to cook. He especially admired a handsome bosom. He expected her to be tall, pretty, intelligent and refined. In general, she must be a woman of whom nothing derogatory could be said; he must never feel the least embarrassed or ashamed of her. He liked the phrase 'above reproach'. Moreover, he wanted a wealthy girl whose father had a good business he would inherit. His marriage should not diminish his contributions to his mother. The girl must love him only and for himself alone, not for what he could give her. He broke off relations with a girl because she suggested that he take her to the theater. He complained that all girls eventually showed

some defects, even though he might have been enthusiastic at the beginning.

He became aware of his unconscious sexual interest in his mother and sisters and its relationship to his sense of guilt, his hypermorality and his depressions. He dreamed about the younger sister who slept in his room:

> 'My sister came into bed with me and she snuggled up to me; it was very comfortable. I don't know . . . the feeling like a mother for a child . . . for a few minutes, until I had an erection and when that occurred she left me and went back to her bed. In the dream I tried to figure out if her leaving me was a coincidence or if she felt the erection or if I sent her away.'

'I was upset and embarrassed by the dream. The other psychiatrist had said I might be in love with female members of my family. I was like a mother in the dream. I feel uncomfortable when my mother puts her arm around me, or my sisters kiss me. My sister goes in for snuggling. When I was a child I snuggled up to my mother especially when I was sick. She took me into her bed. The erection was something extraneous. The whole idea connected with the erection is too horrible.'

This dream occurred when he was entering a period of depression. It is noteworthy that he identified himself with his mother in the dream. He had the sister take the initiative in coming to his bed, thus absolving him of some responsibility. The presence of his sister in his bedroom was a strain for him and his pretense of 'not giving it a thought' was a defense.

He had another dream in which he sought the permission of an elderly couple to give an educational but practical demonstration of sexual intercourse to a twelve-year-old girl. The associations identified the girl as his sister and the old couple as his parents. His sexual desires were disguised as altruism.

He had a dream in which he masturbated in his mother's presence.

> 'I'm at home and I don't know if in the dream I thought that although I had intercourse twice with J I didn't have an

orgasm the second time. I'm masturbating at home. The family is home too. I'm masturbating just by friction with my clothes on. No one is watching me. I got myself excited and then I ran to the bathroom and finished masturbating standing over the toilet. I didn't lock the door and my mother came by. She wanted to get something. She saw me and walked out. I don't know whether she thought I was urinating. I hope so; otherwise it would be disturbing. But in the dream I'm not so disturbed as I might have been. I feel she wouldn't mention it, and I wouldn't, and the whole thing would be forgotten.'

'Saturday morning after J went to work I defæcated in the bathroom and while doing so I felt like masturbating. Since I didn't have a second orgasm I though it would disturb me if I didn't masturbate because I'd still have sex desire. In the evening I took my sister to see a moving picture. My mother's name was like the heroine's. I was especially impressed in the movie that the heroine didn't love her husband. I have no love for J when I hold her in my arms. Because I'm so tied to my family I can't marry, so I masturbate. There is some anger at my parents because they didn't encourage me as a boy to mingle with other boys and girls. Maybe I felt I could get more excited if I masturbated publicly than in a private place. There may be elements of defiance in it and I used to lock the door when I masturbated. Mother sometimes does come in while I'm in the toilet, perhaps to get something. She usually says, "I won't look". I don't think much of it.'

This dream established a connection between his feelings about his mother and masturbation, and led to the analysis of the link between sexual excitement and excretory activities related to his infancy when his mother attended to his excretory functions. The secret understanding between himself and his mother was related to his mother's fantasy of leaving her husband and making a home for the patient. His exhibitionism was literally expressed in its unconscious relationship to his mother. The element of defiance was also present. The

dream also demonstrated to him his inability to endure sexual tension which he evacuated like urine and fæces.

His castration complex appeared in one dream in which he almost lost his leg in the elevator of a building into which, he dreamed, he had followed the analyst's wife. Another dream had the latent content that girls had lost their penises because of masturbation.

There were times when the patient masturbated in the office toilet and had the idea that the president of the firm could see him by some arrangement of wires. The idea was sufficiently persistent that he carefully scrutinized the toilet. He had fears of being seen by his parents when he used to masturbate at home. This was interpreted as relating to a time in early childhood when his parents had seemed omniscient to him. The idea of his parents and the prohibitions he ascribed to them had become built into his conscience which watched over his behavior, and was projected onto the president whom he also made omniscient with appropriate rationalizations. He dreamed:

> At a corner drug store there is a man with a rifle shooting at another man, trying to kill him. He misses. I'm happy over the fact that he is trying to kill the third party but I don't want it to be seen that I am pleased about it, although down deep in me I want to see him killed. The shooter sees me and says he knows I want to see the other one killed. I won't admit it, but I go around the corner and continue to watch to see if he is killed.'

'The shooter works in the drug store. The other man is a competitor; maybe he is doing something unethical. I don't want to take the responsibility for the shooting. I must hate someone very much. I don't know whom. My own name occurs to me. The first person I ever hated was my sister-in-law during her courtship and I told her to leave my brother alone; also my school teachers for making me feel I had to get perfect grades by showing pleasure in high grades; also my father for losing his temper at me when I was a kid and for shouting at my mother. Once when I was twelve my father

threatened to kill himself because he was being pressed by a third mortgagee. He ran to the back of the store, seized a pressing iron and threatened to dash it against his head. He frightened me. I hated him for it although I suppose I should have been sympathetic.'

The hated person in the dream was the father and the unconscious wish for the father's death was apparent. The hated persons in the associations included the teacher who wanted him to be perfect, thus expressing his hatred towards all disciplining and moral agencies to which in his conscious life he deferred and whose commendation he sought. The occurrence in his associations of his own name as one of the persons being shot was a hostile identification with his father and a rebellion against his own superego.

The druggist in the dream was the analyst who made him aware of the excesses of his conscientiousness which he described as a 'foreign power' which made him feel guilty and uncomfortable. He made me and his father rivals (competitors), wishing me success without accepting the responsibility for the deed. The dream made the patient aware of his unconscious hatred and aggression.

Rado *(3)* commented on melancholia: '. . . from the paroxysm of rage in the hungry infant proceed all the later forms of the aggressive reaction to frustration (e.g. devouring, biting, striking, destroying, etc.), and it is on these that the ego in the period of latency concentrates its whole guilt'. Rado indicated that the manic-depressive patient in his cycle repeats a pattern of guilt, atonement, and forgiveness, which in infancy can be traced to the sequence rage, hunger and drinking at the mother's breast (alimentary orgasm, self-satisfaction, intoxication). The action takes place in the inner world of the patient's mind and not in reality; it is not the love and pardon of his object which he procures but that of his superego.

Our patient had recollections of paroxysms of rage as a little child, when he lay on the floor, kicked and screamed because he could not get a toy that he wanted.

The patient at first stated he had no fantasies associated with

masturbation. In the second month of analysis he brought this one: 'I am standing on all fours. A girl creeps under my belly to suck my penis.' Several months later he had another: 'If only I could suck my own penis'; still later: 'J is on her knees and she sucks my penis'. The first is reminiscent of an animal being suckled by its young, and the interpretation seems warranted that these fellatio fantasies represent an infantile wish fulfilment of being suckled at his mother's breast.

As the treatment progressed the depressions diminished in regularity and intensity. He undertook work of a nature he had formerly dreaded. A year following treatment he wrote that he had had no disturbances of mood, that he was married and felt well.

COMMENTS

It is noteworthy that this patient's depressions began about the time he learned that masturbation was not a unique sin of his, when there was a decrease in the intense conscious feeling of guilt. The depressions represented a redistribution of the punishment in the psychic economy. The punishment was not lessened by the participation of others because masturbation for him was an unconscious infantile sexual striving for his mother, and the associated hostile impulses connected with this drive.

There was a megalomanic quality in his identification with the world, an example of 'negative narcissism'. He reacted to the onset of cold weather (Mother Earth) as though it were a frustration. This corresponded to other respects in which he regarded the world as unfriendly. There was also a period of a diffuse rebellious, aggressive reaction preceding the depression in accordance with Rado's observation that the acute phase of melancholia is regularly preceded by an arrogant embittered feeling.

In connection with this equation of aggression against the mother and the world and depression, Lorand *(2)* has written:

'Aggression directed against the whole world concerns primarily the first environment, in which the "whole world" was represented by the siblings and the father as well as the mother'.

That the recurrence of the depressions in late summer and early fall might be memorial observances of the births of his brother and sisters was suggested by Bertram D. Lewin, a surmise supported by their actual birth dates which fell in this season. The patient's dreams of unconsummated seduction (his sister comes into his bed, provokes an erection, and then leaves him) are about the mother who neglected him for the other children. She is the prototype of the female who seduces him and then jilts him, justifying his hostility towards women. Freud *(1)* noted that the self-reproaches of depression are reproaches against a loved object which has been introjected and become a part of the patient's own ego.

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Psychology of Women. By Helene Deutsch, M.D. New York: Grune & Stratton, 1944 and 1945. 2 vols. 905 pp.

To cite this article: (1946) The Psychology of Women. By Helene Deutsch, M.D. New York: Grune & Stratton, 1944 and 1945. 2 vols. 905 pp., The Psychoanalytic Quarterly, 15:3, 365-393, DOI: 10.1080/21674086.1946.11925649

To link to this article: https://doi.org/10.1080/21674086.1946.11925649

Published online: 11 Dec 2017.

BOOK REVIEWS

THE PSYCHOLOGY OF WOMEN. By Helene Deutsch, M.D. New York: Grune & Stratton, 1944 and 1945. 2 vols. 905 pp.

The history of psychoanalysis has been as much the subject matter of misconceptions as the history of man. There seems to be a tacit agreement that history is the history of *events,* and with this false premise we usually concentrate on the *conspicuous* events rather than on the *significant* ones. The most conspicuous events in human history are usually considered to be the various crises: the fall of a hero, a war, a revolution, the San Francisco earthquake, Churchill's Fulton, Missouri speech, Stalin's reply to an American newspaperman's letter of inquiry.

Psychoanalysis has not escaped this human prejudice. Imperceptibly, although quite in contradiction to Freud's own attitude, psychoanalysts have acquired the habit of viewing the history of psychoanalysis as a chain of strifes and crises. Much has been made of the fact that Breuer broke with Freud, or Freud with Breuer, that Jung broke with Freud and Freud with Adler, that Rank left psychoanalysis, that Horney resigned from something or other. Stress has been laid upon the fact that an individual or a group of analysts decided to become 'liberal' analysts, that the liberals began to divide themselves into sub and super liberals, and that the conservatives (or the reactionaries or the orthodox—the choice of term depends upon the temperament or temper of the chooser) began to break up into their own subgroups, official and unofficial. The fragmentation of the psychoanalytic movement as a scientific unit was the inevitable result of this state of affairs. It was inevitable not because psychoanalysts lacked unity of theory, or the ability to seek and search for scientific data, but apparently because there was one foundation and one only on which psychoanalysis was based, and this was the clinical foundation from which all the essential psychoanalytic concepts were born.

It is precisely this clinical foundation, this strictly empirical, therapeutic orientation that seems to have lost its rôle in modern psychoanalysis in the course of the past decade and a half. It is precisely this singular loss of clinical orientation that seems to have made it easy to turn the field of psychoanalysis into an unculti-

vated, almost unarable plot of multicolored weeds. Stress has been laid on the shortest contact with patients, and on claims of the best therapeutic results thus obtained, rather than on any clinical, empirical orientation. Psychoanalysis became both rigid and brittle; its tenets became either dogmatic or eclectic. The dogmatic psychoanalyst was hard put to say what he stood for. It was much easier for him to state what he was against. In the midst of a growing world crisis, psychoanalysts could continue to say that they were against 'unsound' psychoanalysis; they could quote Freud well and fully, if not always accurately; they tended to stand on the ground of a vague philosophy which was partly based on freudian metapsychology, all literally understood. They knew they were against 'short analysis', against the 'culturalist', against the extreme biological or biochemical trends in psychoanalysis, against religion, against the reëstablishment of the dichotomy of man's functioning, falsely paraded as a hyphenated synthesis of this functioning. This 'being against' of necessity reduced that humanism which had always before inspired and developed freudian thought.

On the other hand, the various 'other groups'—the secessionists, the proponents of new heterodoxies, the schismatic salvationists of the good name of Freud from the tentacles of orthodoxy and reaction—generated a spirit of strife and made pontifical attempts to save psychoanalysis from itself. Emphasis began to be put on training rather than learning, on organization rather than functioning, on theoretical 'orientation' rather than work. The catchwords and clichés of the world crisis began to be utilized. We heard of totalitarian and democratic psychoanalysts, of neo-Adlerians and neo-Freudians: words and terms seemed to have becomes substitutes for phenomena. Clinical psychoanalysis seemed almost forgotten, fewer and fewer clinical papers were being published, more and more numerous generalizations began to take their place.

All this fragmentation and conceptualization at the expense of true clinical thinking belongs to what might be called the American Era of Psychoanalysis. This era is in itself a paradoxical phenomenon. Freud never had any liking for America, nor did he have much respect for American ways and manners in scientific matters. History, however, decreed that America become the asylum for this hated and persecuted branch of knowledge. Freud's pupils, with few exceptions, emigrated to America, the biggest psycho-

analytic institutes were built in America, the greatest number of books and articles on psychoanalysis were published in America, the hottest psychoanalytic fights were fought in America, the most conservative psychiatric circles in America were deeply influenced by psychoanalytic thought.

Apparently some sort of silent, slow process was taking place. This process was not punctuated by 'events' or 'crises', but it proved strong and effective and produced lasting results. History as a rule, despite our biases and our textbooks, goes its own way and does its work without benefit of crises—or despite them.

It is to this history that Helene Deutsch's two volumes on the Psychology of Women belong. It *is* psychoanalysis. It is clinical psychoanalysis. One may seek in vain for the tone of controversy, for the trend to establish a 'school'. One finds no disingenuous contrition, or public confession of past errors in following or in failing to follow Freud, or this or that of his statements. Instead one finds a clear and clean statement of what the author has learned from patients, and of what she thinks may be gleaned from some of the puzzling and not yet fully understood clinical phenomena. Helene Deutsch stands out in this most recent of her contributions as the steady, earnest, and persistently clinical worker she has always been, unspoiled by the deserved respect and popularity which she enjoys in America.

As one peruses these two volumes, one finds one's self *reading* rather than noting carefully points with which one agrees or disagrees. It is not a question of whether you do or you do not accept what Helene Deutsch says; it is interesting to learn *what* she says. Of the first volume, the first chapter, Prepuberty, is a fundamental contribution to psychoanalytic thought and practice. The chapter on feminine passivity in the first volume, and the one on the mother-child relationship in the second are masterly presentations in their clarity and simplicity.

There are a great many points in the author's teleology with which one might disagree, but one is reluctant to do so because Helene Deutsch is an empirical clinician and her parenthetical, philosophical biases do no injury to her clinical and scientific work. Throughout both volumes there is a consistent trend to evaluate fantasy life as a dynamic factor, which sounds almost trite, but it is a point that can never be overvalued, and Helene Deutsch achieves a clarity of differentiation which is enviable.

It would be idle if not unfair to take up in detail the various issues which Helene Deutsch discusses in these two volumes. The book should be read carefully, even though the reading is not easy at times. The difficulty in reading is due to rather poor editing, which is the fault of the publishers. The 'neutralization' of transitive verbs into such words as 'identify', or 'adjust', is always regrettable. Here and there pure germanisms are left to stand. These things are particularly regrettable in the case of Helen Deutsch, because her exposition is always direct and simple, never turgid or redundant, and editorial slips therefore stand out much more prominently.

One might also find one's self a little uneasy about Dr. Deutsch's tendency to be encyclopedic, so to speak; she attempts not to miss a single article or a single idea brought forward by others touching on her subject. What is gained in completeness and thoroughness by such a presentation dims the clarity of the author's own thought because she has no time to give a full critical evaluation of every idea cited.

The two volumes lead us through the psychological jungle of the growth and conflicts of women—from prepuberty (Chapter I, Volume I) to the climacteric (Epilogue, Volume II). The psychopathological aspects are barely touched upon; these are promised full treatment in a future volume. Nor has Helene Deutsch paid much detailed attention to the cultural aspects of the problem; to these she promises to devote yet another volume.

Helene Deutsch has produced a reconstruction of a normal woman on the basis of almost exclusively pathological material. This is in itself an extraordinary feat.

Psychoanalysis is to be congratulated on the appearance of these two books. They came out of the mist and fire of a world tragedy during which psychoanalysis sustained great losses in manpower, in brainpower, in cultural solidarity, in philosophical depth, and most of all in clinical breadth and depth. Helene Deutsch's two volumes stand out as examples of true scientific thought uninjured by the cataclysms of internal and external strife. This is what should happen in scientific work, as it happens in life itself: work must go on with faith and serenity regardless and in spite of all the inhuman tragedies of man.

C. Z.

THE PSYCHOANALYTIC THEORY OF NEUROSIS. By Otto Fenichel, M.D. New York: W. W. Norton and Co., Inc. 1945. 703 pp.

The famous Digests, the greatest code of Law and Jurisprudence of all times, consist of a compilation of all the important decisions, responses, definitions and arguments, gathered from the works of men of high authority. By the order of the emperor Justinian these were detached from their continuities and arranged according to a rigidly fixed system. After the completion of this vast scheme the emperor had all the books that had been used for it, destroyed in order to avoid confusion and duplication. As a consequence hardly anything is left of the writings of the pre-Justinian jurists outside of those fragments which have been incorporated in the Digests.

Fenichel's book is, in its own, less extensive field, quite comparable to the Digests. It is much more than its title announces—not a mere exposition of theory, but an encyclopedia of stupendous completeness. Everything that has been written on any subject related to the psychoanalytic theory of neurosis is contained in it, in an abbreviated and condensed, but perfectly lucid presentation. It might be said that almost the whole psychoanalytic literature is made easily accessible by this book and that many contributions toward it in future will be at the disposition of every student who wishes to acquire general information before starting on a laborious and time-consuming special study.

Yet, in one important point the technique, employed by Fenichel, differs from that of Tribonian and his associates. He has not been satisfied with selecting the material and combining it mechanically within the framework of a system, but has imbued every part of his work with his spirit, the spirit of painstaking research and scientific clarity.

Although Fenichel avoids entering into lengthy counter-arguments and polemics he is by no means the merely passive mouthpiece of the opinions of other psychoanalysts. By arranging them in a coherent and logical sequence, by comparing and sifting them and by interspersing them with his own original contributions, most of all by using his gift of precise and lucid formulation he puts on them the stamp of his personality. The different observations from divergent viewpoints become, not a mosaic of the work done by various psychoanalytical investigators, but an organic entity.

The first part of the book (Introduction, and The Mental Development, pp. 3–116) gives an exposition of the general principles underlying psychoanalytic theory and of the fundamental facts on the broadest basis. We find here, arranged in straight order, the results of the long and intricate, sometimes necessarily meandering development of psychoanalytic science. The theory of libido, infantile sexuality, defense mechanisms, the structure of the personality are explained, with a summary of the method. This first part shows a special mastership of clear outline and solid construction and is, taken by itself, worth the attention of every student of psychoanalysis. We regret that it is so much condensed, but this was evidently necessitated by regard for the economy of the whole.

The following chapters (VII–XX) contain the psychoanalytic theory of the neurosis in full, with all desirable details. Besides the psychoneuroses in the widest sense—including Perversions, Depressions and Mania, Schizophrenia—it discusses all the important borderline problems such as Traumatic Neuroses, Organ Neuroses, Pregenital Conversions (Stuttering, Tic, Asthma) and the long list of Character Disorders.

The third part is an epitome of the course, therapy and prophylaxis of psychoneurosis (pp. 547–589), touching on these topics only in so far as they cannot be separated from the theory, as a sort of indispensable appendix by which the material is rounded off.

The general standard of the book is kept on such an equal level throughout from beginning to end, its context is so closely knit that any attempt to pick out a single item for special inspection and criticism must appear as arbitrary. To do justice to its rich content by a critical dissection it would be necessary to write a running comment that would by far exceed the limits of a review.

The only point in which the book gives less than full satisfaction is the abbreviated rendering of case histories. It seems to be an insoluble problem to make an analytical case history, or even a small section of it, short and easy reading and yet preserve all its essentials. Unlike all other presentations of a similar nature, the omission of detail leaves always an irreparable gap in the complicated net of determinants. The smallest facts are as indispensable as the impressive ones.

The Bibliography of this book will arouse the liveliest interest and retain the lasting attention of all students of psychoanalysis.

It contains in seventy-four pages (pp. 590–664) a complete collection of all psychoanalytic publications, concerned with the theory of neurosis. It is arranged in the alphabetical order of the names of the authors, whereas the text of the book puts every article in the place where it belongs within the framework of our science.

The real value of Fenichel's work and of his indefatigable, conscientious industry will be demonstrated when a new edition of this truly fundamental book will be required—which should be in the not too distant future. Then it will appear that the mere reëditing and bringing up to date of the task he accomplished singlehanded, can be done only with the coöperation of several experts. With him psychoanalysis has lost more than one man's contribution.

H. SACHS (BOSTON)

THE PSYCHOANALYTIC STUDY OF THE CHILD. Vol. I, 1945. New York: International Universities Press, 1945. 423 pp.

This volume ushers in a new Annual in the field of Child Study, written exclusively from the psychoanalytic point of view. Important as it is in itself, its long range value will be in proportion to its ability to stimulate research in this relatively unexplored field.

A review profitable for students would include a review of each of the six sections by specialists in the specific field. The coverage given here to the individual papers is based on the reviewer's special interests and limitations rather than on the merits of the contributions and should serve as a basis for supplementary, detailed reviews.

In the first section on Genetic Problems, the paper by Heinz Hartmann and Ernst Kris, The Genetic Approach in Psychoanalysis, is important in content, Olympian in style, and too economically written. Its purpose is twofold: to defend the genetic approach of psychoanalysis from the criticisms of the deviationist schools of psychoanalysis and from the academic psychologists (Kurt Lewin, among others); and to point out lacunæ in the genetic approach, as well as the need for verification of certain genetic propositions which have long been taken for granted by analysts. There are cross-references to succeeding papers which bear on points raised in this paper, thus partially filling the need for an introductory chapter to the volume.

Dr. Greenacre's paper, The Biologic Economy of Birth, discusses

the contribution of the birth experience to the psychic organization of the individual. On the pathogenic side, Dr. Greenacre correlates the specific features of an individual's birth experience with subsequent symptoms. Thus increased skin erotization as in dry labor 'seems the earliest determinant . . . of a body-phallus identification'. Some connection is also postulated between birth experience and psychogenic headache. On this subject the author promises a detailed paper, as well as one on the effect of birth on the later sexuality of the individual, especially in relation to masochism.

Hospitalism, by Rene A. Spitz, adds to the already substantial data accumulated by Bender, Dufee and Wolf, Bakwin and others on the traumatic effect of institutional care for children under three years of age. These findings receive startling confirmation in the research directed by Dr. Spitz. His investigation has the additional merit of being the first devoted to large groups of institutionalized children during the first year of life. Two groups of infants were observed in two different institutions: one in which the mother was resident and attentive throughout; the other in which the mother came in to nurse the infant during the first three months, after which it shared one nurse with seven other children. The Developmental Quotient (based on Hetzer-Wolf tests) of the first group during the first three months of life was 101.5 and rose to 105 by the end of the year; whereas the D.Q. of the second group was 124 for the first period and dropped to 72 by the end of the first year! This deterioration was progressive throughout the next two years and affected the physical as well as the psychic development of the child. Though there were many minor differences in the two institutions, the one significant factor which the author holds accountable for the spectacular difference in development of the two groups was the presence of stimulation in the form of a mother in the one, and the almost complete absence of human stimulation in the other group after weaning.

The Examination of the Klein System of Child Psychology, by Edward Glover, is one of those papers which cannot be intelligibly summarized in a brief review. It is hoped that a detailed review will aim at making the important and critical contents of this paper accessible to a greater number.

Notes on the Analytic Discovery of a Primal Scene, is a charmingly written essay by Marie Bonaparte and an interesting example of what Hartmann and Kris call psychoanalytic prediction of the

past. A dream in the fourth week of the analysis of a forty-two-year-old woman is interpreted by the analyst as the observations of a primal scene in early childhood. Though strenuously resisted by the patient, the interpretation receives ample confirmation from subsequent material and finally from one of the partners to the scene.

Section II is devoted to Problems of Child Analysis and Child Development and is introduced, properly enough, with a paper by Anna Freud, Indications for Child Analysis. A preliminary discussion of controversial areas in child analysis takes up the different use made of play techniques by the Klein and Freud schools. With the former it is the equivalent of free associations, and interpretations are made in the form of quick flashes of analytic insight into play and symbols. This method is rejected by Anna Freud on the sound scientific principle that the interpretations are not adequately corroborated, and it is criticized for going too precipitately into the child's unconscious without first working through the conscious and preconscious levels. This discussion presupposes a further difference of opinion on the indispensability of speech for analysis, the Klein school maintaining that speech is not essential to analysis, which, therefore, can be undertaken in earliest infancy. Finally the two schools differ as to the application of child analysis, the Kleinians maintaining that every child passes through phases of abnormality in infancy (depressions, psychotic states, etc.) which warrant analytic intervention; whereas the Freudians suggest analysis only for severe child neuroses, relying on analytically-influenced education to guide the others over the hurdles of their infantile neuroses.

This brings the discussion logically to the problem of criteria for the selection of cases for child analysis. The two most important criteria for adult analysis, neurotic suffering and disturbance of normal capacity, are not regarded as decisive for the child. But 'there is only one factor in childhood of such central importance that its impairment through a neurosis calls for immediate action, namely, the child's ability to develop, not to remain fixated at some stage of development before the maturation process has been concluded'. The criteria for this prognostic judgment are to be found in the sequence, age-levels, and intactness of libidinal development, including the component instincts. Another set of relevant data is the effect of the neurosis on the development of the ego:

if neurotic defenses have resulted 'in a faulty knowledge of the outside world' . . . or 'if he is seriously estranged from his own emotions, with blank spaces in the remembrance of his own past beyond the usual range of infantile amnesia, with a split in his personality, and with motility out of ego control; then there can be little doubt that the neurosis is severe and that it is high time to take therapeutic action'. The clinician is reminded to make due allowance for overlapping of libidinal stages, for individual differences, and for spontaneous recovery, for which the optimum time is the phallic phase and puberty. In effect, this discussion bases diagnosis not on the neurotic manifestations as such, but on the meaning of these for the total development of the child. This inevitably points up the wide-open gaps which still exist in our knowledge of the libidinal development of the child and is thus a challenge to further research.

The scientific sincerity and humility which infuse this paper are admirable. But the paper is too strongly tinged with the author's reaction to the Klein system, which seems to interfere with a more definite formulation of 'indications for child analysis'. This leaves the reader with a sense of deprivation.

Berta Bornstein's paper, 'Clinical Notes on Child Analysis', is rich in case material and clinical wisdom. The author makes an important criticism of immediate and continuous interpretations of play as practiced by the Kleinian analysts, not made by other critics of the Klein system, namely, that it may upset sublimation in the very process of formation. There is also a welcome enrichment of Anna Freud's book, The Ego and Its Mechanisms of Defense, in her discussion of the analysis of ego-defenses.

The notable feature of Analysis of Psychogenic Anorexia and Vomiting in a Four-Year-Old Child, by Emmy Sylvester, is the short duration of treatment with successful results. A discussion of the factors which made it possible to clear up this neurosis in about five months would have added to the value of the paper.

In The Formation of the Antisocial Character, Kate Friedlander undertakes to 'clarify the factors that may lead an individual in emotional stress to react with antisocial rather than with neurotic behavior'. This she does by contrasting two boys in analysis, with similar instinctual development, one of whom is antisocial and the other neurotic because of a striking difference in their superego formation. While the author gives a detailed picture of the

family background of the delinquent boy, she fails to do so in the case of the neurotic boy, thus depriving the reader of an opportunity to compare the dynamics of the two patients which is the basis of their divergent development.

The Fantasy of Having a Twin, by Dorothy T. Burlingham, is a brief paper dealing with a well-known fantasy of the latency period which consoles the child for its œdipal frustrations.

Section III presents a number of papers on Guidance Work. The Uncompromising Demand of a Three-Year-Old for Her Own Mother, is an interesting human document of an eighteen-months-old child forced to leave her mother. She strenuously fought every mother-substitute with the well-known repertory of hostile and regressive symptoms. She clung instinctively to one social worker in whom she sensed a strong countertransference and literally forced herself into her home. Only then was she able to reintegrate her ego toward normal progress.

In The Use of Dreams in Psychiatric Work with Children, Hyman S. Lippman not too convincingly discusses the interpretation of the manifest dream content as a means of getting at deeper material than is ordinarily accessible in guidance work. He issues an appropriate warning against this technique in the hands of other than an experienced analyst.

A Contribution to the Education of a Parent, by Margarette Ruben, is a courageous piece of work inspired by Little Hans. A girl of five is helped over her neurotic symptoms through guidance of the mother. Some interpretations appear arbitrary and theoretical, rather than derived from the child's experience. Without a broader discussion of the types of cases suitable for such treatment, from the point of view of symptomatology, age of child, personality and other requirements of parents, this paper misses its opportunity of making a specific contribution.

Reluctance to Go to School, by Emanuel Klein, is a valuable contribution to the problem of truancy. The motives underlying truancy are shown to be anxiety, aggression, and secondary gain. The twin objectives of treatment are to get the child back to school as soon as possible, on any terms, to prevent the fear from spreading and deepening; and to give the child insight into the meaning of its fear. It is gratifying that such a clean-cut, though necessarily circumscribed therapeutic job is being done within the school system.

Section IV, Problems of Education, makes a negative contribution. It traces the influence of psychoanalysis on education, stressing the mistakes. Dr. Fenichel's paper is a theoretical discussion of the problem which sets the frame of reference. Dr. Hoffer's paper seems an unduly severe criticism of progressive education. Dr. Sterba's paper demonstrates, with the help of excellent case material, the importance of observing caution in the use of interpretation as an educational tool in the hands of teachers and parents.

Section V deals with Problems of Group Life. Erik Homburger Erickson's long and interesting paper contrasts character formation in two American Indian tribes in relation to their respective cultures. As in all such investigations, psychoanalysis proves to be a remarkable tool and anthropology a rich source of control data. The other two papers by Edith Buxbaum and Fritz Redl deal with group and gang formations. Dr. Buxbaum discusses mainly the emotional needs which groups serve at the two critical periods, latency and adolescence. Dr. Redl describes the special defenses encountered in psychiatric work with delinquents.

Section VI, Surveys and Comments, consists of: 1. A searching review by Bertram D. Lewin of those portions of Balinese Character, by Bateson and Mead, which confirm and illuminate psychoanalytic data. 2. A comprehensive survey of the literature on Evacuation of Children in Wartime, with a bibliography, by Katherine M. Wolf. Though many discrepancies are shown in the literature, the areas of agreement are important, namely, the low percentage of neurosis caused by evacuation, and enuresis as the dominant symptom of evacuation neurosis. It is also agreed that adjustment to the billet is directly proportional to the stability of the child's relationship with his own parents and is facilitated by a suspension of imagery and thoughts about his parents. But it is precisely this suspension which also accounts for difficulties in concentration—a common characteristic of evacuated children. 3. An exhaustive survey by Lillian Malcove of Margaret E. Fries's pioneer, long-range research in Problems of Infancy and Childhood. 4. A brief but provocative comment by Dr. Kubie on Dr. Ribble's The Rights of Infants. 5. Comments by Katherine M. Wolf on that part of Edouard Pichon's *Le developement psychologique de l'enfant et de l'adolescent,* which attempts 'for the first

time . . . to give a picture of human development based on the findings of psychoanalysis and . . . experimental child psychology'.

A vote of thanks is due the Board of Editors, too numerous to list, for conceiving the idea of the Annual, and to the managing editors, Anna Freud, Dr. Hartmann, and Dr. Kris, for the burden of work in executing it. They have given us a representative cross-section of psychological work with children based on psychoanalytic hypotheses. The papers describing modifications of psychoanalytic technique would have been more valuable, had the discussions been related more to techniques and to indications for such techniques—the *raison d'être* of these papers—than to dynamics. If the volume is intended for the enlightenment of those who are not analysts, as the jacket avers, subsequent volumes should strive for greater clarity and simplicity of language, for which even analysts would be grateful! An improvement in type, now that the exigencies of war are over, will also go far toward increasing readability.

AUGUSTA ALPERT (NEW YORK)

HYPNOANALYSIS. By Lewis R. Wolberg. New York: Grune & Stratton, 1945. 342 pp.

With the publication of this remarkable book, it becomes necessary to take seriously the potentialities of a form of psychotherapy which combines hypnosis with psychoanalysis in a technique called 'hypnoanalysis'. As a result of the investigations of the last decade, the harsh judgment which Freud passed on hypnotherapy seems no longer tenable. In his Introductory Lectures, for example, in addition to stating that hypnosis was a sort of mechanical drudgery, 'hodman's work', reminiscent of magic, conjuring and hocus-pocus, unreliable and capricious in its results and calculated to rob the patient of his independence, Freud raised three more serious objections. First, and still valid today, is the failure of a very large percentage of subjects to attain a somnambulistic trance. Second, Freud believed that hypnosis 'drives back the resistances and frees a certain field for the work of the analysis, but dams them up at the boundaries of this field so that they are insurmountable'. Third, in several places in his works, Freud relates the story of the young woman who, on emerging from a trance, threw her arms around his neck. This kind of thing he felt made it imperative to inquire into the problem of the nature and source of suggestive authority. It was historically important and necessary for Freud

to abandon hypnosis and to investigate the dynamics of resistance and transference by the method of free association. But now precisely because we have available what he has taught us about the dynamics of these processes, the possibility exists of utilizing hypnosis as a rational form of therapy.

The statement on the jacket of the book that hypnoanalysis has received impetus from its widespread use in the treatment of neuroses in World War II is both incorrect and misleading. The type of hypnotherapy used during the war, and by no means extensively, bears the same relation to what is here called hypnoanalysis as Freud's early cathartic method bears to present day psychoanalysis. Wolberg has drawn on the important discoveries of the last ten years in the realm of hypnotherapy, has introduced a number of ingenious techniques of his own, and has combined these with psychoanalysis in an original and unique fashion. Only a handful of investigators have used a method which approaches this in scope and breadth of conception.

The cardinal features of the method are the following: hypnoanalysis *is* psychoanalysis in a controlled setting. The emphasis is on psychoanalysis; hypnosis is an adjunct. The method is offered not as a superficial, palliative form of therapy, but as a substitute for psychoanalysis in certain cases and under certain conditions, in an attempt to diminish the number of therapeutic failures of psychoanalysis, to extend its scope of usefulness, and to shorten the duration of treatment. It directs itself not simply to symptom removal, but to the same deep, dynamic personality alterations which are achieved by successful psychoanalysis. It is contended that hypnosis acts as a catalyst in the analytic process, in uncovering both unconscious material and the dynamics of the transference. The method differs from all previous hypnotherapies in that the transference is analyzed. It is pointed out that hypnosis allows a most intimate form of interpersonal relationship which mobilizes attitudes and strivings that lie dormant in the unconscious. These are projected onto the analyst in the same manner as in psychoanalysis. The patient reacts to the hypnotic relationship with all his characteristic defensive machinery and resistances, and this precipitates the full range of affective interpersonal attitudes which are component parts of the character structure. Of great importance is the fact that the hypnotic relationship is itself subjected to analysis, including the motivations which make hyp-

nosis possible. It is alleged that such analysis does not destroy the capacity of the patient to attain the trance state.

Contrary to Freud's contention that hypnosis dams up the resistances so that they become insurmountable, it is shown that by hypnoanalysis the overcoming of transference resistance and resistance to recall may be facilitated. Through the various hypnoanalytic procedures buried memories are enucleated and by means of regression techniques childhood experiences are revivified with a speed and intensity that is rarely possible with psychoanalysis. It is emphasized, however, that this in itself is not necessarily therapeutic, that the neurosis must be restaged in the transference and subjected to constant analysis.

The first part of the book is devoted to the presentation of a hypnoanalysis of a schizophrenic patient. This detailed case report makes fascinating reading and is unique in psychiatric literature. However, it is unfortunate that the author chose to present this particular case for didactic purposes because the transference was subjected to only a cursory analysis. In the hypnoanalysis of a neurosis, predominant weight, according to Wolberg, is placed on the direct analysis of transference, and it would for this reason have been of more value to present such a patient. In view of the successful treatment of this case of schizophrenia, the prevailing view that psychotics cannot or should not be approached with hypnosis may have to be revised.

The case report is followed by a brilliant interpretation by Kardiner, who stresses certain virtues of the hypnoanalytic method. He points out that by means of certain hypnotic procedures such as the experimental dream and the experimental neurosis, it is possible to confront the patient with test situations which may not arise in his ordinary living during many months of analysis. This is one of the factors that may aid in shortening therapy. Kardiner believes that the hazards of suggestion have been greatly exaggerated, that hypnosis cannot confer potentialities for action on a patient who does not have them. He is of the opinion that hypnosis adds no new or startling information about dynamics, but lends an element of speed and directness to therapy without altering its dynamics. It cuts off the patient's opportunity of escape into endless resistance and curtails these manœuvres into hours or days.

The second part of the book is a description of hypnoanalytic

procedures and a discussion of the relation between hypnosis and psychoanalysis, transference, resistance, interpretation and the recall of buried memories. The chapter on procedures is the best thing of its kind available. The use of free association, dream induction, automatic writing, hypnotic drawing, play therapy during hypnosis, dramatic techniques, regression and revivification, crystal and mirror gazing and the induction of experimental conflict are discussed in detail with excellent examples from case material.

Throughout the book an attitude of scientific conservatism is maintained; it is Wolberg's opinion that hypnoanalysis holds promise of becoming an invaluable adjunct to psychoanalysis, but it must be more thoroughly explored before its complete scientific worth can be evaluated. Although it is suggested that hypnoanalysis can shorten therapy, the evidence is as yet more impressionistic than scientific. It is based on the feeling of the few competent investigators in this field that a given case subjected to hypnoanalysis was cured more quickly than similar cases treated by psychoanalysis. More adequate and rational controls need to be set up.

There are several barriers to the extensive revival of hypnotherapy. One is the severe limitation in the numbers of patients able to attain a deep enough trance to make feasible effective therapy. The whole problem of hypnotizability and induction technique requires further exploration. Another barrier is the fact that many analysts may find uncongenial the type and degree of activity demanded by hypnoanalysis. However, if other competent analysts could divest themselves of preconceived prejudices against the method and experiment with it, its ultimate value might one day be determined.

CHARLES FISHER (NEW YORK)

PSYCHIATRISCHE UNTERSUCHUNGEN AN EINER SERIE VON ZWILLINGEN. (Psychiatric Research on a Series of Twins.) By Erik Essen-Moeller. Copenhagen: Ejnar Munksgaard, 1941. 200 pp.

The material on which this study is based comprises sixty-nine pairs of twins of the same sex. It forms a complete series in the sense that of a group of ten thousand patients all the twins of the same sex about whom data could be gathered and whose partners reached adulthood were included. This completeness gives the results of the investigation greater conclusiveness than

if a selection of striking similarities among twins, or of otherwise 'interesting' case material had been made. Forty-eight pairs were probably dizygotic, and twenty-one pairs probably monozygotic. The case histories of the monozygotic pairs are presented in greater detail, while the others are briefly described, and only occasionally used to elucidate certain points by way of comparison.

The study of twins has been of interest in psychiatry to determine the relative importance of heredity and environment; it can also contribute towards a better insight into whether an *anlage* is dominant or recessive. Also, it may be helpful to clarify nosological questions. The author predominantly utilizes this third approach. He attempts to find out to what extent seemingly different syndromes and symptoms may be the manifestation of the same *anlage*.

Limiting this discussion of the author's results to one group of cases, of seven schizophrenic twins none of the partners had a markedly schizophrenic psychosis, and only one can be considered bordering on a schizophrenic psychosis. However, four of the partners had psychoses of another type: depressions ending in recovery without demonstrable defect. But in three of these partners some transitory symptoms could be observed that remind one more or less distinctly of schizophrenic symptoms. Therefore, it seems more important to the author to determine whether symptoms of a type can be observed, than whether or not they appear as part of a true schizophrenic psychosis.

In all the seven pairs both partners were to a certain extent characterologically abnormal; there were anomalies of emotional response, of tonus, of mimical expression. They correspond to what are found in schizoid psychopaths. From this the author rightly concludes that the demarcation between schizophrenics and schizoid psychopaths should not be as rigidly drawn as some psychiatrists would have it; also the characterological abnormalities seem to be a more constant expression of the schizophrenic *anlage* than the schizophrenic psychoses.

While this is no doubt a remarkable conclusion from Essen-Moeller's investigation, the analysis of the environmental factors—particularly the psychic factors that might have contributed to the differences actually observable among the twin partners—is unfortunately incomplete in this as in many similar studies, which the author himself acknowledges. Only a systematic inquiry into the early development of monozygotic twins will fill this gap.

H. HARTMANN (NEW YORK)

PSYCHIATRY IN MODERN WARFARE. By Edward A. Strecker, M.D. and Kenneth E. Appel, M.D. New York: The Macmillan Co., 1945. 88 pp.

The main virtue of this booklet is that it compares the neuropsychiatric experiences of World War I and II. As the authors rightly state, the experiences of World War I were too lightly regarded. A good deal of time, effort and mistakes would have been obviated if more attention had been paid to what had actually been learned during World War I. They point to some of the errors in judgment which resulted in faulty recommendations and procedures at the beginning of this war; for instance, the supposition that screening and selection would be completely adequate to handle the psychiatric problems of the Services. This misconception went so far as to lead to the feeling that it would not be necessary to plan for any large number of neuropsychiatric hospital beds. The thesis was at fault in part because one actually had inadequate knowledge as to exactly what made for a good soldier under combat conditions. Preinduction screening, although of great value, certainly was not the answer.

There is a justified criticism of the lack of neuropsychiatric organization in the early days of the war. It was only late in 1943 that Colonel Roy Halloran was appointed to head a Psychiatry Division in the Office of the Surgeon General. The authors' statement, however, that there was no prominent head of psychiatry in the Air Surgeon's Office and that 'only after considerable pressure were several eminent psychiatrists appointed as consultants to various branches of the Services' is a bit of an injustice to the psychiatrist who had been appointed as consultant to the Air Surgeon and attempted to function under difficult circumstances.

The material presented is highly compressed and is, therefore, difficult to review. All the familiar factors commonly cited as etiological, are presented. The authors' own emphasis is on 'previous condition of the personality' as the single most important factor determining whether a soldier will break or not. They recognize that there is a limit to each individual's endurance.

The emphasis on the rôle of morale in relation to psychiatric conditions in the Service is to be highly commended since it is perhaps the outstanding lesson learned in this war.

To one who has served in the tropics and has been on most of 'The Islands', the statement . . . 'promiscuity is wide-spread.

Debauchery leads to exhaustion, conflicts, and guilt feelings', is a little wide of the facts since the opportunity for promiscuity in the tropics exists, for the most part, only in travel advertisements.

There is a discussion of psychopathology and treatment along familiar lines, with a bow to the value of narcosynthesis and group therapy, though the latter is recognized as an outgrowth of World War I. There is an emphasis on the lack of totally new formulas and procedures for therapy. The statement of the authors that there was a skilful and useful adaptation of known treatments is a fair one. They tend to overevaluate chemical sedation. The recovery figures as reported from World War I compare favorably with those available from this war.

The second part of the book deals with demobilization and the return to civilian life in which there is a good deal of sound, common-sense advice.

M. RALPH KAUFMAN (NEW YORK)

RORSCHACH'S TEST. II. A VARIETY OF PERSONALITY PICTURES. By Samuel J. Beck, Ph.D. New York: Grune & Stratton, 1945. 400 pp.

In his previous volume, Rorschach's Test, I. Basic Processes, Dr. Beck has offered a detailed presentation of the experimental procedure, of the single factors and of the scoring.[1]

The present volume consists of two parts. The first deals essentially with the psychological significance of the various Rorschach factors; the second contains a collection of about fifty Rorschach records and interpretations grouped in selected psychiatric chapters, under the titles: The Intelligence Curve, The Adolescent Years, Schizophrenic Solutions, Neurotic Struggles, Before and After: The test repeated in the same persons.

In an introductory chapter, Concerning Personality, Beck attempts to state the sense in which he understands personality. Intelligence, affectivity, and a third category, creative imagination, are considered basically as constitutional potentialities. 'Some men are bigger and better than other men.' The psychological forces altering, constricting and deforming such a personality are identified as anxiety, repression and inhibition. Anxiety is regarded as of the first importance.

[1] Reviewed in This QUARTERLY, XIII, 1944, pp. 508–512.

Based on this concept, the psychological significance of the Rorschach factors are dealt with. Under the heading The Work of the Intelligence, are reviewed: whole answers and Beck's factor Z ('degree and height of intelligence'); Mode of Approach ('intelligence as an elastic tool'); Animal and Popular answers ('intellectual adaptivity'); Sequence ('orderly method'); F+% ('conscious control, respect for reality, the ego'). The following paragraph, The Fantasy World, presents the significance of the most important Movement responses. 'Producing M is, generically, the creative act.' In the section, The Affective Experience, Beck convincingly offers a developmental exposition of the meaning of the Color responses and also discusses the Vista and Gray answers, the color shock ('neurosis'), and the gray-black shock ('anxiety'). As Responses of Diverse Scope and Significance are treated: the White space precept ('always a nucleus of contrariness'); Blends; Hdx and Adx (Rorschach's Do); Position Response; Response Total and Time per Response. The most important of these factors is what Beck calls 'Change of Tempo'. As a matter of fact he has worked out felicitously two factors, 'Fluctuation of associational productivity' and 'Fluctuation of response tempo'. He could have added that the common extreme of both is the failure, important in neurosis and schizophrenia. Behavioral Factors and the Experience Type, which are characteristic of and important for Rorschach psychology are dealt with at the end of this second chapter.

The factors so far described project personality as a neutral individual psychic structure. For some clue as to personal needs and interests Beck looks to the associational contents. Considering the great importance that Beck attributes to the associational contents, its richness and breadth, his insistence on discarding Rorschach's 'Original Response' seems even more surprising. His main argument, lack of frame of reference, can easily be refuted by quoting Rorschach's definition of Original Response: 'interpretations that are given in about one hundred experiments with *normal people* about once . . . according to their quality they are either good or poor, Original+ or Original— . . .'.[2] Beck begs the question in his polemic by substituting for Rorschach's clearly defined technical term Original Response the word 'original . . . as it is commonly understood'. However, in one respect he is right: apart from the example in his Psychodiagnostics, Rorschach did

[2] Translation and italics reviewer's.

not leave a list of Original Responses. Yet lack of sufficient statistics is no reason for discarding a factor, and one wonders why Beck, who checked so many Rorschach factors statistically did not do so with the Original Response. The answer is that Rorschach's Original Response is derived from a healthy intelligent average, whereas Beck's statistical raw material, as criticized in the review of his previous book, represents a mixture of overtly sick and doubtfully healthy people in an unknown proportion, which could neither furnish nor check Rorschach's Original Response.

This general disregard for the normality of his raw material in his first book is also conspicuously present in the records of this second volume. Thus The Intelligence Curve, that runs with ten records from most superior via middle range to feebleminded, includes one single case which is not complicated by a more or less severe neurosis, a possible psychosis, a psychopathy or immaturity, although all these additional clinical factors change the Intelligence factors in the Rorschach test. Of the eight cases of The Adolescent Years some are suspiciously schizophrenic and all are at least so neurotic that their pathology overshadows whatever may be characteristic of the adolescent years in the Rorschach test. Among the eleven records of the Schizophrenic Solutions, on the other hand, there are two from nonschizophrenic mothers of these patients. One mother, according to Beck's Rorschach interpretations, 'plays the rôle opposite that of her daughter' whereas 'passivity seen in the (other) mother progresses to its ultimate stage (in her daughter)'. Neither 'playing of the opposite rôle' nor 'extreme passivity' make for a schizophrenia as far as we know, nor can the Rorschach prove it, even if Beck's title Schizophrenic Solutions suggests a psychogenic etiology of this still enigmatical psychosis.

The short and insufficient Clinical Notes present another defect. The reader, presumably a Rorschach student, looks to them for crucial proof of the validity of the test, i.e., whether Rorschach's assumptions, deductions and connections are borne out or not. What he gets are interpretations of several pages which are verified not with a clinical description but with a few lines such as: 'The fact that this man is the president of a university is in itself a validation of the Rorschach findings', or, 'This woman . . . is a professor . . .'. Where the Clinical Notes are less laconic they show, with the exception of the records of schizophrenics and feeble-

minded, insufficient relation to the Rorschach interpretations—they are neither proof for nor against the interpretations, neither modifications nor qualifications of them. Beck seems to be aware of that deficiency; however, excuses such as: 'Conditions precluded using biographical information or inquiry', are hardly admissible, since clinical pictures can be given without biographical data, or more suitable material could have been chosen instead. In this connection it should be said that the titles of the cases are misleading, as they epitomize the Clinical Notes throughout, regardless of whether or not the Rorschach interpretation bears out the Clinical Note. For instance, the case with the caption Compulsion in a Young Woman is according to Beck's interpretation a neurosis, although not a compulsive-obsessive one. Nor in A Male Homosexual, can Beck or anyone deduce homosexuality from the Rorschach record at all (as is often the case). More instances could be easily quoted. Incidentally, the presentation of each case in the following order: Response Summary—Interpretation of the record—Clinical note—Response record, does not seem logical, as the interpretation refers again and again to the response record. Any attentive reader naturally will start reading the response record, then the summary, afterwards the interpretation which he will finally compare with the clinical note.

It would go beyond the scope of a review to take up each of the interpretations. One symptom, however, which is contained in almost all of them should be singled out. With the exception of the few feebleminded and some schizophrenics there is hardly a record from which Beck does not infer anxiety. This ubiquity deprives the finding of a more specific significance. Even conceding that there is anxiety in the last analysis behind most psychopathological phenomena, clinically we are more interested in knowing whether anxiety is bound, for instance, by an obsessive-compulsive neurosis or is overt, and how it manifests itself—as free anxiety, or as part of a basic mood and so forth. Here adequate clinical notes could have demonstrated that the Rorschach can show more than unqualified anxiety.

Beck's two volumes on the Rorschach test are conceived as a comprehensive textbook. Such an enterprise would serve its didactic purpose even better could some amendments be made in a future edition.

FREDERIC S. WEIL (NEW YORK)

RORSCHACH PSYCHOLOGY. By Paul Maslow. New York. Brooklyn College Press, 1945. 149 pp.

The Rorschach test is well recognized as a useful adjunct to the study of the total personality. It permits the science of personality study to attain a degree of specificity previously unattainable and represents the closest approach made to compressing the total personality into a pseudo mathematical formula. The test is easily administered, but the correct interpretation is another matter and entirely dependent not only on experience in giving the test but on clinical psychiatric experience and a thorough knowledge of the psychodynamics of human behavior. In the hands of an Oberholzer it can be astonishingly revealing; however, it must always be regarded as an adjunct to and not as the basis of the study of the individual personality. The majority of those who use it freely admit it has all the limitations of an isolated test.

This manual is a perplexing and callow attempt to present the Rorschach Test as an all-revealing expression of the individual's personality to be used not only as the basis for a complete character analysis, but for psychotherapy, as a philosophy and even for social reform! It is exceedingly difficult to ascertain how much of the content of this book is the thought of the author and how much has been torn from the context of the one hundred and four items listed in the bibliography ranging from Freud's Collected Works to Ernie Pyle's Brave Men.

The author begins by stating that the Rorschach test makes possible a quick and accurate insight into the total personality structure of the individual, and then goes on to say, 'When we are quite sure of the subject's personality then we can make the proper recommendations with the hope that correct comprehension will be followed by therapeutic success'. If only it were so!

In the discussion of personality types, which he divides into intraverts and extraverts according to the amount, type and ratio of Movement to Color responses, Maslow confuses the Inner Living of Rorschach with the Introversion of Jung and frequently becomes involved in a vague, discursive and naïve discussion of character traits.

> 'The intravert normally desires to place himself at the disposal of others because he wants to help. Here this trait is raised to the point of masochism since self-punishment and self-deprivation enable him to better achieve his ideal of thoughtfulness and service to others. Even

when there is a legitimate reason for self-recrimination, its masochistic expression, which tends to elevate the spirit as it punishes the body, appears to be far greater than is warranted by the incident which caused it. Thus physical pain and mental self-satisfaction exist side by side. The need for self-abasement can also develop into an unconscious or uncontrolled desire to hurt oneself (by accident), to acquire a psychosomatic illness (such as an itch, restlessness, nervousness, headaches, vague wandering pains), or to plague oneself with hypochondriacal fancies. This subject may even look forward to a session in bed as something soulfully satisfying especially if there is FM as well. At the culmination of a prolonged and severe anxiety attack the need for self-punishment leads to suicidal thoughts (with agg content) and in extreme to suicide itself (with agg/des content). The subject does not restrain masochistic tendencies unless determinants are inhibited (ICF, IC, IM, IAM)' [p. 76].

'This does not mean that if the intraverts capture the culture, the extraverts will be displaced. We need not worry about extraverts in this arrangement for they have shown an aptitude for zestful living that will not be denied, even if it were possible to do so. Far from discouraging extraversion it will be encouraged as never before. The extraverts will thrive beyond their fondest dreams because the intraverts, while utilizing extraversive abilities to the fullest extent to put well-thought-out ideas into practice, will see that the extraverts are never in a position to harm themselves and others or do anything to insult the human intelligence' [p. 143].

Such confused thinking has not been helped by a liberal use of Rorschach symbols not ordinarily utilized, as for instance in the following paragraphs:

'When SF is coupled with EM and AM the whole pattern of anxiety developed in the emotional field is repeated in the social field. The capacity for insight (EM and AM) on the one hand and the lack of objectivity (SF) on the other produces cultural anxiety. The combination of EM FS represents controlled cultural anxiety, EM SF uncontrolled cultural anxiety, EM CF SF uncontrolled emotional cultural uncontrolled anxiety. Reread chapters X and XI, substituting SF for CF and "cultural" for "emotional"' [p. 52].

'There are all degrees of detachment and the strength of the complex, as indicated by the perceptual process, grows relatively more severe as follows: PF, IPF, PF, FP, no perspective, PF–; MC, EM, LM, IM, FM, no human movement, MF: EAM, LAM, IAM, FAM, no animal movement, AMF: EPM, LPM, IPM, FPM. no personal movement, PMF: MC, CF, FC, CF, ICF, C, color shock, no color, CF–: MCS, SF, FS, SF, ISF, S, shading shock, no shading; (c) no complex response; W, D, d, td; P, no populars: aoc, soc, roc, no oral complex (the latter to be discussed below). On the one extreme of the attachment-detachment complex is the magnetic, expansive, full, mature adjusted personality of the WDc MCSPF P

subject and on the other is the neutral constricted personality of the D, d, td F subject' [p. 62].

At times the characteristics attached to the different types of responses are reminiscent of the fortunetelling cards that drop from the pennyweight machines. For example:

'The actions of the CF subject are logical, efficient, vigorous, constructively acquisitive, deliberate, cheerful, sure, easily understood, emotionally balanced (and) combined with a satisfied feeling of personal fulfilment.'

Rationality, Anxiety, Emotionality, the Conscious, Unconscious and Foreconscious, Anal and Oral Complexes are all discussed with vague wordiness and superficial understanding. The most interesting chapters deal with the author's Social Psychology. After discussing shading and perspective responses indicative of sympathy and empathy he opines that these qualities may be based on mental telepathy.

'Because the psychic transference inherent in mental telepathy presupposes that people can transmit their feelings to one another, it is important to know from the point of view of a personality builder just what kind of feelings are involved. So, for instance, it is quite possible in an anxiety attack, when an intense maladjusted sensitivity to others is developed (perspective shock), that the subject "receives" alarming material from someone close to him and upon whom he depends. Perhaps the person who "spends" this material (probably arising in his unconscious) is also "receiving" alarming material and is himself suffering an anxiety attack. By the same token, two people deeply in love, concentrating their mental attention upon each other, transmit a constant two-way flow of lovely thoughts which has a characteristic beautiful effect upon the personalities of both' [p. 118].

In another chapter we are introduced to 'The Rorschacher' who is apparently a combination of priest, analyst and social reformer. The author's conception of the function of a 'Rorschacher' is best expressed in his own words.

'The Rorschach can be employed as an instrument to break down as well as build up people, to do ill as well as good. One person may use the analysis to eliminate psychic deficiencies while another uses the same information to strengthen these deficiencies. . . . The true value of the Rorschach lies in the constructive use to which it is put and the greatest care should be taken to teach it only to the proper people. Therefore the examiner must have, in addition to the ability to learn, the maturity to be rational, the adjustment to be ethical, the goodness to be sympathetic and the common sense to be understanding. He must

> be big and strong enough subjectively to do everything on the basis of another's needs rather than a single thing on the basis of his own subjective need. There must be that purity of motive which transcends egotism. In a word, the first thing the examiner must learn to do is to do no harm' [p. 111].

Evidently not every psychiatrist or psychologist should handle this test.

As a therapist the 'Rorschacher', unlike the psychoanalyst who gives the patient 'only the opportunity of seeing how bad he is', will 'coolly reconnoitre the field before giving advice and then act quickly to restore a measure of objectivity by reducing mounting frightening ideas to their proper size'. Similar absurdities can be found on practically any page.

In conclusion, this book is useless for the student of Rorschach and embarrassing to those interested in the development of this excellent projection test. It is poorly printed in mimeograph form. Errors in spelling are numerous and pages are occasionally duplicated.

WILLIAM F. MURPHY (BOSTON)

MANUAL FOR PSYCHODIAGNOSTIC INKBLOTS. By M. R. Harrower, Ph.D., and M. E. Steiner, M. A. (Josiah Macy, Jr., Foundation). New York: Grune & Stratton, Inc. 1945. 112 pp.

This little manual accompanies and explains a set of Psychodiagnostic Inkblots parallel to the Rorschach series.

It is frequently necessary to repeat the Rorschach test in the same individual during various moods and conditions or before and after psychotherapy. An analogous series of test blots is desirable in order that the results are not distorted by memory.

It is not easy to construct a series that satisfy all requirements. The form of the blot must be simple but suggestible, and the distribution of the parts must fulfil certain requirements as to color, shading and presence of suggestible small details. The authors of this series appear to have solved this problem satisfactorily. All the various types of responses characteristic of the Rorschach record are found in their series. From a comparison with the original Rorschach series the authors feel that their series give rise to slightly more responses per record, and are more productive in F C responses, but as is pointed out, this is not necessarily a

disadvantage and patients showing an absence of color responses to the Rorschach series might well be tested further with the Harrower-Steiner series.

WILLIAM F. MURPHY (BOSTON)

THE GOVERNING OF MEN. By Alexander H. Leighton, Lt. Commander, M.C., U.S.N.R. Princeton, N. J.: Princeton University Press, 1945. 404 pp.

This book is by a man trained in Meyerian psychiatry and social anthropology who had done field work among the Navajo Indians and Eskimos. He was assigned to the Japanese relocation center at Poston, Arizona, under the sponsorship of the American Council, Institute of Pacific Relations. His purpose was to apply the methods of the social sciences to the problem of interrelationships in this community.

The first part of the book consists of a very readable report of the impact of Pearl Harbor and subsequent events upon the West Coast Japanese, the development of pressures which led to evacuation and the establishment of relocation. The story of Poston itself leads up to the tension which developed, and which eventuated in the strike, and finally the manner in which the strike was handled and some of the difficulties resolved.

In the second part of the book the author attempts, on the basis of this study, to reach some fundamental postulates and practical recommendations concerning social organization, reactions to stress and the control of stress. The approach is predominantly sociological although attention is paid to individual make-ups. The individuals are taken more or less as constants and grouped in accordance with common features of attitude and belief. An interesting distinction is made between those administrators who were 'people-minded', treating others primarily as human beings, and those who were 'stereotype-minded' and treated the members as Japanese first and people second. The residents of Poston consisted of Issei, Nisei (American born) and Kibei (American born but educated in Japan). The attitudes of these groups and the difficulties in outlook between the generations is clearly described.

It is impossible adequately to summarize the various principles and recommendations derived by the author. The gist is that in each community there is a social organization and set of beliefs

both of which vary in strength and firmness. Stresses and frustrations result in tendencies to social disorganization and the behavior follows the channels of the beliefs and organization. To control adequately the stress the administration must be aware of this interplay.

During the war all psychologically minded observers had the opportunity to study reactions of men under stress of various kinds. This book deals with the stresses on these groups of Japanese-Americans in a relocation center, from the point of view of the group rather than the individual reactions which have concerned the psychoanalytic students of the war neuroses. The book therefore is an interesting complement to these studies.

LEON J. SAUL (PHILADELPHIA)

A GUIDE ON ALCOHOLISM FOR SOCIAL WORKERS. By Robert V. Seliger, M.D., in collaboration with Victoria Cranford. Baltimore: Alcoholism Publications, 1945. 94 pp.

This book consists chiefly of papers read by the author before various groups interested in the problem of alcoholism and the alcoholic. Like many volumes thus assembled, the book is repetitious and lacks continuity. Dr. Seliger defines alcoholism and describes the alcoholic. He enumerates the social, economic, political influences which he feels have caused maladjustments in those individuals who eventually seek escape in alcohol. Similarly, the factors essential for successful rehabilitation of the alcoholic are presented. An entire chapter is devoted to the Rorschach Analysis Technique as one means of determining the feasibility of therapy. The liquor test, composed of thirty-five questions to ascertain whether or not a person is an alcoholic, brings up many points which, if properly answered, would require a degree of individual insight which is exceedingly rare. There is also a list of thirty-five common-sense re-educational guides for the abnormal drinker. Just how the social worker can help the mentally sick alcoholic to accept to the extent of observing any of these 'common-sense guides', is not indicated. Since psychiatric treatment is not readily available for the great majority of these cases, suggestions along this line would not be amiss. An alcoholic diagnostic clinic for education, understanding, examination, diagnosis, placement, and treatment is strongly advocated.

The function of the social worker as Dr. Seliger sees it is, 1. to aid in the prevention of alcoholism by improving the social conditions which cause maladjustments; 2. to aid in an educational program and, 3. to follow through in the treatment of the group hurt and harmed by the individual alcoholic. The author states, 'No one has a greater opportunity than the social worker in the field of practical education which simultaneously sets forth actual facts and visibly demonstrates in action, what can be done in the salvaging and redirection of human lives'. This is a challenge to the social worker. While this guide is of interest and has some value for the social worker, it is regrettable that the author did not share his knowledge and experience more fully so that the social worker might be better equipped to meet the challenge.

HESTER B. CRUTCHER (ALBANY)

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Language, Behavior and Dynamic Psychiatry. Jules H. Masserman. Int. J. Psa., XXV, 1944, pp. 1–8.

Otto Fenichel

To cite this article: Otto Fenichel (1946) Language, Behavior and Dynamic Psychiatry. Jules H. Masserman. Int. J. Psa., XXV, 1944, pp. 1–8., The Psychoanalytic Quarterly, 15:3, 394-411, DOI: 10.1080/21674086.1946.11925650

To link to this article: https://doi.org/10.1080/21674086.1946.11925650

Published online: 11 Dec 2017.

ABSTRACTS

Language, Behavior and Dynamic Psychiatry. Jules H. Masserman. Int. J. Psa., XXV, 1944, pp. 1–8.

Masserman, in reëxamining 'some of the former concepts of semeiology and semantics in the light of the newer knowledge of behavior dynamics', stresses the fact—self-evident to every psychoanalyst—that 'signals, signs and symbols' are relative in their meaning, dependent on their environment in the 'continuous series of total perceptions', on 'individual experiences' in the person's past and on 'current motivations, attitudes, and environmental adaptations'. This relativity makes it necessary that patients' utterances be taken by the psychoanalyst in their total dynamic significance and not in any isolated way. (This, according to Masserman, is difficult when the patient lies on the couch, a position which may induce the psychoanalyst 'to take the patient's word-sequences with . . . constricted a field of reference'. The reviewer is of the opinion that such constriction, if it occurs, would be more the analyst's than the position's fault.) The relativity of the analyst's interpreting words must be considered too, and again the reviewer, in full accordance with the author's general statements, would disagree with his exemplification that this relativity would necessitate a higher estimation of nonverbal therapy, and of changes of environment instead of, or during, a formal psychoanalysis.

OTTO FENICHEL

A Further Contribution to the Study of Slips of the Tongue. Ludwig Eidelberg. Int. J. Psa., XXV, 1944, pp. 8–13.

Eidelberg's trends of thought are not easily comprehended. Whereas Freud taught that a slip of the tongue is due to a return of a rejected impulse against the person's will, Eidelberg calls slips of the tongue a 'defense mechanism' because the rejected impulse does not find full and undistorted expression. Eidelberg discusses mechanisms of and motives for rejection of impulses as if they were essential for the occurrence of a slip. Among the mechanisms he stresses the turning of impulses against the subject, the compensating and over-compensating mobilization of opposite impulses or opposite 'instinctual fusions', and the turning from activity to passivity and vice versa. Among the motives he discusses the fear of narcissistic hurt (narcissistic mortification) which, by the occurrence of a slip, may be avoided or may nevertheless be experienced. Finally, Eidelberg talks about other defenses against narcissistic hurts. He considers rejection as a protection against being narcissistically hurt by the id (whereas mortifications from the external world and from the superego are accepted), while in introjection the mortification from the external world and from the superego is denied (and that from the id accepted).

OTTO FENICHEL

On the 'Need to Know' as Related to Identification and Acting Out. Minna Emch. Int. J. Psa., XXV, 1944, pp. 13–19.

It is well known that inconsistency in the parents' educational behavior may result in a characteristic pathological development of a child's superego and ego formation.[1] When children are in no position to anticipate the probable reaction of their environment to their actions and when they do not find any opportunity to develop lasting and consistent identifications, the development of both ego and superego is necessarily disturbed since the ego is based on the capacity for anticipating judgment and on oral identification, and the superego is nothing but a result of specifically constructed identifications.

Minna Emch discusses these problems from the viewpoint that 'knowing one's parents' forms the basis for the development of the sense of reality. Where the parents are unknown or unknowable (because of unpredicatable inconsistencies) the sense of reality is accordingly impaired. Emch distinguishes two subtypes of such impairment, characterized by the formulas: 'I must know everything', or, 'I don't know anything'. She reports one case history for each of the two categories. The first patient was characterized by a tendency towards acting out and a corresponding intolerance towards tensions; he was always ready to identify himself fleetingly with whoever happened to be present (for instance, with the woman in sexual situations), the identification having the significance of a caricature and of a 'magical gesture'. The second patient was filled with a spiteful denial of curiosity and scopophilic interests, and showed a kind of aggressive pseudo imbecility, interspersed with a compensating narcissism. Her identification with her mother, who was herself a very neurotic, inconsistent, successively exciting and frustrating person, had a pronounced aggressive note, again turning the patient into a caricature of her mother.

The intolerance and tendency towards fleeting and aggressive identifications makes the analysis of patients of this type very difficult. Certain modifications of the classic technique become necessary. 'From the earliest contacts onward, the analyst must be, as with a smaller child, a person who can be known, alive-in-the-present, and in that sense more a real object that a surrogate in the emotional development of the patient.'

OTTO FENICHEL

A Suicidal Symptom in a Child of Three. Marion Milner. Int. J. Psa., XXV, 1944, pp. 53–61.

Milner is a pupil of Melanie Klein and interprets the material presented by her little patient in the light of Mrs. Klein's theories. The 'suicide symptom' which gave the paper its title consisted in a severe disturbance of eating which became especially intense during a pregnancy of the child's mother. At certain times the child ate well in her grandmother's house, but ate nothing in her

[1] *Cf.* for instance: Hoffmann, Jacob: *Entwicklungsgeschichte eines Falles von sozialer Angst.* Int. Ztschr. f. Psa., XVII, 1931. Reich, Wilhelm: *Der triebhafte Charakter.* Vienna: Int. Psa. Verlag, 1925. Aichhorn, August: *Wayward Youth.* New York: The Viking Press, 1935. Fenichel, Otto: *Ego Disturbances and Their Treatment.* Int. J. Psa., XIX, 1938.

mother's house which she usually refused to leave. The child presented obvious signs of oral (and anal) urethral sexual theories, of hostility against the mother and the baby within her, and of guilt feelings because of this hostility. These impulses are interpreted by Mrs. Milner in accordance with the theory of 'internalized bad and good objects', tendencies to destroy through poisonous urine and fæces, and corresponding attempts at restitution. The reviewer must confess that he could not always follow these interpretations, especially because they seemed to pick out certain details arbitrarily and were not given in connection with actuality and the more superficial layers.

OTTO FENICHEL

Psychoanalytic Fragments. A. A. Brill. Psa. Rev., XXXI, 1944, pp. 121–127.

Brill regrets the scarcity of clinical reports on the psychopathology of everyday life which he believes are both instructive and interesting for the beginner as well as for the experienced analyst. He then reports three interesting clinical examples which occurred in his practice. They afford a good opportunity for psychoanalytic exercises.

RALPH R. GREENSON

Psychoanalytic Remarks on Fromm's Book, Escape from Freedom. Otto Fenichel. Psa. Rev., XXXI, 1944, pp. 133–152.

This important paper by Fenichel may be roughly divided into two parts. The first is devoted to a condensed and systematic psychoanalytic frame of reference as a basis for understanding the psychological aspects of social, political and economic trends and institutions. In the second part Fenichel critically evaluates Fromm's theses and findings with reference to the preceding outline.

Fenichel's approach is based on the fact that there is a dynamic interplay of forces between the individual and his culture. He stresses the dependence of self-esteem on external rewards and punishments, and the transition from external influences to the internalized superego which is itself further influenced by external authority and social pressures. Fenichel points out the importance of the hope of reparticipation in projected omnipotence and indicates how this striving has been manipulated by many social institutions, religions and governments. He believes that satisfactions and frustrations—particularly the way in which children are directed to react to these satisfactions and frustrations—are the two main sources of institutionalized character formation.

Fenichel is of the opinion that all these premises may be developed from the basic concepts of Freud's Libido Theory. It is true that in his writings Freud did stress the biological factors and did write relatively little about political and economic institutions, but by no means did Freud every deny their significance as an important element in the personal history.

Fenichel feels that Fromm, in attempting to reëvaluate the importance of sociological factors, distorts the significance of the biological factors. Fromm denies the genetic derivatives of the partial instincts and minimizes the significance of satisfactions and frustrations. He considers character and attitudes purely as adaptation phenomenon against loneliness and fails to realize that character and attitudes may be subservient to instinctual gratifications or may

represent the failure of adaptation as well. Fromm criticizes Freud by claiming that Freud denied that love and hatred, lust for power and yearning for submission, enjoyment of sensuous pleasure and the fear of it, are all products of the social process. He apparently overlooks the fact that psychoanalytic technique attempts to undo the effect of social processes on precisely these strivings and trace them back to their infantile and biological roots. Fromm also seems to have forgotten Freud's Ego and the Id, in which Freud showed that the superego includes not only an externalized authority but ideals as well. He attempts an asexual theory of sadism and masochism by explaining that these people are trying to get rid of their individual selves and thus avoid loneliness. In this group he includes the suicides but neglects to mention the psychology of mourning and melancholia. The œdipus complex he considers merely a conflict between the urge to be dependent and the quest for freedom. Fromm stresses the inherent tendencies in man to grow and create, but denies the innate character of the biologically rooted instincts. He feels that Freud was mistaken in attributing all the ideals of man to something 'mean' and he believes that ideals like truth, justice and freedom can be 'genuine'.

In summarizing, Fenichel states that Fromm has done a detailed job of describing the relationship of certain psychological processes to certain cultural conditions. Nevertheless, Fenichel believes that in attempting to correct and avoid the mistakes and omissions, that psychoanalysis admittedly has made, Fromm abandons psychoanalysis completely. Fromm's psychoanalysis is incorrect and his sociology tends towards idealism.

RALPH R. GREENSON

Freud on Leonardo da Vinci. Erwin O. Christensen. Psa. Rev., XXXI, 1944, pp. 153–164.

Christensen carefully reviews Freud's famous study of Leonardo da Vinci. He finds Freud's interpretations convincing and his theory on Leonardo's mental development well founded. A review of the literature since Freud's study reveals that little use has been made of the study.

RICHARD STERBA

The Fear of False Teeth. H. S. Darlington. Psa. Rev., XXXI, 1944, pp. 181–194.

A patient of Darlington's was worried about his false teeth. He feared that after death he would have to stand before Jesus Christ either without teeth or with false teeth. Darlington generalizes: 'Some portion of the crippled and deformed men who return from the war will come to entertain the fear that when they die they will meet the crowning humiliation of seeing the door of heaven slammed in their faces even as the doors of factories and offices in many instances will already have been slammed', and takes this as a starting point for anthropological speculations. He collects interesting data on the identification of the palate with heaven and stories about teeth having been knocked out by lightning. Among the Kenyah of Borneo, thunderstones are the teeth of the god of lightning. Among the Babylonians, Greeks and Latins the same word is used for the palate of the mouth and for the sky. The Latin *mundus*

is 'universe' or 'sky', the cognate word *monde* in French means 'world', while in German *mund* is the word for mouth. 'The loss of a single tooth may suggest the precipitation of the totality of soul—fire from the blue stone firmament of heaven.' Data are collected on preserving cut hair, nail parings and extracted teeth, in order to have them ready on the day of resurrection. Further material concerning meteorites has a bearing on the subject only if it is assumed that the equation of the human mouth with the world is universally valid—which is extremely doubtful.

GÉZA RÓHEIM

Bird Language in Schizophrenia. L. Kerschbaumer. Psa. Rev., XXXI, 1944, pp. 195–196.

Whereas the usual auditory hallucinations of schizophrenics are perceived as human voices, Kerschbaumer describes two patients who thought they could hear and understand 'bird language'. The author forgets to mention the fact that this was also true of the famous case of Schreber.

OTTO FENICHEL

Psychosomatic Aspects of Allergy. L. J. Karnosh. Psychiatric Quarterly, XVIII, 1944, pp. 618–625.

Karnosh discusses the relation between allergic reaction and nervous disease and points out that the allergic reaction involves every level of the nervous system, from the highest to the lowest elements. He discusses briefly some clinical manifestations of allergy which still are ill-understood, such as the selective action upon the circumflex nerve following horse serum injection for tetanus prophylaxis. He elaborates on a case of dementia præcox in which, during insulin therapy, a remarkable congruity was observed between the mental condition and a concomitant allergic dermatitis. Several paragraphs deal with the personality changes which result from the allergic condition and their care and treatment during the formative years. There is an excellent psychosomatic evaluation of the skin as a powerful organ of emotional expression. Karnosh concludes by saying that emotions and allergy are 'interlocked' and that it is beyond dispute that one influences the other. However, rather than search for which is cause and which is effect, he prefers the assumption of the occurrence of two afflictions concomitant in the same person.

CAREL VAN DER HEIDE

An Objective Approach to the Personality and Environment in Homosexuality. Carl H. Jonas. Psychiatric Quarterly, XVIII, 1944, pp. 626–641.

Sixty male overt homosexuals were examined with the help of a questionnaire about their family relationships and compared with a control group chosen at random from convalescent surgical patients. The homosexual persons seem clearly to prefer their mothers to their fathers. This favoring of the mother is taken as an indication of mother identification but the question of how identification arises from affection is not discussed. A case of D. Hamilton is quoted, a homosexual street walker who approached his prospective mate

with the question: 'Whom do you like best, your father or your mother?'. Preference for the mother meant an acceptance of the invitation to homosexual contact.

BERNHARD BERLINER

Psychological Adjustment of Soldiers to Army and to Civilian Life. G. B. Chisholm. Amer. J. of Psychiatry, CI, 1944, pp. 300–303.

General Chisholm points out how the youths fighting this war were psychologically ill-prepared for it by the many contradictions and confusions which existed in their political, social and economic background. He stresses the following requirements of a good soldier: He must be able to live intimately with a wide variety of other men. For this to be possible he must be relatively free of internal conflicts. He must be capable of self-sacrifice and devotion. In order for him to become a useful civilian again, his own individual value to the community should remain obviously high to him.

RALPH R. GREENSON

Preventive Psychiatry with Combat Troops. Herbert X. Spiegel. Amer. J. of Psychiatry, CI, 1944, pp. 310–316.

Captain Spiegel gives us an outline of preventive psychiatric measures which can be utilized to help minimize psychiatric casualties in a combat zone, and how such measures can simultaneously increase the fighting efficiency of the soldiers. He points out how the battle situation becomes an acutely personal one for the soldier who often fulfils more than his duty for the sake of maintaining his prestige with his fellow soldiers. Their aggressive action is motivated more by love than by hatred. The bond of comradeship, love of their leader, and identification with the group is the moving force. 'Morale' is a relatively unclear but vital component and must always be considered. The military psychiatrist has three functions: (1) to detect the important factors that give rise to anxiety; (2) to detect the available forces which can effectively thwart or minimize these anxiety-producing factors; (3) to help the command devise practical measures to accomplish this. In order to achieve this result the military psychiatrist must live with his men so that he may be guided by observations based on real experience, rather than by preconceived theoretical speculations.

RALPH R. GREENSON

Aftermath of Operational Fatigue in Combat Aircrews. Milton L. Miller. Amer. J. of Psychiatry, CI, 1944, pp. 325–331.

Major Miller presents the results of his observations of some eight hundred cases seen at a Redistribution Center. He finds three main sources of Operational Fatigue: (1) Excessive combat and harrowing experiences; (2) the remobilization of old psychoneuroses; (3) guilt and depression following the death of close friends towards whom there has been ambivalence.

RALPH R. GREENSON

Psychiatry for Children. Lawson G. Lowrey. Amer. J. of Psychiatry, CI, 1944, pp. 375–388.

Dr. Lowrey has divided his paper into three parts corresponding to three historical periods in the development of child psychiatry. In the first period (1846–1909) interest was centered primarily on the mentally defective and in the establishment of clinics and schools for their care and training. In the second period (1909–1919) begins the study of other problems of children, especially those of delinquents. The third section brings up to date the extension of these studies and the establishment of clinics, special schools, institutions, children's wards and out-patient departments for the treatment of childhood disorders, and training centers for those working with children's problems. The paper gives a comprehensive survey touching on all aspects of the development of child psychiatry with one notable exception—there is no discussion of the important contributions of psychoanalysis to this field, and there is only one brief reference to Freud.

ROBERTA CRUTCHER

A Variety of Furlough Psychoses. Herbert M. Fox. Psychiatry, VII, 1944, pp. 207–213.

Four cases of acute paranoid episodes are described which occurred in soldiers after having traveled on furlough from a post in a sparsely inhabited combat zone in the tropics to a city where they tried 'to have a good time'. The material shows with impressive clarity the connections between the paranoid breakdowns and the (conscious or unconscious) homosexual significance of the furlough experiences.

OTTO FENICHEL

Ferenczi's Contribution to Psychoanalysis. Clara Thompson. Psychiatry, VII, 1944, pp. 245–252.

This paper contains a short critical evaluation of the basic principles of Ferenczi's technical recommendations called 'relaxation therapy'. Thompson emphasizes the necessity of sincere human interrelationship as the basis of successful psychotherapy. She evaluates critically the principles of 'giving love' and of 'dramatic reliving' as a means of emotional mastery of the patient's past experiences, and she discusses the danger inherent in rigidly following these principles, that of nullifying their original purpose, namely, the sincerity of the relationship between therapist and patient.

Thompson's aim is not to give advice for therapeutic technique but to point out that such valuable realistic understanding of the dynamism of the psychoanalytic procedure became possible as a result of Ferenczi's 'main' contribution to psychoanalysis. This could be achieved only after Ferenczi's intentions were understood and his bungling mistakes were corrected by his disciples and others.

To arrive at her conclusions Thompson uses the same sort of psychological calisthenics which we know from the analysis of myths. In order to model a hero, a leader for some definite (propaganda) purpose the biographers select some facts of his life, shift the emphasis on other facts until the desired picture

arises clearly and understandably for the common man. Peculiarly, however, this article is not written so much for the purpose of building up its selected leader, whose contribution it praises, but to depreciate Ferenczi as a scientist and the other leader, Freud, as a man.

To depict Freud as the scientific autocrat who did not permit any independent thinking among his disciples, Clara Thompson describes Ferenczi as a timid, modest, sentimental, gypsy-music-loving fool, who 'did not assert his own point of view except where it coincided with Freud's' and who 'toward the end of his life had to suffer the fate of those who differed seriously from Freud'. It is hard to understand why such a sympathetic disciple of Ferenczi as Clara Thompson should maintain that Ferenczi, who was the first to attempt a theoretical understanding of the psychoanalytic procedure (as in his paper, Introjection and Transference, 1909) 'was not so much interested in systems of thoughts, in theoretical contributions as in human feelings, emotions and fantasies'. This appreciation of Ferenczi's scientific merit serves the purpose by means of inference of making Freud, in spite of the fact that he was the first to investigate emotions, dreams, and fantasies, appear as a person who was not interested in human feelings at all, a man who worked only to build a theory cold and inhuman. Of course his deserved punishment caught up with him. His intimidated disciple published theories motivated by nothing but unconscious rebellion against scientific submission. Even if one could agree with Clara Thompson that Ferenczi's Thalassa, a Theory of Genitality was prompted by an unconscious desire to reduce Freud's libido theory *ad absurdum*, one can not well overlook the fact that many of Ferenczi's speculations already found useful application in the further development of psychoanalytic theory. Clara Thompson, however, reduces Ferenczi's main contribution to nothing but a neurotic acting out, himself to a weakling who only in the privacy of his parlor could permit himself to express his thoughts to his faithful disciples; and while he built up concepts for a new psychoanalytic theory, 'he did not even clearly see that he was questioning the validity of the instinct theory'.

The reviewer does not believe that she has to hurry on to the rescue of Ferenczi's scientific and personal reputation, but she believes that it is necessary to point out the methods of this prejudicial literature in the field of psychoanalysis.

THERESE BENEDEK

Psychopathology of Impostors. Edmund Bergler. J. of Criminal Psychopathology, V, 1944, pp. 695–714.

The impostor is a social climber with a charming, disarming behavior and a specific sense of humor. He plays his rôle, aware of his faking and making fun of the victims. Below the thin layer of pleasure in irony, a deep depression is hidden which does not allow him to enjoy his self-created success and makes him provoke his downfall. The fundamental feature of his psychology, as seen by Bergler, is his narcissism which permanently seeks to overcome an early oral disappointment. To restore that lesion in self-esteem the inner, unconscious necessity arises to prove consistently the capacity to

inspire love and admiration. But, since that proof is only a narcissistic face-saving device, the masochistic 'mechanism of criminosis' comes to the fore immediately afterward and leads to self-provoked, masochistic defeats. Satisfying his masochism means also taking revenge upon people whom he identifies with the precœdipal mother. He proves that he can achieve love, then does not care for it and throws it away, which is a defense mechanism of pseudo-aggression against the deep-seated masochistic wish to reduce the mother to absurdity as a giving person and to enjoy unconsciously her refusal. His humor is an attempt to deny that he is narcissistically wounded. Although he is unconsciously continuously concerned with his having been unloved in the precœdipal situation, the amount of love actually received in childhood is not the determining factor. The real cause of his oral fixation is his inability to overcome the disappointment to his infantile megalomania. He restores his narcissism by making people love him and then cheating them. His genital life is orally regressed and also 'cheating' (perversions, *ejaculatio præcox* or *retardata*, etc.)

BERNHARD BERLINER

Pediatrics Number. Bulletin of the Menninger Clinic, VIII, 1944, No. 6.

This entire issue of the Bulletin is devoted to various practical aspects of emotional problems in children.

Pediatrics and Psychiatry. Karl Menninger. Pp. 167–169.

Menninger stresses the fact that only two percent of American doctors are psychiatrists and as a result it is imperative that more physicians in other specialties add some psychiatric understanding and psychiatric techniques to their professional equipment. The pediatrician has an opportunity to observe and treat abnormal reactions of childhood in *statu nascendi*.

The Pediatrician and the Child. Robert L. Worthington. Pp. 170–177.

Worthington suggests that if circumcision is necessary it is probably best done in the first few days of life for psychological as well as surgical reasons. Immunization of the infant is usually frightening to the child and reassurance is important. Physical examination should be done slowly and easily with the awareness of its possible frightening affects. All examinations of the genitals should be performed as briefly and as casually as possible. Children should be prepared psychologically for surgical procedures. Operations on the genitals should be avoided whenever possible and psychiatric consultation sought. Enuresis must be considered primarily a psychological problem. In all long illnesses the secondary gain and passive-dependent attitudes must be considered. Obesity and emotional problems usually go hand in hand. In general, pediatricians should regard psychological problems as essential and not secondary in importance.

Mothering, Feeding and Toilet Training in Infants. Elisabeth R. Geleerd. Pp. 178–184.

Geleerd discusses the importance of the mother's adjustment, feeding, weaning and toilet training. She establishes the following five general rules: (1)

Infants need a certain amount of their mother's love just as much as they need vitamins and calcium. (2) The relationship between the mother or the nurse and the child is fundamental in determining all later relationships. (3) Self-control develops slowly and one must not demand it of the child until he is physically and psychologically ready. (4) All changes in routine should be made gradually and in periods of comparative freedom from stress. (5) Each infant has his own peculiarities or individuality and taste which must be studied carefully and intelligently so that the routines fit the baby and not the baby the routines.

A Common Type of Anorexia Seen in Run-about Children. C. Anderson Aldrich. Pp. 185–187.

Aldrich discusses the child from the age of one and a half to three years who often begins to refuse food over a period of months after having been a good eater. This often leads to more complicated gastro-intestinal disturbance if it is mishandled. Mothers must realize that children at this age need less calories than they did previously and that they usually drink enough milk to supply most of their needs.

Behavior Problems and Habit Disturbances in Pre-adolescent Children: Their Meaning and Management. Robert P. Knight. Pp. 188–199.

Knight starts off by attacking prevalent misconceptions: (1) the belief that everybody knows enough about human nature and 'psychology' to rear children and 'handle people' if he just uses 'common sense'; (2) the tendency to react to one's own rearing either by copying exactly the disciplinary methods used by one's own parents or else by swinging to the opposite extreme; (3) the belief that children should be as little nuisance as possible; (4) the attempt to follow the precepts supposedly emanating from the 'new psychology'.

He then goes on to discuss the normal behavior of children and stresses how different this is from normal adult behavior. This is followed by a brief insight into seventeen of the most common behavior problems met with in children including temper tantrums, timidity, apathy, sleep walking, thumb sucking, etc. In conclusion Knight states four general rules for normal child rearing: (1) consistent real affection from both parents so that the child feels wanted and secure; (2) consistent firm united discipline from both parents, carried out with reference to the child's needs rather than to the parents comfort; (3) sufficient understanding of, tolerance of, and ability to identify oneself with children to permit sensing what the child needs and what he is trying to accomplish by his various struggles and techniques; (4) willingness on the part of the parents to seek counsel and help from competent child psychiatrists when problems arise which are beyond the parents' understanding.

The Pediatrician and the Evaluation of Emotional Maladjustments in Children. Eunice M. Leitch. Pp. 200–204.

Leitch points out the importance of early recognition and appropriate treatment of emotional maladjustments in children. She urges that the pediatrician help in this task by including a thorough psychological history of the parents and close scrutiny of the child's personality.

The Psychological Testing of Children: Intelligence and Emotional Adjustment. Sibylle K. Escalona and David Rapaport. Pp. 205–210.

The authors state that the 'psychological testing of children meets a variety of needs arising in medical, psychiatric, or educational practice. By means of an analysis of the different degrees of retardation and acceleration of development, and of the specific nature of atypical forms of mental functioning, testing may help to differentiate between the manifestations of congenital mental deficiency, or specific disabilities, and of various types of maladjustment. This type of psychological testing service reaches its maximum usefulness only when it is used in conjunction with clinical investigation procedures.'

The Rôle of the Social Case Worker in the Boarding Home Plan of the Southard School. Dorothy G. Wright. Pp. 211–215.

The author states that 'the boarding home plan of the Southard School has been in operation for almost three years and is now an accepted and proved technique in the school's treatment of neurotic children'.

'The arrangements with each home are based on the child's individual needs.'

'The use of the boarding homes for children under psychotherapy has many unique features which are not found in the usual children's agency boarding home plan.'

RALPH R. GREENSON

The Treatment of Aggression. Round Table Discussion. Amer. J. of Orthopsychiatry, XIII, 1943, pp. 384–440.

Lawson Lowrey introduces the discussion by mentioning two opposing concepts of aggression: one considers its destructive aspect, the other regards it as an expression of impulses to self-assertion and mastery. He quotes the opinions of Menninger, Schilder and Alexander, and refers to the reciprocal relationship between hostile aggression and anxiety. He summarizes by pointing out that theories about aggression vary, that aggression may be diverted to constructive ends, that early affectional relationships play a crucial rôle in development and form of hostile behavior, that frustration is a common causative factor, that the term 'aggression' refers to motor activity, while 'hostility' refers to an emotional tension, and finally, that the redirection of aggressive urges lessens anxiety and hostility.

Gregory Zilboorg points out that aggression is a normal biological phenomenon which insures survival by supplying energy for self-preservative acts and for the mastery of nature. Individuals and groups, however, must direct their aggression outwardly, for in-turned aggression results in personal suicide or disruption of the group. Social living requires that aggression be dammed up and released only in such forms as war, racial prejudice, politics, and the mastery of man by man. 'That culture, which in times of peace allows the individual the maximum social outlet for aggression, will serve as the best prophylactic measure as far as individual mental illness is concerned, and at the same time serve as the best preventive agency as far as wars and revolutions are concerned.'

Lauretta Bender next discusses aggression in childhood. She does not

believe, as do Freud, Klein and Anna Freud, that the child's destructive drives are inborn. According to her thesis, hostile aggression is the child's protest against frustrating experiences which interfere with his normal personality development; it represents a disorganization of his blocked 'constructive pattern drive for action'.

Some of the external frustrations which produce aggression in children are: physical restraint, lack of maternal love, the œdipus situation, and lack of social and cultural outlets. Internal sources of frustration are: organic damage to the brain, dyslexia, and the appearance of adolescence (in rejected children). Bender notes that aggression can produce anxiety only after object relations have been established. Children in institutions may thus behave very aggressively without feeling any accompanying anxiety.

In the next paper, Richard Brickner presents a summary of his well-known ideas about Germany. He discusses the clinical characteristics of paranoid individuals, emphasizing their narcissism, their need to dominate, and the rôle of projection in their behavior. He emphasizes the contagiousness of the paranoid syndrome and the rôle played by the victim or 'paranee'. His program for the prevention of future wars involves the education of democratic nations (i.e. potential paranees) in the tricks of paranoid psychology. The reviewer feels that Brickner is vainly struggling to describe complex sociological phenomena by the use of oversimplified psychiatric concepts.

George Reeve outlines certain general methods in the handling of aggressive individuals, including institutionalization, environmental manipulation, shock therapy, 'application of aggression to work' and 'application of aggression to the environment'.

Hyman Lippman presents a terse description of the psychoanalytic treatment of aggression. He points out the reciprocal relationship between anxiety and aggression, either one stimulating the production of the other, and the well-known relationship between frustration and aggression. He then applies these ideas to the treatment of children. The child who is afraid of his instincts responds to restriction with gratitude. The rejected child, on the other hand, has no motive for giving up the pleasure associated with his aggressive wishes. If the rejection is overt, improvement is easily brought about by removing the child from his hostile environment. Treatment is much harder if the parents are ambivalent toward the child. Psychoanalytic knowledge can be used advantageously in recognizing and eliminating those factors in work, recreation, child-parent relationships and education that stir up unconscious anxiety and aggression in children. The author concludes by emphasizing that ego-building is the most constructive therapeutic aim in dealing with aggression in childhood.

S. R. Slavson describes the treatment of aggression through group therapy. Aggressive behavior is necessary for survival and requires treatment only when it is excessive. He differentiates between an aggressive act, which may or may not be hostile, and hostility, which is simply an emotional state which may or may not result in action. One must take into account the child's cultural norm and the purpose of the aggressive behavior before therapy can be intelligently planned. The group therapy which Mr. Slavson employs permits

children to act out their impulses freely in groups of eight in the presence of a permissive adult. The session always ends in a meal. The children are not threatened or exploited, but neither are they given rewards for antisocial acts. The controls which are necessary in any group activity gradually evolve from the group itself and are not imposed by the adult, whose rôle is essentially passive. A child must have some capacity for forming emotional relationships or else he cannot be helped. The wish to be accepted by his peers, plus praise for constructive activity, impels the child to control himself through identification with other members of the group. A review of eight hundred treated cases reveals nine patterns of aggressive activity, five of which respond favorably to this kind of treatment.

The final contributor, John Slawson, describes the principles of *milieu* therapy used at Hawthorne Cedar Knolls. The population of this New York institution consists mostly of psychopathic delinquents and neurotic characters. The requirements in the environment for successful treatment are as follows: an accepting atmosphere, a culture of impeccable ethical values, respect for the fairness of the cottage parents by the group, and the administration of punishment by the adult to whom the child is most intimately attached (usually the cottage parent).

A. H. VANDER VEER

Some Aspects of the Etiology and Treatment of Schizophrenia. Joseph Perlson. J. Nerv. and Ment. Disease, XCIX, 1944, pp. 243–249.

In this article Perlson gives a short review of our knowledge of the etiology and treatment of schizophrenia. The very disparity of modern viewpoints indicates a high degree or helplessness in our approach to schizophrenia. Kraepelin's terminology, though bringing some order into the confusion of concepts, has afflicted us with a therapeutic hopelessness reflected in the term 'dementia' præcox. Freud's research has led us into a more and more detailed study of early childhood traumata. The sweeping generality that schizophrenia 'is due to a regression to an earlier state of development or a flight from reality into a world of fantasy' still leaves us with an enormous complexity of etiologic factors, which may in each case determine the schizophrenic development in a different way. There are mentioned unfavorable hereditary conditions, physical disease, trauma or infection on the one hand, and frustrations of emotional urges, feelings of guilt and inferiority and disillusionments on the other, which may be due to social or economic degradation or disruption of home and family life.

The same insecurity as to etiology exists about factors that are responsible for remission or recovery. Almost any sort of therapy can make the claim of contributing to the cure of the distressing illness. Perlson dwells particularly on the different forms of shock treatment. He sees in all of them the fear of approaching death as the activating stimulus which brings the patient back to sanity. But he warns of indiscriminate application of these drastic methods, the brain damage of which has not yet been sufficiently evaluated. Perlson stresses the benefits of occupational and recreational therapy for the readjust-

ment of schizophrenics. One has the impression that Perlson does not devote sufficient attention to the potentialities of psychotherapy based on the modern psychological studies of interpersonal relations.

EDITH WEIGERT

Wartime Ocular Neuroses. David O. Harrington. J. Nerv. and Ment. Disease. XCIX. 1944, pp. 622–630.

Freud, in his paper on Psychogenic Disturbances of Vision, distinguished between conversion symptoms in the realm of the eye, that is, functional disturbances which express a repressed instinctual conflict in a distorted form, and 'neurotic disturbances' which are an organic result of psychogenic attitudes. Harrington, without quoting this old paper of Freud, stresses the same fundamental differentiation when distinguishing between 'hysterical' phenomena in the realm of the visual apparatus, and 'psychosomatic' phenomena, while discussing ciliary spasm and photophobia. In addition, eye symptoms may be a part of a general 'combat fatigue'.

OTTO FENICHEL

Psychiatry and Industry. Lawrence S. Kubie. Mental Hygiene, XXIX, 1945, pp. 201–208.

Dr. Kubie was one of 'ten physicians who practice psychiatry in New York City' who 'accepted the invitation of Mrs. Anna Rosenberg and the local headquarters of the United States Employment Service of the War Manpower Commission to join their staff in a study of problems of placement in industry'. The work convinced him of the possibility of the following contributions of psychiatry to industrial placement problems: '(1) screening out those who are totally unemployable and providing for their shelter, care, and treatment; (2) by allocating to specially chosen tasks, or to sheltered workshops, those who can remain well only under special working conditions; (3) by evaluating individuals both as to their special technical aptitudes, and as to their special personality quirks, and by allocating them to jobs for which their aptitudes fit them, and which are at the same time consonant with their personalities; (4) by applying therapeutic principles to the individual worker who is maladjusted and by using therapeutic principles within the industrial setting; (5) by using social-service procedures to assist workers in coping with those out-of-plant problems which affect both their total psychological adjustment and their plant efficiency; (6) by studying the incidence of neurotic disturbances in different types of work, and under different working conditions; (7) by comparing the efficacy of different systems of job training.'

Kubie knows, however, that in practice attempts of this kind will meet with difficulties. Labor may think the psychiatrists and employers in collusion, or may fear losing seniority rights by shifting jobs. Employers, who may be grateful to psychiatrists in time of manpower shortage, may in times of unemployment 'degrade psychiatry to devices which can function as a watchman at the door to screen out those they do not want'.

Kubie makes suggestions on how to avoid dangers of this kind.

OTTO FENICHEL

Psychosomatic Medicine on General Medical Wards. William C. Menninger. Bulletin of the U. S. Army Medical Dept., IV, No. 5, 1945, pp. 545–550.

A recent survey from eleven general hospitals in the zone of the interior indicated that 24.2 per cent of the patients on the 'cardiovascular wards' were 'functional' and that 20.7 per cent of the cases on the 'gastrointestinal wards' were 'functional'. In a station hospital these figures rose to 41 per cent (cardiovascular) and 30 per cent (gastrointestinal). These data were supplied by internists. Surveys by or with psychiatrists would have given higher figures.

Too few physicians have sufficient scientific understanding of these illnesses adequately to diagnose or to treat them. Medical education which stresses anatomy, organic physiology and pathology leaves the physician embarrasingly ignorant of the functioning of the individual as a biological unit.

Several types of problems are outlined. There is a quotation from Crookshank (no reference): 'It has seemed to me odd in the extreme that doctors, who, when students, suffered with frequency of micturition before an examination, or, when in France, had actual experiences of looseness of the bowel before action, should persistently refuse to seek a psychological correlative—not to say an etiological factor—when confronted with . . . enuresis or mucous colitis. I . . . wonder that some hard-boiled and orthodox clinician does not describe emotional weeping as a new disease, calling it paroxysmal lacrimation and suggesting treatment by belladonna, astringent local applications, avoidance of sexual excess, tea, tobacco, alcohol, and a salt free diet with restriction of fluid intake proceeding, in the event of failure, to early removal of the tear glands. . . .'

Physicians must become aware of prevailing mistaken attitudes and practices which make diagnoses by exclusion, examine the patient physically and chemically but have no knowledge or training to proceed beyond the stethoscope, test tube and the x-ray.

Basic in this education is the rôle of anxiety . . . a central dynamic force which must be distinguished from fear. Its manifestations and transformations include direct anxiety, depression, hysterical conversions, hypochondriasis, paranoid trends, etc., etc. The physician must have some rationale for understanding the manifestations he sees, some basis for comprehending the irrationality of treatment by platitudes and placebos, and, most important, that those illnesses which the physician is prevented by his limitations from demonstrating organically are just as real and disabling as valvular heart disease or infectious diseases.

R. G.

Neuropsychiatric Examination of Military Personnel Recovered from Japanese Prison Camps. Norman A. Brill. Bulletin of the U. S. Army Medical Dept., V, No. 4, April 1946.

Neuropsychiatric examinations of four thousand six hundred seventeen men who had been liberated from Japanese prison camps and had subsequently returned to this country, showed that the general mental health was surprisingly good. Nearly all the men revealed tremendous resentment which was

channelized entirely toward the Japanese. 'Mild anxiety' was found to be widespread and seemed to be most intense in the men who had been out of prison longest. However only thirty-four cases of psychoneurosis were diagnosed, and five cases of psychosis were found. The opinion is expressed that only men with 'courage' survived, but apprehension is expressed that serious emotional difficulties may develop during the period of readjustment.

MARK KANZER

Incidence of Somatization Reactions in Psychoneurotic Disorders. (Report submitted by Lt. Col. Norman A. Brill, M.C., Office of the Surgeon General.) Bulletin of the U. S. Army Medical Dept., V, No. 4, April 1946.

A study of the incidence of 'somatization reactions' in five hundred eighty-five unselected and successive cases of psychoneurosis showed that one hundred fifty-nine cases (27 per cent) revealed organ dysfunction as a secondary disorder.

'Somatization' is a term adopted by the U. S. Army to cover disorders which 'probably' result from the channeling of psychopathological impulses through the autonomic nervous system into the viscera with resultant dysfunction.

The reactions covered in the survey include psychogenic gastrointestinal, cardiovascular, genito-urinary, allergic, skin, asthenic and rheumatic reactions. No attempt is made to describe these disorders in further detail or to present individual cases.

The conclusion is reached that orientation of the general practitioner in the psychoneurotic approach is necessary because of the high per cent of psychoneurotic cases with organ dysfunctions who will first consult the nonpsychiatric physician.

MARK KANZER

The Battle Neurosis. Morris W. Brody. Bulletin of the U. S. Army Medical Dept., V, No. 4, April 1946.

This description of battle neuroses recounts once more the well-known symptoms of these nervous disorders. The author is of the opinion that the disturbances are primarily situational anxiety reactions and that the underlying personality and the unconscious emotional conflicts are relatively unimportant.

A case is described in which an acute confusional state developed. The symptoms and corroborative data under pentothal showed hysterical mechanisms underlying a denial of reality and a regression to a state of infantile dependence on the mother. A strong sense of identification with the enemy appears, in Hamlet fashion, to have inhibited his aggressive drives and precipitated the confusion state. After reassurance against return to battle, rapid recovery was noted.

MARK KANZER

In Times Like These. . . . .Some Psychiatric Aspects of the Returned Soldier. Samuel Futterman. The Family, XXV, 1944, pp. 312–314.

Some dismissed soldiers are unable successfully to integrate the traumatic experience of war. They find reorientation in civilian life difficult because their

whole security system has been disrupted. Others, who found reassurance and an outlet for aggression (in military life), may react with depression to the loss of these mental-economic advantages. Social agencies have an important part to play in the program of rehabilitation of returned men. Knowledge of psychodynamics renders the social worker more effective in the service to veterans.

MARGRIT MUNK

The Neurotic Dyspeptic Soldier. S. D. Mitchell and C. S. Mullin. Journal of Mental Science, XC, No. 381, 1944, pp. 869–875.

Mitchell and Mullin surveyed a group of fifty soldiers with neurotic dyspepsia and compared them with a group of one hundred neurotics who displayed little or no gastric symptoms. No dynamic material is given. It is reported that the gastric symptoms were usually vague in character, occurrence and duration; that 86 per cent of the men had been subject to gastric distress in civilian life; that this distress was aggravated by homesickness and by the strain of adjusting to the demands of military life; that the military efficiency of this group was low; and that they tended to be very dependent in attitude. A family history of dyspepsia was present in 74 per cent of the cases. Prolonged hospitalization tended to result in fixation of the symptoms. Eighty per cent of the patients who had gastric complaints were recommended for discharge from the army as compared with 64 per cent of those with other neuroses, and many of them were referred for psychotherapy on their return to civilian life.

ROBERT A. COHEN

Wartime Psychiatry in Britain. E. E. Krapf. Britannica, XXXI, 1944, No. 4, pp. 11–28, and No. 5, pp. 15–34.

The author summarizes the highlights of psychiatric work in Britain during the present war. He relates how the British organized psychiatric facilities to prepare for the psychiatric casualties expected during the blitz. However, there were few psychiatric casualties, due in a great degree to the feeling of being prepared. The high morale of the people was a most important factor in preventing breakdowns. During the 'phoney' war period from September 1939 until May 1940, there were psychiatric casualties due to immobilization, boredom and 'barbed wire disease'. Dunkirk produced the first real war casualties and confirmed the fact that even the healthiest personalities can break down in wartime.

As early as 1940, English psychiatrists were using narcoanalysis. The influence of air raids on the incidence of psychoses was negligible except in old people in whom there was a greater occurrence of senile dementia. Anxiety states predominated and, strikingly, soldiers broke down more frequently from air raid strain than civilians. It was found that the evacuation of children from their homes produced more serious repercussions than air raids. There was a noted increase in juvenile delinquency as a result of the disruption of home life. The ground force had a higher percentage of casualties than the navy or the air force due to the stricter selection of men in the latter two branches. Those of borderline intelligence or less were the most frequent psychiatric casualties,

and these usually developed organic manifestations. The English find that when officers and those with a higher social conscience become ill, they develop anxiety states, while a less select group are prone to hysterical conversion symptoms. 'Effort syndrome', which was so prevalent in the last war, was found to be a neurotic disorder.

The British have found that psychoses cleared up more quickly in the armed service than in civilian life. They have used insulin in extreme exhaustion with good results. Narcoanalysis proved very effective, particularly in amnesias. Brief psychotherapy produced excellent results in personalities with a healthy background. Only nine percent of the men who were found unsuitable for general military service were discharged from service; all the others were given some government job. Doctors had the power to transfer a patient into any special trade or job in line with their prewar interests, and if necessary, even in the neighborhood of their families, in order to maintain them on some form of duty status. The excellent results of these techniques should be a valuable lesson to the armed forces in this country.

RALPH R. GREENSON

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Notes

To cite this article: (1946) Notes, The Psychoanalytic Quarterly, 15:3, 412-417, DOI: 10.1080/21674086.1946.11925651

To link to this article: https://doi.org/10.1080/21674086.1946.11925651

NOTES

The Forty-Seventh Meeting of THE AMERICAN PSYCHOANALYTIC ASSOCIATION convened at Palmer House, Chicago, Illinois, May 25, 26, 27, 1946.

Scientific Sessions: Paul Bergman, Ph.D. (by invitation): Scolding as a Psychotherapeutic Technique; Dr. Emanuel Windholz: The Discharge Neurosis; Dr. Ernst Simmel: Alcoholism and Addiction; Erik H. Erikson: Ego Development and Historical Change; Dr. Martin Grotjahn: Experience with Group Psychotherapy in Cases of Veterans; Dr. Leon J. Saul: The Concept of Maturity.

Business Sessions: Meeting of the Council on Professional Training, May 25, 1946. Presiding: Dr. Dexter M. Bullard, Vice-President, in the absence of Dr. Bertram D. Lewin, President. Secretary: Dr. Robert P. Knight. Members of the Council on Professional Training: Chicago—Drs. Thomas M. French and Helen Vincent McLean; Detroit—Dr. Leo H. Bartemeier; San Francisco—Dr. Ernst Simmel; Topeka—Dr. Robert P. Knight; Washington-Baltimore—Dr. Ernest E. Hadley. Guests: Dr. George J. Mohr, Dr. John M. Murray, Dr. George W. Wilson.

The Secretary read the following agenda:

(1) Application of Los Angeles Society for Constituent (or affiliate) membership.

(2) Application of the Los Angeles Society for recognition of partial training in association with the Topeka Institute for Psychoanalysis.

(3) Discussion of military neuropsychiatric experience in lieu of the requirement of one year of inpatient psychiatric experience as a prerequisite to analytic training.

(4) Report of the special committee, appointed May 1945, to study the psychoanalytic training activities at Columbia University.

(5) Discussion of the relationship between Institutes, particularly referable to transfer of students.

(6) Discussion of training activities of the Washington-Baltimore group.

(7) General discussion of the powers and purposes of the new Council on Professional Standards, especially with regard to setting standards, withdrawing recognition from any institute which does not meet the standards, etc.

(8) Discussion of results of questionnaire to training analysts.

(9) Further discussion of post-war training of candidates, pursuant to discussion held at special emergency meeting in New York, February 1946.

(10) Some questions regarding (a) psychoanalytic training of veterans and (b) additional psychoanalytical trained consultants for Veterans Administration hospitals, especially for those located in cities where there are no analysts.

Executive Session: May 26, 1946. Presiding: Dr. Dexter M. Bullard, Vice-President, called the meeting to order at 5 p.m. Secretary: Dr. Robert P. Knight.

The Chairman, Dr. Bullard called for the members to rise and stand for a moment of silence in memoriam to the following members of the Association

who died since the 1944 meeting of the Association: Dr. Joseph Smith, Dr. Smith Ely Jelliffe, Dr. Clara Happel, Dr. Ruth Mack Brunswick, Dr. Otto Fenichel, Dr. Jacob S. Kasanin.

There being no opposing nominations, the slate of officers for 1947–1949 named by the Nominating Committee in December 1945 was, on appropriate motion, declared elected by acclamation: President—Brigadier General William C. Menninger; Vice-President—Dr. M. Ralph Kaufman; Secretary—Dr. George J. Mohr; Treasurer—Dr. May E. Romm.

The following three nominations for Honorary Membership in the Association were approved by a unanimous affirmative vote: Dr. Edward Glover, London; Dr. Alan Gregg, Medical Director of the Rockefeller Foundation, New York; Dr. Frank Fremont-Smith, Medical Director of the Josiah Macy, Jr. Foundation, New York.

The unofficial recommendation of the Council on Professional Training and of the Executive Council for approval of the applications of the Los Angeles Psychoanalytic Society and of the Association for Psychoanalytic and Psychosomatic Medicine, New York, for affiliate society status under the new By-Laws was submitted to the Executive Session of the Association for vote. Each Society was approved without dissenting vote.

REMARKS ON ACCEPTING NOMINATION FOR PRESIDENCY OF THE AMERICAN PSYCHOANALYTIC ASSOCIATION. CHICAGO, ILLINOIS, MAY 26, 1946.

BRIGADIER GENERAL WILLIAM C. MENNINGER, M. C.

I wish to express my appreciation to the Nominating Committee for the honor they have accorded me in suggesting my name for the presidency of the American Psychoanalytic Association. I regard it as a warm tribute and an expression of high confidence. However, I feel that in fairness to the Association and to myself, I should like to express my feelings and hopes about our Association.

First may I express my conviction that much of the real meat in psychiatry has come from psychoanalysis. I have been keenly aware of this before my Army experience, but the necessity to understand the many milder disorders and the combat casualties in the military reënforced the importance of the need of all psychiatrists to have a dynamic orientation that can be provided only through indoctrination by those familiar with psychoanalytic theory and practice.

In the past I have had little contact with the Association's organization and affairs and, therefore, am not too familiar with the details of its history and present aims. My impression of the Association over the last ten years—and they are held by many of us outside the 'inner circle'—is that there has been too much discord, which our critics have delighted to capitalize. One of our first aims must be to develop a spirit of unity toward the enormous jobs to be done so that personal differences and sectional disagreements will be eclipsed.

My experiences within the Army, coupled with my conviction of the needs and the great possibilities of a socially minded, militantly organized, and

dynamically oriented psychiatry, make me feel that I may be out of step with some of the thoughts and standards of some in this group. I want to indicate that I am delighted with the change in our Constitution which appears to me to be a very forward and aggressive step toward obviating many of the difficulties that have occurred in the past. My experience for nearly four years in a large and complicated organization leaves no vestige of doubt as to the necessity of vesting full authority and confidence, particularly confidence, in our leaders, that they may make decisions and effectively direct their full energy into big problems, rather than in those occupying much of their energy in recent years, namely, continuous inter-society political maneuverings.

I hold a strong conviction that psychoanalysis will and can reach fruition only when it becomes an established section or department of the psychiatric faculties in our medical schools and general psychiatric training centers. Highly valued and worthwhile as our Institutes have been, I am sure that they must strive for eventual integration with medical centers and not continue indefinitely as isolated units. It is in this connection that it seems unwise, and even presumptuous to me, that we in part or as a whole, should dictate to a university the standards it must establish in accepting us. It certainly *is* our responsibility to recommend standards and to lend every possible aid to those rare educational groups which might invite us to be a part of their program. Even further, we should aggressively be taking the initiative to encourage our inclusion in all medical centers, both for undergraduate and graduate training.

From my vantage point I think psychiatry is in a very critical period. Its needs and possibilities are enormous. I am convinced that the psychoanalytically oriented psychiatrist and not the psychoanalyst per se represents the greatest hope in providing for these needs. As the result of my Army experience, I believe we have a large number of excellent prospective psychiatrists, many of whom want individual analysis. I wish to protest at this time, which seems a near crisis to me, against the direction of some, if not much of our best analytic teaching power into the intensive training analyses of a handful of candidates, when those same brains could give a helpful, working, dynamic orientation to ten times the number. If the two can be combined it is excellent; for it is from research effort in this field that we have made our real gains, but I feel we must carefully consider priorities for the greatest immediate need. Without any doubt, I feel, that for the next two or three years, providing the largest possible number of dynamically oriented psychiatrists is of paramount importance.

There is another point, perhaps quite unorthodox, about which I have convictions. The verities of analytic theory in practice seem to me to be far past the need for constitutional or legislative protection. I feel our training analysts should be 'credited' for whatever qualifications that term might indicate. On the other hand I can see the strength and influence of this organization greatly increased were we to develop some form of membership for many intelligent, interested, sympathetic confreres who have not and may never have a personal analysis. We are all familiar with the intelligent use of psychoanalytic concepts and techniques by many competent psychiatrists, who have not been analyzed according to classic requirements. Our present regulations and restric-

tions certainly do *not* control or standardize the individual method of analysis that each of us may use. If our orientation and practice is what I believe it to be, and the fundamental tenets of psychoanalysis are what I know them to be, every serious student and prospective analyst would obtain an analysis. But requiring it as one of the chief criteria for membership, when it is largely based on the personal equation in judgment of any two or three of our members, seems to me arbitrarily to exclude a group of great potential value to psychoanalysis. We could become the spearhead of a movement and not a fraternity. I think we could present and represent the best in dynamic psychiatry.

My Army experience has made me acutely aware of tremendous needs and opportunities for all psychiatry. Its rôle in medical education is woefully inadequate; the level of practice and even care in our state hospitals should be regarded as gross negligence on the part of organized psychiatry; we are in a golden age for public education in psychiatry and we are doing almost nothing about it; we face a crisis in the need for trained personnel: except in the military and veterans facilities, we remain too isolated from the other fields of medicine; the psychiatric problems confronting the Veterans Administration and Public Health are staggering; we can, if we will, make a contribution to the social issues of the hour. We are faced with really big challenges. I do not know how you or I can best attack any or all of these, but I am sure we must, and they should absorb every bit of energy and time that we can give them.

Whomever you choose for your leaders, I urge that you give them your confidence; give them your authority to act; let them guide the organization with your full support; let each of us, each of our affiliate groups and, most of all, the American Psychoanalytic Association itself contribute its utmost in these challenging times.

The NEW YORK PSYCHOANALYTIC SOCIETY and the NEW YORK PSYCHOANALYTIC INSTITUTE elected the following officers for the year ending April 30, 1947: *Society:* President—Dr. Philip R. Lehrman; Vice-President—Dr. Henry A. Bunker; Secretary—Dr. Emeline P. Hayward; Treasurer—Dr. Harry Weinstock. *Institute:* President—Dr. Adolph Stern; Vice-President—Dr. Ruth Loveland; Secretary—Dr. Otto Isakower; Treasurer—Dr. Harry Weinstock.

THE MEMBERS OF THE CHICAGO PSYCHOANALYTIC SOCIETY elected the following officers for 1946–1947: President—Dr. George W. Wilson; Vice-President—Dr. Maxwell Gitelson; Secretary-Treasurer—Dr. Roy R. Grinker.

THE PHILADELPHIA PSYCHOANALYTIC SOCIETY, at its annual business meeting held on June 15, 1946, elected officers for the year as follows: President—Dr. LeRoy M. A. Maeder; Vice-President—Dr. George W. Smeltz; Secretary-Treasurer—Dr. Robert S. Bookhammer; Representative on the Executive Council, American Psychoanalytic Association, for a term of two years—Dr. LeRoy M. A. Maeder;

Representatives on the Board of Professional Standards, American Psychoanalytic Association—Dr. G. Henry Katz and Dr. George W. Smeltz. Education Committee: Chairman until June 1947—Dr. Sydney G. Biddle; Vice-Chairman until June 1947—Dr. LeRoy M. A. Maeder.

THE AMERICAN SOCIETY FOR RESEARCH IN PSYCHOSOMATIC PROBLEMS elected the following officers at its third annual meeting, May 1946: Honorary President—Dr. Adolf Meyer; President—Dr. Edward Weiss; Secretary-Treasurer—Dr. Edwin G. Zabriskie. Council: Dr. William Dock, Dr. Flanders Dunbar, Dr. Roy G. Hoskins, Dr. Jules Masserman, Elizabeth Healy Ross, Dr. Leonard G. Rowntree, Dr. Leon J. Saul, Dr. Milton J. E. Senn, George Soule, and Dr. J. Murray Steele.

SCHOOL OF APPLIED PSYCHOANALYSIS: Extension Courses of the New York Psychoanalytic Institute, 1946–1947. The academic year, which extends from September 23, 1946 to June 13, 1947 inclusive, is divided into trimesters of (usually) twelve evenings each. Sessions are held throughout the above period in the evening. Courses will be given:

A. For Qualified Physicians: The Relationship of Physicians and Patients in the Light of Psychoanalysis—Dr. Ralph M. Kaufman in coöperation with Dr. Harry Weinstock and Dr. Sidney Margolin; Psychoanalysis and Dentistry—Dr. Henry H. Hart; Sexual Pathology—Dr. Sandor Lorand; Psychoanalytic Psychopathology—Dr. Nathaniel Ross; Problems of Child Development—Dr. Margaret S. Mahler; Indications and Contraindications for Psychoanalytic Psychotherapy—Dr. Samuel Atkin; Principles of Psychosomatic Medicine—Dr. Lawrence S. Kubie.

B. For Nurses: Introduction to Psychoanalytic Psychiatry for Nurses. Parts I and II—Dr. John Frosch.

C. For Social Workers: Case Seminar for Psychiatric Social Workers. Part I—Dr. Abram Blau; Part II—Dr. I. P. Glauber.

D. For Psychologists: Study Group in Psychological Diagnostics—Dr. Lawrence S. Kubie; Study Group in Psychoanalytic Psychology—Dr. Heinz Hartmann, Dr. Ernst Kris, Dr. Rudolph Loewenstein, Dr. René Spitz.

E. For Sociologists: Study Group—Psychoanalysis and Sociology (under consideration); Psychoanalysis and the Social Sciences—Dr. Robert Waelder.

Special courses will be organized for groups of physicians interested in special problems. Applications should be submitted to Dr. Sidney Kahr, Chairman of the Educational Committee, at the New York Psychoanalytic Institute, 245 East 82d Street, New York 28, N. Y., giving full particulars of applicant's qualifications.

A NEW DIRECTORY OF PSYCHIATRIC CLINICS IN THE UNITED STATES is available from the National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y. Price fifty cents. It lists 688 community clinics in the United States and

also state institutions, state government departments promoting mental hygiene, Veterans Administration Regional offices and hospitals, mental hygiene societies, family welfare societies, community welfare councils and veterans information centers.

THE NATIONAL MENTAL HEALTH ACT (HR 4512 and S 1160) passed the House by a large majority in March and on June 14th unanimously passed the Senate. On June 18th the differences between the House and Senate versions of the Bill were considered in Joint Committee and final passage took place before Congress adjourned.

THE UNIVERSITY OF CALIFORNIA EXTENSION DIVISION in coöperation with the Division of Psychiatry, UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL announces a twelve-week refresher course in psychiatry and neurology, starting Monday, September 16th, 1946 at the Langley Porter Clinic, San Francisco Campus, Medical School, University of California. It is open to physicians generally and particularly to those returning from the armed forces. Registration is tentatively limited to sixty doctors, and the University of California reserves the right to give preference to its own graduates and to veteran physicians. The course will not be given for less than twenty-five applicants. Instruction will be given under the direction of Dr. K. M. Bowman, Professor of Psychiatry, University of California Medical School, with the assistance of staff members from the various divisions of the Medical School. The course will be given Monday through Friday, from 9 a.m. to 5 p.m. Subjects to be covered will include: general psychiatry, child psychiatry, psychobiology, psychoanalysis, psychology and psychopathology, functional and organic psychoses, psychoneuroses, therapy, psychosomatic problems, neuroanatomy, clinical neurology, neuropathology, neurophysiology, electroencephalography, x-ray diagnosis, and other related topics. Registration is open to graduates of approved medical schools with nine months' general internship.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Books Received

To cite this article: (1946) Books Received, The Psychoanalytic Quarterly, 15:3, XX-XX, DOI: 10.1080/21674086.1946.11950957

To link to this article: https://doi.org/10.1080/21674086.1946.11950957

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