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: Bertram D. Lewin (1946) Sleep, the Mouth, and the Dream Screen, The Psychoanalytic Quarterly, 15:4, 419-434, DOI: 10.1080/21674086.1946.11925652

To link to this article: https://doi.org/10.1080/21674086.1946.11925652

SLEEP, THE MOUTH, AND THE DREAM SCREEN

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In this paper I make use of an old familiar conception of Freud's—the oral libido—to elucidate certain manifestations associated with sleep; and I apply ideas gained thereby to other observations of psychoanalytic practice and to psychoanalytic theory.

Freud, in The Interpretation of Dreams *(10)*, assumes a wish to sleep, which he makes the prime reason for all dreaming, the dream being the great guardian of sleep. Of this wish he has little to say. In the Introductory Lectures *(11)*, at the start of the discussion of dreams, he makes his famous, humorous statement about what we do when we go to sleep. He tells us that we strip off most of our ego with our clothes, glasses, false teeth and other removables, and assimilate ourselves to the babe newborn, or the babe *in utero*. This comparison struck M. J. Eisler *(4)* forcibly, and he reported several cases of sleep disturbance (not entirely lucid ones perhaps), which were intended to show that sleep was a regressive phenomenon, a return to a hypothetical preoral or apnœic stage, such as might be imagined for the unborn child. Incidentally, however, Eisler made the important remark that the first going to sleep we know of takes place when the nursling has drunk its fill at the breast. Recently in the concluding remarks of a valuable symposium on sleep disturbances, Simmel *(28)* saw fit to call attention to Eisler's old statement, thinking it worthy of note even today.[1] Another author, Isakower *(16)*, in an important paper, turns to the same familiar idea to explain certain hypnagogic phenomena that precede sleep and sleep-like states.

There is nothing new, therefore, in the idea that sleep, even

[1] *Cf.* also Windholz, Maenchen, and Fenichel in the same symposium.

in adults, repeats an orally determined infantile situation, and is consciously or unconsciously associated with the idea of being a satiated nursling; and the idea has found some limited application in psychoanalytic literature. I should like to present a few new findings relevant to this idea and to exploit it more fully. To begin with, let me introduce a term, the *dream screen*. The dream screen, as I define it, is the surface on to which a dream appears to be projected. It is the blank background, present in the dream though not necessarily seen, and the visually perceived action in ordinary manifest dream contents takes place on it or before it. Theoretically it may be part of the latent or the manifest content, but this distinction is academic. The dream screen is not often noted or mentioned by the analytic patient, and in the practical business of dream interpretation, the analyst is not concerned with it.

The dream screen came to my notice when a young woman patient reported as follows: 'I had my dream all ready for you; but while I was lying here looking at it, it turned over away from me, rolled up, and rolled away from me—over and over like two tumblers.' She repeated the description several times at my request, so that I could substantiate the gist of her experience, namely, that the dream screen with the dream on it bent over backwards away from her, and then like a carpet or canvas rolled up and off into the distance with the rotary motion of machine tumblers. The idea naturally occurred that the patient was describing a hypnagogic phenomenon of the type reported by Isakower, who also mentions their occurrence on waking up, though he interprets those at the beginning of sleep. Forgetting dreams, as we know, is like no other forgetting. Like a patient's comments on awaking or when telling a dream ('This is an important dream', or 'a stupid dream' and the like), forgetting or remembering a dream belongs to the dream content itself, and may be analyzed as a manifest dream element. Hence, when my patient's dream rolled away from her while she was on my couch, she was putting the final element into the dream. Theoretically, under

pressure of her resistances, she was taking the last step in waking up (forgetting the dream) which was several hours after she had awakened in the conventional sense of returning to consciousness in bed. The dream screen rolling away was the final event in her complete awakening. As long as she remembered the dream, it might be said, she was partly asleep. Partial sleep, an idea suggested by posthypnotic and other phenomena, is coming to be employed in the explanation of certain apparently waking states (Kubie [*19*]. See also Grotjahn and French [*14*], Grotjahn [*15*] and the 'Symposium' [*28*]).

Isakower interprets the large masses, that approach beginning sleepers, as breasts. As it approaches the sleeper, the breast seems to grow; its convex surface flattens out and finally merges with the sleeper, often to the accompaniment of mouth sensations. My patient's belated waking up was the reverse experience. The flat dream screen curved over into a convex surface and went away. This appears to end the process that begins with going to sleep. When one falls asleep, the breast is taken into one's perceptual world: it flattens out or approaches flatness, and when one wakes up it disappears, reversing the events of its entrance. A dream appears to be projected on this flattened breast—the dream screen—provided, that is, that the dream is visual; for if there is no visual content the dream screen would be blank, and the manifest content would consist solely of impressions from other fields of perception. I shall try in this paper to show that there are such visually blank dreams, and shall also suggest their meaning.

Another dream of the patient referred to, appears to give us another glimpse of the dream screen. She dreamed of a large iron lattice work, which stood between her and the landscape. On analysis, this lattice was found to represent the metal frame pad which her mother had worn after an ablation of the breasts. The operation took place when the patient was seven, and a good part of her analysis revolved about the three year interval that began with the breast operation and ended with her mother's death. For these three years the patient had an

unusually refractory amnesia to everything that touched upon her mother. In contrast, her dream life dealt almost exclusively with this stretch of time; so, when she forgot her dream—when it rolled away—her wish to avoid and forget the topics, mother and breast, was being realized.

The dream screen appears to represent the breast during sleep, but it is ordinarily obscured by the various derivatives of the preconscious and unconscious that locate themselves before it or upon it. These derivatives, according to Freud, are the intruders in sleep. They threaten to wake us up, and it is they in disguise that we see as the visual contents of the dream. On the other hand, the dream screen is sleep itself; it is not only the breast, but is as well that content of sleep or the dream which fulfils the wish to sleep, the wish that Freud assumes to enter into all dreaming. The dream screen is the representative of the wish to sleep. The visual contents represent its opponents, the wakers. The blank dream screen is the copy of primary infantile sleep.

Accordingly, there should be dreams without visual content in which the dream screen appears by itself. Such dreams are obviously rare. They would be pure fulfilment, and under the circumstances the sleeper might not note that he had dreamed. The statement that a given night passed without a dream is always received sceptically by analysts, for dreams are readily forgotten and often come to mind later, when the dreamer, in analysis or by chance, has overcome a resistance. However, I suggest that in a special sense there are dreams without content, the special sense being one which the Russians, who call dreaming 'seeing in sleep', might find hard to phrase. I refer to the visually blank dream, accompanied by lower level, so-called organic sensations. Such a dream, we may suppose, is what hungry babies are having when they smack their lips before awakening to cry for nourishment.

Confirmation that the visually blank dream does occur, and that it represents the breast situation in a nearly pure state, came from the dream life of a schizophrenic patient. This

young woman, most clearly of all my patients, was fixed precœdipally on her mother. Her apparent heterosexuality was spurious, at times delusional; her true sexual interest was bound up exclusively (though entirely unconsciously) with mother surrogates. The dream I refer to was dreamed four times during her analysis, in each instance after a day spent shopping and lunching with a mother figure. Due to the pleasurable stimulation of such a day, she would enter an excited, blissful, erotic abstraction. That night she would have 'no dream', as she said, but a sexual orgasm. This blank sexual dream each time heralded a hypomanic attack of varying duration, with grandiose and erotomanic content.

Orgasm during sleep without a remembered dream is, of course, familiar enough. Ferenczi *(7)* states that 'pollutions' without a dream are incestuous, which is true but not illuminating. Some compulsive patients must masturbate before going to sleep to prevent sexual feeling from entering their frankly incestuous, but emotionally empty, dreams. But in the case I am speaking of, in spite of alternatives of slight probability, I am inclined to trust the patient's introspection that she had no visual dream, and to assume that she was stating a fact.

Certain other facts may be adduced in support. Her psychosis began with a stupor lasting several days, of which she could tell nothing. Efforts to pierce the amnesia surrounding those days brought out nothing but obvious confabulations, mixed with false 'memories' of her infancy. The patient's orality in general was intense and pervasive. The elated delusional states that followed directly upon the herald dream, may be considered a belated part of the dream. The heterosexual delusions of the manic state correspond to the content that was lacking in the blank dream. They are the secondary elaboration and the denial of the wish fulfilled simply and purely in the dream: union with the mother in visually blank sleep. Her delusions were erotomanic reversals of content, such as we encounter frequently in the secondary elaboration of dreams. They resembled dream more than waking consciousness; for

she thoroughly believed in the truth of her erotic fantasies as a sleeper believes in what he dreams. The same oral wishes dominated the dream and the manic attacks.

That manics may banish their sexual life completely into the realm of sleep was stated as far back as Abraham's first paper *(1)* on manic-depressive states. In the terminology of the time, Abraham attributes this to increased withdrawal into 'autoerotism'. Abraham's manic patient had ordinary erotic dreams, not blank ones followed by erotic delusions. It would harmonize with Abraham's later views on the rôle of orality in manic states *(2)* to say that the sleep manifestations in mania are oral in origin, even when in adults they culminate in genital orgasm. The blank dream of genital satisfaction, which follows an intense oral stimulation and heralds or initiates an elation, fulfils the requirements of the hypothetical primal dream. In the primal dream, the ego takes no part and does not exert its distorting influence. In short, this dream repeats the very young infant's dream after nursing—the dream which is pure breast or dream screen, and which fulfils the wish to sleep.

The dreams which Grotjahn *(13)* reports of a baby two years and four months old, are structurally far in advance of the blank dream screen. Grotjahn says: 'Sleep, to which the child in very early infancy devotes most of its time, seems to be much more important and preferable to waking life during the first year. . . . During early childhood the waking state seems to be a continuation of getting the same pleasure as in sleep by similar means.' Like my patient of the blank dream, the very young ego carries dream wishes and dream mechanisms into waking life, with less distortion to be sure. The young ego does not separate dreams from waking. The taste hallucinations of the very young baby's first dream have everything any other taste sensation has, except the real chemical basis. Yet in the dream they have the spurious psychological reality that sleep provides the dreamer; and if in waking life the baby recaptures this sense of dream reality, it is foreshadowing what

may happen later in a psychosis. As in my patient's case, the sense of reality may be carried over from the dream on to the secondarily elaborated delusions that serve as a cover, a defense and an attempt at recovery.

Piaget's *(23)* questioning of small children about 'where they dream' furnishes us no useful information. Usually the children (older than the ones we have in mind) told him that their dream was in the room or in their eyes, although one little boy said, inexplicably in terms of Piaget's method, that he dreamed in his mouth. To have followed this up would have gone beyond Piaget's fixed questionnaire and spoiled the tabulations.

I return at this point to an element in Isakower's description of falling asleep—the flattening of the world, equated or reduced to a breast, as it is taken into the mouth. This flattening brings to mind the same process in the case of Natalja N's influencing machine, described by Tausk *(29)*. It will be recalled that with the appearance of new areas of depersonalization in Natalja N's own body, a smoothing out took place in the corresponding areas of the machine, which was a sarcophagal replica of her own body. When she lost her capacity for genital feeling, the genital knobbiness on the machine disappeared, and similarly the other organs and parts that were alienated from her body ego lost their roundness on the machine and flattened out. By a clever piece of psychoanalytic algebra, Tausk equated the machine to the genital (invoking dream symbolism), and since the machine was also her body, he equated the body with the genital. Tausk's paper, which professes to treat of the most primitive ego states, omits all reference to the breast and orality. Influenced by his equation, Tausk assumes that the libido is still genital, and the formulations he applies are accordingly derived from the psychology of genital sexuality, as his terminology and analogies prove. For example, he speaks of 'body finding' when the infant is learning to know its own body and is investing its parts with libido; and this term he invents by analogy with

the term 'object finding', which belongs to later object libidinal psychology. Following consistently the scheme of genital development, Tausk uses only the conception of object regression to explain the changes in Natalja N's symptoms and libido distribution, skips over the early oral phenomena and the breast, and lands at a hypothetical intrauterine stage of elementary narcissism. Tausk thinks of the bodily part as if it were a love object, and interprets the withdrawal of libido from it as if this were a regression from object love to narcissism, which gets him into difficulties not satisfactorily solved by his ideas about two kinds of narcissism. Though he defines the object of the libido (or its absence) in Natalja N, Tausk ignores the other attribute ascribed by Freud to an erotic impulse, namely, its aim.

The time that has passed since Tausk's paper was published (in 1919), and the discoveries and literature of the intervening years warrant a revaluation of his findings. There will be some gain, especially, if we invoke early oral rather than genital conceptions, and libidinal aim rather than object relationship to explain some of the changes that took place in Natalja N's influencing machine. The smoothing out of the machine suggests the flattening of the breast in the hypnagogic hallucination. A third part, therefore, might be added to Tausk's classic equation of body and genital, so that it would read: body equals genital equals breast.[2] According to this line of thought, the breakdown of Natalja N's body ego boundaries would be due to an oral ingestion of the parts, a partial autocannibalism (to follow Abraham's terminology[2]), and the disappearance of each part of her body would mean that she had in fantasy swallowed that part. The particular piece of the world represented by the organ-representation is subjected to a (partial) world destruction.

It will be recalled that Spring *(27)* in his study of world destruction fantasies *(12)* came to the conclusion that world destruction was an oral act, an ingestion of the world. Spring's

[2] See Lewin *(20)*, pp. 36, ff. and 43, ff., for a discussion of this point.

schizophrenic patients and Dr. Schreber (as Spring's reworking of the Autobiography proved) identified themselves with the world, then destroyed it by swallowing it. World destruction and the abolition of bodily boundaries follow the same course. Indeed, the idea that bodily boundaries are lost because of oral action is already familiar to us in many other connections. The baby does not distinguish between its body and the breast, and Isakower makes use of this idea to explain the hypnagogic events preceding sleep. Ego boundaries are lost when there is a fusion with the breast; the absence of ego boundaries implies an antecedent oral event.

That the ego boundaries are lost in sleep and dreams we know, due to Federn's classic paper (5). I should like to utilize Federn's discovery to support my contention that the dreamer, or sleeper, remains in unified contact with the breast and that this determines constant characteristics of the dream, such as the dream screen, which are not always readily noted. Federn's finding that the body ego disappears in sleep is to be aligned with the analogous loss of Natalja N's boundaries and interpreted in the same way. The sleeper has identified himself with the breast and has eaten and retained all the parts of himself which do not appear outlined or symbolized in the manifest dream content. The sleeper has eaten himself up, completely or partially, like Natalja N or Dr. Schreber, and become divested of his body—which then is lost, merged in its identification with the vastly enlarged and flattened breast, the dream screen. In short, the sleeper has lost his ego boundaries because when he went to sleep he became united with the breast. Representations of the body or its parts in the visual content of the dream then mean that the body or the part is awake. It is an intruder and disturber of sleep. Symbols of the phallus, for example, appearing in the dream, represent the unconscious or preconscious waking of that part and signify a tendency to wake up, which opposes the tendency expressed by the dream screen—that is, pure fulfilment of the wish to sleep. The visual content of the dream in general

represents the wakers; the dream screen, primary infantile sleep.

Beyond the witty remarks alluded to, in which he compares it with undressing, Freud has little to say of the process of falling asleep. In The Interpretation of Dreams he assumes the wish to sleep as the great motive for all dream-making, but of this wish as such he offers no explanation. So, in order that Freud's almost casual remarks about the sleeper's return to the uterus may not be thought to offset what I have brought forward about the oral meaning of sleep, it should be noted that what we know of so-called intrauterine regression is in fact our acquaintance with fantasies of returning to the womb (Freud, Ferenczi [*8*], Simmel [*28*]). So far as they have been studied, such fantasies appear to be based on oral ideas. Thus, in claustrophobia *(21)*, where the retreat to the uterus is used as a defense, and the fantasy represents a going into hiding, the mother's body is always pictured as being entered orally, either actively or passively. Either one bites one's way in or one is swallowed by the mother. To rejoin the mother, whether inside or out, appears to rest on the oral pattern and to get its basic mold from the earliest oral experiences. The fœtus with which the claustrophobe identifies himself is a retro-projected neonate and is supposed to be either eating or sleeping. The fantasy of returning to the mother's body is a secondary fantasy, combining the idea of union with the mother at the breast and later impressions.

I referred above to the two polar ideas of eating and being eaten and their interchangeability. This interchangeability is intrinsic in oral psychology. The effect of eating is an identification with the thing eaten. As Isakower and others have stated, there is primarily no appreciation in the baby of the distinction between itself—that is, its skin and mouth—and the surface of the mother's breast. The baby does not know what it is eating: it may be eating something on the breast or in the breast, or something that belongs to itself. Perhaps for this reason, the psychology of the skin is closely bound up with

oral eroticism (*cf.* Fenichel [*28*]). Certainly in many cases, patients equate skin lesions with bites. From their dreams I learned that two depressed patients believed that their skin symptoms were due to worms eating their dead body. They thereby identified themselves with dead mothers. Another version says that the skin is a mouth, and when there are multiple lesions, many mouths. Healing and treatment are regarded as 'skin-feeding'. It is tempting to wonder, in passing, whether the mouth may not originally have been felt as a wound, so that the first healing attempt (to use the schizophrenic term) coincides with eating. The possibility of this interpretation is indicated by the fantasies reported in Nunberg's paper *(22)* on schizophrenic attempts at cure.

The dream screen may partake of cutaneous qualities; the original fusion of breast and the sleeper's skin in babyhood may enable the skin to register itself on the dream screen. This point is still obscure. One of the depressed patients referred to above dreamed of being in a small bed under a bassinet, which was protecting her from swarms of mosquitos that were trying to bite through the netting. She awoke scratching. The bassinet represented her skin, but a skin without sensation projected from her body against the dream background. The other depressed patient, during an attack of poison ivy, in a dream projected her very much awake and rather disfiguring lesions not on to a screen or neutral surface but on to the round arms of her children's nurse, in the form of beautiful tattooed pictures. This is more in line with Natalja N's projections; tattooing does not itch, and some of the poison ivy lesions were on the patient's genital, which along with other 'pictures', her children at the time were very much interested in seeing. But the nurse's tattooing did not represent only the patient's body and genital; it also referred to the tattooing of her mother's chest after the breast ablation. The patient's awakened skin was projected on to an unusual representative of the breast, to put it into the region of sleep.

The appearance of sleep at the end of the oral series—hunger,

nursing, satiety—prompts us to find a place for it in the psychology and symptomatology of the disorders which repeat this sequence in pathological form. We should expect sleep to be represented in the psychology of manic-depressive and allied conditions, and in pharmacothymia. The frequent finding that death and sleep are equated psychologically suggests itself as a proper point of departure, especially since the interesting metapsychological treatment given this topic by Jekels and Bergler *(3, 17)* and by Jekels independently *(18)*. My own approach does not involve metapsychology or the dual theory of instincts but proceeds from a consideration of the meaning of the stubborn insomnia of certain depressions.

The neurotic depression of the woman who dreamed of the bassinet will serve for illustration. A persistent insomnia, her presenting symptom, which had been present for eleven years, began shortly after the death of her mother. The first analytic material showed that the patient feared going to sleep, and that the devices she used ostensibly to put herself to sleep, such as reading, in fact had the contrary effect; furthermore, that she feared going to sleep because she was afraid of dreaming. When she overcame this fear and began to dream, it turned out that all her dreams dealt with her dead mother. Once she dreamed of the Heaven which, when she was a child, her pious mother had depicted to her, and of which the mother herself had dreamed in her last illness. The patient's dreams were fulfilments of the wish to be a passive, submissive child, although she was an aggressive person in waking life. About the time of the bassinet dream, for example, she dreamed of being wheeled in a baby carriage by her nurse. In many dreams she rejoined her mother, and it was clear that beneath the more superficial fear of dreaming was a fear of dying. This fear could be analyzed: it concealed the corresponding wish to die, and this wish in turn meant an infantile wish to sleep with her mother. The idea of sleeping with her mother had several implications; but at the age of three, she remembered, she had waked up in bed next to her sleeping mother, and wondered whether her mother was asleep or dead. In

short, her conflict was whether to sleep with her mother and be dead, or to stay awake and alive. The sleep she feared was not the pure sleep of the satiated infant—this she desired—but the complex, dreaming sleep, from which she could not trust her censorship to delete the wish to die. Her vigil was designed to frustrate the entrance of her wish to die (perceived with anxiety) into the visual manifest content of her sleep.

To recapitulate, the neurotic fear of sleeping was based on a fear of death, which warded off a wish to die. The wish to die represented the infantile wish to sleep in union with the mother. The prototype of this wish for death is the wish for the undisturbed, blank sleep, that is the probable state of mind of the satiated sleeping infant. This was the death yearned for in the depression. This blank sleep would be the fulfilment of Freud's assumed wish to sleep. Many neurotic wishes for death are basically the desire for oral satisfaction and the ensuing sleep. Death fears are the anxious equivalent of this wish. Suicide and suicidal fantasies represent a breaking through in a distorted form of the primitive wish for infantile sleep.

Strict analytic logic compels us to see in the wish to sleep a wish to be eaten up. Falling asleep coincides with the baby's ingestion of the breast; the result is an identification with what was eaten. Hence, the wish to fall asleep means an assumption of the qualities of what was eaten, including, in accord with animistic mentality, the wish to be eaten. The ramifications of this wish in psychoanalytic theory and practice require fuller discussion; but as we meet it in the neurotic depressions with insomnia, it coincides completely with the wish to sleep. In some of the dreams cited above, there are indications of its appearance as such, notably where the skin is the recipient organ for the biting.

Infantile sleep that follows nursing has not received adequate attention in formulations of the narcissistic neuroses. It has not been included in the chain of oral phenomena that underlies the events of manic-depressive and pharmacothymic disorders. Yet there should be no difficulty in fitting it into the

sequences which Rado *(24, 25, 26)* formulated. For in the intoxications, most of the drugs produce not only elation but a subsequent sleep as well, and the wish for sleep may rank more or less with the wish for elation, or be considered as part of the same wish. In the pharmacothymic's fantasy, elation would include or be followed by the same effect that the baby gets from drinking—namely, sleep. Rado's category, 'bliss' after oral satisfaction, need only be broadened to include the sleep of early infancy.

Similarly, in the affective disorders, the primary infantile wish to sleep should play a rôle in fantastic or real suicide. Without some such hypothesis, we must fall back on the assumption of a primary impulse to kill one's self, and equate this with the primary, inwardly directed death impulse, a metapsychological proposition, which, to be sure, in no way conflicts with the clinical, oral hypothesis (*cf.* Zilboorg [*30*]). Or, if we fall back upon the tested idea that suicide is symbolic murder, we cannot rest analytically with this statement as if it were a primary premise. For the statement implies an identification with the object and this in turn an antecedent oral event. Therefore, it does not contravert the idea that the wish to die that motivates suicidal fantasies repeats the earliest wish to sleep. In the affective disorders, Rado's sequence would need a slight expansion. Again we should add the provision that the bliss sought and obtained at the mother's breast includes the sleep that follows. Perhaps it is in sleep or while going to sleep that the hypothetical 'alimentary orgasm' takes place. In the pharmacothymic series, we have only to add the sleep that comes from the drug; and among the pharmacothymic sequelæ, we find symbolic infantile sleep represented, when, as Rado puts it, the pharmacothymic regime breaks down and the addict turns to fantasies of suicide—to infantile sleep at any cost. Thus, sleep, mania, suicide and world destruction complete and partial, are all the very different results of the same simple, primary, oral wish.

Rado has correctly stated that the person who kills himself does not believe he is entering death, but immortality, the

paradis artificiel of the addict's imagining. But there is another, an unwelcome immortality, as we know from the deathlessness, or extreme longevity, of the Wandering Jew, to whom it was a curse and a doom. Because he did not permit Christ bearing the Cross to rest in his shop, this character had a rare penalty inflicted upon him: long life. I suspect that this extraordinary sentence represents the 'immortality' of the sleepless, a bad case of insomnia. The poor Wandering Jew, for his sin against the weary Christ, may not sleep until the Second Coming, a prospect that still appears remote.

In conclusion, I recapitulate the main points made in this paper. The baby's first sleep is without visual dream content. It follows oral satiety. Later hypnagogic events preceding sleep represent an incorporation of the breast (Isakower), those that follow occasionally may show the breast departing. The breast is represented in sleep by the dream screen. The dream screen also represents the fulfilment of the wish to sleep. The intruding preconscious or unconscious wishes that threaten to wake the sleeper form the visual contents, and lose their place in the sleeper's ego by being projected on to or before the dream screen. The visual contents fulfil wishes other than the wish to sleep, and are the mental life during sleep to which Aristotle refers in his definition of the dream. The pure infantile dream without visual content, which repeats the infantile situation, was found heralding states of elation. The flattening out of the breast into the dream screen is analogous to the smoothing of Natalja N's influencing machine, and the unreal figures of Dr. Schreber's *Weltuntergang*. Finally, the blank sleep of oral satiety is seen to fit readily into the sequences which underlie the psychology of the narcissistic neuroses, to be one of the oral desiderata of the drug addictions, and the prototype of the death implied in the fantasy of suicide.

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The Psychoanalytic Quarterly

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

Constant Elements in Psychotherapy

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To cite this article: C. P. Oberndorf (1946) Constant Elements in Psychotherapy, The Psychoanalytic Quarterly, 15:4, 435-449, DOI: 10.1080/21674086.1946.11925653

To link to this article: https://doi.org/10.1080/21674086.1946.11925653

CONSTANT ELEMENTS IN PSYCHOTHERAPY

BY C. P. OBERNDORF, M.D. (NEW YORK)

The aim of all psychotherapeutic treatment is to impel or induce the patient through influencing his mental processes to convert symptoms which may be reflected in mental or physical sickness into a state contemporaneously regarded as healthy. The psychic methods by which this can be accomplished are extremely numerous, diversiform, and are not necessarily limited to verbal communication. Like other procedures in healing, it is offered by the physician and accepted by the patient with the implication and hope that it will relieve him of his suffering. Until the latter part of the nineteenth century there had been little scientific basis for many of the psychological methods which have been therapeutically effective. Generally speaking no systematic or consistent approach had been made up to the time of psychoanalytic investigation of psychic determinism and it is such psychoanalytic discoveries that have made possible the concepts and comments which follow.

The clinical elements entering into all forms of medical psychotherapy, whether it be brief, superficial or penetrating, and whether the condition for which it is applied be mild, severe or chronic, and upon which its efficacy depends are roughly five. They are: (1) who undertakes to perform it; (2) what is said or done; (3) the time when it is undertaken; (4) how (and even where) it is done or said; and finally, (5) the susceptibility of the person upon whom the psychotherapy is practiced. The overlapping of each of these factors and their mutually supportive interaction are obviously highly variable and complex.

Based upon a paper read before the Joint Meeting of the New York Neurological Society and the Section on Neurology and Psychiatry of the New York Academy of Medicine on April 9th, 1946, and one read by title at the American Psychiatric Association on May 27th, 1946.

Every form of psychotherapy is deeply indebted to psychoanalytic investigation for the invaluable light which its theories have shed upon unconscious factors operative in all psychogenic cure. This includes the nature of transference in such procedures as witchcraft, or Christian Science, also in persuasion, indirect and suggestion, in group therapy among children and adults, in hypnosis, and even with medicaments having no definite physiological effect (placebos), whether prescribed by doctors of medicine or others. It should be noted that transference phenomena are universal and are especially important in psychoanalytic psychotherapy and orthodox psychoanalytic treatment.

The element of suggestion enters subtly but almost invariably into all the forms of psychotherapy. Throughout this discussion the term suggestion is not used to mean something supernatural, or forced obedience or submission, or even in the limited sense of an idea directly implanted in the mind of the subject. It is confined to Ferenczi's concept and application of the term: '. . . it consists of influence on a person through and by means of the transference manifestations of which he is capable'. The inference, of course, is that certain people are more suggestible than others and that such persons are likely to develop transference manifestations more quickly and more intensely although not necessarily more prolonged or permanent transference than the average individual. Neither the physician nor the patient is always aware when or how some of the ideas take root.

Freud in his original need to explore the dynamics of mental disorder sought to avoid the term suggestion because it connoted the imposition of the will, the authority of the physician upon the patient. He felt that such domination led to the suppression of the patient's reactions which were seeking expression and which above all things he desired to investigate and interpret. Nevertheless he appreciated that the suggestive influence of the physician is 'inevitably exercised in psychoanalysis but is diverted on to the task assigned

to the patient of overcoming his resistances—i.e., of carrying forward the curative process'.[1] At that time, as it does today, the working theory of psychoanalysis aimed not at the direct removal of the symptoms of the illness but this occurred as a by-product of thorough analysis. A certain contempt arose in psychoanalytic circles for the term suggestion while, at the same time, it tacitly admitted the presence of suggestion in each psychoanalytic session where it supposedly was exerted solely in the removal of resistances—which, by the way, should theoretically disappear through analytic interpretation alone. The difficulty, one may say, the impossibility of limiting the interplay of suggestion to a single phase of analysis without its overflowing into others seems not to have been noted. Only Ferenczi, one of the most independent and original thinkers in Freud's earlier entourage, ventured to reflect in 1932 that 'the truth cannot be entirely spontaneously discovered—it must be suggested'.[2]

Perhaps it may be advantageous first to consider the qualities of the agents effecting the treatment. The quality attributed to such agents is usually power, either in the form of authority or of persuasion, ultimately in images of the firm father or the sympathetic mother. There is much which speaks for the postulate of psychoanalysis, that the comforting and calming influence of encouragement, of almost magical reassurance and tenderness—such as the child received from its mother originally in the form of stroking, warmth, etc.—is a fundamental element in all psychotherapy.

Emotional interaction, later known as transference, often with an erotic tinge, was recognized as a force in hypnotic suggestion, an immediate predecessor of psychoanalysis. Today in psychoanalytic psychotherapy and psychoanalysis when symptoms disappear because the patient's anxieties have been relieved due to confidence in the physician, this is called

[1] Freud: *Untranslated Freud.* Int. J. Psa., XXIII, 1942, p. 104.

[2] Ferenczi, Sándor: Suggestion in (nach) der Analyse. In *Bausteine zur Psychoanalyse.* Bern: Hans Huber, 1939. Vol. IX, p. 282.

'transference cure'. Such symptomatic relief is theoretically transient because the unconscious factors responsible for the symptom formation have not been thoroughly worked through (analyzed). Nevertheless so-called transference cures may be surprisingly enduring in severe neuroses where the infantile roots have not been uncovered. Sometimes neither the physician, even though he be a psychoanalyst, nor the patient may be entirely sure which mechanisms brought about the improvement.

I have followed two such cases for a long period after the completion of their treatment. Both of these seriously ill patients came under my care at a time when my experience and training in psychoanalysis were limited and before any formal instruction or training analyses had been introduced.

The first case, seen in 1909, was a woman, aged thirty-five, married, who suffered from depression, hallucinations in a clear sensorium and intense anxiety. All of these were immediately dependent upon an extremely difficult marital situation. She was seen only twice a week and recovered after a year of psychoanalytic therapy. She has stayed well and active up to the present time when she has reached the age of seventy-two.[3] The patient has written me once every year to report her condition and each letter is filled with expressions of continued faith and gratitude.

The second patient treated in 1913 was a young man of twenty-six from a devout Catholic family. He suffered from a claustrophobia and a severe chastity conflict. After about a year of psychoanalytic therapy he married, raised a family, was employed steadily and remained sufficiently well to require no psychiatric care until 1945 when he became depressed at the time of his waning potency and consulted me again.[4]

In neither of these cases had the transference to the physi-

[3] Oberndorf, C. P.: *A Case of Hallucinosis Induced by Repression.* J. of Abnormal Psychology, February–March, 1912.

[4] Oberndorf, C. P.: *Analysis of Claustrophobia.* Medical Record, LXXXVIII, 1915.

cian been resolved but treatment was discontinued because the patients were symptom free. Nevertheless the physician remained a sustaining force because of images which each of these patients formed of him and the faith they had in him although more than twenty-five years have elapsed since I had seen either of them.

What is said in the course of psychotherapy and its acceptance or denial by the patient is often dependent upon the character attributed to the person who advances the idea and need not be related to the latter's intelligence, truthfulness or scientific orientation. Such belief or rejection, and we may call it acceptance, confidence, faith, or disbelief, opposition, distrust, in the person or agency may depend upon his exalted position, his physique, his age, his brilliance, etc., or even at times his ignorance. Always a certain amount of identification exists between the therapist and the patient so that even an unintelligent person may be more effective in changing doubt into acceptance, by scientifically untenable means in the case of persons of a similar level of intelligence, than the most scientifically trained medical psychotherapist who may frighten and baffle them. With simple-minded patients the simplest suggestive approach is usually the best psychotherapy.

It must be mentioned that the interpretation of the same symptoms by psychoanalysts may differ categorically and that, as the years have passed, the stress on the importance of various aspects of psychoanalytic theory have fluctuated widely —infantile trauma, genital zones, the now almost forgotten primal scene, ego-synthesis, the present enthusiasm for repressed aggression as the fountain head of all somatic conversions, etc. Nevertheless the therapeutic successes of the group of analysts now dead may have equalled those piously guided by the most approved present day therapy.

The psychoanalytic observations on transference (who says it), on theory and interpretation (what is said or done) in the process of psychotherapy are extensive, but little is found in psychoanalytic literature about the fact that the same explana-

tions or interpretations from the same agent to the same person (patient) may at one time be accepted with apparent or genuine conviction and at another fail to impress. The importance of the inception of any psychotherapy and of the appropriate timing of interpretations is well recognized in psychoanalytic procedure, but the choice in timing such interpretations shows wide variation with competent analysts. It has always been one of the delicate problems of technique and has an intuitive aspect. It seems likely that the clinical effectiveness of every psychotherapist rests not only in the accuracy and appropriateness of his comments and interpretations but equally in his skill in timing them.

The time when most persons come for psychotherapy is often extremely significant. They usually have resorted to many forms of treatment before they finally decide to accept some form of psychotherapy which involves confession and its transference dynamism. From the experience of private psychoanalytic practice it seems to me that where the family or the doctor have induced, sometimes forced, the reluctant patient to come for treatment the results are far less likely to be favorable than when he comes spontaneously because of his own mounting tension, that is, at a time when he feels himself ready to attempt to change the intra-psychic situation.

The questions of how psychotherapy is performed, and the susceptibility of the patient will be mentioned only briefly. The first involves matters of technique and shows wide variation even in such a method as psychoanalysis where the essential principles are fairly well established and a recognized procedure is taught to mature physicians in the course of long preparation. I will merely refer to such extremely controversial questions as the pervading attitude of activity or passivity on the part of the physician. As we have already mentioned, according to the original concepts of Freud, the analyst avoids direction and seeks to stimulate the patient's power of initiative through the analysis of inhibiting forces and resistance. However, we must admit that the influence which the

physician's personality—his activity in therapy—i.e., his tone, his manner, his phraseology, his countertransference exerts upon the patient is subtle and extremely difficult to estimate. When he initiates active therapy, i.e., orders the patient to test himself in certain situations which seem precarious to the latter, he has not only overstepped the boundaries of interpretation but also those of transference-suggestion and is in the position of authoritative command. His shift in attitude is not likely to escape the patient.

Another moot question is the number of times the patient should be seen weekly. Deviation from the custom of six hours a week which Freud originally insisted upon has become widespread and apparently is closely associated with the physician's activity in therapy, and use of active therapy. These are apt to go hand in hand with a decreasing number of visits and the intrusion of intentional or unintentional suggestion or direction into treatment. As I have mentioned in previous papers, other factors are the intentional interruption of the analytic procedure to allow spontaneous integration, the tapering off of therapy, the purposive setting of a time limit for the cessation of treatment, etc.[5] Here it is permissible to say that the physician may unconsciously choose his patient quite as frequently as the patient chooses the physician, and sometimes selects consciously those who appear amenable to his therapeutic approach. Generally speaking the susceptibility of a patient to psychotherapy from purely psychological considerations is dependent upon the plasticity of his superego and his ego integration. From the biological standpoint, future investigations may demonstrate a specific cellular susceptibility or insensitivity of certain patients to the fundamental pain-pleasure principle.

What is said or done may range from well-founded analytic interpretation to an accidental though auspiciously timed psychological shock or the almost arbitrarily administered con-

[5] Oberndorf, C. P.: *Factors in Psychoanalytic Therapy.* Amer. J. of Psychiatry, XCVIII, No. 5, 1942.

vulsive shock. Generally it is postulated that in shock therapy a dire threat to the patient's existence through shock induces the patient to abandon mechanisms he has developed as a protection against intolerable life situations rather than to retain them. Also it is often advanced that the convulsive shock sets free the patient's energy and disrupts libidinal fixations whereby transference becomes freer subsequently.

At the risk of further complicating the issues in psychotherapy I will refer briefly to two instances which occurred in my practice within the past three years because they seem particularly pertinent to the question of elements operative in the cure of psychogenic disorders. The first I report reluctantly, for the course of the case has been disturbing to certain psychoanalytic theories to which I have been devoted for over thirty years.

For over a year I had been engaged in the psychoanalysis of a teacher, about forty, suffering from great anxiety and a fear to appear in school because he might faint. But this was only one of many neurotic symptoms such as a compulsion to associate with his wife from whom he had been divorced and who had remarried, a fear to be seen walking in crowded streets and numerous sexual deviations. From early boyhood the patient had suffered from many other typical compulsions such as putting his shoes in a certain position before he could go to sleep. In high school he developed a fear of reciting in the classroom for which he consulted a leading neurologist of the time. Inability to cope with this fear compelled him to leave school before graduation.

At the age of twenty-two he was afflicted with a severe depression following an inappropriate love affair, and fleeing from the situation, he went to Europe where he consulted an eminent psychoanalyst who referred him to a well-known New York analyst with whom he was under treatment for six months or more. Perhaps he was not entirely well at the end of the treatment but he returned to his profession. At thirty-one a distinguished psychiatrist referred him to an outstanding

analyst who treated him actively for nearly two years. The patient discontinued therapy without improvement. Subsequently he tried to resume teaching but was ineffective because of numerous incapacitating neurotic residues and difficulties in emotional and social adjustment. At thirty-eight he resumed analytic treatment for about four months. Again failing to improve he entered treatment with me and continued for about eighteen months with very few changes in his condition. Then I lost track of him.

I was interested in the repeated analytic failures in this case because it seemed to me that the dynamics were particularly of a pattern which psychoanalysis is intended to benefit. Therefore I communicated with the doctor who had originally referred him to me, who reported that the patient had been treated by Dr. X with electric shock therapy, and that he had returned to his profession where he was working effectively. Inquiry two years after he had completed the shock treatment yielded the information that the patient was continuing at work but occasionally came to his family physician with minor complaints for which he was treated symptomatically. He has little love for the psychoanalytic method and the various physicians who had attempted to cure him by it.

About the same time that this patient left me the aforementioned Dr. X referred to me a case which he had been treating actively with shock therapy for a long period, at the request of the patient's father. The patient was a twenty-year-old man who had suddenly found himself unable to do his school work at the age of fourteen and at twenty was still struggling along in his sophomore year at high school.

Previous to the shock therapy he had been under the care of a neurologist who had treated him symptomatically for about two years. The patient explained that he had told Dr. X he had improved because the terror occasioned by the shock therapy had been so great that he felt by claiming he was better he might escape from its torture. However, he had not advanced at all in school and spent most of his time reading

or doing minor chores about the home. At the first interview it was evident that this young man possessed an unusually keen and original mind.

Although the patient had become sceptical of psychiatry and suspicious of psychiatrists he consented to try psychoanalysis and I began treatment to determine the cause of his thought block. Gradually he developed a strong transference. Eventually we discovered that he had identified good scholarship with femininity. In the mixed high school he attended the girls usually attained the highest marks, those boys who were good students were 'sissies'. Because he had been unable to cope with certain feminine traits which he possessed, his mind had unconsciously rebelled at an activity (study) which it considered as an evidence of femininity. An important reinforcing factor to this particular attitude toward scholarship was the excessive emphasis which his parents had placed upon it. To fail in his studies constituted a measure of triumph over their authority.

The patient was seen for a total of ninety-five hours from February 1943 to the end of that year. Because of the fact that he continued at school and lived some distance from New York, it was impossible to see him more often than four times a week and this only now and then. During 1944 there were sixty-eight visits, and in the first half of 1945 thirty-three.

His mental processes gradually began to function normally, and within two years he had not only made up his high school studies but by extra work had been accepted in one of the leading universities in the premedical course where his record in the recent midyear examinations shows very high grades. He has not been under active treatment for over a year and his comments upon shock therapy show little love for it or those who employ it.

Some analysts would maintain that the improvement after shock in the first instance was attributable to the previous analytic work or that the original diagnosis was erroneous. In my opinion the first claim is untenable and if the second

is true, the correct diagnosis should have been 'depression' or 'schizophrenia', but extremely competent psychiatrists considered the patient a subject for psychoanalysis and several analysts were hopeful of curing him of his illness.

It might similarly be asserted that the favorable outcome in the second case depended upon the shocks which preceded the psychological approach, but this also seems unlikely—nor would I subscribe to the explanation that in each case the patient got well 'to spite his previous physicians' as was suggested by several psychoanalysts with whom I discussed these situations.

Many physicians using narcotherapy or sedative drugs, convulsive shock therapy or lobotomy are of the opinion that they reduce underlying anxiety but do not affect the essential schizoid or depressive processes. They regard them as a preparatory step to modification of ego attitudes, reëducation and psychotherapy. The regressive phenomena observed after these pharmacological or surgical procedures are reminiscent of those which the patient experiences in the deepest psychoanalysis. In adults the shock may provide a pathway for the discharge of aggression and sexual tension. In children, especially little girls, the shock treatment often seems to have the effect of a sexual experience. So deep is the regressive behavior in lobotomy that rehabilitating personnel must include tiger tamers and wet nurses—and the latter sometimes may have a life job—i.e., for the life of the patient. On the other hand, psychically induced shock, panic, rage, excitement, or the startle reaction are often regarded as therapeutically valuable aids in the psychoanalytic procedure.

Cases which have been under psychoanalytic treatment for years and which show only slight improvement are familiar. Where such long continued analyses reach a stage of stasis, we call the failure to improve 'resistance' and the analyst proceeds doggedly to attempt to alter such unconscious opposition by 'working through' its components. Occasionally after many months of work the patient accepts something which he has

often heard before because by this time his mental state has reached a point where the even balance of conflicting forces has been disturbed.

Although the word suggestion has become practically obsolete in psychoanalytic literature for the past ten years the entire procedure of psychoanalysis has a suggestive implication. The very fact that the patient understands that his illness is due to certain unconscious factors which when discovered and analyzed will benefit him has a suggestive value and at each session tends to repeat and reaffirm the need for and ultimate hope in cure through the long psychological quest.

We may say that psychoanalysis operates in the sequential breaking of tensions and in the timing of interpretations at moments fitting for their receptivity by the patient. In this sense psychoanalysis becomes an intentionally planned procession and sequence of psychic situations. Each of these situations in turn at some point in the treatment becomes favorable for interpretation intended to alter fixed psychic tensions and to permit a realignment of values through an intellectual and emotional approach.

The inclusion of formal psychoanalysis in psychotherapeutic procedures in which suggestion operates must not be construed as a depreciation of Freud's genius, nor of the value of deep psychoanalytic therapy in certain cases. Nor does it indicate a tolerance of lay therapists or an acquiescence to the inferior training of medical psychotherapists. On the contrary, it calls for the thorough education of the physician in what is established in psychotherapy by scientific psychoanalytic theory. When he has attained this, the individual therapist will gradually select from this fundamental knowledge and procedure those features which he discovers he can manipulate best. As his clinical experience grows, the better grounded he is, the more flexible will he become in his technique and perhaps bolder in attempting modifications and abbreviations, more aware that suggestive forces are constantly operative along with his interpretative efforts. He will also discerningly allot

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to certain rigid, narcissistic neurotics five hours a week and remain unperturbed and undiscouraged if they show little response after two hundred hours or more of treatment.

Clinically, at least, we cannot separate psychoanalytic theory from psychoanalytic practice, and the dissimilarity and disparity of thought on critical questions among matured and experienced psychoanalysts reveals an extraordinary degree of individualism in both theoretical basis and procedure, and also in the results achieved with different illnesses—such as the compulsion neuroses, homosexuality, hysteria, etc.[6] Such variance is probably attributable to the fact that each analyst shifts emphasis to certain aspects of psychoanalytic theory which seem best to meet his subjective clinical talents and slants. In this connection it has been interesting to observe how these attitudes changed with experienced analysts during their years in military service in the recent war. From their writings and from conversation with several of them it was evident that the emphasis on the goal in therapy shifted sharply from the individual integration of the patient to his adaptability to the group.

Predilections of this kind may also account for the many deflections which have occurred among Freud's adherents both before and since his death. Sometimes they seem to be restating some accepted elements of Freud's extensive theories, which changed so frequently as they developed during the half century of his scientific productivity. Thus the idea that the essential conflict in neuroses is due to a basic attitude on the part of the patient of 'moving away from', 'moving toward', or 'moving against' people (Horney) is basically similar to the pain-pleasure principle of Freud's earlier writings. Each of these innovators seems to be striving unconsciously to attain a greater assurance in therapy by accenting points of theory, philosophy or procedure which have worked well with him and for which reason he clings to them tenaciously. This

[6] Oberndorf, C. P.: *Results of Psychoanalytic Therapy.* Int. J. Psa., XXIV, 1943.

would apply to those who adhere reverently to long and deep psychoanalysis intended to and often successful in reversing long existent characterological defense mechanisms and equally to the proponents of 'brief' (short or superficial) psychoanalytic therapy.

Further disagreements have occurred among these new groups of dissenters. As a random example, Clara Thompson disagrees with Izette de Forest (both followers of Ferenczi) in that the latter feels that definite assertions of liking by the physician for the patient are necessary and also that the building up of tensions deliberately in the patient has a constant therapeutic value.[7] Often the dissenter ascribes universality to his own personal strengths and regards them as fundamental. Essentially they represent individual adaptations to intangible and indefinable elements present in all psychotherapeutic healing and I do not doubt that each group and individual can point to striking therapeutic successes, in some instances where a 'short cut' succeeded, after the orthodox psychoanalytic procedure had failed. The converse is also true and it has become an apologetic conventionality for psychotherapists reporting symptomatic improvement following cathartic therapy—with or without narcosis or hypnosis—to add that for more permanent and complete results a deep psychoanalysis would be necessary. To date no investigation exists which could help determine the preferential procedure in a given symptomatology and with specific patients.

In conclusion, I cannot entirely subscribe to one noted psychoanalyst's statement that 'the most important factor in psychotherapy is the therapist'.[8] In addition to and aside from the physician's personality we must include the content, the timing, and the manner of presentation of his suggestions,

[7] Thompson, Clara: *On Therapeutic Technique of Sándor Ferenczi: A Comment.* Int. J. Psa., XXIV, 1943, p. 64.

[8] Brill, A. A.: *Various Schools of Psychotherapy.* Connecticut State Med. J., VII, 1943, p. 530.

explanations, and interpretations, and the impressibility and sensibility of the patient as constant essential elements. Success in treatment will depend not only on the skilful consideration and manipulation of these factors but also on favorable or prejudicial external conditions which support or thwart the therapist's efforts. Further investigation of these elements will lead to a broader, eclectic application of freudian principles in psychotherapy and psychoanalysis to the innumerable medical conditions affected by or consisting of the psychic attitude of the patient.

The Psychoanalytic Quarterly

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

Fetishism and Object Choice in Early Childhood

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To cite this article: M. Wulff (1946) Fetishism and Object Choice in Early Childhood, The Psychoanalytic Quarterly, 15:4, 450-471, DOI: 10.1080/21674086.1946.11925654

To link to this article: https://doi.org/10.1080/21674086.1946.11925654

FETISHISM AND OBJECT CHOICE IN EARLY CHILDHOOD

BY M. WULFF, M.D. (TEL AVIV, PALESTINE)

Of primary object choice in earliest childhood the finer details have never been completely and definitively clarified by psychoanalytic investigation. Of what is known of this subject, that which is most important derives from Freud, who, indeed, emphasized repeatedly that on this important question there was a great deal that still stood in need of further elucidation. Hence it is not surprising that it is precisely this part of psychoanalytic doctrine that has been subjected to the sharpest criticism among psychoanalysts and has been the occasion for the widest differences of opinion.

In addition to the direct observation of the infant, psychoanalysis has taken a further step in investigating the development of the libido through the study of disturbances in this development as manifested in neuroses of adults and in perversions. Of the sexual aberrations with regard to object choice there are two forms known to us: homosexuality and fetishism.

For the present discussion, however, the finer details of primary object choice in relation to the development of homosexuality yield relatively little information, since the primary object is in both sexes always the mother, and throughout the individual's development up to and beyond puberty both sexes may serve as potential objects. We know also that the psychological constellation which favors development in the direction of homosexuality is more or less independent of biological predisposition.

Of greater interest and importance to our topic are the developmental phenomena of early childhood which characterize fetishism. Although it has long been known, through the work of Binet, Havelock Ellis and others, that the first expressions of fetishism may make their appearance at any

early age, we know only very little of the psychological processes which lead thereto; and indeed, two questions thrust themselves immediately upon our attention: (1) Are there such things as fetishism, or fetishistic manifestations, in young children? (2) What component instinct achieves gratification in autochthonous and exclusive fashion in the fetishism of adults, comparable to the impulse to look and be looked at in exhibitionism? As is well known, psychoanalysis finds perversion as consisting in regression to a primary infantile component instinct, which consequently becomes autochthonous, dominates the whole sexual life of the individual, and becomes the principal source of his sexual gratification.

The answer to the first question of fetishistic manifestations in young children is obviously not a simple one. So far as I know—and I should be grateful for additional references—only one case of fetishism in the young child has been published in psychoanalytic literature, by Joseph K. Friedjung, of Vienna, in the issue of October 1927 of the *Zeitschrift für psychoanalytische Pädagogik*. On account of its great interest this case is here presented in detail.

'A boy sixteen months of age fell ill of whooping cough. His violent protests against the doctor's examination and the anxious attitude of his parents betrayed immediately the neurotic setting involved. The parents were German musicians, the father considerably older than the mother. The household included the seven-year-old son of the father's first marriage. The patient had thrived moderately well on nine months of feeding at the breast of his nervous mother. He was badly spoiled; whenever his mother was at home, he wanted her completely at his disposal. If he was not given his way, he became enraged. He was taken every morning into his parents' bed. For several months (perhaps since being weaned, his mother said on questioning) he had had a peculiar *sine qua non* for going to sleep: he had to be given a stocking or brassiere which had been worn by his mother. This object

he pressed between his hands, stuck a thumb in his mouth, and forthwith fell asleep. Whenever the parents returned home at night, the boy woke up. In undressing, as his mother took off her brassiere, he demanded it be given him, and with it soon fell asleep again. Refusal provoked an attack of rage. Freshly washed things, or garments his father had worn, he refused. My knowledge of this I owe only to the circumstance that I found in the child's bed a woman's stocking which had obviously been worn and was turned inside out after the habit of many housewives, and in some astonishment inquired as to its presence there. I emphasize this to show how dependent we may be in such cases upon the accidental; thus the uniqueness of this observation does not suffice to prove its isolated character. A week later, the parents being absent, I learned from the grandmother and from an elderly servant that the child's play had begun some months before with a nightgown which had been discarded by his mother. This nightgown continued to play occasionally the rôle now taken over by the stocking and brassiere. (This fetish had been concealed from me by the parents.) Very intuitively the grandmother described how the boy flirted with his fetish "in a very animal way", as she expressed it. The servant added that he now gave preference to the stocking; also, that at supper, which she served him in his mother's absence, he refused to eat unless he had it with him.'

This contribution was followed by the following postscript in Volume VII of the *Zeitschrift für psychoanalytische Pädagogik* (p. 235): 'When in July of 1927 I communicated this unusual observation of mine to Professor Freud, I received from him this reply: "It has been shown beyond doubt in a number of adults that the fetish is a penis substitute, a substitute for the missing penis of the mother, and hence a means of defense against castration anxiety—and nothing else. There remains to test this in the case of this child. If proof is to be forthcoming, the boy must have had ample opportunity to convince himself of his naked mother's lack of a penis." Sub-

sequently to this Freud's study on fetishism was published (in Volume XIII of the *Internationale Zeitschrift für Psychoanalyse*),[1] in which this interpretation was established.

'Recently I had the opportunity of seeing this now two-year-old boy, grown to be very lovable, physically well developed and mentally advanced beyond his age. The weakness of his parents, especially the mother's, permitted the boy to keep his fetish as the best means of getting him to sleep quickly. Only garments which his mother had worn he spread over his face, and then sucked his fingers. That he still refused articles of clothing freshly laundered or any which his father had worn made his mother believe the smell of the fetish as derived from her body to be significant. But to this it may be added that Freud's expectation was completely fulfilled; for the parents, whose bedroom the boy shared, undressed completely before him without embarrassment, in order, as the mother put it, to accustom him to their naked bodies, and that he might be allowed to recognize the difference between the sexes. Daily, then, he had ample opportunity for the comparative observation of mother and father of which Freud speaks. My observation of fetishism *in statu nascendi* thus confirms the results of analysis of adult neurotics.'

So much for the case reported by Friedjung—a case raising a number of problems which will be discussed in further detail.

I have come upon a second case in the paper published in the 1935 volume of the *Zeitschrift für psychoanalytische Pädagogik*[2] by Editha Sterba, under the title: A Case of Eating Disturbance. In the case history the following, *inter alia,* is reported:

A little girl about twenty months old, 'had clung tenaciously to a particularly beloved possession dating back to her nursing

[1] Freud: *Fetishism.* Int. J. Psa., IX, 1928, p. 161. [Tr.]

[2] English translation of this case in *An Important Factor in Eating Disturbances of Childhood* by Editha Sterba. This QUARTERLY, X, 1941, pp. 370–371. [Ed.]

period. It was a drooling cloth, somewhat smaller than an ordinary bib, about the size of a woman's handkerchief and consisting of four layers of fabric. Although she had been weaned at six and a half months and showed no reaction to it, after weaning as she was going to sleep, she would always demand to have the little bib that she had worn when she was being suckled at the breast. She would press this against her cheek with one hand and go to sleep contentedly sucking her thumb. At this early age she could not be fooled, and whenever an attempt was made to substitute a diaper or a handkerchief for the drooling cloth, she became very angry. The first distinct syllable that she pronounced was a name for this cherished possession which she called her 'my-my'. At seven and a half months she would clasp it tightly and if one in fun tried to pull it away, she would protest 'my-my'—meaning 'mine, mine, it belongs to me'. This became a favorite game in which one could plainly observe the development of the feeling of possession. The 'my-my' was both her comforter and her protection in all the difficulties and dangers of her small life. When she was vaccinated, the 'my-my' was her best soothing draught for the pain. Other children playing in the park sometimes took her toys from her. She would then cry for her 'my-my', suck her thumb a little while and be quite consoled. The same was true whenever in a quite strange environment she felt insecure and lacking in confidence.

During a walk her father took with her one afternoon, she suddenly asked urgently for her 'my-my'. It was given her, whereupon deliberately, with a definite aim, she threw it at once into some dirt in the street. Her father did not want to give her the dirty cloth again. She demanded it however, began to cry, which very seldom happened with her, and as soon as she got it back, immediately threw it into the dirt again. This was repeated several times. . . .'

In the following paragraphs I should like to add a few observations of my own, which are of interest because they throw further light upon the subject under consideration.

Many years ago I visited friends, a family consisting of father, mother, and a very nice boy of between four and five years of age. It was evening, and the child's bedtime, but although he was already undressed and in bed when I arrived, he did not want to go to sleep and continually called his mother, screamed and wept. She had to go to him several times to quiet him, but all to no avail. The young woman said, 'I will give him the "magic blanket", and he will quiet down right away'. 'What sort of a thing is a "magic blanket"?' I was interested to ask. 'It's a curious thing with him', the mother replied, 'that ever since he fed at the breast he has had a small, warm and very soft woolen coverlet which he prizes more than anything else in the world—more than me and his father. If only he can have this coverlet—we call it the "magic blanket"—he is so happy that nothing else matters. For instance, he is very unwilling for me to leave the house and leave him alone, but if I give him the coverlet I can generally disappear and it is all the same to him. It is the same way with every other difficulty—if he has a pain or is in a bad humor or something unpleasant has happened to him, he has only to be given the "magic blanket" and he will wrap his head in it and fall asleep peacefully and happily.' The 'magic blanket' in this instance was not lacking in its magic spell.

A second example comes from a Moscow orphanage where I worked. The children were from one to five years of age, and each child, to the youngest, had its own plate, spoon and chamber pot. Each child prized these objects highly and in addition to their practical usefulness they served as playthings. Of particular interest was the relationship of a boy of not quite two years to his pot. He would not be separated from it, it was his favorite toy, which he dragged about with him all day long unless it was taken away from him by some subterfuge. It was for him the most precious object in the world. He complied readily with the most difficult and disagreeable demands of training and upbringing made upon him, if only he were allowed to keep his pot as a reward. I mention this by no means striking—indeed I might say com-

monplace—example in order to show that such instances of a fetishistic relationship to any object in the environment, are not particularly infrequent and are familiar to nearly every one from his practice or his daily life. What is largely unobserved or unappreciated is the fetishistic nature of such behavior. The unmistakable cases of fetishism contribute to the understanding of these fetishistic commonplaces which pass unnoticed or are considered simple childish whims.

I quote in this connection the following passage from Havelock Ellis: 'A very complete kind of erotic symbolism is furnished by Pygmalionism or the love of statues. It is exactly analogous to the child's love of a doll, which is also a form of sexual (though not erotic) symbolism.' [3]

A third interesting example I owe to the communication of my colleague, Dr. Idelsohn.

'A boy, one year and three months old, exhibited a special preference for and an exclusive interest in one of the bibs that was tied around him at meals. On going to bed after a meal he took the bib to bed with him, whether during the day or for the night, smelled of it, and sucked it. He would not be parted from it on any account, held it in his hand and, in dabbing his nose with it, it was clear that he smelled of it vigorously. It soon proved that the little boy wanted only one particular bib, one to which he had given the name "Hoppa". Various others which were tied around him at meals he rejected. The name "Hoppa" came from a dancing movement which he carried out in the evening in bed, while singing "hoppa, hoppa, hoppa". This was a kind of rhythmic dance on tiptoe, in which he moved his whole body backwards and forwards.

'When the bib was washed and presented to him in clean condition, he was displeased with it and pushed it away, slept restlessly at night, cried, and called for his "Hoppa". After

[3] Ellis, Havelock: *Erotic Symbolism.* Vol. V of *Studies in the Psychology of Sex.* Philadelphia: F. A. Davis, 1906, p. 12. [Tr.]

several days' use, when the bib had lost its freshness and cleanliness, the youngster began to take pleasure in it and use it in his accustomed manner.

'When he was about two and a half years old the "Hoppa" disappeared one day and could not be found. The result was that the child would under no circumstances take his midday nap, and for the first few days had great difficulty in going to sleep at night, called continually for his "Hoppa", wept, was in low spirits, and obviously missed the bib, whereas prior to this he ordinarily fell asleep immediately and without difficulty. Every effort on the part of the parents to find a substitute for the "Hoppa" failed completely. But there was worse to come. The child was already toilet-trained, but after the disappearance of the "Hoppa" he became a regular bed-wetter. Simultaneously, however, he stopped sucking.

'A month before his fourth birthday his mother got some colored checkered handkerchiefs such as she had never used before. Since the child had a cold, the mother gave him one of these handkerchiefs to take to bed at night. After this he demanded this handkerchief again and again, smelled of it, and refused to be parted from it. During this period his enuresis entirely disappeared. This handkerchief he often stuffed into his pyjama legs and pressed against his genitals, saying that in this way it could not get lost. After being freshly laundered, the handkerchief gave him no pleasure; its use was pleasurable only when it had a mixture of odors which had to do with his mother—from her eau de cologne, her pocketbook, her linen cupboard, etc. It often happened that he would waken at night and cry, "Handkerchief!", and then finding it, would lay it over his nose, and immediately fall quietly asleep.'

The cases of Friedjung and of Sterba exhibit a number of interesting similar phenomena which I should like to emphasize: (1) in both, the manifestations of fetishism made their appearance immediately after weaning; (2) in both, they were

associated with sucking; (3) in both, they made their appearance before falling asleep and quickly induced quiet and 'satisfied' sleep. In Friedjung's case, furthermore, the fetishistic behavior even included the evening meal. On the other hand, a very important difference between these two cases is to be noted: in Friedjung's case the fetish was connected with the mother's body, with her odor, and thus was definitely a mother substitute—as cannot be said unequivocally of Sterba's case. The association with sucking is patent in the latter case, to be sure; but this is displaced to the 'drooling cloth' and its properties.

The third case, of my own observation, is interesting in the respect that the characteristics of the fetish, in addition to its warmth and the pleasurable feeling on the skin of contact with the softness of the wool, probably included, besides, the smell of the child's own body, and thus provided a narcissistic gratification.

In the fourth case, the anal reference is so definite as to call for little comment. But it should be added that this was an extremely obstinate child, aggressive and bad-tempered, and that the fetishistic relationship to the pot developed shortly after his removal to the orphanage, and separation from his mother.

The fifth case, Dr. Idelsohn's, is of particular interest. Here we see not only the origin but the further development of the fetishistic relationship. Here too, as in the cases of Friedjung and Sterba, the association of oral activity and gratification with the fetish marked its inception: the fetish, the bib, was first used at meals and was valued in its rôle as a fetish only when it retained bits of food and the smell of food; its use, again, was associated with sucking before falling asleep. After the bib was mislaid, bedwetting—a well-known reaction in young children to the loss of a love object—was resumed. In this child's fourth year, another fetish suddenly appeared upon the scene in a new and somewhat modified form. It was now outspokenly related to the mother, and to her odor, and no

longer to eating, sucking or the oral. Instead of to the face, or to the nose, the child now pressed the fetish against his genital, under the remarkable pretext of not losing it—as though to this four-year-old child the freudian concept of the phallic stage were already known!

We now return to the question put at the beginning: may the fetishistic phenomena of early childhood, in their clinical and psychological character, be completely identified with the fetishism of adults?

As regards the external and clinical manifestations, the observations cited supply a fairly unequivocally affirmative answer to the question. In all the cases described we see an object possessing no qualities whatever which would justify its choice as a love object, although it has nevertheless become such, that is, has taken the rôle of a fetishistic substitute object, exactly as holds true in the case of adults. What the actual primary object might be said to be in the cases cited cannot altogether definitely be perceived. In the first case (Friedjung), it seems to be the mother's body, with its particular and individual odor. Because of its association with eating and sucking and its inception immediately after weaning, the suspicion is aroused that it is not the mother's body, but more specifically the mother's breast which might be the primary object; but if with regard to the brassiere as a fetish this supposition seems to be justified to a certain extent, it does not at all fit the most important and principal fetish, the stockings which had been worn by the mother, which had a particular and specific odor. We can thus assert with certainty in this case that it is the mother's body *in toto,* with its individual and specific odor, which becomes substituted by the fetish, the (washable) articles of wear. On the other hand, the maternal breast has the same odor and the same properties as the mother's body as a whole, and could well be the child's first object of all. The circumstance that the fetish possesses a quite specific relation to sucking and later to the taking of food would then be explicable on the basis of the child's age, i.e., the oral stage of development.

Likewise in Sterba's case we find a definite relationship to the oral inception of the fetishism as it appeared immediately following weaning, and was associated with sucking before falling asleep. Whether a specific relation between eating and the fetish existed cannot be told from the article in question; but something else extremely characteristic emerges in very clear and unequivocal fashion. Mrs. Sterba writes the following about the developmental state of this child: 'This example illustrates clearly the close interrelation between the oral and anal zones and the substitution of one for the other. This little girl was in the difficult position, for her, of having not only to learn to give up the content of her lower bowel, but to comply with the demand of her nurse that she should give it up at a stipulated time. This could not be done without resistance on her part, since the tendency to retain, as we have seen, was already very strongly developed in her. The conflict between giving and withholding was expressed very clearly in the game with the "my-my" which was an oral fetish from the nursing period. The intense feeling of possession for it, bespeaks a strong anal cathexis. . . .' In short, with the progress of development from the oral stage to the anal, the originally oral love object, the oral fetish, was brought into relation with the anal phase of development which succeeded it.

What the primary love object may be, for which the fetish is the substitute, still remains unknown. The original connection of the 'drooling cloth' fetish with suckling at the mother's breast is clearly evident, but whether a connection later with eating also existed, as in the cases of Friedjung and Idelsohn, cannot be learned from Sterba's presentation. There is likewise in the latter no evidence that the odor of the fetish can be said to be of any significance for its rôle as such. But we learn that the nature of the material of which the fetish was made (four layers of textile fabric) was of particular importance in casting it for its rôle. Perhaps this material had a particular odor at first, but it is difficult to suppose that before its first use, and on numerous occasions afterwards, it was not

laundered, which must have caused the disappearance of any odor originally peculiar to the material. Hence another property of the fetish would seem more important, namely, the particular tactile sensations which the material gave rise to on contact with the hand or the skin of the face. The same must be said of the third fetish, the soft woollen 'magic carpet', where clearly the pleasant tactile sensations it gave rise to, and its warmth, were the decisive characteristics which determined the choice of this coverlet as a fetish.

That tactile sensations of a pleasurable nature may be the cause of the 'fetishization' of an object is not a particularly surprising novelty. We know also of adult cases of fetishism in which sensations of touch of a particular kind constitute the factor which stimulates sexual excitement. Freud is also of the opinion that in hair and skin fetishism, for example, the particular odors produce a sexually exciting effect. It must be noted in addition that very often mere touching of the hand or the skin of the face, stroking or smoothing the hair or the skin, have an orgastic effect upon fetishists; furthermore there are known to exist fetishisms of velvet and silk in which odor can have no particular influence, only tactile sensations.

Freud wrote of the nursing infant in suckling the following passage: Simultaneously with sucking, 'there is also a desire to grasp things, which manifests itself in a rhythmical pulling of the ear lobe and which may cause the child to grasp a part of another person (generally the ear) for the same purpose. . . . Pleasure-sucking is often combined with a rubbing contact with certain sensitive parts of the body, such as the breast and external genitals. It is by this road that many children go from thumb sucking to masturbation'.[4] It is an entirely plausible assumption that with this act of sucking, important to life, there comes into being from the beginning a whole complex of sensations and feelings in the nursling, such as the sensation of warmth and of smell and tactile sensations on the

[4] Freud: *Three Contributions to the Theory of Sex*. Trans. A. A. Brill. 4th ed. New York: Nerv. and Ment. Dis. Pub. Co., 1930, p. 41. [Tr.]

hands and face, which originate from the mother's breast and the mother's body. And all these sensations and feelings may be transferred to any indifferent object in an associative manner, and in this way make of it a fetish for the child. We thus come to the conclusion that in the young child the fetish, through its odor, its pleasant warmth, and the particular tactile sensations which it produces, takes the place of and is the substitute for the mother's breast and the mother's body.

It is further striking that the young child makes use of the fetish chiefly before falling asleep and directly in connection with thumb-sucking, as seen in all the cases here reported. In order to fall quietly asleep, the child in this early period apparently feels the need of restoring the situation of the happy moment in which, satisfied by the various pleasurable sensations which have their origin in the body of the mother nursing him, he fell into a quiet sleep.

But now come difficulties. In establishing that in the young child the fetish represents a substitute for the mother's breast and the mother's body we have come into complete opposition to the content of the letter of Freud which Friedjung published, in which there occurs the following: 'It has been shown beyond doubt in a number of adults that the fetish is a penis substitute, a substitute for the missing penis of the mother, and hence a means of defense against castration anxiety—and nothing else. There remains to test this in the case of this child. If proof is to be forthcoming the boy must have had ample opportunity to convince himself of his naked mother's lack of a penis.'

I must confess that this statement seems to me incomprehensible. If we are to find fulfilled Freud's requirement of ample opportunity to see the mother naked, then the long and complicated psychological pathway must be traced whereby in a child of one and a half years the nakedness and observed penislessness of the mother has led to castration anxiety and to the creating of fetishism. Such a possibility, it must be said, is in complete contradiction to our very certain and well-

established knowledge concerning the development of the child and its various phases. In order for fetishism to develop, the one-and-a-half-year-old boy would not only have had to evolve the castration complex in full but would also have had to overcome it. As opposed to this, I wish to cite two passages from Freud's works. One of these is from his paper on fetishism, in which it is stated: 'What had happened, therefore, was that the boy had refused to take cognizance of the fact perceived by him that a woman has no penis. No, that cannot be true, for if a woman can be castrated then his own penis is in danger; and against that there rebels part of his narcissism which Nature has providentially attached to this particular organ. . . . The oldest word in our psychological terminology, "repression", already refers to this pathological process'.[5] We should therefore have to allow that the one-and-a-half-year-old child had already accomplished this work of repression. And what would be the driving force behind this repression? There can be but one answer: castration anxiety.

Vis-à-vis the foregoing, I would quote the following passage from another very important work of Freud: 'When a little boy first catches sight of a girl's genital region, he begins by showing irresolution and lack of interest; he sees nothing or disowns what he has seen, he softens it down or looks about for expedients to bring it into line with his expectations. It is not until later, when some threat of castration has obtained a hold upon him, that the observation becomes important to him; if he then recollects or repeats it, it arouses a terrible storm of emotion in him and forces him to believe in the reality of the threat which he has hitherto laughed at. This combination of circumstances leads to two reactions, which may become fixed, and will in that case, whether separately or together or in conjunction with other factors, permanently determine the boy's relations to women: horror at the mutilated creature or triumphant contempt for her. These develop-

[5] Freud: *Fetishism.* Int. J. Psa., IX, 1928, p. 161. (*Vide* p. 162.) [Tr.]

ments, however, belong to the future, though not to a very remote one'.[6] And in another place we read: 'It seems to me, however, that the significance of the castration complex can only be rightly appreciated when its origin in the phase of *primacy of the phallus* is also taken into account'.[7]

I believe that I too may appeal to analyses of abnormal manifestations and reactions in children in the preœdipal period. These analyses show that all such abnormalities of neurotic nature are of a different psychological structure from the neurotic symptoms of adults. They lack the etiology characterizing the latter, namely of psychic conflict between id-impulse and superego prohibition, and the resultant compromise between these contending forces in the form of neurotic symptoms and perversions. The abnormal manifestations in the young child in the preœdipal period are in their psychological structure nothing other than a simple reaction formation to an inhibited or ungratified instinctual impulse, in which the inhibition or the forbidding of gratification comes from the external world.

In the psychoanalytic literature there are to be found published a large number of such analyses—notably in the *Zeitschrift für psychoanalytische Pädagogik.* Merely as an example I would refer to my contribution in the *Zeitschrift für Psychoanalyse,* XIII, 1927, on a phobia in a one-and-a-half-year-old child. Michael Balint, it is true, in his paper entitled *Zur Kritik der Lehre von der prägenitalen Libidoorganization,* expressed a contrary opinion in asserting that 'All these analyses show unequivocally that these infantile neuroses are in no way less complex than the neuroses of adults'. Without wishing to dispute the complexity of many childhood neuroses, I believe that it must still be insisted that their structure is much simpler, especially in the period prior to the formation of the

[6] Freud: *Some Psychological Consequences of the Anatomical Distinction Between the Sexes.* Int. J. Psa., VIII, 1927, p. 133. (*Vide* p. 137.) [Tr.]

[7] Freud: *The Infantile Genital Organization of the Libido.* Coll. Papers, II, p. 244. (*Vide* p. 247.) [Tr.]

superego. Accordingly, there must also be introduced into the technique of the analysis of young children the important modification that a direct influencing on the part of the analyst must replace the lacking superego and the purely analytic work joined with pedagogical.

Hence I believe it necessary to adhere to the assertion that in the young child the fetish represents a substitute for the mother's body and in particular for the mother's breast. With this statement, also, an answer is supplied to the question posed above, whether fetishism in the young child can be completely identified with that of the adult, and the difference between the two thus cleared up. More precisely stated: fetishistic manifestations in the young child are not at all uncommon, but the psychological structure of childhood fetishism, as of other pathological manifestations, is a different one.

There arises at this point the obvious question whether a relation to the different periods of life exists between the two kinds of fetishism, and if so, what this relation may be. Unfortunately we can throw no light upon the question whether there exists an etiological connection between them, in the sense of the fetishism of the adult being a direct continuation of childhood fetishism, for the little that has hitherto been published in the psychoanalytic literature on the fetishism of the adult supplies no information and contains no material bearing upon the question. But the childhood material here brought forward furnishes a few interesting hints on the matter and contains suggestions regarding the development of childhood fetishism which perhaps may hint of a probable connection between childhood and adult fetishism. Let us attempt once again to set forth this development very briefly. We saw how fetishism in early childhood often appeared as the direct heritage of nursing at the mother's breast, its first indications noticeable shortly after weaning. Its oral origin is thus to all intents certain. In its later course as well it preserves for some time a direct connection with oral drives, eating and sucking. A characteristic trait must be emphasized in this connection:

the relation to the fetish is distinguished during this period by the fact that only a specific property in it is valued, as for example its particular odor or its capacity for giving rise to particular and specific tactile sensations and thus for yielding a specific kind of gratification. If the special properties of the fetish were to be done away with, it would lose all value; in other words, it is in reality not the object itself which is utilized for gratification in fetishistic manner, but only a single and specific property, a characteristic possessed by it; the object itself and as a whole is not yet appreciated and valued—a phenomenon, moreover, not infrequently present in the fetishism of adults as well, but which represents a very characteristic trait in the relation of the child to its object. No sign of any emotional tie to the object, apart from gratification in relation to the erogenous zone, is to be observed.

The case reported by Sterba shows in very instructive fashion the further course of development in the anal-sadistic stage. The originally orally cathected fetish becomes invested with anal and sadistic impulses, it is deliberately thrown into refuse in the street, and a fresh impulse of anal origin is immediately transferred to the fetish, namely the wish to seize and possess it; the fetish becomes 'my-my'. Now it becomes not simply a single specific property of the object which is valued, but the object as a whole is highly esteemed and must be taken into possession.

In Idelsohn's case we find new hints regarding the further course of development of fetishism in early childhood. We see the boy at the age of the phallic phase. The fetish was now no longer brought into relation with any component instinct, but exclusively with the now present love object, namely, his mother, with her odor, her things, and so on. Furthermore, we find in the boy *anxiety* lest he lose the fetish, and this anxiety was somehow brought by him into relationship with his penis: 'this handkerchief (the mother)' Idelsohn relates, 'the youngster used often to stuff into his pyjama legs, to press against his genitalia, saying that he hid it in order not

to lose it'. Thus he identified the fetish with his genital, transferred therewith a portion of his narcissistic libido to the fetish and converted it into object-libido, but at the same time the dread of losing the penis—castration anxiety—was apparently also carried over to the fetish. The objection that the fear of losing the fetish has nothing to do with castration anxiety and arose out of his own experience, since he had actually lost his first fetish, is not difficult to refute by reference to the fact that this was not the fetish which the youngster had first lost, long mourned, found again, and then experienced anxiety lest he lose it again, but on the contrary a quite different object, his mother's handkerchief—and of these handkerchiefs, as he was fully aware, there were several. Indeed, he was not in the least anxious to possess always one and the same handkerchief, but merely that it should be a handkerchief of his mother's, of a certain kind and possessing certain properties, such as the odor of her perfume, her linen, the linen closet, etc. And when during the space of the year and a half which elapsed between the loss of the earlier 'Hoppa' and the recovery of a new fetish in the form of his mother's pocketbook he had found no substitute for his first fetish, it did not matter that he had had no opportunity to come into contact with his mother's things; but in the course of his development in the anal-sadistic stage, in which as we have seen the wish to possess or perhaps the impulse to seize possession is so dominant, he reacted to the loss of the fetish with restlessness, depression and substitutive urethral gratification, but the fetish remained irreplaceable because the youngster's relation to the objects in the environment was of an anal-sadistic character. It was only in the phallic stage, and after successful object choice, that he found again his now correspondingly modified fetish, but at the same time there appeared along with castration anxiety the fear likewise of object loss. This identification of the refound fetish object with his own penis in the phallic stage is perhaps the most interesting finding in the whole inquiry. It throws an illuminating light upon one of the most obscure phenomena of object

choice, for it suggests that the first genuine libidinal tie to a strange object takes place along the path of an identification of this object with the individual's own penis. This perhaps explains why it is that rejection on the part of the object is felt as a very severe narcissistic injury and is experienced by many neurotics as a direct castration, such that serious disturbances of potency may follow thereon.

How matters proceed in the case of the little girl is meanwhile an open question which waits upon corresponding observations for its elucidation. But it must be mentioned that in the girl also a phallic phase is assumed to exist—*mutatis mutandis,* obviously. Accordingly, in the girl narcissistic object choice consists in the identification of the object with the ardently wished for penis, her possession of which is in this phase and despite the contradiction of reality definitely assumed. In the boy, then, the first object, the mother, is given up under the pressure of castration anxiety, while the female, as Freud has said, never in her unconscious completely gives up her first love object, the father, just as she forever retains in the unconscious the wish for the penis and the fantasy of her possession of it.

The final phase of the development of fetishism, subsequent to the phallic stage, that is, in the genital stage, in the adult, must then logically correspond to that which Freud discovered in his analyses of fetishists: that they hold fast to the fetish, which has not been lost but has been retained in firm possession through a regression to anality imposed by castration anxiety, to which the libido thus becomes fixated, and which thereby acquires in the unconscious the potentiality of denying castration.

We may now turn to the second question raised above: in fetishism, what component instinct attains an autochthonous position through regression and serves as a substitute for genital gratification (as in exhibitionism, for example, is the case with the desire to show)? For the present the answer must be a

negative one, since it does not appear possible to demonstrate the existence of any such component instinct in fetishism. There is something else that strikes one in this connection, however. Freud has demonstrated the great importance of the pleasure in smelling, of the sense of smell, in fetishism in the adult; and our material has corroborated this in the fetishism of the young child also. In addition to the sense of smell, the sense of touch appear to play a very important rôle, indeed a decisive one, in many cases of fetishism. When it is considered how large a rôle is played in animal life by the sense of smell, in so far as in many animal species it is the most important orienting agency in the struggle for existence as in their sexual life, and generates not only passive receptive but very actively pursued forms of activity, one is obliged to say that it would seem permissible to speak of an 'instinct of smell' *(Riechtrieb)*. The part played by the sense of smell among higher animals (quadrupeds, insects), however, is played by the sense of touch in the lower animals (protozoa, cœlenterates, etc.). In man these two senses never achieve full development and importance, or perhaps they atrophy after the other senses increase in strength and importance. But in earliest childhood, at a time when the child is still very limited in its mobility and its capacity for movement and can perceive only its most immediate environment, the sense of smell and the sense of touch, which act only upon the most immediate surroundings, retain the greatest sphere in, and have the most decisive importance to, its orientation in its still extremely limited world. It is only later, when the child acquires mobility in space and as it were conquers space with its contained objects, that it learns from experience three-dimensional vision. The sense of hearing is the last to reach its full importance and value in conjunction with the development of speech and of consciousness. In contrast thereto, the senses of smell and of touch recede gradually in their biological value and their importance. But in earliest childhood they dominate the field, and it is perhaps

permissible on this account to see in fetishism a very far-reaching atavistic regression.[8]

Still another question is connected with this. Freud has emphasized a particular characteristic of the libido which precisely in fetishism comes quite strongly to the fore—namely, its *adhesiveness.* The assumption seems to me justified that the particular adhesiveness of the libido in fetishism has originated in the close connection of libidinal impressions with the ontogenetically oldest perceptions of smell. It is well known how firmly recollections of vague, obscure and hazy character often are preserved in the memory if they are connected with the sense of smell, and how often an odor may revivify vague experiences out of the past, awaken various moods or obscure and indefinite feelings, or dominate the mood or frame of mind of a person. Poets and psychologists have often known how to evaluate and to make use of this phenomenon.

It remains to draw attention to what Freud has said with regard to the fate of the various instincts in the precœdipal period, prior to object choice: 'Certain of the component

[8] On the question of the extent to which fetishism may be regarded as an atavistic phenomenon, the opinion of Havelock Ellis is interesting: 'The tendency, which we thus find to be normal at some earlier periods of civilization, to insist on the sexual symbolism of the foot or its coverings, and to regard them as a special sexual fascination, is not without significance for the interpretation of the sporadic manifestations of foot-fetishism among ourselves. Eccentric as foot-fetishism may appear to us, it is simply the re-emergence, by a pseudo-atavism or arrest of development, of a mental or emotional impulse which was probably experienced by our forefathers, and is often traceable among young children today.' To this the author appends a footnote: 'Jacoby (*Archives d'Anthropologie Criminelle,* December, 1903, p. 797) appears to regard foot-fetishism as a true atavism: "The sexual adoration of feminine foot-gear", he concludes, "is perhaps the most enigmatic and certainly the most singular of degenerative insanities, and is thus merely a form of atavism, the return of the degenerate to the very ancient and primitive psychology which we no longer understand and are no longer capable of feeling".' Havelock Ellis continues: 'It may be added that this is by no means true of foot-fetishism only. In some other fetishisms a seemingly congenital predisposition is even more marked. This is not only the case as regards hair-fetishism and fur-fetishism.' (Havelock Ellis: *Erotic Symbolism, loc. cit.,* p. 27 [Tr.]). This congenital predisposition consists in my opinion in a strong sense of smell and of touch from birth, which may be regarded as characteristic manifestations.

impulses of the sexual instinct have an object from the very beginning and hold fast to it: such are the impulse to mastery (sadism), to gazing (scopophilia) and curiosity. Others, more plainly connected with particular erotogenic areas in the body, only have an object in the beginning, so long as they are still dependent upon the nonsexual functions, and give it up when they become detached from these latter.' [9]

Thus the first object of the oral component of the sexual instinct is the maternal breast, whereby the nursling's need for nourishment is satisfied. In the act of sucking the erotic component simultaneously gratified in suckling is made independent, gives up the alien object, and replaces it with a locus on its own body. The oral drive becomes autoerotic, as the anal and the other instinctual impulses had been from the beginning.

In the cases of infantile fetishism this development into complete autoerotism appears to be disturbed by a tenacious adherence to the first component-instinctual object of all, the maternal breast. The oral impulses, and then through further disturbance in development the anal, retain from the beginning their specific alien objects, and it is this situation which persists through the whole future course of development. What the special causes are which result in this particular turn of development cannot in the meantime be definitely stated. There might be fortuitous external occurrences and circumstances which played some part, or even constitutional peculiarities of one kind or another, such as an excessive sensitiveness of the erogenous zone in question, an unusual strength of the component instinct which very early gains a privileged place in the libido economy, or a premature interlocking of the component instinct with the constitutionally hypertrophied instinct of smell. Obviously a number of these factors may be operative, or all of them together.

Translated by HENRY ALDEN BUNKER, M.D.

[9] Freud: *Ges. Schr.*, VII, p. 340. (*Introductory Lectures on Psychoanalysis.* London: Allen & Unwin, 1929, p. 276. [Tr.])

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 Schmideberg (1946) On Querulance, The Psychoanalytic Quarterly, 15:4, 472-502, DOI: 10.1080/21674086.1946.11925655

To link to this article: https://doi.org/10.1080/21674086.1946.11925655

ON QUERULANCE

BY MELITTA SCHMIDEBERG, M.D. (NEW YORK)

The clinical syndrome of querulance is a familiar one. The patient reiterates his complaints endlessly in a stereotyped manner and with intense feeling. This grievance constitutes a major, if not the main interest in his life. He is unable to forget or forgive. Time makes no difference: a grievance thirty years old is as fresh as one which arose only yesterday. He feels that the wrong he has suffered can never be remedied. The pathological lack of insight is characteristic, and while he himself is extremely sensitive, he usually shows scant consideration for the feelings and rights of others. He is mostly unaware of the intensely aggressive attitude which finds expression in his complaints, or else considers it more than justified by the wrongs he has sustained. He is deaf to any argument, although he often provokes argument, and refusal to reason with him only increases his querulance. He expends much time and emotion in proving his case (often having recourse to litigation), and it must be admitted that he frequently has perfectly valid arguments, but either his reaction is altogether excessive or else he is unable to see anything but his own point of view. It is perfectly true that it is unfair that a customer who comes in later should be served first, but no ordinary person would nurse a grievance for days or weeks because of such an 'injustice'.

Only by listening conscientiously to the arguments of my querulent patients did I realize how good-natured and peaceful the ordinary person is. He does not even forgive; he just forgets. The problem of the querulent patient is largely his inability to forget. Another problem is his inability to see the other person's point of view. The following is a characteristic incident. The importation into England of two hundred cigarettes from the Isle of Man is allowed duty free. When a patient, who imported a few more than this authorized maximum, had

to pay duty on the lot she displayed a violently querulent reaction: how could the customs officer be so petty as to object to a few cigarettes? It was impossible to make her realize that she imported not merely a few cigarettes but more than two hundred. She discounted the two hundred because they were within her rights. Similarly, she always had to demand more than was conceded to her, and when eventually she met with a refusal she was deeply hurt and reacted contentiously, forgetting all the other person had done or suffered for her. This type of patient usually loses all his friends, which in turn stimulates further his sense of grievance.

Contentiousness is most commonly found in borderline cases with seriously disturbed object relationships, and is one of the most difficult symptoms to cure. Although at first sight the significance of the patient's sense of grievance seems easy to understand analytically, its structure is overdetermined and, owing to its defensive function, of great dynamic importance—a fact which explains the difficulty of curing it. The handling of the patient demands great tact. He is obsessed by his grievance and does not want to listen to anything else. He is not interested in the interpretations, which he stigmatizes as evasions; he wants to get the analyst to take sides, and his querulent reaction increases if the analyst declines to discuss the issue 'objectively'. A slight stimulus is sufficient to rouse all his contentious feelings against the analyst. Two of my patients wanted to start proceedings against their former analysts. Such patients generally have a number of standing grievances, going back over many years, but they are always ready to adopt fresh ones. A patient started a 'new life' every few years with high hopes; as soon as she commenced this new life her old life with all its grievances faded into insignificance. As soon as her high hopes for a new life became disappointed—as they invariably did—she acquired new and deep-seated grievances.

A patient concentrated all her feelings on one event which had occurred more than ten years before. By reason of her failure in an intelligence test (she was schizophrenic and some-

what defective), she had been refused admission into a certain class in school. Whenever she thought of this she fell into a rage, behaved violently, cried, screamed, bit the pillow, and could think for many days of nothing else. Once she wrote such a querulent letter to the teacher—with whom she had had no contact for over ten years—that this woman answered by advising her to undertake treatment. The patient is still unconsciously attached to this teacher; as long as the attachment persists the grievance persists too. The low level of intelligence causing her to be rejected signified her lack of a penis which prevented her from being loved by her mother. Being hindered in her intellectual development meant for her being prevented from developing into a man. She was compelled to regard the treatment meted out to her as a grave injustice; otherwise she would have had to acknowledge her low level of intelligence, and thus suffer an unbearable narcissistic wound. Her querulent phases subsided at times (partly because she escaped into a pleasant fantasy far removed from reality), and it was interesting to see on what occasions they sprang into existence again: for example, after she had taken her cat to be castrated. To avoid the unconscious guilt at having had the cat castrated, she had to exaggerate her own grievances; to avoid being reproached, she reproached others.

This defensive function of querulance is most important. A patient told me that her parents used to keep count, so to speak, of every kind action and expected her to be eternally grateful. The only way this unbearable burden could be lightened was by keeping count of her grievances against her parents. She collected grievances as others collect stamps, but as she felt guilty over the pleasure which she derived from every new and cherished grievance she overcompensated by becoming querulent.

A patient was full of grievances and reproaches against his former analyst and played with the idea of taking her to court in order to recover the fees. There was reason to assume that he had been seduced as a child by his nurse and he feared that

she might betray him or give him up to the police. The analyst was a substitute for this nurse and his wish to take proceedings against her was prompted by the desire to prevent her from giving him away.

A prostitute, who came for analysis, and her friend were put on probation for stealing. The patient found this situation particularly unbearable and induced the friend to transgress the conditions of probation with the result that the latter was sent to prison. The violence of her querulance on both occasions surpasses imagination. For many months there was no limit to the reproaches she heaped upon everybody who had been responsible for getting her put on probation (i.e., had helped her to this end), saying how much more she would have preferred to go to prison. When her friend was sent to prison she launched equally violent reproaches against everybody for not being able to prevent this happening. Her querulent attitude was her reaction to the shock of being caught stealing (in her fantasies of omnipotence she had been convinced that this could never happen) and a defense against the frightening reality. In blaming everybody—her solicitor, her friends, the doctors and myself—charging them with the responsibility, she behaved as if prison and probation existed solely through our fault; she tried to deny her own guilt and the existence of the police and of the legal system. The sentence on her friend proved the seriousness of the matter and revived earlier experiences, but the main point is that she was anxious to prove that it was everybody's fault but her own, which it was exclusively.

After being put on probation, this patient became frightened of the police and avoided prostitution for some time. When she resumed it she developed a tendency to call in the police in order to have her client ejected. She was prone to suspect him of stealing (partly because of her fear he might hurt her, partly in order to show that he was no better than she). This behavior was designed to prove to herself that she had no fear of the police; that far from avoiding them, she actually summoned them to her aid.

The same extremely querulent patient (she was frequently involved in litigation) was in arms at the amount of her electricity bill and anxious to prove that the company's charge was an unjust one. It became clear that she felt guilty for having spent so much on heating, an indulgence of which her father would have severely disapproved; accordingly she had to show that the blame fell on the company and by means of legal proceedings to reproach and punish the company as her father would have done to her.

When a neon light was placed on the roof of her house she became wildly querulent for weeks, and went so far as to damage the electric wires under the planks of her staircase—a punishable offense. She contended that the neon light interfered with her sleep through its reflected light and vibrations—she suffered severely from insomnia—and that the electric wires which she had gone to great trouble to unearth might endanger not only her but her friend. In the analysis she had a fantasy that she could safely commit murder by inducing a person to touch the live wires in ignorance of their existence.[1] While in her fantasy she hoped for impunity through pretending ignorance of the danger, her querulance served to draw everybody's attention to this imagined danger.

I need not point out the symbolism of the dangerous electric wires in her house, or the sexual anxieties and introjection fears expressed in her pathological sensitiveness to light, noise and vibrations. But the main factor in this example of querulent behavior was the suppressed wish that her friend should die.

In another instance, the patient threatened to take out a summons against her landlord for not having sent her a receipt. It turned out she was afraid that he might charge her again, and when I told her that she could safeguard herself by giving

[1] The details of this fantasy corresponded to the way in which she induced her friend to break probation; because an extreme degree of unconscious sadism was expressed in sending her friend to prison she displayed such intense querulent reactions when this happened.

checks she let the matter rest. At another house she felt that she had a legitimate grievance against her landlady, so she stole various things and wantonly destroyed the electric fittings (another expression of her castration complex). In this case she avoided a querulent reaction by expressing her resentment in antisocial conduct. Against yet another landlord she took legal proceedings because he addressed the receipts to her and not, as she had asked, to her friend. She had become homosexual during the course of the analysis and she insisted that her friend with whom she lived should be regarded and acknowledged as her husband. Her parents were very much against this friend and refused to have anything to do with her. In her innumerable complaints that a homosexual girl is not treated as a man, she had shifted her grievances derived from the castration complex to her friend. Her legal dispute with the landlord over his omission to give receipts in her friend's name was also motivated by her ambivalent attitude towards this friend. She wanted to make the friend feel a financial dependence on her with the same bitter sense of humiliation she had herself felt when she had been dependent upon her parents. She overcompensated this overbearing attitude by quarreling with everyone who did not treat her friend as well as she demanded.

Every time she got a bill she was deeply frightened. She unconsciously thought of the bills she ran up as insatiable demands (oral sadistic attacks as a punishment for her oral greed displaced from eating to shopping) as well as proof of her wicked extravagance. The only small return for the pain of having to pay bills was the receipt to which she attached a quite unusual significance. Her parents used to impress on her how grateful she ought to be for all the money which they so grudgingly spent on her. She paid her bills equally reluctantly and demanded a receipt in the proper form as her parents had demanded thanks in the proper form. Her attitude to money, apart from the anal reactions which were expressed in it and were very important, revealed a wish to return to babyhood,

to the time when she still knew nothing of money. Many people have a mildly querulous attitude towards paying bills which often takes the form of a suspicion that they have been overcharged; it is partly to be explained by the narcissistic injury implied by the fact that one is no longer cared for for one's sake but for money.

A schizoid patient for two or three years spent the first half of every session in pointing out that I had been a few minutes late, or commenting on the remarkable fact that I was not late, or complaining that the analysis did not help him. In so doing he wasted time and thus forestalled any possible reproaches on my part. He treated me as a naughty child who arrived late, did not learn well (did not analyze well) and could be kept up to the mark only by nagging. In this he was following the example of his parents and teachers but exaggerating their unpleasant manners. This exaggeration was a mocking caricature of them, but feeling guilty about mocking them he had to take his own exaggerations seriously. The projection of these exaggerations to others caused anxiety; the identification with them made him querulous.

In another aspect, the analytic situation was felt by this patient as a repetition of the experience of being beaten by his father. As a child his reaction of hate and vexation towards his father for beating him was quite out of proportion, and largely a denial and overcompensation for the unconscious homosexual masochistic gratification. A querulent attitude and pathological jealousy, which often contains a querulent element, are largely due to fear of masochism and an overcompensation for this. The patient reacted excessively to any minor injury as he was afraid of his tendency to submit to anything. In several patients querulent attitudes were observed to form a reaction to a brief phase of masochistic adaptation, but in all other cases the masochistic tendencies were very important.

The following 'case history' is taken from H. von Kleist, a German writer of the last century: Michael Kohlhaas was an

honest horse dealer and a model father until the *Junker* von Tronka illegally detained two of his horses, put them to work in the *Junker's* fields, and subsequently returned them to their owner in an emaciated condition. From that moment Kohlhaas lost all pleasure in life and as he was unable to obtain an order of the court compelling the *Junker* to restore the horses to their original condition, in accordance with his demands, he sold his property, sent his family away, and turned incendiary. He mustered a band of men, calling upon every good Christian 'to support his cause against the *Junker* von Tronka, the enemy of all Christians', and described himself as 'without obligation to his country or to the world, and one who obeyed God only'. He issued decrees in which he styled himself a 'vice-regent of the Archangel Michael who had come to avenge with fire and sword the knavery of which the world was full upon all who had taken the part of the Devil'. In this 'just war' he murdered, looted and burned until Luther addressed an appeal to him. On Luther's promise to see that he obtained redress he disbanded his followers. The Elector ordered that his claim be satisfied, punished the *Junker* von Tronka, but sentenced Kohlhaas to death for his incendiary crimes. Kohlhaas died at peace with the world in the knowledge that he had received justice.

His querulent mania had ever more disastrous consequences, leading in time to the death of his wife. These served only to increase his despair and strengthen his unyielding spirit. He was driven to obtain compensation not only for the initial injustice done to him but for what he suffered in consequence of his querulent reaction to it, and he had to justify all he had done while fighting for his rights. 'Had I known that the horses were to have been fed on my wife's heart's blood, it may be that I would not have spared a bushel of oats. But now they have cost me so dear, let things take their course. . . . This thing has cost me my wife.' Kohlhaas would show the world that she had not perished in an unjust cause. He explained his conduct by saying that the wrong he suffered made him feel an outcast from the community.

We may assume that the ignominy and ill-treatment suffered by his horses was felt by him as castration and probably also as a homosexual assault. He had overcome his fear of his father (undoubtedly a 'godfearing man, strict but just') by relying on his belief in justice. If there was no justice or higher authority to protect him against his father he was completely at his mercy. The traumatic injury caused by the *Junker* upset his previously normal emotional relations and caused a pathological increase of narcissism resulting in delusions of grandeur in which he believed himself to be the viceregent of the archangel and regarded the wrong he had suffered as one affecting the whole of Christendom. These megalomanic ideas were largely an overcompensation for a sense of insecurity; as there was no father on earth to protect him he had to believe that he was the special representative of God. Hate took the place of every other object relationship; he turned away from his wife and family and all his interest was concentrated in hate on the *Junker* (instead of homosexual attachment). He clung to his boundless aggression in the fanatical expectation that he might yet be able to exact justice and thus preserve his faith in a just father and recover his ability to love. His mental balance had been founded on the idea of being and having a just father; he reacted to the loss of this object relationship by introjecting authority and taking the law in his own hands. Kohlhaas always prided himself on having been a just father and master; in other words, he had successfully suppressed his impulses towards cruelty and injustice. This explains why it was so imperative for him that the *Junker,* whom he identified with a cruel and unjust father, should be subdued and punished. Kohlhaas assumed the rôle of the superego. This identification with his superego (a reaction to the injury to his narcissism) reënforced his ideas of grandeur and his surprising conversion from a good citizen into one who commits murder and arson without scruple. Although he had lost all confidence in secular authority, he preserved enough faith to remain accessible to Luther's influence.

The person whom the patient persecutes with his grievances may represent either a frightening or a frustrating parent substitute (teacher or probation officer) or he may stand for the patient's own id. Sometimes the struggle both against the superego and the id may be expressed in different grievances. Sometimes it is fused in a single one (the *Junker* signified for Kohlhaas both an unjust and cruel father and his own suppressed sadistic self). The patient who behaved like an unpleasant control analyst towards me, identified me both with a naughty child and with his father beating him. The patient tries so desperately to secure the support of the authorities and of public opinion in proving that he has been wronged because his greatest fear is of being in the wrong and finding everyone's hand against him. In paranoia the patient fears persecution or believes that he is being persecuted; the querulent patient wards off his persecutory fears by persecuting others in a comparatively mild way. His pathological sense of grievance is often a reaction to some situation that has stimulated his paranoid anxieties, as being put on probation. By doing actively to others what he fears may happen to himself he avoids recognition of his paranoid anxieties (e.g., the patient who wanted to take his analyst to court, thereby attempting to overcome his unconscious fear of being given away by his nurse). His paranoid fears cause the patient to read intentional injustice into painful or even into ordinary everyday events, and to magnify wrongs greatly, which is why he cannot get over them in a normal manner.

A patient became morbidly querulent because his naturalization took somewhat longer than that of a friend. This delay stimulated all his persecutory anxieties and his fears that things might be found out and held against him, of being unwanted, etc. But he was also vexed at receiving less consideration than his friend and, as it seemed childish to him to admit this, he tended to exaggerate the injury to his narcissism into paranoid anxieties about which his friends were more ready to reassure him. In some cases it is felt as a kind of lèse majesté to be kept

waiting, neglected, wronged, etc., and a certain narcissistic compensation is derived from imagining that these hurts are not due to chance, but inflicted with hostile intention (justifying one's own hostility). The attempt to deny narcissistic injuries by raising them to the level of hostile intentions usually stimulates and intensifies the basic paranoid anxieties. In other cases the grievance allays paranoid fears, and it is a characteristic trait in some individuals of this type that they repeatedly contrive means of justifying grievances. The feared superego punishment is projected in paranoid anxieties, while the grievance represents the (unjust) punishment already received. The unjust punishment diminishes guilt and sanctions further aggression. The patient by turning his paranoid apprehensions into actual happenings hopes to master them, to find allies and protectors, and to establish his innocence. Often he succeeds in libidinizing the situation and then derives much masochistic-libidinal satisfaction from feeling himself a martyr. Sometimes the paranoid fears are not all bound in the contentious attitude but are expressed openly and independently. Thus in one patient three systems could be observed (apart from obsessional, hysterical and depressive symptoms): (a) being wronged by parents and parent substitutes; (b) a morbid sense of grievance against a person representing himself; (c) paranoid fears of the police or the authorities and fear of being taken to court.

Querulent behavior is an antisocial activity within the law and, the patient hopes, one encouraged by the law. In the case of the prostitute who reacted to similar situations with either querulent or antisocial behavior, the intense aggression underlying the former was restrained and concentrated on a single aim; but when she felt particularly unfairly treated, restraint was thrown overboard and she indulged in openly antisocial conduct. When Kohlhaas failed to get justice in the courts he turned incendiary.

The contentious type is usually unaware of any conscious satisfaction from his aggressive tendencies; the antisocial patient is usually not conscious of his feelings of grievance and need

for justice.[2] According to Edoardo Weiss[3] the paranoiac projects his persecutory object, the manic patient his persecuted object to the outside world, while in depression both remain internalized. I have the impression that certain antisocial acts of aggression represent a mixture of manic and paranoid mechanisms,[4] in so far as both the persecuted and the persecuting objects are externalized. I believe that this is also true of morbid contentiousness. This sometimes resembles manic reactions, as when the patient talks ceaselessly for twenty-four hours. The instinctual eruption is, however, more controlled and restrained than that of the manic patient. All my contentiously minded patients suffered from serious depressions. The phenomenological difference between contentious and manic reactions is largely that the sense of grievance which the manic patient denies in his elation, the querulent type particularizes and overemphasizes. Another difference is the presence in the latter of obsessional traits which represent the restraining and canalizing factors. The mechanisms of denial, isolation, undoing, displacement and condensation are typical of the querulent patient. In his inability to compromise, to forget or overlook trifles, his lack of humor and of any sense of proportion, and the vehemence with which he wants to impose his rigid standards, he resembles the obsessional neurotic. He wishes to establish a world which does not admit of the slightest deviation from his standards of justice, just as an obsessional neurotic must have things scrupulously clean, exact or symmetrical.

Kohlhaas dies happily because both he and the *Junker* receive the punishment they merit, although Kohlhaas's own punishment is far more severe. But order and justice have won the day; his obsessional urge has been satisfied. In trying to order the world according to his obsessional standards he behaves

[2] I believe that a disillusionment with justice and a fight for right is an essential factor in antisocial behavior, but it is often not conscious.

[3] Weiss, Edoardo: *Clinical Aspects of Depression.* This QUARTERLY, XIII, 1944, No. 4.

[4] *Cf.* Schmideberg, Melitta: *The Psychoanalysis of Asocial Children and Adolescents.* Int. J. Psa., XVI, 1935, Part I.

like a patient who has projected his obsessions from himself to others on whom he then tries to impose conformity with his obsessions. The querulent reaction expresses the hate and fear and punishing impulses felt when these others do not conform to his rituals. This evinces a greater degree of projection than is present in the ordinary neurotic and brings him closer to the paranoiac. The aggression implicit in the attempt to control others, followed by punishments if this fails, is more open and in this respect approximates more closely antisocial types. In feeling responsible for the whole world and trying to control everybody he reveals his ideas of grandeur and his narcissism more nakedly than the obsessional neurotic, and in this he resembles more the psychotic.

The querulent patient exalts himself by taking over the rôle of authority, or of God, in his attempts to set the world to rights. Several of my querulent patients had half-conscious fantasies of saving the world, or future generations. These dictated patients' choices of professions as economist or psychotherapist, and in another case the decision to become a communist. The querulent phase usually started either as a reaction to injured narcissism, being rudely disturbed in some preconscious fantasy of grandeur, or to everyday frustrations which were felt as a kind of lèse majesté. It is unpleasant to have to pay rent or to be kept waiting, but the worst of it is that these bring home the fact that one is not the Queen of England. Frustrations are painful to everybody, but in narcissistic people they are always accompanied by the shattering of dreams of grandeur, and it is this that gives rise to the contentious attitude.

Marked as the narcissistic attitude of all these patients was, it was always a secondary and compensatory narcissism, a reaction to a sense of insecurity, guilt, anxiety and the loss of an object relation. All were seriously disturbed in their object relations. None of them had satisfactory personal contacts, although in several cases there was a deep devotion to a person or cause that was highly exalted and idealized, and which invariably turned out to be a narcissistic projection of themselves.

I was impressed by the excessive and unreal character of the idealizations in all my querulent patients. These far surpassed anything I have ever observed in other cases. A part of the idealization is genuine, containing much of naïve trustfulness, and memories of happy moments in infancy isolated from all that is hurting and disappointing. But the greater part of it is an overcompensation. The child exalts the parents in order to protect them against its own hostile criticism and soiling contact. Extreme idealization is largely based on isolation, which is a reaction-formation against genital or anal contact regarded as soiling or contaminating. The more painful or humiliating it has been made for the child to be in the wrong, the greater will be its satisfaction in finding grounds for criticizing its parents. Often the knowledge that parents are in the wrong gives rise to the fear (or hope) that God will punish them. But if the triumph releases more aggression than the child can control, it will only feel guilty and upset, and try to avoid recognizing that its parents are ever in the wrong by idealizing them excessively and denying reality. Excessive idealizations also serve to overcome intense reactions of disgust and pity and paranoid anxieties by means of equally intense libidinization. A patient idealized in an altogether excessive and unreal way a girl who was found to represent his most dreaded father substitutes. The idealization of justice is another example of an attempt to deal with paranoid fears by libidinization. The prostitute said that not only could she not tolerate any sign of weakness on my part, but even found it painful to realize that I was human. As a child her ideal of perfection was to bear children who had no bowels. A young child, still unable to live up to its ideals of perfection (cleanliness), displaces them to adults whom it admires enormously for never dirtying themselves and, as it often imagines, never defæcating at all. On this ideal of cleanliness are based all later conceptions of mental perfection, e.g., justice; and this explains why patients react so often to disillusionments with overwhelming feelings of disgust. The patient who is unable to love himself

because he falls short of his superego demands projects his narcissistic ideal of perfection to his parents, or at a later stage to certain highly idealized persons. A disturbance of these idealizations comes as a narcissitic shock. A patient told me that he must always have love centers and hate centers; he concentrated all his love on one person and all his hate on another. It was essential for him to maintain a sharp separation between his feelings of love and hatred. Extreme idealization presupposes a far-reaching suppression of criticism and hostility, and may thus lead to pathological aggression in other directions, and account for querulent or antisocial behavior. Excessive idealizations (the parents do not defæcate) based on a denial of reality are bound to lead to conflict when reality can no longer be ignored. Consequently an upbringing which sets too much store on idealizations is a bad preparation for life in a world which is far from being an ideal one. Because extreme idealizations are based so much on overcompensation, a disappointment is likely to change devotion into hostility. The object of the querulent patient's hatred is often a person who was at some time idealized but then disappointed him. Both the patients who contemplated taking their former analyst to court and nagged me ceaselessly had originally gone to absurd extremes in their idealization of analysis. A morbidly querulent attitude is the patient's reaction to narcissistic hurt of being disappointed in his ideals (intensified by paranoid anxieties, reactions of disgust, etc.), and expresses his refusal to accept the injustice of this world. By this attitude, which is a copy or caricature of his parents' educational methods, of their scolding, nagging, beating and punishing, he hopes to compel society or certain individuals in it to conform to his ideals.

Paradoxically enough, excessive idealizations may not only give rise to querulance, but may also be responsible for criminality. The prostitute had extreme ideals of cleanliness, justice and correct behavior. Not being able to live up to these

ideals, she went to the opposite extreme and became a prostitute and a thief. Normal people would have found some compromise between their ideals and their instinctual life. For her this was impossible, not only because of the gulf between the two, but also because compromise and contact with anything profane was in her eyes tantamount to giving up or soiling her ideals. In becoming a prostitute she not only gratified her instincts but also acted out masochistically her humiliation, projecting her ideals of perfection to her mother. It was most important to her that these ideals of perfection should be preserved in others, and it was impressive to see how great was her emotion when, believing that the magistrate had acted unfairly, she told me that her father had always brought her up to believe in British justice. When she was told that her extremely provocative behavior towards the probation officer was inviting serious trouble, she reproached me for being and wanting her to be a hypocrite. This was all the more paradoxical as she had cheated, lied and broken the law on numerous occasions without any qualms.

Contentious types and criminals overestimate the law. It is astonishing how much knowledge of the law they possess compared with the average individual. The litigious spirit clings fast to the law and tries to enforce it, the criminal breaks it, a few 'good citizens' are afraid of it, but the majority is not particularly aware of it. They treat it like an old parent, recognize its beneficial aspects, tolerate its shortcomings, humor it, show it some respect—a little with tongue-in-cheek—and do not take it all too seriously. Because the contentious type takes law and justice too seriously, and is lacking in a sense of humor, he is severe both on himself and on others. One tends to feel sceptical when such people declare that they only care for right and justice, because of their absurd behavior and intense aggression. Analysts are often inclined to study only the deeper unconscious, i.e., symbolic meaning or the defensive or rationalizing functions of such an attitude, and omit to con-

sider such declarations at their face value.[5] The child believes that justice is the prerogative of adults.[6] A querulent patient never forgave her mother for saying 'one does not argue with children'. Another remembers with great bitterness that she was blamed when she stole, but when somebody stole from her, instead of taking her part, her father blamed her for leaving her things about.

A child may be punished for something which was passed over yesterday and is joked about tomorrow; it is blamed for things its parents do without qualms. Adults usually have some neat explanation at hand to cover up their inconsistent and unjust behavior against which children are helpless. Whenever trouble arises the child is likely to be held responsible, and there are very few adults who would ever admit to a child that they had been in the wrong. Justice between parents and children does not exist because there is no equality, and those in authority are judges in their own cause. The nursery is like a fascist state: a great parade is made of justice but it depends on the good-will of the authorities whether they dispense justice or punish whoever dares to complain.

The fact that men may prefer death to a life without freedom and justice shows how bitterly they must have resented the lack of these in their childhood. Seeing that most children put up with the situation fairly well, the factors which make injustice

[5] I believe that the conscious motive put forward by the patient not only serves to cover up an unconscious one, but at the same time corresponds to another genuine unconscious tendency. In another paper (*The Psychoanalysis of Asocial Children and Adolescents, loc. cit.*) I expressed the view that even in deliberate hypocrisy the motive put forward by the patient, which he consciously disbelieves, corresponds to a deeper unconscious impulse.

[6] Some modern parents of course try hard to be just and consistent; but according to my experience these attempts fail or are bought at the price of a more fundamental insincerity or artificiality. Parents with a spontaneous attitude cannot have the detachment necessary for justice, and man is too complex and life too varied for people to be consistently fair. But apart from this, justice and consistency are in my view only conscious and largely obsessional values; it is fortunate that parents cannot manage to bring up their children in such an atmosphere of justice as the children would later on have to live in a world which is far from just.

either tolerable or intolerable require examination. It is a great achievement for a small child to adapt itself to standards of justice and social codes. The harder it has found this task, the more intense will be its reaction to any departure from these standards. If it cost a child a great deal to learn to wait its turn, it will be especially resentful if a late arrival receives prior attention. 'Justice' is a compromise between parent and child, an agreement that the parent will not hurt ('punish') the child, unless it 'deserves' it. The more a child dreads its parents, the more will it cling to 'justice' as an obsessional compromise and defense against paranoid fears. A child brought up without kindness and forbearance cannot renounce justice. God, Justice and morality are authorities above the parents to which the child appeals for protection. Adaptation to the environment presupposes much forbearance on the part of the child, but it cannot be expected to display this virtue when the parents themselves are self-righteous, severe and intolerant, or devoid of a sense of humor. Justice is an obsessional compromise between parent and child, between society and the individual, between superego and id, between vengeance and crime. The obsessional traits in our legal system and forms of procedure—the firm adherence to the letter of the law, the absurd attempts conscientiously and correctly to assess the punishment according to the wrong done—are noteworthy, and are due to the fact that the law is a compromise between and a defense against primitive sadism and equally primitive pregenital anxieties. The detachment essential to the performance of justice is a reaction-formation against primitive hate and rage. The contentious personality stands in such great need of justice to enable him to keep his sadism in check, while he still hopes for the injustice that would justify its breaking through. Kohlhaas fought so desperately for justice that he might be able to suppress the murderous impulses which eventually broke through when he failed to secure redress in the courts. The little child does not at first distinguish between 'just' and 'unjust' punishments but resents them equally. By taking over

its parents' standards it gradually succeeds in suppressing its hostility in the case of 'just' punishment. The reaction of most people to 'unjust punishment' is out of all proportion because the hostility suppressed in connection with deserved punishments is then released in full force.

Although the grievances of these patients are not objectively justified, they are always in some way subjectively justified. Freud says that it is not enough to consider the factors of wish fulfilment and flight from reality in the formation of delusions. He suggests that the patient's conviction of the reality of his delusion springs from the fact that it contains a nucleus of reality.[7] It seems to me that in the same way there is always an element of justification in every morbid grievance and that it is necessary for therapeutic purposes to discover this.

I analyzed a patient who had numerous convictions for exhibitionism. He was an irascible Irishman, full of grievances and prone to fighting at the least provocation. As a child he had been a 'sissy', and after joining the navy he became tough. Both his fighting and his exhibitionism served as assertions of his manhood. That he had been sentenced to prison, strongly reënforced his sense of inferiority and made him morbidly sensitive.

Against this general background each of his querulent grievances could be analyzed individually. On one occasion he complained bitterly—and had almost had a fight over it—because the girl in the canteen served others before him. I inquired whether as a child he ever had been kept waiting for meals. He denied it. I persisted, 'Surely every child is kept waiting sometimes'. Then he told the story of his childhood. His father lived with a woman, not his wife, who brought the boy up. His foster mother spent many hours in bars flirting with men and neglecting the children. The boy was attached to her and tried to hide these facts from his father. He was very much ashamed of his foster mother's flirtations and of the

[7] Freud: *Konstruktionen in der Analyse.* Int. Ztschr. f. Psa., XXIII, 1937, p. 468. (Trans. in Int. J. Psa., XIX, 1938, Part 4.)

quarrels at home. He was very sensitive lest somebody at school might allude to them, as later he was quick to read an allusion to his prison past even into harmless remarks.

It is essential to discover the element of justification in every querulous grievance. Neither the analysis of the instinctual factors nor of their defensive function is by itself likely to cure the trouble. The apparent paradox is easily explained. This pathological mode of reaction is the patient's weapon against a painful reality and guilt, and the analyst's efforts to induce the patient to face facts he finds intolerable only increase his need for defense, i.e., his pathological behavior. The usual attitude of adults is to minimize the child's grievances or to blame it for 'making a fuss about nothing'. It is extremely rare for an adult simply to acknowledge his guilt without trying to explain it away or turning the tables on the child. This attitude not only increases the child's guilt but interferes with its sense of reality. If an analyst does not take the patient's complaints at their face value but regards them only as a defense, or as an expression of his guilty instinctual impulses, and fails to distinguish sufficiently in his interpretations between reality and fantasy, he will seem to the patient to be repeating the parental attitude of putting all the blame on him and not listening to his complaints.

The querulent patient reproaches others with his grievances, a reaction to the accumulation of guilt connected with serious or trifling incidents. Such patients at once assume that they are to blame, whatever happens. A characteristic example was a patient who could not hear anything when telephoning, and immediately began to fear she was becoming deaf. Only later did it occur to her that perhaps the telephone was out of order, which in fact it was. On the second day of her analysis she looked, when leaving, for the doorknob on the left side instead of on the right, and asked what unconscious motive she might have for making the mistake. She was tremendously relieved when I said that the mistake was due to the fact that the knob was not on the side that it usually is. Her former analyst's

assumption that every mistake, every misfortune, and most illnesses were her fault had increased her guilt considerably. This patient was greatly impressed because I went to some trouble to change her appointment to assuage her fear that others might find out that she was being analyzed. The fact that I gave consideration to what she regarded as unreasonable oversensitiveness substantially diminished her querulent attitude. Children who are told not to make a fuss about what appears unreasonable to the adult, displace their resentment to the few 'rational' injuries they are permitted and overemphasize them to a ridiculous extent.

It is essential to consider the patient's feelings, but to humor him indiscriminately or simply to agree that his grievances are justified would be of little therapeutic value. The patient tries so desperately to convince others that his grievances are legitimate because he himself does not believe that they are. His allegations and denunciations are voiced loudly to drown his own doubts. The intensity and endless repetition of his complaints is partly due to the fact that he is not voicing his real grievance but a displaced one. Each repetition of the complaint is a fresh and unsuccessful abreaction. Often too the patient's grievance is fully justified, but he is too guilty to allow himself to realize this, and he overcompensates his doubt by a belated and exaggerated insistence. In a sense, querulance is an attempt to establish that one's grievance is justified, thus to recover one's sense of reality. But often, paradoxically enough, the assertion of a grievance itself expresses denial of it. Denial by assertion or exaggeration seems to me an important defense mechanism. I have been impressed at seeing how upset some patients become when I agree that their complaints —which they had reiterated endlessly with the greatest vehemence—were justified. Having voiced their grievances they ceased to believe in them. They frequently put themselves in the wrong by attacking the person (against whom they had a justifiable grievance) for the wrong thing or in the wrong way, thus preventing others from taking an objectively critical attitude,

or inducing them to defend the person wrongfully attacked. Because of the complicated mechanisms of displacement, denial and asseveration, it seems essential in the analysis to isolate any elements of justification for the patient's grievance and to acknowledge their existence. It is our task to strengthen the patient's sense of reality, to give him the right to complain, and to avoid increasing his guilt by invidious attitudes or interpretations.

A patient had a querulent attitude towards her husband, in accordance with her general attitude. I had the impression that her reproaches were on the whole justified and that their intensity was due to her having had too much to contend with for many years. After having analyzed her fear and guilt towards her husband, who was largely a substitute for her mother, she gradually came to the conclusion (to which others had come long ago) that he was an impossible person and separated from him. Her querulance had been partly a defense against becoming completely indifferent to him and to giving him up.

Often grievances become justified if viewed in relation to their whole setting. Measured by normal standards the grievances of the prostitute when her father refused to comply with her increasing demands for money were unreasonable. But as a child she was blamed for any striving for independence and deeply reproached at the bare mention of the idea of earning her living later on. For her parents' sake she renounced her independence and perpetuated her childishness into adult years by developing severe inhibitions. It was therefore quite logical that after having sacrificed so much she should deeply resent any suggestion that she should work, and demand money from her parents to compensate her for all she had sacrificed. But the loss of her happiness and independence could not be compensated by money so she always had to repeat her demands, and her reaction, when she met with a refusal, was due to the hostility aroused by her submissiveness, and by being cheated even out of a price for it.

This patient had reacted with a phase of intensely querulent and unreasonable behavior to being put on probation, and no interpretation, reasoning or reassurance seemed to have any effect. The first change came when I admitted that I had been wrong in advising her to accept probation, and that I had been responsible for her relapse into stealing, and thus indirectly for her being put on probation. She reacted to this by admitting to her friend that she had been in the wrong, a thing she could not have done otherwise. The fact that I could bear to be in the wrong made it possible for her to tolerate guilt. Her father, a Victorian, consistently impressed upon her that she had no rights whatsoever and that he was under no obligation to her. He would never admit having been in the wrong, made a point of not apologizing to or thanking her, was harsh and unforgiving. Giving the patient the right to complain often diminishes his need to complain. A querulent attitude is largely a struggle for one's right to have grievances.

The same patient, while violating every law and social code, was, when she got the chance, most severe in her condemnation of everyone who did not behave perfectly correctly towards her. However badly she behaved towards a person she never considered it a reason for understanding or forgiving a minor slight. But that was just how her parents had treated her. They made most exacting demands upon her, never overlooked her shortcomings and never admitted their own.

A pathological grievance is always partly a displaced one. We must, however, pay as much attention to the substitute as to the original. The former is not chosen merely for its symbolic meaning. Little is said in this paper about the symbolic significance of the patient's grievances since these are obvious to every analyst. The danger is that we should remain satisfied with having understood the symbolic meaning and so come to overlook the reality aspect of the grievance. A patient who after thirty years cannot get over the fact that as a child she was once not allowed to have a banana although her sister was given one, obviously suffers from penis envy, but she may have

been quite right in concluding that her parents preferred her sister. Instead of saying this, however, she only remembers with a painful sense of grievance an unimportant incident (according to adult standards) when her sister was given preferential treatment. It is essential to understand what an event which appears trifling to an outside observer means to the patient consciously or preconsciously—and not only symbolically. Thus it may have had the effect of a last straw, or it may be a detail typifying a whole attitude. If a patient reacts excessively to 'trifles'—with tantrums, querulance or depression—it is because these trifles are all he has ever had. A patient who does not believe in analysis is likely to cling to every minute that is his due, and one who has no satisfactory contact with the analyst will set his heart on securing a few extra minutes for which he does not pay. A child may go on crying for a toy even after it has got it. This reaction will appear less unreasonable if we realize that the fuss it makes is not so much about its toy as about the happy mood it has lost. At first it cries for the toy, but soon it starts to mourn for its mood which has become poisoned by hate and fear and which it cannot recover even after it has been given the toy. The reaction of querulent patients is more easily understood if we remember that they are upset not so much by the actual frustration, which may be a minor one, as over the happy mood, pleasant fantasy or idea of grandeur which has been shattered by this; the patient's complaint that nothing can remedy the wrong he has suffered is thus subjectively justified. The more unhappy and unstable the patient is the more precious his rare happy moods become and the more difficult will he find it to recover them if he has been upset. In making a fuss about nothing the patient often repeats his parents' way of treating him, as he does when he claims that he is not interested in the specific case but in the 'principle'. The fact that the patient is impelled to create certain grievances in order to justify his hostility or rationalize his feelings of being hurt, etc., should not be forgotten.

I consider that the complete picture of the querulent reac-

tion consists of (1) the grievance, (2) the querulent complaint, and (3) the idea of compensation or hoped for revenge. Generally the sadistic or libidinal content of the compensatory fantasy is rather blurred by repression or rationalization in the shape of demands for money or for an apology. The more the querulent aim is repressed, the more querulent complaining becomes an aim in itself. The repression of libidinal aims leads, as usual, to a regressive increase of sadism.

The unconscious content of the fantasy of compensation corresponds to the original grievance. The schizophrenic patient who could not get over the fact that because of her low intelligence quotient she was not accepted in a particular class in school, bit the pillow in her fits of rage. Her grievance was that she had no penis, and was not loved by her mother. Both these complaints went back largely to unsatisfactory weaning experiences. Her oral disturbances led to severe eating difficulties, and at a later stage to intellectual inhibition. In biting the pillow (breast or penis) she was expressing the oral sadistic wishes, the fulfilment of which would have remedied her oral grievances.

Money demanded in compensation is not only a rationalization but also a symbolic expression of libidinal wishes. The symbolism of money is a very varied one; it can be a substitute for fæces, food, a protecting parent, a baby, the penis, sexual pleasure, etc. The patient, who wanted to start legal proceedings against his analyst (a substitute for his nurse who probably seduced him) in order to recover the fees, avoided spending money on anything that gave him pleasure in order to be able to continue analysis. By demanding the money back from the analyst (the nurse) he was not only turning the tables in respect to his training in cleanliness, but demanding the pleasure (sexual) he had lost from the person who had seduced and then left him.

The prostitute who always hoped to obtain vast sums of money to compensate her for her various grievances, derived such satisfaction from these fantasies that she sometimes tried

to convert them into realities by embarking on litigation. The clinical fact that she was a prostitute, a thief, homosexual, full of penis envy and hatred towards men, and full of violent resentment against her parents, makes it a plausible supposition that money symbolized for her power, her father's love, a penis, semen, a baby, her mother's milk, sexual pleasure and every other type of libidinal gratification.

The unconscious situation of grievance may correspond, in my experience, to any important situation in the child's life:

(1) Weaning: the prostitute intended to take proceedings against her bank over a delay of two days in paying her allowance; the patient who feared that I might cut short his time or give wrong interpretations (bad food).

(2) Training in cleanliness: the prostitute's reaction to bills; wanting the analyst to refund the fees; another patient's querulent hate against a certain 'dirty, filthy, disgusting' person identified with excrement.

(3) Guilt and interference with masturbation: the querulous reaction of the same patient on being interfered with while daydreaming; intention to take the analyst (substitute for his nurse) to court.

(4) Castration fear: querulous reaction to my interpretations regarding them as attacks; substitute for beating or castration; frequently displaced to politics, championing the cause of the oppressed (Kohlhaas).

(5) Penis envy: schizophrenic patient's grievance at not being allowed to enter a class in school because of low intelligence; the prostitute's plea that homosexual women should be treated like men.

(6) Homosexual frustration: schizophrenic patient feels badly treated by teacher; several patients disappointed or disillusioned by friends or superiors.

(7) Œdipus frustration: a litigious grievance concerning inheritance when the patient reproached his mother for taking sides with his brother (father substitute).

(8) Jealousy of brothers or sisters: a patient's grievance that

his naturalization takes longer than his friend's, accompanied by fear that he is not wanted; feelings that brother is being preferred.

(9) Interference with scopophilic impulses, etc.: grievance of schizophrenic for not being allowed to enter class in school; grievance that I give wrong interpretations, or at getting a stupid, or not getting an immediate answer.

(10) Also to situations that do not represent major injuries to primary libidinal urges.

The fantasy of compensation expresses equally varied libidinal wishes, and the sadism expressed in querulance is also derived from manifold instinctual sources. The fact that querulance is most frequently found in borderline cases (although it may be observed in certain hysterical types), and that its mechanisms are allied to paranoid, manic and obsessional mechanisms, are indications that it is mainly related to pregenital phases. Thus even when the grievance corresponds to phallic or œdipus frustrations these would seem to have their effect largely by activating earlier pregenital ones: the patient who in his grievance that his naturalization took longer than that of his friend expressed his reactions to his brother's birth; he had been very abruptly weaned owing to his mother's sudden illness, and had been unable to get over this; the fear of losing his mother's protection and love was reactivated by the birth of his brother and found expression in his various paranoid anxieties.

I do not believe any particular instinctual frustration or fixation can be regarded as being specific for querulance. Unconscious homosexuality is sometimes an etiological factor, but by no means always. The grievance of the schizophrenic against her teacher sprang from frustrated unconscious homosexuality; the grievances of Kohlhaas and of the patient who identified me with his father beating him express fear of unconscious homosexual attitudes. The prostitute became manifestly homosexual in the course of her analysis and this change neither diminished nor increased her tendency to querulance. Her grievances, which were concentrated either consciously or

unconsciously on her friend, sprang from her suppressed hostility. Her annoyance over the neon light expressed her reaction to parental intercourse and her wish to induce her mother to have intercourse and be destroyed by it (to induce her friend to touch the electric wire); her desire to remove the neon light and the electric wires on the stairs represented an attempt to rid herself and her mother of the dangerous penis.

A serious disturbance of pregenital development seems to be present in every case of querulance but to bring about this particular symptom a number of secondary factors seem necessary: lack of humor and nagging on the part of the parents, harsh ideas of justice combined with actual injustice, giving the child much cause for feeling aggrieved while denying him the right to complain. Characteristic for querulance is a particular combination of the mechanisms of projection, denial and isolation. The sadism expressed in it belongs to equally varied instinctual sources: oral sadism was clearly shown in the case of the schizophrenic who bit her pillow in her querulent fits of rage; anal sadism, in another case, in which the patient used exclusively anal invective against the object of his reproaches. A patient described such a state as *'ein Loch in den Bauch reden'*. The prostitute once went to bed when she was upset and talked ceaselessly at her mother for twenty-four hours. Litigating and complaining are substitutes for screaming or making scenes about parental nagging and beating. The endless repetition of the complaint represents the refusal to make the smallest concession (anal obstinacy and mastery).

It is known that speaking may symbolize oral and respiratory attacks, anal and urethral ejection and vomiting, as well as genital activities.[8] Endless and stereotyped but not unfriendly

[8] (a) 'Biting words', to 'jaw at somebody'; (b) *'anhauchen'* in Berlin for *anfahren;* (c) 'flow of words', 'Munddiarrhoe', 'running off at the mouth' (U. S. dialect).

The literature is quoted in detail in my paper, *The Rôle of Psychotic Mechanisms in Cultural Development.* Int. J. Psa., XI, 1930, p. 398. In my paper, *The Psychoanalysis of Asocial Children and Adolescents, loc. cit.,* I put forward the suggestion that many asocial individuals are deeply disturbed in their object relations and establish contact with the outer world predominantly through their antisocial activities.

criticism of my clothes and the way I did my hair in querulent male patients stood midway between hostility and open sexual interest. Querulance is a substitute for and sometimes the only means of an object relationship, and that interest in the external world is in some patients expressed almost exclusively through their symptom. In this they are often only modeling themselves upon their parents whose only way of showing an interest in them had been by criticizing them.

In the antisocial tendencies which find expression in querulance, the patient is usually the only person who is unaware of the sadism revealed by his behavior: he 'only said' or he 'only tried to prove his right'. The mechanisms of 'denial' and withdrawal of affect are characteristic and difficult to influence. The prostitute who was, as she thought, innocently and through sheer bad luck always getting involved in litigation, allegedly much against her will, became for the first time conscious of the satisfaction it gave her when a doctor sued her for not paying his fees. It excited her greatly to imagine how much trouble and time the doctor had wasted by taking her to court and how his efforts would all come to nothing as she would eventually avoid paying him.

In remaining unaware of the sadism expressed by his querulance, or that his sense of grievance is excessive, the patient emulates (or caricatures) his parents who were usually equally unaware of their nagging behavior and of making mountains out of molehills. It is a sign of his loss of capacity for emotional contact that the patient is unable to see other people's points of view. All that matters is that he has been wronged. He genuinely believes—in his condition of pathologically heightened narcissism—that the wrong he has suffered involves the whole of mankind and eternal principles of justice. He is unable to believe that any good may reside in a person who has shown himself capable of hurting him. Identification with his superego leads to an exalted conception of himself and protects him from guilt and from having to acknowledge reality. The patient often projects his own id on to the person he condemns

but strictly isolates any connection between himself and him. The patient denies his own sadism and any wrong he may have himself committed. He is all white, his adversary all black. He isolates the sense of grievance from everything else; hence whatever good the other person may have done him is of no account. It is first and foremost the mechanism of isolation which protects him from yielding to reasonable argument even if he admits its justification.

One patient proved an exception to this rule. She was very intelligent, had a good sense of reality as well as a sense of humor, and was aware of the pathological nature of her querulance. Nobody could have put the case of her adversary better than she did herself, but this did not prevent her from displaying a most violent and unreasonable querulance; on the contrary, she felt that the knowledge of how understanding she had been was an additional justification for her querulance. 'Understanding' was the main expression of her positive feelings towards others. Having done so much for them as to understand them, she was free to express her hostility querulently. Her bitterest reproach against her parents was not that they hurt or bullied her, but that they were completely lacking in understanding. Her ideal was that of a just and unforgiving God, in contrast to her weak father whom she despised, and to her aggressive and querulent mother who was equally without understanding or fairness. This patient's mechanism of denial was not marked (this accounted largely for her good sense of reality), but her mechanisms of isolation and withdrawal of affect were all the stronger. Owing to the strength of her isolation mechanisms her insight was perfectly detached from her emotional reactions.

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The Psychoanalytic Quarterly

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

The Oedipus Complex and Infantile Sexuality

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To cite this article: Géza Róheim (1946) The Oedipus Complex and Infantile Sexuality, The Psychoanalytic Quarterly, 15:4, 503-508, DOI: 10.1080/21674086.1946.11925656

To link to this article: https://doi.org/10.1080/21674086.1946.11925656

THE OEDIPUS COMPLEX AND INFANTILE SEXUALITY

BY GÉZA RÓHEIM, PH.D. (NEW YORK)

In a recent publication, A. Kardiner asserts that if children are not prevented from indulging in sexual play with each other they will have no œdipus complex. After describing the œdipus complex in his own terminology, Dr. Kardiner writes:

'This constellation was identified by Freud as the œdipus complex and represents the consequence of an anxiety system created by repressive mechanisms. The œdipus complex is therefore the record of such a repressive process, not as commonly assumed the cause of it'; [1] and in an earlier book, 'This particular constellation describes the pressure created on man by certain forms of restrictions on the sexual impulse'.[2]

The Baiga, in the Central Provinces of India, appear to have as much sexual freedom as any human group:

'Baiga children grow up free and unrestrained. They are underfed and often diseased; they suffer from itch and every possible affection of the eyes; not a few have hereditary or acquired venereal disease; but on the whole they have a happy life, for it is free.' When the Baiga see their children indulging in erotic play they simply laugh tolerantly. Sujji of Kawaraha said: 'If I catch my young daughter with a boy I let her alone. I don't beat her or abuse her; otherwise the neighbors may say, "Is she your wife or your daughter that you are so jealous? Why are you making trouble, you impotent old man? Let her do what she likes." [3]

[1] Kardiner, A.: *The Psychological Frontiers of Society*. New York: Columbia University Press, 1945, p. 374.

[2] Kardiner, A.: *The Individual and His Society*. New York: Columbia University Press, 1939, p. 445.

[3] Elwin, V.: *The Baiga*. London: John Murray, 1939, p. 230.

'The Baiga themselves believe that children are born with a complete equipment of phallic knowledge. Certainly the language of even the youngest child is amazingly well informed. Soon after a child is born, directly it is able to talk, it says, "I'll copulate with your mother".'

Children seek the privacy of the jungle to play at cow and bull, horse and mare, cock and hen, pig and sow, and play them with a wealth of detail that reveals considerable physiological knowledge. The part of the female animal is taken by little girls or younger boys.[4] The sexual life of the tribe is free, warm, spontaneous. Marriages are based on love.[5] There are love affairs that are conditioned by sex only, but they are warm and spontaneous, and there are usually an addition to one or two emotionally deeper experiences. A Baiga is very rarely frustrated in his amorous desires, but when this happens the suffering is very real.[6]

Considering these and other similar data—which may be found in Elwin's book, The Baiga—Dr. Kardiner would, according to his writings, assume that these people have no œdipus complex.

In the folklore of the Baiga, Nanga Baiga, the ancestor of the tribe, receives a curious gift from Bhagavan (Creator). From his left side black blood will flow, from his right side red blood will flow. Whoever drinks the black blood will be a witch; whoever drinks the red blood will be a magician. A snake drank the black (destructive) blood and a mongoose the red (life-giving) blood.

Bhagavan, being jealous of Nanga Baiga, sent a snake to bite him Nanga Baiga, wanting to scratch his back with it, picked it up. It bit him and he died. As he was dying, Nanga Baiga told his sons and disciples not to bury him, but to divide his body into twelve portions, put them into twelve pots and cook

[4] *Idem*, p. 231.
[5] *Idem*, pp. 239. 250.
[6] *Idem*, p. 254.

them for twelve years. At the end of that time they were to eat him and all his magic would pass to them.

Bhagavan, wanting to avert this eventuality, came disguised as a Brahmin ascetic smeared with ashes, and told the sons what a great sin it would be to eat their father's flesh. They agreed, but one of them got just a whiff of the steam from one of the pots (or a scrap of flesh) and he became the first magician.

The flesh from the pots floated down the river and other supernatural beings got hold of it. They ate the meat but the magic had turned into bad magic, or witchcraft.

The death of their father and the loss of his magic was a great blow to the tribe. The witches launched an offensive and turned the brothers into parrots. The youngest son, however, who despite his depleted magic was stronger than all the witches, immediately turned them back into men again.[7]

Elwin quotes this legend as having a striking resemblance to Freud's theory of the primal horde. He believes, however, that the fact that the father is here not killed by the sons but by a jealous deity makes a great difference.[8] In attempting to analyze this myth, it is noteworthy that the attitude towards Nanga Baiga is ambivalent; his magic is half good, half bad (two kinds of blood, flesh that turns into bad magic). Examining the function of Bhagavan, we note that he is 'half good, the other half is rotten with wounds and disease'.[9]

The myth says that Bhagavan, becoming jealous of Nanga Baiga, made him die in a peculiar way, although, in a sense, by picking up the snake Nanga Baiga unwittingly commits suicide. This leads us to hazard the hypothesis that Bhagavan is a projection of Nanga Baiga's superego. This hypothesis gains support from his appearance in the rôle of an ascetic in which he persuades the sons that it would be a sin to eat their father's flesh. The brothers disclaim responsibility for the deed, the (primal) father having been killed by his own feelings of

[7] *Idem*, pp. 341, 342.
[8] *Idem*, p. 419.
[9] *Idem*, p. 294.

guilt. Not the father, but the witch (mother) becomes their open enemy, responsible also for fantasies of body destruction.[10]

This myth would not have continued to exist as a mere survival (a record of the past) if it did not serve as an expression of currently existing instinctual tensions incident to the œdipus complex. The myth ends with the oral introjection of paternal magic.[11]

The power of magic is regularly handed down from father to son. In initiation, the disciple ingests the master's excretions. 'The older man takes liquor in his mouth, spits it back into a leaf cup and gives it to his disciple to drink.' A Brahmin asking a magician to initiate him was told that he must first eat the teacher's excreta. Elwin states in his book that he could have been initiated if he had drunk his teacher's blood.

Magic is therefore acquired by symbolically 'eating' the father. The trait of 'magic only partially acquired' exists in actual practice, just as it does in the myth. The younger generation of magicians complain that their fathers have not told them everything; have held back vital information.[12]

A myth need not necessarily reflect only the past. A 'primal horde' myth of this type may be simply a combination of reaction formation to sibling rivalry (i.e. the alliance of the brothers) and the œdipus complex.[13]

If there were any doubt about the existence of an œdipus among the Baiga, some of their dreams, reported by Elwin, would dispel it:

'I went with my father to the jungle with my bow and arrow. My father shot a sambhar but hit and killed me instead. . . . All the time I was saying to myself, he killed me purposely, so

[10] The witches kill and revive corpses, remove the livers and eat them, etc. (Elwin, V.: *Op. cit.*, pp. 341–342). Body destruction fantasies and sibling rivalry are closely related to each other.

[11] On the 'eating' of the primal father and the oral phase of infantile development, *cf.* Róheim, G.: *Nach dem Tode des Urvaters.* Imago, IX, 1923.

[12] Elwin, V.: *Op. cit.*, p. 343.

[13] Dr. Kardiner was the first to study myths from the point of view of their significance in the present tense.

I must kill him. . . .' Mahatu, the dreamer, said he could not understand this dream because there was nothing but mutual love in their relationship.[14] Mahatu related another dream in which he went into the jungle with his father. There they saw a dead man whose blood had been drunk by a tiger. They ate the dead man together, and Mahatu vomited.[15] This is a dream of eating the father as in the myth of the primal horde.

Another man reported to Elwin the dream: 'I was in a rage, wrestling with my father; then a tiger knocked me down and killed me. I went down below the earth, and there I turned into a tiny man only a foot high. A great snake saw me and said, "I'm going to eat you". I said, "Open your mouth", and in I went and came out at the other end. At once I flew away; up to my own house.'[16] The tiger is a representation of the father. The tiny man a foot high who goes into the earth is the dreamer's penis entering Mother Earth. The snake in this dream represents both father (phallus) and mother (devouring).[17] Entering and flying are symbols of coitus. The latent dream wish is to kill the father (tiger) and have intercourse with mother.

To the œdipus complex, castration anxiety is an inevitable consequence. The Baiga provide abundant direct evidence in their dreams of such anxiety, as in the dream: 'Someone cut off my penis with scissors as sharp as the claws of a crab'. The same dreamer in another dream cuts off his friend's penis for having slept with his sister. In many dreams and stories the *vagina dentata* is given explicit representation. Menstruation too evokes castration anxiety among Baiga men.[18]

Elwin explains these dreams as the effect of sexual over-indulgence which leads to a fear of being found sexually inadequate. A Baiga boasts that in his youth he had intercourse

[14] Elwin, V.: *Op. cit.*, p. 419.

[15] *Idem*, p. 426.

[16] *Idem*, p. 414.

[17] *Cf.* for this symbolism, Róheim, G.: *The Eternal Ones of the Dream.* New York: International Universities Press, 1945, pp. 178–199.

[18] Elwin, V.: *Op. cit.*, pp. 423, 424.

with his wife four or five times a day; if he failed to maintain this standard, his wife would accuse him of infidelity.[19] This superpotency is more likely to be the consequence than the cause of castration anxiety. The individual strives to dispel anxiety by repeated reassurance in coitus. The thesis that unrestricted sexual behavior among children obviates the development of an œdipus, or that repression exists for some unknown reason which is the cause of the œdipus complex, is putting the cart before the horse.

The contemporary psychological 'culturalist' is prone to sweeping generalizations. Kardiner states that castration anxiety is inadmissible in a culture where knowledge of the sexual organ in both male and female is learned from earliest infancy, from observation and direct experience.[20] It may be 'inadmissible', but there it is, nevertheless.

[19] *Idem*, p. 422.

[20] Kardiner, A.: *The Individual and His Society. Loc. cit.*, pp. 202, 203. *Cf.* Róheim, G.: *Society and the Individual.* This QUARTERLY, IX, 1940, pp. 526–545.

The Psychoanalytic Quarterly

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

Lectures on Psychoanalytic Psychiatry. By A. A. Brill, M.D. New York: Alfred A. Knopf, 1946. 292 pp.

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To cite this article: Philip R. Lehrman (1946) Lectures on Psychoanalytic Psychiatry. By A. A. Brill, M.D. New York: Alfred A. Knopf, 1946. 292 pp., The Psychoanalytic Quarterly, 15:4, 509-539, DOI: 10.1080/21674086.1946.11925657

To link to this article: https://doi.org/10.1080/21674086.1946.11925657

BOOK REVIEWS

LECTURES ON PSYCHOANALYTIC PSYCHIATRY. By A. A. Brill, M.D. New York: Alfred A. Knopf, 1946. 292 pp.

Two generations of psychiatrists and psychoanalysts have been stimulated in their interest to alleviate mental illness by the founder of psychoanalysis in America. First to bring Freud's monumental discoveries to this country, and, by his translations of Freud's major works, to the English-speaking world, Brill's place in the history of twentieth century psychiatry has been fully acknowledged here and abroad. A hint as to his zeal in publishing several volumes on psychoanalysis, translating Freud, Bleuler's Textbook of Psychiatry, Jung's Psychology of Dementia Præcox, and his numerous valuable contributions of papers in the field of the mental sciences is perhaps found in Dr. Brill's words of dedication of these Lectures: 'To the State Hospital Physicians who bear the brunt of curing and alleviating mental ailments; in whose ranks I served and to whom these lectures were first addressed'. Today, at the age of seventy-two, Brill is still serving in the 'ranks'. The reviewer who counts it a privilege to be one of Brill's many students, who listened to his Lectures at various times, feels certain that the greater audience of students and practitioners of psychoanalysis and psychiatry will learn much of permanent value from these Lectures in book form.

It is Dr. Brill's special talent to convey to the reader the distilled essence of an impressive accumulation of sound observations in the science of the mind. There is abundant evidence of profound scholarship, but no impression of pedantry. Alive and brilliantly presented clinical material is interlaced with a critical digestion from the heterogeneous storehouse of psychiatric and psychoanalytic literature. Psychoanalytic psychiatry has grown along with Dr. Brill and he writes intimately of this growth from its early beginnings in Burghölzli to the recent pharmaco-shock-narco-therapies. Students should want to attain the wide base of learning covered in the numerous references. The arrangement of a table of contents before each of the ten chapters is a helpful summary of the topics covered in each lecture. At the end of most of the chapters, there are a few pages of discussion of the problems raised by those who

attended these lectures, many of the questions serving as a critical evaluation of the lecture method of instruction in this intricate field.

Method alone however is not what counts, especially in a science which arouses the greatest affective prejudice from wounded self-esteem. Here, too, displacement operates from the subject matter to the one who presents it. Many who acclaim the teacher who first brings knowledge of Freud to them, become less inclined to believe in it or take an interest in it because 'sleep is disturbed'. Their ambivalence appears in some of the questions. Here the instructor can learn from Brill how he manages with humor and narrative skill the subtle resistances in his audience.

Brill calls attention to the structure of neurosis and psychosis as representing 'pathetic human documents of the struggle for supremacy between the most primitive and most ideal components of mankind'. In recording these conflicts he gives some 'tragi-comic fluctuations of mental adjustment'. From his own diary of memorable experiences, the 'Lapin' case (chapter 3) continues to be the best example of the psychopathology of everyday life. This and many other significant case histories from an active practice serve to clarify the intimate relationship between psychiatry and psychoanalysis and the rôle of each in the development of the study of the human mind.

PHILIP R. LEHRMAN (NEW YORK)

THE YEARBOOK OF PSYCHOANALYSIS. Volume I, 1945. Edited by Sandor Lorand. New York: International Universities Press, 1945. 370 pp.

This is a new publishing venture undertaken with the purpose of bringing annually to people in fields allied to psychoanalysis a group of selected contributions to psychoanalytic literature which they might otherwise not get around to read. This, the first volume, has been judiciously compiled from sources from 1942 onwards and contains sixteen reprints from five journals, chapters from four books, and a special survey and bibliography on the psychoanalytic literature of alcoholism prepared by the editor, Dr. Lorand.

The volume is attractively got up and should look nice on any psychoanalyst's bookshelf. Dr. Lorand and his co-editors are to be congratulated on their initiative and judgment.

JULE EISENBUD (NEW YORK)

PSYCHIATRY TODAY AND TOMORROW. By Samuel Zachary Orgel, M.D. New York: International Universities Press, 1946. 514 pp.

Doctor Orgel states in the preface that he has converted into book form his lectures on psychiatry to nurses, social workers, teachers and others. This is an admirable thing to do, but the title chosen for the book is misleading. At least this reviewer was led to expect a survey of the 'tomorrow' aspects of modern psychiatry—the horizons, the unsolved problems, the frontiers. These, however, are missing, and there is more 'yesterday' than 'tomorrow' in the text. A more accurate title would have been 'A Textbook of Psychiatry for Nurses, Social Workers, Teachers, and Other Interested Persons'.

Following an opening twenty-seven page chapter on the history of psychiatry there are two chapters on the psychoanalytic viewpoint, presented in standard, simple terms, and entitled, The Psychological Development of the Individual, and Mental Mechanisms or Dynamics. There follows a simple presentation of the symptomatology of mental disease from the standpoint of yesterday's descriptive psychiatry, followed by the longest section of the book—one hundred twenty-nine pages of standard, descriptive psychiatry of the organic mental disorders, beginning with General Paresis, and following faithfully the A. P. A. classification of syndromes. The functional psychoses receive sixty-four pages, the neuroses twenty-four pages, and mental deficiency twenty-seven pages. This material is accurate, condensed, and complete, but bears almost no relationship to the introductory chapters dealing with dynamic viewpoints. It is actually a compendium for students. A regular section on nursing care for each syndrome is included as a special feature of value to those who actually take care of the mentally ill. Concluding chapters on war neuroses, social work, occupational therapy, care and management, causes and prevention, insanity and criminal law, and commitment laws occupy about one hundred pages, and a glossary of psychiatric terms is given at the end. This section of the book contains much valuable factual material, and presents an enlightened point of view. One could only praise such a book if its title were as unpretentious as the content, but it seems to this reviewer that the publishers are to be criticized for directing to a wide public a book which contains much material unusable to them.

The typography is inferior, careless and uncorrected, giving a somewhat cheap cast to the book. These defects combine with the misleading title and the somewhat thrown-together content to produce a volume which does not do justice to Doctor Orgel's excellent lectures to nurses.

ROBERT P. KNIGHT (TOPEKA)

THE HUMAN MIND. By Karl A. Menninger, M.D. Third Revised and Corrected Edition. New York: Alfred A. Knopf, 1945. 517 pp.

This is the third edition of the semipopular presentation of the facts and theories of dynamic psychiatry which first appeared in 1930 and has since been acclaimed as a minor classic in the field. While some portions of the book have been altered or expanded to reflect recent developments in diagnostic and therapeutic methods, its plan and basic content remain essentially the same as the two former editions—uncompromisingly psychoanalytic in orientation, full of illustrative case histories and sharp clinical vignettes, wisely and beautifully written. The well-chosen bibliography has been considerably enlarged and brought up to date.

At this date, an extended critical review of The Human Mind is scarcely required; it has worn too well for trifling comment. No layman can read it without developing genuine warmth and sympathy for the mentally and emotionally ill—and, in some measure, a better understanding of himself. For the beginning student of psychiatry, I know of no text more apt to spark the imagination and broaden the understanding. And for the advanced psychiatric or psychoanalytic practitioner in the mood for a busman's holiday, a book offering a more pleasant, fascinating or profitable excursion would be difficult to find. We may be certain that the last edition has yet to appear.

JULE EISENBUD (NEW YORK)

CASE STUDIES IN THE PSYCHOPATHOLOGY OF CRIME. A Reference Source for Research in Criminal Material. Vol. II. By Ben Karpman, M.D. Washington, D. C.: Medical Science Press, 1944. 738 pp.

It was a great adventure for Dr. Karpman to prepare for publication the very extended histories and hundreds of dreams related

in these two huge volumes, or, as in one case, to record the outpourings of many psychoanalytic sessions—and then to get all this actually published, despite the cost and the obvious limited saleability. The fact that Dr. Karpman won over these fellows to do such a great amount of writing for him proves that either they were in a transference relationship or identified themselves with him as a scientific investigator. There are some definite suggestions of the latter whenever the patient expresses his own desire to know the why of his career.

This second big volume is devoted to only four cases and it is evident that they developed much interest in their past; otherwise they would not have stayed with the author so long on the job of revealing themselves. Of course they were all diagnosed as psychopathic personalities—either with or without psychosis—by the hospital staff, seemingly for the most part on the evidence of their long criminal careers. If they had to be labeled for psychiatric classification, what else was there to call them? But Karpman is not particularly sarcastic about this.

The patient, Cleary, gives a miserable story of stealing and sex irregularities over long years. He was found guilty on a white slavery charge—forcing his young wife into prostitution. Evidently he had psychotic episodes of the cyclothymic type. Dr. Karpman, after some eight months of gathering his story and his dreams, given us without associations, leaves the case, feeling that it was impossible 'to delimit clearly and precisely the rôle of heredity and environment'.

Elton was apparently the only case definitely analyzed. Convicted of sex misbehavior with little girls, 'attempted rape', the penchant of this sex-obsessed fellow for female children was based on his phobia of pubic hair. At times he succeeded in getting women to shave their pubes, but that was not enough or entirely satisfactory. (The reader of these cases can but be struck by the extraordinary number of easily accessible females found by men and boys looking for them.) A very traumatic episode came out in the analysis: as a young boy Elton was seduced and threatened by a woman whom he remembers with horror, particularly because of the excess of hair in her pubic region. Dr. Karpman concludes that Elton was helped by psychotherapy because for seventeen years now he has merely not heard of further offenses.

When we come to the story of Jerry Briggs, a big-time bandit who carefully planned train robberies and single-handed rifled registered mail pouches in mail cars, getting away with big loot in money and securities, we have a thriller as good as an old dime novel, 'Deadeye Dick' or 'The James Boys'. There is a lot more to the story: robbing a jewelry store in daylight, planting a bomb in a mine when others were afraid to do it, etc. Briggs began his career as an overactive, fearless boy who later had a severe head accident and was not helped by that. Through the years he has been a keen, shrewd, reckless criminal. For a time he won acclaim as a rough but expert prize fighter and occasionally he earned well through being clever mechanically. In the federal penitentiary he was so belligerent and argumentative that for periods of months he was kept in solitary confinement and received other punishments; but all this he stood with extreme obstinacy and fortitude, never giving in though he was worn down physically. However, all along he appears to have been much attached to his wife and child. What Briggs particularly wanted was an explanation of his mania for gambling—why when he had plenty of money and was living comfortably with his wife, did he hie himself to Tia Juana or some other gambling resort, lose everything, and feel compelled to recoup by another robbery? He was removed from St. Elizabeths before his tale was completely told and before he got the explanation. But as Karpman says, this man's own story illuminates the background of a desperate antisocial career. A psychiatric diagnosis tells little. There was early conditioning in family life and the associations of a tough Western town, but as we see it, there was also the constitutional make-up, the wonderful physique, and the ever-ready outpouring of adrenal secretions. Anyhow, the story is well worth reading and one may be free to think of various additional interpretations.

Finally, Manson, born in 1892, truant, chronic thief from the time he was thirteen, shrewd passer of cold checks, occasional hold-up man but only when with companions, morphine and cocaine addict, fornicator extraordinary, whose self-written story drags rather repetitiously over nearly all of the 355 double-column pages devoted to his case. This is of chief interest to the reviewer because Dr. Karpman has recently identified Manson as a fellow known long ago to me in Chicago and has asked me to confront this story

of 1929 with our earlier records which, dug up, prove to be quite extensive. I find many pages written by this rather bright young man, I.Q. 112, at our solicitation, detailing his career and his thinking about it. Evidently we gave him his start in autobiographical writing and perhaps also in moralizing, at both of which he later became adept. The requested comparison has been a laborious job, though perhaps worthwhile on account of general principles made plain.

I knew Manson at four periods, 1909 to 1923, had many interviews with and communications from him, his mother and others who knew him well. Two photographs of him, before, when he was a round-faced, mild looking adolescent, and after prison confinement, tending to show the effects of the latter, figure in The Individual Delinquent (1915). At twenty-three he had already been sentenced to correctional institutions some ten times, and he has been many times since. In all fairness it must also be stated that in the intervals when he was on parole, which he usually readily earned, several kindly people and one especially skilled in dealing with parolees, tried again and again very hard to help him. Curious, but perhaps not, that in this story for Karpman he says nothing of these friends, except to praise his brother and his long-suffering really good mother, both of whom he repeatedly robbed. Our own efforts were at the solicitation of some whom he impressed as being personable and salvable. Even later an experienced social worker who did much for him when he was under commitment to a hospital as a criminal with drug habits characterized him as 'gentle, appreciative, courteous, wistful, needing a friend'. On the other hand, one of our early statements shows that we had grave doubts about what could be done for him.

Some very significant issues for the psychiatrist are involved in this confrontation of the two records. In general, these are concerned with the value of even such a detailed autobiography as compared to a clinical case study. Of course anyone might question the exact validity of the material produced by a man who had over long years been a heavy user of narcotics. Be that as it may, I find on Manson's record my notation of long ago: 'This goes to show that such own story writing cannot be taken at face value'. Cross questions concerning immediate and earlier statements were even then necessary to substantiate facts. It should be realized

that for the study of a criminal career even by psychoanalysis, which was not done in this case, it is scientifically wise to have at hand data which can only be obtained through a good case study. Certainly Alexander and I found this to be true, as we tried to make clear in Roots of Crime. What a pity that Karpman did not work from the background of the earlier records.

Only some major discrepancies related to Karpman's 'comments' and Manson's story can be discussed here; there is much else in the printed pages that does not ring true. Was his heredity bad, especially from his father? Really there were some good people on both sides of the family, and some very successful. The father, at intervals a hard drinker and violent, was, his wife stated, at other times 'a thoroughly good man.' The older brother 'a wanderer'? Well, he was honest and worked up to become a hospital laboratory technician before he was sent overseas and died there. The younger sister has had a fine record. The fact is that Manson's career is in tremendous contrast to that of any other member of the family, near or remote. Early institutional life? All three children were placed and paid for in the orphanage nearby after the father died when our patient was five (not seven) years old, and the mother visited very frequently. Later the boys were both in G. Manual Training School. 'Inferiority feeling' from lack of education? We never discovered this; Manson did well enough through the grammar grades and was quite a reader. 'Affection lacking'? Evidence tends to show that affection was showered on him in his early years, indeed he speaks of having been much petted and later his mother, who told us, 'I loved him best', stood by him wonderfully.

Mention is made of the mother's extreme misery during her pregnancy with this child in a sawmill town, but nothing about the fact that she was very ill in the last months, she has repeatedly said, with typhoid fever. Manson himself tells Karpman of his birth as a painful and hazardous event, with his father arguing for saving his wife and rejecting the child. The mother told us that it was 'very easy and rapid'. (Here and in various other places we are left wondering whether Manson's considerable acquaintance with psychopathological literature has not led him to confuse fact and fancy.) At six months (not at three years) the baby came in contact with a hot stove and was terribly burned

on one side of his head. This figures in both records. It was a year in healing, the mother says, and she *and the father* took turns in sitting up nights to dress the burn. (Some severe diseases in childhood and manhood we may leave out of consideration.)

We have then two outstanding possibilities of early brain-cell damage. One a pathological pregnancy of the type one finds definitely in the background of some cases of abnormal personalities. Second, a trauma that quite likely effected what Lauretta Bender in particular describes as burn encephalopathy with ensuing changes of personality. And certainly we are warranted in concluding that Manson is an abnormal personality exhibiting a deeply defective character development.

From his early years loyalties, often verbally expressed, were never normally sustained in behavior; the satisfaction of instinctual impulses he could not inhibit. All through his life object relationships never meant anything as compared to immediate gratification. At three he used to take things belonging to others; he was a placid and good child otherwise; at five, when his mother had a little shop after her husband died, she supplied him with candy but he often pilfered from her. Once engaged to a nice girl, he could not remain loyal to her. Many jobs were found for him. Being bright and personable he readily obtained them and earned well but was dishonest or quickly gave them up. Well trained as a printer in one reformatory, he found he could make good money in this occupation; however, he worked at it only sporadically. Karpman's comment that he was employed for about two years in a steel mill, which would seem to mean that he was steady at times, is not in accord with the facts. He really worked there 'off and on' for nearly a year, though it should be added that under the stimulus of his mother's sickness he did then give her some money. Taking it altogether it forms a life-long story of weakly antisocial, though not viciously aggressive conduct trends. Manson has been thoroughly inadequate in meeting the demands of social living.

But all this does not preclude enlightening consideration of psychodynamic factors in Manson's career, interpretable through analytic theory and experience. Superego formation: Though his kindly, good and religious mother did her best to teach him right and wrong, and Manson has many times given lip-service to ideas

of morality and religion, her teachings never reached the stage of real introjection. As Greenacre has so well put it, 'The isolation and unusability of the conscience in these patients is due largely to its gossamer substance. . . being valued as an adornment rather than for its utility.'

Identification: In the old days Manson often said, 'If I only had had a father'. The mother righteously kept from the children any knowledge of the father's weakness and in his latter years the man worked mostly away from home and supported the family in fair comfort. Our boy thought of him as a pretty good father who might have taken him duck-hunting, and so on. (It is rather informative that Manson never partook in any sports at any time.) Yes, he certainly lacked a good father figure, although in the light of his later behavior we doubt to what extent a father could have built up his character. Surely he never identified himself with his mother. I went into the matter carefully with him and found that he never felt that he found any man to whom he wanted to respond or, indeed, any admirable figure whom he desired to emulate in the good books that he sometimes read, the latter representing what we have known some other fatherless boys to do. Nor did he regard any criminal character as a hero. It is possible that there were no good father figures available the first two times he was in institutions, until he was nearly twelve, or at least he did not attach himself to them. The second time we saw him we discovered that at least two very wholesome men had in the past almost camped on his door-step in the endeavor to help him. In the old days, musing on his career, he repeatedly said that he had somehow been strangely ambitionless, he never thought of anyone whom he would like to be like or of anything special that he would like to do or be; he always lived day-by-day without anxiety about the future. (That, however, he hated to be sent to prison is shown by the motivation of one almost successful attempt at suicide.) The very possibility of strong object relationship, the basis of identification, seems questionable in this case.

Early sexual experiences: Among other experiences related Manson tells and reiterates in the Karpman publication a great tale of how he, at the orphanage (really from six to nine years) and also at G. school (from nine until almost twelve years of age), often witnessed the matrons and and teachers 'boldly' have sexual

relations with their men friends and saw 'the looks of rapture on their faces', whereupon he would lie on the grass, go through similar motions and have emissions which caused 'great lassitude and weakness' (pp. 14, 16, 176, etc.). Since so much is made of this I am obliged to state that I entirely discredit the story for the following reasons briefly stated. (a) The alleged remembrance of rapture, lassitude, etc. Emissions at that age! (b) It is almost inconceivable that teachers and matrons in these institutions of good repute, as we well knew, engaged 'boldly' or at all in illicit sexual affairs. (c) The story is in absolute contradiction (see below) to statements about his sexual life made by Manson when he was much younger and more naïve. (d) His fantasy life, always about the opposite sex, has been most extraordinary in frequency and vividness ever since puberty, as known to us earlier. Here we may leave out of account his hallucinatory episodes which began long before he went to St. Elizabeths. (e) Finally, is it not possible that this incriminatory story of women in authority is a screen memory for a much earlier primal scene.

Dynamic associations—sex and stealing: When much younger Manson gave us a clear and almost classical account, which he corroborated later, of beginnings in serious delinquency. When he came home—he was then not quite twelve—from G. school where he had no bad record, he knew little or nothing of sexual matters. (This quite invalidates his story written for Karpman.) Before long he fell in with a couple of older thieving boys who masturbated and 'taught me everything'. His mother also gave this as the time when the trouble with him really began and before he was thirteen he was sent to the Parental School for truancy and stealing. According to his accounts, association with these boys did not immediately lead to the excessive masturbatory practices which was his great problem in later institutional life, but he quickly developed a great deal of vivid fantasy about girls' bodies which continued as a specific indulgence over many years. A teacher in the detention home said that he showed considerable ability in drawing but he did not go on with it, and it is rather interesting that he said much later that he was never able to find a girl as beautiful as the ones, when he lay in bed, he would visualize on the wall or ceiling. The point about associations of sex and stealing he made himself and gave various striking illustrations. After what

he learned from those boys he would see a girl, think of her sexually, make no advances but have 'feelings of upset and wildness' and 'then I would steal things whether I wanted them or not'. He enumerated a most miscellaneous lot of articles taken. This was a pattern of behavior sustained with 'more than a hundred' episodes of stealing during his younger years whenever he was out of institutions, which was never for long, and included his quitting jobs on account of the same feelings of 'wildness', until he began his many heterosexual activities and started his career of dishonesty for pecuniary reasons.

Symbolization: Several times in the printed pages Manson talks of watches: they have played some important and strange part in his life, and he is puzzled about what this means. Aside from stealing watches he often bought them in later years and traded them, always trying to get a more beautiful one, something that would satisfy him. It sounds similar to his never finding a girl as satisfactory as the ones he imaged in his visual fantasies. Nor is this interest in watches, or other timepieces, unfamiliar to me as occurring in cases of sexual conflict with or without criminality. Manson's early stories again are revealing about beginnings. It appears that when a young adolescent he was at a beach with another boy who had a girl there who 'seemed pretty tough'. These two started fooling and the girl said Manson was jealous; then the other boy told him just what they were going to do sexually at her house. Manson 'got excited' and went to a bath house and took a man's gun-metal watch from his clothes. That night he took a girl to a park, spent money on her but only kissed her. Later he went to a boarding house instead of going home. The next day he got to thinking about this girl of the night before, went back to the house and stole from a man boarder there a 'lady's gold hunting case watch': 'I did not look for money or anything else'. Then he found the boy who had the girl at the beach and 'I gave him the gun-metal watch'. Later he was arrested and with his previous record was sent to the reformatory for larceny of the gold watch. There was other stealing of watches, his brother's for example, about the antecedent circumstances of which we do not know; but the above is enough to prove Manson's own point that watches had some unconscious meaning for him.

Homosexuality: In our 1923 interviews I suggested that Manson

tell me about this. He spoke, as he had earlier, of some involvement in, but disgust with the usual affairs that go on in institutions for delinquents. But I was impressed by a dream that he said he had long remembered, about a short dark fellow 'who was standing with a sword curved like a Turk's showing it to me. He cut off my head and was holding it up.' Then it came out that years earlier an Italian in a park introduced him to fellatio and gave him some money. After that he met for a time various well-dressed men who went with him to out-of-the-way places for the same purposes and gave him as much as five or ten dollars. He claimed that he was always the passive agent, they did it to him, and it was as pleasurable as going to a disorderly house. He did not continue with this and 'I never found out why they did it'. So Karpman is right in suspecting that there was more homosexuality than went on in institutions, but I cannot agree with his inference that homosexual tendencies interfered with Manson's satisfactory heterosexual adjustments. He got too much pleasure out of sex relations with women on so many occasions; and after he was married it was mainly the money question that lead to the break-up. No, it is much more likely that his unsatisfactory adjustments in this as well as in other areas were due to his inability to be stable in object relationships.

Projection: For a man with his criminal record there is in the Karpman story a most unusual lack of display of hostilities or blaming others. This is all the more strange considering his years of drug addiction and alcoholism. More readily understood was his old attitude with us; it seemed then to have been 'I am what I am and that is all there is to it'. Can this be because innately Manson has suffered from defective ego development and consequently has had a minimal amount of ego striving?

Unconscious fantasies: At various places in the narrative for Karpman (too numerous to mention here) I am left wondering whether discrepancies in our case studies are not due to disintegrating memories on the part of a man who has been mentally ill more than once; or do they represent unconscious fantasies, though, as Freud said about children, such fantasies often can scarcely be distinguished from conscious thought? The story about teachers and matrons in the orphanage and school opened the question for me. And there is another instance about the girl on the farm

who came into bed with Manson during a thunderstorm and on following nights. He told me too about this, saying that he had entirely resisted temptations to do anything at all with her, taking it out in masturbation the next days. In these last writings he states that he, in his ignorance, repeatedly tried to have umbilical intercourse with her. And this on the part of the boy who was over sixteen and who, according to other parts of the writing for Karpman, had learned much through early sex information from boys, seeing girls' bodies, and observations of actual intercourse! It does seem as if, perhaps on the basis of something read, or a common childish notion of impregnation and birth, this variation of the episode with the girl may represent the elaboration of unconscious fantasies.

In the concluding paragraphs of his long autobiography Manson states that through working with Dr. Karpman he understands his 'prime motives': jealousy, hatred, envy, liking to have his own way, etc. A lot of these I never found, but it may be that I missed some of them while impressed with the mild and negative qualities of the more youthful personality. Then we hear sounded once again a very familiar note of optimism about himself: determination to make good, lack of anxiety about the future; 'the toils of the law have closed on me for the last time'.

By way of epilogue Karpman's last notes on the case should be added. In the intervening years practically nothing was known of Manson, but in 1937 he received a penitentiary sentence for stabbing to death his common-law wife. This erstwhile mild fellow, according to a very meagre report, said something to the effect that he had had a hang-over that day and later could not remember that he intended to kill her.

The reviewer dislikes to say anything that in any way reflects on the sincere endeavors of Dr. Karpman. However, it does seem that for the sound interpretation of genetic factors in these criminal cases, full historical data are essential. If a competent case study had been at hand in 1929 it is fair to guess that of the book space given over to Manson some three hundred pages of good paper and printer's ink could have been utilized to better ends.

WILLIAM HEALY (BOSTON)

PSYCHOLOGY OF SEX RELATIONS. By Theodor Reik. New York and Toronto: Farrar & Reinhart, Inc., 1945. 243 pp.

Reik's thesis is that the sex drive must be regarded as a biologically determined reaction conditioned by chemical changes within the organism; that love, tenderness, affection, in sharp contrast, are culturally determined; that Freud has created a great confusion among psychologists by extending the term sex to include a wide variety of biologically and psychologically determined reactions in person to person relationships. 'Between love and sex are differences of such a decisive nature that it is very unlikely they could be, as psychoanalysts assert, of the same origin and character' (p. 17). Freud and his fellows, he states, have emphasized the sexual drive and neglected the ego impulses. There is no such thing as sublimated sex, and the concept that cultural achievement represents in considerable measure the results of redirection of sexual impulses is incorrect. 'To assume that the crude sex drive can be used as a stepping stone to high cultural aims has as much sense as the assertion that the need to discharge urine can be deflected and the resultant pressure utilized as energy for achieving noble ends' (p. 58).

According to Reik, it was a 'fatal blunder' to conceive of love as aim-inhibited sex, but it is appropriate to characterize romantic love as 'an aim-inhibited desire of conquest or of the possessive urge' (p. 102). Love is younger than sex, was not derived from the relationship between the sexes, but was later fused with sex. Love was brought about by women, who reacting with envy and hostility toward the privileged position of men, revolted and began to play hard-to-get. 'They began to hold out on their men.' This set into motion reactions of courting, friendliness, kindliness; romance is derived from the opposition to sex on the part of women.

The author summarizes his theme in A New Theory of Drives which he suggests '. . . may represent the first contribution of neo-psychoanalysis to biology' (p. 15). He postulates the existence of two principles, one which creates tension, the other extinguishes it. The biological goal of the former is development, hence progressive in nature; the latter aims at constancy, hence is conservative in character. Instincts are executives of these principles. We recognize here Reik's reaction to phenomena dealt with by others in terms of progress and inertia, and on the social level as social develop-

ment and cultural lag. One may accept the concepts, but questions the necessity for a ' new ' theory of drives.

This is a curious book. There is considerable of interest to the student of psychoanalysis as reflecting a development of psychoanalytic thought; a questioning of instinct theory, some healthy protest against the (now largely outmoded) *furor symbolicus* that characterized the thinking of some analysts. There are numerous clinical observations that reflect the extensive experience of the author. His elaboration of hostility between the sexes and the nature of the actual adjustments in sexual relations is rewarding reading. The lively, sensitive discussion of love between man and woman constitutes a fine contribution to the mental hygiene of sexual relations. But the challenges to psychoanalysis and the presentation of concepts dubbed neo-psychoanalysis reveal all the defects of the very thinking that is challenged by the author. Reik's emphatic distinction between sex and love harks back to the body-mind dichotomy: sex belongs to the body, love to the soul. Freud's use of the term sex to cover a wide range of reactions to personal relationships reflects his awareness that the reactions of the organism cannot be understood except in relation to the physical and social environment within which action occurs. Reik in his terminology ' assigns ' sex to a biology, love to culture, and his emphasis is on the separateness of their origin. Separateness of origin does not impugn the usefulness of Freud's more general use of ' sex '.

There is much practical wisdom in what Reik says about the effect of women's resistance to sex and to the position of men in society. But to elaborate this reaction as the primary source of love and affection between men and women is to ignore the obvious. Reik tends to ignore the fact that at one time adults were children, that their emotional responses are profoundly influenced by the behavior of the adults toward them, and that as adults, they are profoundly influenced by the fact that they bear and care for children. Reik does include a ' letter of criticism ' from one of his readers, who suggests that the existence of babies may have something to do with the nature of tender relations between men and women, but this is brushed aside as ' typical of a kind of rational argumentation which does not consider the unconscious processes '.

It is curious that in the extremely limited acknowledgment of the rôle of the child's early experience in determining the later

responses in human relationships, the harsher training aspects—particularly toilet training—are emphasized. The experiences directly related to love and the tender care children receive are largely overlooked. Perhaps it is this basic oversight that makes it necessary for the author to look far afield in anthropological mythology to find what it is that makes men capable of love.

GEORGE J. MOHR (CHICAGO)

EMOTIONAL PROBLEMS OF LIVING—AVOIDING THE NEUROTIC PATTERN. By O. Spurgeon English, M.D. and Gerald H. J. Pearson, M.D. New York: W. W. Norton and Co., Inc. 1945. 438 pp.

To those who look with a jaded eye upon the flood of print designed to popularize psychiatry currently roaring from the presses, this fine book will come as a welcome relief. Not directly addressed to psychiatrists, but intended for medical students, social workers and allied professional groups, it can be read with great profit not only by physicians generally but by those specialists in psychiatry whose training in psychodynamics has not been particularly intensive. The vast clinical experience of the writers satisfies the most exacting demands, and manifests itself on every page in a wealth of cogent illustrations which makes the book extraordinarily readable.

The enormously leavening influence of psychoanalysis, applied with an exactness and consistency which leave nothing to be desired, makes every case history come to life, and should give sober thought to those who are too easily satisfied with the various mechanistic, habit training and so-called common sense approaches to problems of human behavior. As reflected in too many textbooks and in too many medical curricula, these psychiatric viewpoints, so comforting to the ego defenses, exert an influence upon the education of our medical youth which takes many of them years of frustration to overcome. This book is so sober and yet so stimulating, so free of polemic and expletive, that it stands out as a modest monument to the fact that psychoanalysis has come of age.

Using the libido theory as their nodal point, the authors follow the vicissitudes of the instincts through infancy to maturity in painstaking detail. Every aspect of feeding, weaning, toilet training, psychosexual development and the rest is covered with satisfying thoroughness. If at first there appears to be no systematic

treatment of the ego defenses, a careful perusal will demonstrate that this difficult matter has been handled with effectiveness precisely because it has been done unobtrusively. It has been incorporated into the body of the discussion of the various aberrations from normal functioning with a minimum of technical complexities discouraging to the beginner. This skilful handling is refreshingly apparent in the account of neurotic character. On the whole, the experienced analyst should have no fault to find with the theoretical assumptions implicit in this as in numerous other problems treated in the book, implications which will of course escape, and properly so, those to whom the book is addressed.

There are, to be sure, lapses from the general high standard of excellence. For example, the following quotation is a little surprising: 'Someone has said that if a parent wants to have a well-behaved, socially well-adapted child, that parent should figure out what kind of person that implies and be such a person himself, and the chances are pretty good that through association with the parent the child will become much the same kind of person when he is twenty-one or thereabouts'. While we may be reasonably certain that Drs. English and Pearson do not believe that parents can become what they 'figure out' they should be, it does seem somewhat careless to leave such an implication in the minds of their readers. This is particularly true at a time when so much of 'mental hygiene' has been presented to the public in the form of lists of golden rules solemnly advising people to get themselves into the 'right' frame of mind. From time to time, too, one gets the impression from the text that conscious intent plays a much greater part in the aberrations of childhood behavior than is actually the case. Discussing the appearance of feeding problems shortly after the onset of toilet training, the authors note the regressive meaning of this phenomenon properly enough, but add, 'This could only be partially successful because he *knew* [italics reviewer's] that big children must not obtain their entire gratification through the activity of the mouth'. Again, we do not doubt that the authors are aware that this is not a conscious process they are describing, but the impression left upon the unschooled reader must be confusing. Another example in point: 'Any parent who will put himself at ease on the subject of sex, not try to show how much he knows or how little he knows, not be flustered with

embarrassment but just answer what the child asks, will manage sex education in a very satisfactory manner.' If only we could share the optimism of Drs. English and Pearson! Such remarks leave one a little perplexed, in view of the eminently wise and conservative tone of this excellent work.

Scanning the modern surveys of psychiatry, it would be difficult to find a book better suited to arouse the interest and enthusiasm of prospective students of psychiatry, nor one which could more effectively steer them away from the deceptive shoals of mechanistic thinking in this discipline.

NATHANIEL ROSS (NEW YORK)

PERSONALITY IN ARTERIAL HYPERTENSION. By C. A. L. Binger, N. W. Ackerman, A. E. Cohn, H. A. Schroeder, J. M. Steele. Published under the sponsorship of The American Society for Research in Psychosomatic Problems, New York, 1945. 230 pp.

Physicians generally agree that psychic factors play some part in essential hypertension. Thus, it is always emphasized that allowance must be made for the emotional element in individual blood pressure readings. It is also well known that rest and reassurance play a large part in the management of hypertensive patients, both in relief of symptoms and in reduction of blood pressure levels. The early symptoms of hypertension are often exactly those of a psychoneurosis. Emotional stress at times seems to precede the onset of hypertension, and anxiety bears a close relationship to the aggravation of existing symptoms in hypertension. Studies of personality often reveal conflict which seems to stand in close relationship to anxiety.

In an effort to throw further light on this subject Binger and his associates present a monograph containing the detailed psychological and physiological studies of twenty-four patients with hypertension. No effort is made to prove 'psychogenesis'; on the contrary, the authors refrain from drawing conclusions regarding the rôle of psychic factors in the development of essential hypertension. Minute observations and psychological data are contained in the first case which was studied by psychoanalysis (Ackerman), and much corroborative material was obtained from other patients who were interviewed by Drs. Binger and Ackerman.

The patients were chosen from cases undergoing investigation in the hospital of the Rockefeller Institute for medical research. The only selection was to choose young people in the early stages of essential hypertension. Tables are presented for each patient showing the results of the physical studies, and in addition to the usual studies, blood pressure recordings are recorded in almost every instance for a period of many years. These are fully documented case studies, physically and psychologically. Another table makes an effort to show a relationship between the time of onset of personality disorder, prodromal symptoms and the discovery of hypertension.

Regarding pathogenesis, the authors suggest that chronic emotional tension associated with anxiety may be related to impairment of the flow of blood through the kidneys, and cite observations by Smith (also Goldring and Chasis) in which emotional disturbances could be correlated with impairment of renal circulation.

While all of their patients presented evidence of a disorder of the personality which could be classified as 'neurotic' the appearance of an organized neurosis with specific symptoms was the exception rather than the rule.

A particular configuration of tendencies was consistently found, and an approximate composite picture of the personality and its development described: '. . . the failure of the integrative functions of personality, the inadequacy of the characteristic defenses against anxiety, the inefficiency of the repressive mechanisms and the inability to develop an organized neurosis, rather than the nature of the underlying "instinctive" drives, are what appear to differentiate this disorder from other seemingly similar ones'.

The outstanding feature of the personalities studies was found to be an early sense of insecurity. In the majority of cases it was possible to discern a critical shock-like reaction in which the patients felt overwhelmed by danger against which their usual defenses were ineffective. In general, what seemed to epitomize the major threat was separation from a parent. The discovery of hypertension, or the appearance of its prodromal symptoms, usually occurred in such emotional settings and followed acute emotional disturbances. Study of the childhood of these patients showed that death of the parent or separation occurred in twelve out of twenty-

four cases. In twenty-three of twenty-four cases the existence of high blood pressure was first observed after the occurrence of an emotional disturbance such as the illness or death of a relative; injury, illness, or other trauma to the patient; changes in the patient's life such as separation from parents, marriage, illness of a child, loss of a job, or loss of savings. In thirteen of the twenty-four cases the emotional disturbances seemed to be mainly a reaction to a serious illness or the death of a relative. The one common factor was loss of security with exposure to the aggressions of the person on whom the patient was dependent.

The authors point out that unlike such disorders as asthma and migraine, in which the psychological setting of an attack can easily be studied, it is difficult to show a correlation between psychological stimulus and physiological response in a disorder like hypertension which is not episodic and in which there is not even always a parallel between the level of blood pressure and the existence and severity of symptoms. They review previous observations, such as those of Alexander and Saul, and agree with the descriptions of the conflicts in which aggressive impulses are inhibited but not deeply repressed, but 'the assumption that psychic factors causative of the somatic disturbance are of a specific nature, is by no means clear'. The authors regard their investigation as a clinical study contributing to the nosology and development of hypertension but not to its etiology. They do not consider the disorder of the personality as the cause of hypertension; rather they prefer to regard the disorder of the pesonality and the 'constitutional vasomotor instability' as different aspects of the same fundamental pathological process.

Despite the studies here reported, and others referred to, it seems to the reviewer that insufficient evidence is available to establish a specific relationship between the personality of the patient and hypertension; rather it would seem that these are individuals with neurotic tendencies in whom emotional factors, which make an impact upon their neurotic personality structures, initiate hypertension in the same way that other vegetative neuroses may be precipitated. But the essential element seems to be the inherent tendency to vascular disorder without which there would be no hypertension. It may very well be that the personality struc-

ture and the inherent vasomotor instability are simply different phases of the same basic fault, the latter 'constitutional' and the former more nearly related to the environment.

It seems unfortunate that such a carefully documented work, representing such painstaking study, should not be more rewarding from the standpoint of understanding and influencing hypertension. Others have attempted to show the day-to-day relationship between blood pressure readings and the life situations of hypertensive patients. Perhaps such studies could be combined with the kind of observations here reported.

As a first step, every serious student of hypertension should study this monograph. The investigator will find detailed observations to provide a background for his own studies, the clinician will find a way to assist his hypertensive patients to lead more useful lives even if he cannot learn the secret of their hypertension.

EDWARD WEISS (PHILADELPHIA)

AVIATION NEURO-PSYCHIATRY. By R. N. Ironside, M.B., F.R.C.P. and I. R. C. Batchelor, M.B. Baltimore: William Wood & Co., 1945. 167 pp.

This textbook, the first of its kind known to this reviewer, represents a solid achievement. The book was entirely written by these R. A. F. psychiatrists while stationed overseas, but suffers little from this fact. The book is well written, the clinical observations are sharp, the case histories achieve a comprehensive picture of the types of psychiatric problems found among flying personnel during World War II. The prognoses indicate extensive experience, and the recommendations for disposition reveal the practical rôle of the psychiatrist as a member of an army trying to win a war.

The book is divided into three parts: Flying and the Normal Individual, The Neuro-Psychiatric Examination, and Neuro-Psychiatric Disorders in Aviators.

Following a brief description of such environmental problems as anoxia, the effects of accelerations, and fatigue, the problem of selection of flying personnel is discussed. It is noteworthy that in the main the authors' recommendations are in agreement with the psychiatric criteria eventually adopted in aviation cadet selection centers in U. S. A. during the war. The chief point of divergence between British and American selection techniques had to do with special aptitude tests, devised by our A.A.F. psychol-

ogists, which came to be given more and more weight in selection as the war progressed. These tests were alleged to prognosticate a candidate's aptitude as pilot, navigator, or bombardier. They were the source of great divergences of opinion. The majority of our flight surgeons who were working directly with operational personnel came to believe that the requirements for successful performance in aircraft were essentially the same whatever the particular assignment.

Part II, the Neuro-Psychiatric Examination, is a presentation of the technique of obtaining the material necessary for arriving at a diagnosis and prognosis. It is brief, with the precipitated wisdom of experience.

Part III, Neuro-Psychiatric Disorder in Aviators, comprises the bulk of the text. Chapters are devoted to the etiology of neurotic reactions to flying; the psychological reaction types, their characteristics, prognosis, prophylaxis, treatment, disposal; sickness in the air; disturbances of consciousness in the air; neurotic visual disorders; migraine syndrome and other types of headache; unclassified nervous disorders; head injuries; prognosis for flying after injuries and diseases of the nervous system.

The authors use the term 'neurotic' with greater frequency than was the case in our Air Forces. Rather early we came to use the term sparingly. For a time we employed the euphemism 'operational fatigue'. This was followed by the general adoption of the more satisfactory term 'anxiety reaction'.

Forty-four case histories are reported to illustrate the subject matter. They will make interesting, comprehensive reading to all flight surgeons with theatre experience, especially those assigned to operational units.

ALEXANDER HALPERIN (WASHINGTON, D. C.)

RECENT PROGRESS IN PSYCHIATRY. Edited by G. W. T. H. Fleming. Journal of Mental Science, No. 378. London: J. and A. Churchill, Ltd., 1944. 509 pp.

MODERN PSYCHIATRY. By William S. Sadler, M.D. St. Louis: The C. V. Mosby Company, 1945. 896 pp.

Recent Progress in Psychiatry represents the joint effort of a group of distinguished British authorities in psychiatry and related fields. Its purpose is stated in the introduction by the editor: 'It was

felt that, having regard to the stagnation which is so apt to happen to everyone in wartime, the time was ripe to gather together information on recent progress in psychiatry and its ancillary subjects. It is fifteen years since Henry Devine, whose early demise was such a loss to British psychiatry, issued his Recent Advances in Psychiatry. The period of time since then is too great to cover adequately with paper supplies restricted, so the present review is confined to work published during the five year period 1938–1942, and in some instances the first half of 1943.'

In this volume the literature of the period surveyed has been very thoroughly explored and the essential data are firmly compressed within the limits of the book; hence it is impossible in a brief review to do more than indicate the scope of the project and allow the interested reader to consult original sources. A. A. W. Petrie contributes a chapter on administrative and organizational plans for a national mental health service. Following this there are several chapters on preclinical subjects and on various laboratory adjuvants in psychiatry: genetics in psychiatry (E. T. O. Slater), the anatomy of the nervous system (W. E. Le Gros Clark), physiological psychology (F. L. Golla), electroencephalography (W. Grey Walter), biochemistry of the nervous system (D. Richter), vitamin deficiency and the psychoses (W. A. Caldwell and S. W. Hardwick), neuro-endocrine relationship (M. Reiss), mental testing (M. B. Brody), neuropathology (A. Meyer). Recent contributions in psychopathology are summarized by S. M. Coleman. Recent developments in clinical psychiatry include schizophrenia (W. Mayer-Gross and N. P. Moore), depression (Aubrey Lewis), psychopathic personality (D. Curran and P. Mallinson), the psychoneuroses (W. H. Gillespie), psychotherapy (H. Crichton-Miller and G. H. Nicolle), arteriosclerotic, senile and presenile psychoses (W. Mayer-Gross), psychiatric aspects of head injury (E. Guttman), neurosyphilis and its treatment (W. D. Nicol and E. L. Hutton), child psychiatry (E. M. Creak and B. J. Shorting), delinquency and crime (W. Norwood East), mental defect (L. S. Penrose), endocrinology in clinical psychiatry (R. E. Hemphill), convulsive therapy (L. S. Cook), insulin therapy (T. Tennent), prefrontal leucotomy (G. W. T. H. Fleming), legal aspects of psychiatry (P. K. McCowan).

Conditions of war excluded much of the continental literature from consideration, but apart from this the available literature has

been diligently drawn upon and each chapter is implemented with an impressive list of references. It is apparent, also, that despite the overlapping of subjects in various chapters, a studied attempt has been made to avoid reduplication. The volume is undoubtedly weighted in favor of the organic approach to mental disease. The psychoanalytic viewpoint has its hearing, notably in the chapter on psychopathology where the contributions of Bibring, Anna Freud, Fenichel, H. Deutsch, Reik, the Klein school, as well as the critical estimates of Dalbiez and Herold receive attention. However, the space allotted it will doubtless seem disproportionately small to readers of this journal. On the other hand, various schools of thought are generously represented in the composite study, and while at times an impression of *quot homines, tot sententiae* is present to a disconcerting degree, the volume is a sobering reminder of the complexity of modern psychiatry and should have the salutary effect of shaking the complacency of those who work with psychic blinders in their own private ruts.

Sadler's Modern Psychiatry has little to recommend it to psychoanalytic readers. The author belongs to that considerable group of psychiatrists who grudgingly render a certain amount of lip service to Freud and his teachings, but who then with qualifications here, reservations there and gross rejections elsewhere, end up by leaving psychoanalysis with but little of its original integuments. Thus, for example, the unconscious is (p. 89) reduced to 'more or less a figure of speech'. The author, in fact, seems to propel his psychiatric bark with one oar beating against materialism and godlessness and the other against a thouroughgoing freudian exploration of the unconscious. And just as the sceptic and agnostic must remain deprived of psychiatric salvation, so those who seek to plumb the depths of the unconscious, according to this viewpoint, work endless havoc. The significance and the vast dimensions of the unconscious are, one must infer, acknowledged in the reference to the familiar simile of the iceberg; but one can apparently cope with its disturbing influences by sitting on the peak rather than by diving and working *de profundis*. 'While it is true that the psychiatrist must delve into the depths of the human subconscious and possess himself of the details of the inner psychic environment, nevertheless, there are domains of personality which should not be lightly invaded. It is neither wise nor profitable to tinker overmuch with the human soul, and every psychia-

trist should be actuated by common sense as well as by high ideals and a profound respect for the sacred rights of the human personality before he essays to embark on his journeys of psychic exploration.' The author shares the naïve, market-place view of what analysis consists: 'There are daily, or almost daily, long-continued conversations on sexual matters extending over many months of time—sometimes as long as three years—conversations of the most intimate character'. This lack of information does not prevent him, as it has not so many others in the same class, from stating authoritatively which parts of analytic doctrine are acceptable and which are not.

Since the psychopathology is superficial, so must the psychotherapy be. It is essentially rationalistic and hortatory. It is assumed that if the patient is sufficiently encouraged he will reach down to the deeply seated sources of his difficulty; the possibility that there will remain material that the patient cannot disclose because he is not and cannot become aware of it by ordinary methods is not envisaged. With the constant invocation of free will and the appeal to reason, the therapeutic accent is on reëducation, remotivation, retraining, prescribed schedules of daily activity, and golden rules of conduct. While the author stresses the importance of the psychiatrist not obtruding his own predilections and biases, he includes in his program of an adequate philosophy of life, which his patients are expected to acquire in the course of treatment, sixteen 'musts'.

Perhaps the book will succeed in its avowed aim of familiarizing general practitioners with some of the fundamental concepts of psychiatry. However, this aim likewise is marred by evidence of hasty compilation, careless errors (e.g. 'intercranial' for 'intracranial' p.22), faulty grammar, facile generalizations, unsystematic presentation and—what makes for very tedious reading—repetitiousness to which there seems to be no end.

WILLIAM NEEDLES (NEW YORK)

A HANDBOOK OF PSYCHIATRY. By Louis J. Karnosh, M.D. with the collaboration of Edward M. Tucker, M.D. St. Louis: The C. V. Mosby Company, 1945. 302 pp.

A concise and factual report on clinical psychiatry which has grown from the experience of the authors at the Psychiatric Division of

the Cleveland City Hospital, the strength of this Handbook lies in the simple but able descriptive presentation of the psychoses and their clinical features, without too much theoretical discussion. In this honest and unpretending way, the finer aspects of institutional psychiatry are developed with references only to the most essential literature. The little volume may well become a popular textbook for medical students.

To psychoanalysts some of the diagrams, e.g., the one on the personality disorganization of schizophrenia (p. 101), will be somewhat questionable. A well-worded review of the defense mechanism (Chap. IV) is the only instance where the authors accept psychoanalytic psychiatry without reservation. In this booklet there is much practical information of value, in particular regarding drug and shock therapies, nursing care, physiotherapy, and the legal aspects of psychiatry.

CAREL VAN DER HEIDE (LOS ANGELES)

EVERYDAY PSYCHIATRY. By John D. Campbell, M.D., Commander, M.C., U.S.N.R. Philadelphia: J. B. Lippincott Company, 1945. 333 pp.

This book aims to provide a practical psychiatry, 'usable at the bedside', for medical students and social workers. It will appeal to readers who are ignorant of psychiatry outside of the State Hospital, chiefly because of its simple language and colorful case histories which the author has taken from his private and Naval practice as well as from the newspaper columns.

The chapters on mental deficiency, constitutional psychopathy, and chronic alcoholism, presented with due emphasis on the social implications, reflect a rich experience with these problems.

The author's assumption of 'four basic personality traits (intelligence, conscience, emotional reactions, and psychosexual development) and two secondary personality factors (sociability and special modes of adjustment)' serves as a frame for the discussion of psychiatric abnormalities. 'These traits are inherited, constitutional, and immutable, and are not subject to change by environment, education or training' (p. 3). Thus, in 1945, we are confronted with a psychiatry which reaffirms inherited constitution as the primary and predominant genetic factor in personality disorder. In accordance with this point of view, there are many violent and

bitter attacks on the psychoanalytic school of thought, a rather thin polemic which seems out of place in the scope of this volume.

CAREL VAN DER HEIDE (LOS ANGELES)

TOTAL WAR AND THE HUMAN MIND. By Major A. M. Meerloo. New York: International Universities Press, 1945. 78 pp.

This little book presents the experiences and thoughts of a Dutch psychiatrist during the Nazi occupation of the Netherlands, and as a bit of on-the-spot reporting is a useful addition to the literature concerning the impact of war on the individual.

The shattering effect of the first days of the occupation, with the disruption of the government and the consequent inability of the citizen to find symbols of a group with which to identify himself, are portrayed, and then the gradual development of a sense of unity, focusing in hatred of the oppressor. Traitors there were, of course, many of them previously well recognized as psychopaths and misfits. This group was small, however—not over two per cent of the population, says the author.

In speaking of the 'Deutschland Complex' exhibited by the Nazis, Dr. Meerloo comments: 'It is dangerous to speak of a collective psyche unless we remind ourselves constantly that it is a literary image without reality. It is, after all, individuals who make up a collectivity. A bad or a good collectivity may be built up with the same individuals; the results depend on the social system' (p. 28). He discusses at some length the tensions, guilts and insecurities which led to the development of the primitive 'participation mystique' among the Nazis.

In Chapter Four, on Hitler's Psychological Weapons (fear, slander and suspicion, hypnosis, propaganda and 'psychological artillery'), the author discusses the various methods utilized on the Dutch. He comments, 'All-out propaganda does not pay in the long run. It inevitably arouses suspicion, and once people start checking statements made by their own Government against outside information, it is no longer possible to tell downright lies' (p. 41). 'A people accustomed to think for itself may become immune to propaganda and may develop a resistance against the most insidious of slogans' (p. 43).

There are illuminating comments on Democracy and Fascism Within Us, Delusion and Mass Delusion, The Psychology of Cour-

age, How the Body is Affected by Fear, and The Psychological Preparation of the Next War. Dr. Meerloo has some convictions on the requirements for reconstruction which should be noted. First, the internationalization of war strategy, something perhaps of the sort visualized in the United Nations. Second, an international statute dealing with the fundamental rights of human beings. Third, the organization of an actively democratic education—education in self-knowledge and in the theory of society. 'Either the world is lost through the vicious circle of this self-destroying process in which fear inspires aggressiveness, aggressiveness brings a sense of guilt, and guilt seeks an outlet in more aggressiveness, or the fundamental instinct of self-preservation must arrest this headlong rush to destruction' (p. 77).

Let us hope that these words, written by a brave man in time of travail, will not have been in vain! The book can be read with profit by every thinking citizen who is interested in the establishment of a lasting peace.

WINFRED OVERHOLSER (WASHINGTON, D. C.)

VICTORIA THROUGH THE LOOKING-GLASS. By Florence Becker Lennon. New York: Simon & Schuster, 1945. 387 pp.

Lewis Carroll is the nom de plume of the Reverend Charles Dodgson, born in 1832, Don of Christ Church, Oxford, from 1855 to 1898. As Charles Dodgson, he wrote mathematical treatises, books on logic and invented mathematical games. As Lewis Carroll he wrote poetry, Sylvie and Bruno, Alice's Adventures in Wonderland, Through the Looking-Glass. These are fantastic stories with a strange logic about the experiences of a little girl lost in a fabulous country of humorous horrors and nonsensical surprises.

In Victoria Through the Looking-Glass, Mrs. Lennon has endeavored to find how it happened that a shy, awkward, meticulous mathematics teacher produced as his chef-d'oeuvre, a whimsical account of a little girl's adventures in an enchanted garden.

A student of Freud, Mrs. Lennon has searched for her answers in Dodgson's early environment, in the years of his adolescence, and finally in the Victorian atmosphere in which as an adult he worked. A precocious, sensitive child, the eldest of eleven children (only two of whom ever married), seven of them girls, Dodgson was born into a model Victorian upper-class home of sweetness and light,

of duty and devotion, of tradition and conservatism. His mother was a gentle, shadowy person who seemed to favor him. His father was a Canon of the church, a charming man with great ambitions for his children. From this loving circle of conformity he went to a preparatory school where life was a heartbreaking series of bullyings and Spartan physical discomforts. From there he went to Oxford where after completing his studies, he stayed as teacher and curator for the rest of his life.

From a detailed study of his letters, his friends, his books and his activities, Mrs. Lennon has deduced what happened to his instinctual urges. He never overcame the œdipus; he remained always tied to his mother, and by extension, his little sisters. He never succeeded in resolving the hostility to his father, not even in his writings. He was, in his books, Alice in search of his childhood's Garden of Eden. In life he was a celibate, retiring Oxford Don. Emotionally he never matured remaining fixated in the ecstatic happiness of his early years from which he was exiled to the hostile atmosphere of school. The rest of his life was a struggle to keep repressed not only his immature desires but, it must be inferred, his hatred of his parents for his castration and attendant frustration. He worked apparently against great resistance, just missing the mark: '. . . the poet was no prosodist, the artist who could not draw, the actor who stuttered, the preacher who could barely believe his own doctrine, the dramatist who could not write plays, the instructor of geometry who bored his students'. Except in the Alice books he never reached the heights of which he was capable. He had insomnia and frantically invented games to keep his active mind from brooding. His social life was one of monotonous inactivity, doubtless so arranged to prevent upsetting the narrow margin of adaptation he so painfully preserved. His few friends were mostly little girls.

From the window of the room where he worked when he was sub-librarian of Christ Church, Dodgson looked down on the garden of Dean Liddell where Lorena, Alice and Edith played and frolicked. Was this the crystallizing event? Did it awaken to expressive pitch Dodgson's nostalgia? In any event, on a boat trip with these children, he related for Alice a story of adventure, and thus by symbolic expression of repressed infantile desires, frustrations

and perversions made a happy sublimation not only for himself but for all children and for adults who can share with him (in a highly literate form) the pleasure of infantile fantasy.

Unfortunately, as he matured, Dodgson developed into a stuttering, limping eccentric, delivering dull lectures, writing second-rate mathematical treatises, arguing with the illustrators of his Carroll books.

Mrs. Lennon has written an interesting analysis of Dodgson's personality and a scholarly portrayal of the repressive atmosphere of Victorian England.

MARGARET JONES GILL (NEW YORK)

The Psychoanalytic Quarterly

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

A Case of Stammering. Ruth D. Usher. Int. J. Psa., XXV, 1944, pp. 61–70.

Otto Fenichel

To cite this article: Otto Fenichel (1946) A Case of Stammering. Ruth D. Usher. Int. J. Psa., XXV, 1944, pp. 61–70., The Psychoanalytic Quarterly, 15:4, 540-559, DOI: 10.1080/21674086.1946.11925658

To link to this article: https://doi.org/10.1080/21674086.1946.11925658

Published online: 11 Dec 2017.

ABSTRACTS

A Case of Stammering. Ruth D. Usher. Int. J. Psa., XXV, 1944, pp. 61–70. It is well known that for stutterers words may have the significance of fæces. Beyond this, words may also represent introjected objects which have been identified with fæces. The reviewer summarized this once in the following way: 'A conflict which originally took place between the individual and an object is now expressed . . . by means of a conflict between the ego and its speech apparatus or its speech products.'[1] This was also the case in Mrs. Usher's seven-year-old patient. In the terminology of Mrs. Klein, however, this looks as follows:

'Since first interviews have a peculiar interest all their own, I should like to describe his opening gambit. He started examining the two toy trucks, one of which he mistakenly decided was broken. "One of them must have bumped into the other", he said. He then picked up a brick which had a hole in the middle of it, remarking "something's missing". I interpreted the two trucks as representing his parents in sexual intercourse, and the brick as his sister.

'He next turned to the little train which he made run about very fast. He agreed it contained his parents, and he volunteered: "Mummy and Daddy are strapped in so that the wind won't blow them away."' And so he staged for me the *mise-en-scene* of his personal conflicts. I mentally concluded that I was going to witness a drama where the severest struggle would be played out internally. He seemed to be showing me symbolically that the parents were internalized and strapped down, not only to prevent them from copulation but also to protect them from his own aggressive attacks by flatus. And as his remarks were accompanied by an access of stammering, one determinant at least of this symptom had been revealed.

'. . . One day he got out his box of chalks. It fell on the ground and his pencils rolled out: "I've eaten too much and my tummy's bursted", was his comment. It was clear from his preceding play that these represented the penises inside me which he thought he had eaten out of me. I thereupon interpreted his stammer as these stolen penises falling out of his mouth.'

The following game was played by a London child during the certainly very impressive blitz:

'He made an enclosure into which he put all the bombs, some big, some little. At the entrance to it, he placed a toy lion, "watching to see no one goes in", he said. Behind the lion he erected a piece of paper on which he had written: "Alive bombs! Do not go near and do not touch them". Behind the paper were ranged his tank, gun and warship, etc., with their guns pointing towards the enclosure.'

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[1] Fenichel, Otto: *Outline of Clinical Psychoanalysis*. New York: The Psa. Quarterly Press and W. W. Norton & Co., 1934, p. 214.

And this is interpreted as follows:

'This surely meant that his id was full of dangerous bombs, guarded by his lion superego and covered by the guns of his ego, or rather of his ego identifications.'

An understanding of the paper is further made difficult by certain terminological peculiarities. The child reports: 'I couldn't sleep that night. I kept on *seeing the places*, and I saw things in the porridge. . .' . This is called 'hallucination'. The child, 'when it was time to go, twice fell over'. This is called 'a suicide reaction'. In all cases where we would talk about the child's 'parents', Mrs. Usher talks about its 'external parents', as contrasted to the images of 'internalized parents'.

OTTO FENICHEL

Endopsychic Structure Considered in Terms of Object-Relationships. W. R. D. Fairbairn. Int. J. Psa., XXV, 1944, pp. 70–93.

Fairbairn, who has already made various proposals to change psychoanalytic theory in a previous paper,[1] undertakes in this paper no less than the construction of a new and supposedly better theory of the structure of the mental apparatus, including as by-products new theories of the dream and of the neuroses.

His argument is exclusively theoretical, the only clinical example being a dream which is interpreted in a way so different from Freud's method that it cannot be convincing to an analyst. Fairbairn's theoretical argument is not easy to follow, not only because his terminology is somewhat different from the usual psychoanalytic vocabulary, but also because differences arise at the starting point which make all ensuing conclusions doubtful. Reforms of theory seem necessary to Fairbairn, especially because of 'the illuminating conception of internalized objects, which has been so fruitfully developed by Melanie Klein'. He thinks, Freud's concepts need revising on two points. First, Freud 'adhered theoretically to the principle that libido is primarily pleasure-seeking, i.e., that it is directionless. By contrast, I adhere to the principle that libido is primarily object-seeking, i.e., that it has direction. . . . In the second place, Freud regards impulse (i.e., psychical energy) as theoretically distinct from structure, whereas I do not accept this distinction as valid, and adhere to the principle of dynamic structure.' Both assertions regarding Freud are not entirely correct. Libido is not 'primarily pleasure seeking', but rather primarily discharge seeking, and there are physiological reasons for the discharge being felt as pleasurable. True, it is not primarily object-seeking, since the concept of objects comes into being with the understanding that something is needed through which discharge can be achieved. As to the second point, 'impulse' and 'structure' have always been considered inseparable and striving for discharge, presupposes the idea of direction. Under the influence of experience counterforces develop which tend to block

[1] Fairbairn, W. R. D.: *A Revised Psychopathology of the Psychoses and Psychoneuroses.* Int. J. Psa., XXII, 1941.

the discharge, that is, which have an opposite direction, and complicated structures come into being with the progressing differentiation of both discharge-seeking impulses and discharge-blocking defensive forces.

According to Fairbairn, impulses are not the object of repression, but rather objects which one wants to get rid of, that is, 'bad internalized objects'. These objects, he states, cannot be repressed without repressing part of the ego which seeks relationships with these internal objects. Thus, there is a multiplicity of egos, each of which is paired with special objects. 'I was accordingly led to set aside the traditional classification of mental structure in terms of ego, id and superego in favor of a classification couched in terms of an ego-structure split into three separate egos—(1) a central ego (the "I"), (2) a libidinal ego, and (3) an aggressive, persecutory ego which I designate as the internal saboteur.' The object, paired with the 'libidinal ego', is called 'the (internal) needed object', the object paired with the 'internal saboteur', 'the (internal) rejecting object'. Fairbairn defends himself against the possible objection that the 'central ego' may be another term for Freud's 'ego', 'libidinal ego' for 'id', and 'internal saboteur' for 'superego': 'Unlike Freud's "ego", the "central ego" is not conceived as originating out of something else (the "id"), or as constituting a passive structure dependent for its activity upon impulses proceeding from the matrix out of which it originated, and on the surface of which it rests. On the contrary, the "central ego" is conceived as a primary and dynamic structure, from which, as we shall shortly see, the other mental structures are subsequently derived. The "libidinal ego" corresponds, of course, to Freud's "id"; but, whereas according to Freud's view the "ego" is a derivative of the "id", according to my view the "libidinal ego" (which corresponds to the "id", is a derivative of the "central ego" (which corresponds to the "ego"). . . . The "internal saboteur" differs from the "superego" in a number of respects. For one thing it is in no sense conceived as an internal object. It is wholly an ego structure, although, as we have seen, it is very closely associated with an internal object. Actually, the "superego" corresponds not so much to the "internal saboteur" as to a compound of this structure and its associated object. . . . At the same time, the "internal saboteur" is unlike the "superego" in that it is conceived as, in itself, devoid of all moral significance.'

In a long digression, Fairbairn tries to reconstruct the typical mental ontogenesis. The experience of frustrations makes for aggressions, aggressive tendencies for ambivalence, ambivalence for splitting of objects, splitting of objects for fear of bad objects, this fear for internalization of bad objects, the internalization for the bad objects remaining bad, and this for repression with help of the structurization of subsidiary egos. In these processes, libido and aggression have different vicissitudes. The child is endangered by the possibility of a full loss of his self-esteem and saves himself by various mechanisms.

The shibboleth for psychoanalysts is their attitude towards dream and œdipus complex. It seems that Fairbairn does not pass this test. The essence of dreams is seen as follows: '. . . dreams are essentially not wish-fulfilments but snapshots, or rather "shorts" (in the cinematographic sense), of situations existing in the inner reality. . . . According to my present view, therefore, the situa-

tions depicted in dreams represent relationships existing between endopsychic structures.' And concerning the œdipus complex, its significance, it is true, was somewhat reinstated by the research on precœdipal development. To Fairbairn, however, this appears as follows: '. . . *A sufficiently deep analysis of the œdipus situation invariably reveals that this situation is built up around the figures of an internal needed mother and an internal rejecting mother.* . . . The child finds it intolerable enough to be called upon to deal with a single ambivalent object; but when he is called upon to deal with two, he finds it still more intolerable. He, therefore, seeks to simplify a complex situation, in which he finds himself confronted with two needed objects, by converting it into one in which he will only be confronted with a single needed object and a single rejecting object; and he achieves this aim, with, of course, a varying measure of success, by concentrating upon the needed aspect of one parent and the rejecting aspect of the other. He thus, for all practical purposes, comes to equate one parental object with the needed object, and the other with the rejecting object; and by so doing *the child constitutes the œdipus situation for himself.*'

Readers of this abstract, who feel a little confused, are asked to read the original paper.

OTTO FENICHEL

Neurotic 'Acting Out' as a Basis for Sexual Promiscuity. J. Kasanin. Psa. Rev., XXXI, 1944, pp. 221–232.

Kasanin finds that some forms of sexual delinquency in women may be manifestations of an acting out process by which the individual discharges energies and tensions resulting from repressed conflicts usually involving the father. By demonstrating the irrationality of such behavior, the analyst splits the observing part of the ego from the acting part. He may ameliorate or even completely stop the acting out by timely interpretations of the transference. Three illustrative cases are described. In one of these the patient developed a psychosis which was interpreted as being due to a weak ego's inability to deal with hostility—a situation which the author finds the basis of all forms of acting out.

ROBERT COHEN

The Treatise of the Two Married Women and the Widow. K. M. Abenheimer and J. L. Halliday. Psa. Rev., XXXI, 1944, pp. 233–252.

The treatise consists of the statements of three women about their experiences in their conjugal relationships, and from it the authors draw conclusions as to the character and libido disposition of the poet, William Dunbar (1460–1520). They say, 'Dunbar could be described as an anal character. He failed to achieve communication with his fellow men and women and continued isolated, stuck in the mud and mire of the dirty mother. The world for him was full of witches—fear figures of his own anal aggression—and in futile strivings for security he passed his years. *Timor mortis conturbat me* was the recurring refrain not only of his last

and most famous poem but of his life also for—he who fears to love must also fear to die.'

RICHARD STERBA

Eight Prerequisites for the Psychoanalytic Treatment of Homosexuality. Edmund Bergler. Psa. Rev., XXXI, 1944, pp. 253–286.

After reviewing various theories of homosexuality, Bergler summarizes previously reported cases of his in which the predominant characteristics were: (1) an intense hatred for the mother, (2) oral character traits, (3) a weak œdipal hatred toward the father, (4) a repressed interest in the mother's breast, (5) an intense secondary narcissism, (6) a strong tendency toward identification. The homosexuality is looked upon as an outcome of oral conflicts. The experience of weaning created strong aggressions in the child which were inhibited in expression. A part of this aggression was used in identification with the mother; another part was displaced onto the penis, the child displacing his ambivalence towards mother's breast onto his own penis; a third part remained toward the mother as object. The anal zone, according to Bergler, was charged by way of the fantasied oral incorporation of the breast. In healthy people the œdipus complex destroys the effectiveness of the 'breast complex'. Homosexuality is the result of the unsolved breast complex.

Bergler's observations on homosexuality have modified some of his earlier theories and verified others. He has found the oral, precœdipal basis of male homosexuality confirmed without exception in all his cases. The oral regression is to be regarded less as a striving to get and more as a striving to take revenge for having got too little. In latent homosexuals the symptom of ejaculatio præcox is a frequent one. Its unconscious significance is an ironic refusal: the woman is being given the sperm but in a way which prevents her from deriving any pleasure from it. It is an orally conditioned revenge.

Bergler then suggests criteria on which to base the acceptance of homosexual patients for analysis. An honest wish for change and a willingness to accept treatment are absolutely necessary but by no means sufficient. The patient must not have too extensive an amount of self-damaging tendencies. It is better if he has already entered into homosexual relationships, rather than if he uses his analysis as an excuse for starting them. The prognosis is more favorable if there is no reason for using homosexuality as an aggressive weapon against the hated family. A case should be considered cured only if there is (1) complete lack of sexual interest in the same sex, (2) normal sexual enjoyment, and (3) characterological change.

IRENE M. JOSSELYN

The Meaning of Asthma. Ethan Allan Brown and P. Lionel Goitein. Psa. Rev., XXXI, 1944, pp. 299–306.

This very complete review of symbolic interpretations of the asthma syndrome cannot but have a bewildering effect on the reader. All the historical, ideo-

logical and psychogenic concepts are there. To name only a few: cell memory, psychic allergy, the trauma of birth, smothering at the breast, the vector approach, erotization of the turbinates and the symptom as an upwards displaced manifestation of unmastered flatus. However, critical discussion as well as case material is absent. A redundance of interpretation obscures the already overdetermined nature of the symptom, thus conflicting with the discipline of psychosomatic research.

CAREL VAN DER HEIDE

The Aztec Indian and the Greek Horse. J. C. Moloney. Psa. Rev., XXXI, 1944, pp. 307–315.

Moloney reports in a manner somewhat lacking in clarity the analysis of a very condensed hypnagogic hallucination in which a patient expressed her transference wishes and anxieties, and simultaneously her deeper scopophilic and narcissistic conflicts which formed the basis of her neurosis. The material provides an opportunity to discuss the 'psychosomatics' of an ovarian cyst.

OTTO FENICHEL

Fantasy Objects in Chidren. Jack Rapoport. Psa. Rev., XXXI, 1944, pp. 316–321.

The author points out that certain neuroses or psychoses are characterized by certain types of fantasy objects. The recognition of these types and of their changes is very helpful for the understanding of the clinical picture as well as for diagnosis and prognosis. Rapoport discriminates between 'internalized' and 'less internalized' parents. Generally he finds fantasy objects of the latter type in neurosis, while the psychotic cases tend to fantasy objects which are 'bizarre and markedly dissociated from reality'. The material presented is occasionally brought out through direct questioning such as: 'What have you within your body?', or, 'Have you a little person inside of you?'.

In his explanations of the material Rapoport follows closely the English school of thought, particularly Melanie Klein and Susan Isaacs. We miss the analytic material which should support his very interesting discussion and hope that he will be able to fill in this gap in the future.

EDITH BUXBAUM

A Savoyard Note on the Freudian Theory of Manic-Depressive Psychosis. Saul Rosenzweig. Psa. Rev., XXXI, 1944, pp. 336–339.

The author reprints a poem by W. S. Gilbert, the first published of the famous Bab Ballads. It tells of a sailor who, stranded with nine shipmates, eats them all one by one, so that finally he is,

> 'At once a cook, and a captain bold,
> And the mate of the *Nancy* brig,
> And a bo-sun tight, and a midshipmite,
> And the crew of the captain's gig.'

Saul Rosenzweig connects the cannibalistic content of the poem with W. S. Gilbert's humor as a manic compensation for underlying depression.

RICHARD STERBA

A Note on the Treatment of Aggression in Emotionally Disturbed Children. L. R. Wolberg. Psychiatric Quarterly, XVIII, 1944, pp. 667–673.

Wolberg points out that the therapist must understand 'the dynamic function that aggression serves in the psychic economy' in order to be able to react in an appropriate way. A neglected child who did not have a chance to build up an adequate superego has to be subjected to certain limitations to which he will adjust in time. Another type of aggression is that of a 'power striving individual'. In these cases 'a permissive environment is essential. . . . As the child's attitude toward authority gradually undergoes a change, he usually finds it permissible to enjoy his softer impulses.' Wolberg thinks that 'an element of magical wish fulfilment is involved in the child who clings to the therapist in a submissive and ingratiating way, but breaks out into aggressive behavior seemingly without provocation; rage occurs when wishes are not automatically granted'. At the same time the person who is helpful in fulfilling his wishes is blamed for 'crushing' the child's desire to be independent. The author warns the adult against 'being over-protective'. 'Shy and detached children need a permissive environment' in order to bring out their repressed aggression. They should take part in groups and compete with others. 'As the permissive environment begins eating away at his repressive image of authority he may begin experiencing feelings of love toward the therapist.'

Wolberg presents a lively description of different types of aggressive behavior. However, we do not expect the treatment of these patients to consist merely of freeing or restricting aggressions. We would like to know how Wolberg arrives at his understanding of these different types, whether he bases his explanations on observation, exploration, history or analysis. We also are interested to know how much of his insight the therapist conveys to the patient, since we consider this knowledge essential for his recovery.

EDITH BUXBAUM

Positive Transference in Schizophrenia. D. A. Barbara. Psychiatric Quarterly, XVIII, 1944, pp. 674–686.

This paper deals with the remarkable improvement of a paranoid male patient who had for twelve years been an inmate of a State Hospital. He had to be tube-fed during the twelve years and was a passive, dependent, withdrawn, and in all probability, latent homosexual individual, in whom severe mental changes were not evident until at the age of forty-four 'he gave himself up entirely to God' and became hospitalized. The 'Horney analytic approach' was started when the patient had attained the age of sixty, and through lasting intensive sympathetic and understanding contact, a clinical cure was obtained.

The question as to whether this case of paranoid psychosis with twelve years hospitalization and complete absence of hallucinations still can be called 'schizophrenia' (under which diagnosis it is presented) is not discussed. Freud's

concept of transference is violently attacked and it is restated as something new that transference is by no means impossible in psychotics without reference to the several papers of Freud's earliest pupils, Landauer and Federn, in which they reported results in healing psychotics with essentially the same methods applied by Barbara.

CAREL VAN DER HEIDE

Narcolepsy. I. Combat Experience of a Soldier with Narcolepsy. Howard D. Fabing. Arch. of Neurology and Psychiatry, LIV, 1945, pp. 367–371.

In this paper Fabing very carefully describes the case of a thirty-five-year-old soldier suffering from narcolepsy, cataplexy and trancelike cataleptic attacks. This condition was not recognized prior to army life and the patient participated in two major military campaigns. He performed adequately and had only rare seizures. Fabing points out that the patient did have attacks while boxing, swimming, hunting, and during sexual intercourse. Nevertheless, because the soldier did not have attacks during combat when his life was endangered, the author doubts that cataplexy results from emotional stimuli.

RALPH R. GREENSON

Psychologic Studies on a Patient Who Received Two Hundred and Forty-eight Shock Treatments. Joseph Perlson. Arch. of Neurology and Psychiatry, LIV, 1945, pp. 409–411.

Perlson discusses a patient with paranoid schizophrenia who received two hundred and forty-eight shock treatments. Psychological testing performed almost three years later did not reveal any evidence that convulsive shock therapy had produced mental, emotional or physical deterioration. The patient is now paroled and appears to be making a satisfactory adjustment.

RALPH R. GREENSON

Masculine and Feminine. Some Biological and Cultural Aspects. Gregory Zilboorg. Psychiatry, VII, 1944, pp. 257–296.

Zilboorg's interesting paper may be divided into four parts. In the first he gives a brief description of recent revolutionary changes in the cultural rôle of women. In the second part Freud's ideas about female psychology are objectively and informatively outlined. The third part criticizes various psychoanalytic theses and shows that psychoanalysis, in regard to female sexuality, betrays a denite 'cultural lag'. Neither the development of female sexuality, nor the bio- and psycho-sociological rôle of woman has been sufficiently understood. Freud was guided by an androcentric bias, and though he was fully aware that such problems as matrilineal inheritance, feminine deities, and man's hostility toward woman were worthy of consideration, he only hinted at them and did not offer any solution.

The fourth and last part of Zilboorg's paper constitutes his most constructive contribution. Zilboorg starts by reviewing Lester F. Ward's address before the Six O'Clock Club in Washington in 1888. Ward thought that the female

originally reigned supreme, as she still does in the animal kingdom, and that the male was but an afterthought of nature. A great deal of material is offered to prove the primariness of femininity—psychoanalytic material referring to the prœdipal phase as well as anthropological material referring to a 'pre-Totem and Taboo' phase, to matriarchy and mother goddesses. Before gods of the type of 'the great father' were created, the 'great mother' had to be dethroned. This was not done through an economic establishment of patriarchy, but rather through sexual passion. The mother was raped and enslaved and became the first 'property'—when and why is not stated. Therefore man eternally fears woman's revenge and since this rape and enslavement there has been hostility between the sexes. All fantasies of amazons, and all ideas of sadistic and castrating women are projections of man's hatred of women onto the women. This hatred is motivated by a mixture of retaliation fear and remainders of a still older and original envy—man's envy of the free and omnipotent mother.

With a surprising turn, Zilboorg interprets the male's recognition of paternity. If man could only be a mother, his superiority would be supreme. It is out of this identification with the mother that fatherhood was achieved.

'I am inclined to think that it is not penis-envy on the part of woman, but woman-envy on the part of man, that is psychogenetically older and therefore more fundamental.' It is the perennial struggle between the free woman-mother and the man who envies her and wishes to deprive her of her primordial right, that is found in religion, philosophy, and sociology, and the expression of which is reflected in the course of psychoanalytic thought.

Zilboorg's work constitutes a very important contribution and a logical continuation of the psychoanalytic theories concerning the relation of the sexes.

MARTIN GROTJAHN

Divided Loyalty in War. A Study of Coöperation with the Enemy. Bingham Dai. Psychiatry, VII, 1944, pp. 327–340.

Dai describes the analysis of a Chinese quisling of the North China Government, whom the author analyzed while working in China. The patient's collaboration with the Japanese represented a repetition of his early patterns which were reactivated by the patient's unconscious identification of the enemy with his father. His hostility towards his father was severely repressed through the traditional anti-aggressive child rearing of the Chinese, and overcompensated through an ingratiating homosexual submission. Although the patient wished to fight the Japanese, he felt compelled to submit to them in a homosexual way. To this convincing psychoanalytic interpretation, Dai adds some speculations about the basic concepts of analysis, which assume incorrectly that this interpretation were not along 'classical freudian lines'. 'The conflict, therefore, was not one of instincts or impulses functioning as such in a social vacuum, so to speak, but that of socially acquired rôles with their characteristic emotions and psychic mechanisms. Nor can the patient's symptoms be thought of as a repetition of his early instinctual conflicts, but rather they are to be seen as attempts to adjusting to a concrete present situation by means of outmoded patterns of reaction, patterns that are characteristic of an earlier rôle,

and one that he found difficult to reconcile with his conception of a patriot.' The reader is supposed to believe that Freud saw his patients in a social vacuum, and denied connections between neurotic patterns and actual life situations.

MARTIN GROTJAHN

Dynamic Patterns in Group Psychotherapy. Nathan W. Ackerman. Psychiatry, VII, 1944, pp. 341–348.

In individual psychotherapy the patterns of the child-parent relationship are relived and their pathogenic elements removed. The transference in group treatment corresponds to the fact that the child's character is influenced not only by the parents, but by the total family group as a social unit. Where group therapy is looked upon as therapy through a group, the group functions as a substitute family and provides a wide field for the testing of various forms of social reality.

Ackerman's formulations as to the details of the dynamics effective in group therapy seem a little premature and not quite as impressive as his reports about what is actually going on in this form of treatment.

MARTIN GROTJAHN

An Unconscious Determinant in 'Native Son'. Frederic Wertham. J. of Clinical Psychopathology, VI, 1944, pp. 111–116.

In this article Wertham attempts to fill what he feels as a gap in the application of psychoanalytic knowledge to works of art. In trying to arrive at valid conclusions through access to the living author, he takes Richard Wright and his novel Native Son, attempting to determine the derivation of certain elements in the novel. He of course meets the difficulty of obligation to discretion about personal matters so that the results of the investigation can be communicated only fragmentarily. Wertham does not describe the exact technique he used, but in a kind of analytic investigation memories were revived which showed that the key scene in Native Son, the unintentional killing of Mary Dalton by Bigger Thomas in the presence of her blind mother, is based on childhood experiences, the memory of which was not available to the writer before analytic measures were used. The name 'Dalton' of the victim could be traced back to 'Daltonism', a term used for color blindness. This interesting little article proves the unconscious determination of theme and elaboration in works of art.

RICHARD STERBA

The Psychosis that Psychiatry Refuses to Face. Hervey Cleckley. J. of Clinical Psychopathology, VI, 1944, pp. 117–129.

This paper gives a conventional description of behavior that is traditionally described with the static term 'psychopathic'. The main point made by the author is that these people should be treated by courts and mental institutions as if they were psychotic, though their disturbances do not, by present classification, fall in the category of psychosis. It is easy to agree with this

suggestion; however, there are serious doubts that anything is gained by substituting the term 'semantic psychosis' or 'semantic dementia' for psychopathic personality. Psychoanalysts know that the difficulties of these patients certainly are not rooted in the superfificial 'semantic' level but stem from far deeper layers of the personality.

FREDERICK J. HACKER

Psychoanalysis and Brief Psychotherapy. Emil A. Gutheil. J. of Clinical Psychopathology, VI, 1944, pp. 207–230.

A brief review is presented of some of the contributions made by various authors to the problem of expediting psychoanalysis. Gutheil suggests a somewhat cryptic 'reform of the technique of interpretation', especially a 'simplification of dream interpretation'. The analyst is supposed to merely abstract the psychodynamic factors of a dream without the 'selective' associations of the patient to the parts of the manifest content. The analyst, Gutheil thinks, will by the method of Stekel secure a penetrating psychodynamic insight into the instinctive cravings, defenses, gratifications, anxieties, etc. An illustrative case is presented wherein the author's own associations to the dream clarified his other available material. It would appear to be a truism that his twenty years of experience permits him to judge when 'experience and intuition tell him that the opportunity has arrived' to make an active interpretation in the analysis. It is not, however, entirely clear how he, himself, avoids the criticism which he levels at those who, 'in their own free associations' use the older concepts of dream symbolism.

H. M. SEROTA

Psychosomatic Regression in Therapeutic Epilepsy. Thomas D. Power. Psychosomatic Med., VII, 1945, pp. 279–290.

The author presents evidence that the convulsive process involves a recapitulation of old behavior patterns and modes of thought. In the somatic field the series of starts resemble the Moro reflex of infancy; the tonic and clonic spasms resemble the movements in the developing fœtus and the decerebrate rigidity resembles a similar state in premature infants. In the post-convulsive state, sucking movements and babyish crying have been noted. Repetition and perseveration are almost invariable features of this state and of infantile behavior. It appears that the psychic and somatic past strives to repeat itself and succeeds in doing so when the higher cerebral functions are blocked. In a sense, the regressive behavior and thought processes are an attempt to cope with the convulsion in terms of past experiences.

RALPH R. GREENSON

The Purpose and Fate of a Skin Disorder. Lester W. Sontag. Psychosomatic Med., VII, 1945, pp. 306–310.

Sontag reports on the treatment of a patient with an extremely severe acne rosacea. The skin condition appeared over a period of many years whenever

the patient found herself unable to solve an involved sexual conflict. When she finally found a solution she became and remained free from eruptions. The patient was seen during three such attacks of acne all of which appeared in similar conflict situations. The final psychological solutions was again followed by a cure which has now lasted several years.

MARTIN GROTJAHN

Sleep Paralysis and Combat Fatigue. Carel Van der Heide and Jack Weinberg. Psychosomatic Med., VII, 1945, pp. 330–334.

Three cases of sleep paralysis—defined as a state in which consciousness is awake while motor functions are asleep—in returned Air Force personnel suffering from combat fatigue are reported. The condition occurred singly, not in association with cataplexy, narcolepsy or somnambulism. Analysis led to the impression that sleep paralysis is, in all probability, related to a state of confusion as to emotion and intention, with resulting indecision. With undue modesty the authors call their analysis and therapy 'superficial'. Actually, their description and analysis is a valuable contribution to the understanding of this psychogenic sleep disturbance.

MARTIN GROTJAHN

Correlation Between Emotions and Carbohydrate Metabolism in Two Cases of Diabetes Mellitus. Albrecht Meyer, Ludolf N. Bollmeier and Franz Alexander. Psychosomatic Med., VII, 1945, pp. 335–341.

This is a report on the psychoanalysis of two patients with diabetes mellitus—a man and a woman—both of whom developed their illness under the strain of an emotional conflict of striking similarity. Both patients showed unusually strong needs to receive and to be taken care of. The first patient's essential demands were stimulated by a physical trauma at the end of his weaning period; the second patient's by a traumatic weaning process. Both retained an infantile dependent and demanding attitude, and felt frustrated because their demands for attention and love were out of proportion to the reality situation of an adult and were consequently never adequately satisfied. To this frustration they reacted with hostility. Diabetes developed in both when their infantile wishes were frustrated and the sugar output decreased when they temporarily renounced their demanding attitudes. It seems probable that these frustrated food-demanding drives may turn to an autoplastic satisfaction in a metabolic process which mobilizes glucose out of the glycogen stores of the body. The observation of increased sugar output during the night (independent of the carbohydrate intake) under certain emotional conditions is consistent with these assumptions. This interpretation is in conformity with recent experimental findings, namely, that in certain cases of diabetes mellitus the rise of the sugar level is dependent not on failure of sugar utilization but on sugar mobilization.

Both patients were under analysis for two years and during this period they underwent careful clinical observation including four to six sugar tests daily.

One patient was found free of sugar for five years subsequent to the end of his analysis. The authors' research may very well mark a turning point in the psychosomatic understanding of diabetes. MARTIN GROTJAHN

Levels and Applications of Group Therapy. Round Table. Amer. J. of Orthopsychiatry, XIV, 1944, pp. 478–608.

The first paper in this symposium, Some Elements in Activity Group Therapy, by S. R. Slavson, describes a special type of treatment which he has developed at the Jewish Board of Guardians in New York. Carefully matched groups of seven or eight children are permitted free acting-out in crafts or games, the session ending with a meal. The rôle of the group worker is permissive and nonauthoritarian. Five elements are emphasized as important in the therapeutic process. The author points out that individuals always feel threatened by group contacts because they involve comparison with others and revive other early intra-familial conflicts. In 'activity group therapy', this anxiety is minimized by the worker's positive attitude and respect for the individuality of each child, by the emphasis on constructive achievement and the development of skills, and by the repetitious nature of the sessions. It is felt that the group also affords the child substitute gratifications for earlier frustrations. The group leader not only exercises little authority but also gives minimal satisfaction to passive wishes. Through various techniques, he gradually withdraws support from dependent children, thus encouraging them to form child-to-child relationships. Activity group therapy aims at 'eliminating dependence and helping the child find security within himself'. The atmosphere of freedom encourages the discharge of suppressed impulses with resultant 'expansion of the quantum of inner life', and a presumed strengthening of the ego. Identifications and close relationships (either child to child, or child to adult) do not play a major rôle in this type of treatment, as they do in psychotherapy or in 'interview group therapy', which is used for adolescents. Activity group therapy is said to aim at developing the capacity for forming relationships rather than at strong relationships *per se*. (This statement seems like a contradiction in terms.) It has been noted that the behavior of the group shows rhythmic swings from hyperactivity to a state of equlibrium. Mr. Slavson believes that these swings mark the points where personal integration and emotional growth occur. The 'instigators' in the group enable the more inhibited members to obtain catharsis during the periods of hyperactivity while the 'neutralizers' supply the group with social controls.

In the second paper, Dr. Lawson Lowrey briefly describes a different sort of group treatment which is used with mothers at the Brooklyn Child Guidance Center. Five or six women meet with a therapist once a week for a fifty-minute session. A therapeutic relationship develops initially between the leader and each client but it recedes in importance as the meetings progress. The therapist's attitude is extremely permissive. The technique used is based on John Levy's relationship therapy and emphasizes the individual's current attitudes and his attempts to modify them. 'This is treatment in a group rather than by a

group.' Membership in a group seems to alleviate guilt by helping each member to discover that his problems are not unique. Dr. Lowrey's presentation is unfortunately so cursory that the reader does not learn what actually occurs in this form of therapy.

In Group Treatment for Adolescent Girls, Betty Gabriel of the Jewish Board of Guardians describes her experience with a group of six girls who met once a week for two years. The worker functioned as a noncritical participant observer. The members appear to have suffered mostly from infantile acting out character disorders. All had previously received individual psychotherapy, with limited success. The group was formed because the girls needed friends. The agenda consisted of general discussions about family relationships, marriage, habits, etc. After the participants felt comfortable with one another, free examination of their own attitudes and difficulties gradually occurred. At first, the girls blamed the environment for their troubles; gradually, as a result of comments by the others, each began to assume responsibility for her problems, acquired sympathy for her hated siblings and parents and developed self-control. They all dressed better as the meetings progressed and most of them derived permanent benefit, as was shown by their more mature behavior. The inhibited members of the group, however, were not helped. The therapeutic process seemed to occur by way of abreaction, relief of guilt and of feelings of inferiority, more objective evaluation of self through observing similar behavior in others, and gradual mobilization of the wish to change.

The last paper in the symposium, Therapy within the Group as a Biological Entity, by Dr. Hans Syz, describes 'phyloanalysis', a system of pseudoscientific yoga invented by Dr. Trigant Burrow for the study of 'cotention', a mental state in which the subject's attention is focused on his kinesthetic sensations. Practice in cotention is said to result in the amelioration of every sort of neurotic symptom through 'the removal of impeding social images, and the concurrent activation of the biological assets that coördinate the function of the organism within the group and within the larger community'.

A. H. VANDER VEER

The Closeup of Psychosexual Gratification. W. Eliasberg. J. Nerv. and Ment. Disease, XCIX, 1944, pp. 179–195.

In this confused and confusing paper, Eliasberg tries to answer the question, 'What is an erotic situation?' Through many quotations and inadequate, unconnected statements he finally arrives at a 'formula of sexual gratification' which contributes nothing to the problem.

RICHARD STERBA

The Psychological Structure of the Obsessive Neurosis. J. S. Kasanin. J. Nerv. and Ment. Disease, XCIX, 1944, pp. 672–692.

The obsessive or compulsive neurosis, according to Kasanin, represents a link between neurosis and psychosis. The competence of the ego is limited by pre-

occupation with fantastic fears and magic and grandiose operations of defense. The vacillations between attitudes partially adjusted to reality and demonic wishes and fears deprived of their emotional cathexis calls forth typical symptoms of indecision and elaborate ceremonies by which the compulsive neurotic defends himself against the danger of harming or destroying others and being harmed or destroyed by them.

Kasanin illustrates these concepts by a detailed case history. In the first year of psychoanalysis only a certain amount of alleviation of symptoms was reached without insight into the dynamics of the condition. After this year the patient's entrance into the army accelerated the pace of analysis. The external pressure revealed an abundance of secret autistic preoccupations that encumbered the patient's reality adjustment with fantastic expectations. They originated in his early childhood when the emotional barrenness of an unhappy family life between an erratic, undependable father and a severe, rigid mother left the helpless child in unbearable loneliness. In the destructive atmosphere of this early environment the child developed an extraordinarily ambivalent relationship with death wishes against those he depended upon and a fantastic anxiety of retaliation, which made him withdraw from all intimacy into autoerotic fantasies. In particular his concepts of sexuality became imbued with castration fears and imaginations of other deadly dangers. The revelation of these fantastic childhood fears led to a correction of their character-distorting influence and opened the channels for development towards adulthood.

Kasanin confirms Freud's concept of the obsessional neurosis as a 'fixation on an anal-sadistic level of sexual organization with severe castration anxiety'. The author succeeds in illuminating the close relationship between the obsessional symptomatology and the autistic dream world of the schizophrenic.

EDITH WEIGERT

The 'Placing-into-Mouth' and Coprophagic Habits. Silvano Arieti. J. Nerv. and Ment. Disease, XCIX, 1944, pp. 959–964.

The hypothesis is advanced that the habit, commonly observed in schizophrenics, of placing things into the mouth, is 'not due to any visual agnosia, but is an expression of a certain level of development at which complex apperceptions elaborating visual stimuli are not yet possible'. The same holds true for coprophagic impulses. The psychoanalyst certainly will agree with this general statement.

OTTO FENICHEL

Somnambulism in the Armed Forces. Samuel A. Sandler. Mental Hygiene, XXIX, 1945, pp. 236–247.

Twenty-two cases of somnambulism showed a great number of concomitant neurotic symptoms of other kinds, infantile character structure, poor marital adjustment and considerable unconscious homosexuality. Most of the cases came from large families with strong sibling rivalries, and showed a mild, gentle disposition during the waking state contrasting with marked hostility

and aggressiveness during somnambulism. Psychotherapy was expedited by the use of sodium amytal. As the somnambulism improved, it was often replaced by other symptoms.

LINCOLN RAHMAN

The Hospital Treatment of Emotionally Disturbed Children. Lewis R. Wolberg. Mental Hygiene XXIX, 1945, pp. 395–403.

Psychiatric hospitals for children are still in the experimental stage. However, 'there are many children who have been reared in environments so destructive that transfer to an institution that provides them with a minimum of mental health requirements opens the floodgates of self-development. . . . Unfortunately, by the time the average child comes to the hospital for therapy, his difficulties have been structuralized so deeply that he continues to react to the hospital environment as if it were a replica of his home.'

The psychotherapeutic methods and tools employed in children's institutions are discussed. The therapeutic value of the relationship between the child and the psychiatrist, the child and the hospital personnel, and especially between the individual child and the children as a group is pointed out. The author is of the opinion that it is of primary importance to let the patient express his impulses freely, 'within the limits of reason and safety', in order eventually to rebuild his attitude towards authority. A firm but kindly discipline must aid the child to establish 'necessary normal repressions'. Therapy and hospital environment should provide the child with preparation to reënter the outside world with a greater measure of self-sufficiency, independence and an increased aptitude to coöperate with other people.

MARGARET S. MAHLER

Enlisted Men with Overseas Service Discharged from the Army Because of Psychoneurosis: A Follow-up Study. Norman Q. Brill, Mildred C. Tate, William C. Menninger. Mental Hygiene XXIX, 1945, pp. 677–692.

A questionnaire investigation of enlisted men discharged from the service because of psychoneurosis for a period of at least six months was reported in a previous paper. This time, a comparison is made between the data and subjective views of five hundred thirty-six individuals with overseas service and approximately five thousand who had served only within the continental limits of the United States.

From this study, through tabulation and skilful interpretation of the replies, valuable conclusions are drawn. Among these are: the discharged overseas psychoneurotic soldier is more apt to be single, poorly educated and older; he suffers from anxiety reaction rather than conversion hysteria; he manifests a greater need for help (hospitalization, assistance in job finding), and is more reluctant to return to his former job; he has a better understanding of the psychological origin of his symptoms but considers the impairment of his health 'service-incurred' to a greater extent than his fellow psychoneurotic who has not been overseas.

The last finding might well be explained by the elimination from overseas service of the soldier with a psychoneurotic history, though the authors do not mention this factor. Neither group, however, justifies the expectation of

spontaneous improvement upon return to civilian life. Of the overseas men only 11.4 per cent reported improvement since their discharge.

CAREL VAN DER HEIDE

Toward a Dynamic Psychology of Cognition. Edna Heidbreder. Psychological Rev., LII, 1945, pp. 1–22.

The process of thinking and the formation of concepts has always entertained the attention of intellectual persons. Nevertheless few hypotheses about these processes have endured or been susceptible to experimental verification. Heidbreder has presented a general theory of cognition which she admits is based on speculation as well as experimental evidence and one which she hopes will bring back into focus the cognitive aspects of behavior. The use of the word 'dynamic' is meant to include all significant determinants of behavior on a psychological level, of which cognitive processes form a part. Such processes are divided into two classes, the perception of concrete objects and the attainment of concepts. The perception of concrete objects is taken to be the 'typical and dominant response' and the attainment of concepts is taken to be a modification of object perception. It is believed that all cognitive reactions can be made meaningful in terms of these two processes or responses. The significance of the review is not easily apparent and perhaps bears out the author's contention that intellectual determinants of behavior have for too long been neglected as fertile ground for psychological research.

JAMES E. BIRREN

Physiological Differentiation of Emotional States. M. B. Arnold. Psychological Rev., LII, 1945, pp. 35–47.

Cannon's theory of emotion as a mobilization of the organism for greater muscular effort is subjected to a revealing analysis by Arnold. Several discrepancies between the conditions required by Cannon's theory and experimental findings are noted. Specifically, the evidence for Cannon's views was based on the observations that fear and anger increased adrenalin secretion and that adrenalin restores fatigued nerve muscle preparations. It has now been shown that the adrenals secrete two substances, adrenalin and cortin. The latter rather than adrenalin is presumably the substance with which Cannon was dealing. Evidence shows that adrenalin has a depressant action, both centrally and peripherally. Its apparent energizing effect is due to parasympathetic stimulation which may be masked by large doses with resultant fatigue rather than stimulation.

Other considerations of adrenalin activity relevant to the mobilization view of emotion are discussed, i.e., vasoconstrictor effect, glycogenolytic action, effect on heart rate and polycythemia, and heat regulation. Arnold has presented a convincing, well developed argument for viewing fear as enervating instead of energizing. She further distinguishes between fear, anger, and excitement (elation) on a physiological level: fear is predominantly sympathetic excitation; anger, strong parasympathetic activity; and excitement, moderate parasympathetic activity.

JAMES E. BIRREN

The Psychological Self, the Ego, and Personality. Peter A. Bertocci. Psychological Rev., LII, 1945, pp. 91–99.

This article is an extension of a previous paper by Allport who reviewed the many contemporary concepts of the ego. Bertocci's principle contribution is the development of a concept of the 'psychological self' which will help '(1) to understand the close functional relationship between ego, personality and self, and (2) to explain the possibility of continuity, succession, and interaction within the personality-ego systems'. The three concepts of self, ego, and personality are generally defined, interrelated and also contrasted. The unique adjustments that a 'self' makes with regard to its particular needs constitute the personality, whereas the ego is the self's evaluation of its activities. The concept of the psychological self is not, as the author admits, a hypothesis which one might attempt to verify directly by experimentation. It is offered as an aid to understanding and interpreting human experience.

J. E. BIRREN

Psychogenic Incontinence of Fæces (Encopresis) in Children. Edward Lehman. Amer. J. of Diseases of Children, LXVIII, 1944, pp. 190–199.

Three cases of psychogenic encopresis and one case of obstipatio paradoxa, ameliorated or partly cured by psychotherapy, are reported. The literature pertaining to the subject is thoroughly discussed.

MARGARET S. MAHLER

Psychopathology of Ingratitude. Edmund Bergler. Diseases of the Nervous System, VI, 1945, pp. 226–229.

Because of the natural egoism, the feeling of omnipotence and the unlimited demands of the infant, ingratitude can be looked upon as an original human state of mind and 'the fact that grateful people do exist proves that pedagogy is not as hopeless a task as some pessimists assume'. Ungrateful people are not only those who have remained infants in this respect but also people who, throughout life, are occupied with taking revenge for not having gotten everything. Whatever they get 'is compared inwardly to the alleged lack of love, attention and kindness about which the beneficiary inwardly grieves'. Several special types of ingratitude are discussed in detail.

OTTO FENICHEL

Racial and Religious Prejudice in Everyday Living. The Journal of Social Issues, I, 1945, Nos. 1 and 2, 56 pp. each.

This is a new publication put out by the Society for the Psychological Study of Social Issues. The first two numbers deal with racial and religious prejudices. The special editor is Dr. Gene Weltfish, Columbia University anthropologist. Thirty contributors have participated in the gathering and writing of the material.

Causes of group antagonism and prejudice in the individual personality are the subjects of discussion. One's own failure or misfortunes in life as a cause

of prejudice are to be dismissed: 'The scapegoat explanation is simple and complete while the real causes are complicated and vague in some respects'. Seven different 'Episodes from Life', picturing the social and psychological effects of prejudice are described and discussed to portray the problems in terms of concrete situations. 'The ego satisfactions derived from interpersonal aggression or martyrdom are often a far more important factor than economic, political, or ideological differences which might appear to be the basis of the cleavage.'

Among other suggestions for the elimination of prejudice is a widespread popularization of its psychological mechanisms. The coöperative work of this society seems to be a valuable attempt to apply psychological concepts to vital social issues.

HENRY LOWENFIELD

British and German Psychiatry in the Second Half of the Eighteenth and Early Nineteenth Century. Max Neuburger. Bulletin of the History of Med., XVIII, 1945, p. 121.

The confusion, mysticism and sadism in psychiatry in the period discussed by Neuburger were strikingly similar in both England and Germany. Hosts of authors are mentioned with quotations from some of the more interesting ones. From the chaos emerged the system of treatment by 'non-restraint', sponsored chiefly by Conolly in England and by Langermann and Griesinger in Germany.

NORMAN REIDER

Neurosis and Sexuality. Eliot Slater. Journal of Neurology, Neurosurgery and Psychiatry, VIII, 1945, pp. 12–15.

Neuroses, according to Freud, are based on an unconscious rejection of instinctual drives, especially of sexual urges. Accordingly, gross disturbances in the realm of sexuality should be expected in neurotics. Even though patients may at first not be aware of these disturbances and may state in the first interviews that their sex life is adequate and satisfactory, nevertheless later analytic experience makes them fully cognizant of them—and yet it is amazing how little statistical research has been done to correlate neuroses and sexual disturbances. The only attempt of this kind known to the reviewer was published by Wilhelm Reich in the first part of his book *Die Funktion des Orgasmus*.[1]

For this reason, psychoanalysts are grateful for a statistical study like that of Slater, who investigated the clinical records of twelve hundred thirty-three British neurotic soldiers and came to the conclusion 'that the factors which tend to bring about neurotic breakdown and those which predispose to sexual inadequacy are related'. However, though the analyst would also agree with Slater's hypothesis 'that the common factors are to be sought in an imbalance of the endocrine system', he would add that the socially determined way in which the instinctual demands of children are treated plays a still more important rôle.

OTTO FENICHEL

[1] Wilhelm Reich: *Die Funktion des Orgasmus*. Vienna: Internationaler Psychoanalytischer Verlag, 1927.

An Account of Lowenfeld Technique in a Child Guidance Clinic, With a Survey of Therapeutic Play Technique in Great Britain and U. S. A. Phyllis M. Traill. Journal of Mental Science, XCI, No. 382, 1945, pp. 43–78.

The technique here described follows the theory propounded by Margaret Lowenfeld at the London Institute for Child Psychology in 1931. Lowenfeld differs from the classical psychoanalytic view that play is the representation in symbolic form of wishes, impulses and fantasies derived from infantile sexuality. Instead she maintains that play is 'the expression of the child's relation to the whole of life' and refers it to 'all activities in children that are spontaneous and self-generated; that are ends in themselves; and that are unrelated to "lessons" or to the normal physiological needs of a child's own day'.[1]

The present paper states in elaboration that the 'flow of impulse, idea, ambition, and feeling . . . is a complex phenomenon made up of many elements, such as pure bodily experience, experiment with material, endeavor to understand the environment and experiment with it, the acquirement of skill and of emotional expression', all expressed in play. These elements in their interrelationship are referred to as the 'primary system'. 'This form of thought is personal, multidimensional, irrational and largely unrelated to objective external fact.' Speech is stated to be the instrument of the individual's objective relationship to the outside world and is referred to as the 'secondary system'. The primary system remains active throughout life and constitutes its 'unconscious' matrix. The secondary system channels the primary system into contact with objective reality.

The rôle of the therapist, accordingly, becomes one of fitting the words to the actions of the child. An examination of the protocols of the five illustrative cases reveals that this consists of rather explicit verbalizations of trends revealed by the play. In general the 'interpretations' tend to be quite direct but remain at the level of what the child has explicitly acted out.

At the same time the relationship to the therapist is one of utter 'neutrality'. This is carried to such an extent that during the course of the treatment of any one child there may be a succession or alternation of a number of different workers. Or the child may be a member of a play group exclusively or at intervals in the course of individual treatment sessions.

There is rather heavy dependence on intellectualization. Thus, a nine-and-a-half-year-old hysterical girl is told: 'there are two kinds of pleasure—the passive, sensuous pleasures, and the active, striving, creative kind, and that the latter gave great satisfaction—we needed both types to get the most out of life'.

Yet it must be said that the therapeutic results are good. The Birmingham Child Guidance Clinic at which the work was done seems to have been very well organized as a therapeutic *milieu*. 'Neutral' or not, the personnel seems to have transcended its theoretical intentions.

MAXWELL GITELSON

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[1] Play in Childhood. London: Victor Gollancz, Ltd., 1935.

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, 15:4, 560-562, DOI: 10.1080/21674086.1946.11925659

To link to this article: https://doi.org/10.1080/21674086.1946.11925659

Published online: 11 Dec 2017.

NOTES

THE VIENNESE PSYCHOANALYTIC SOCIETY, founded by Sigmund Freud in 1908 and dissolved in 1938, was reëstablished in a meeting held on the tenth of April, 1946. The meeting was attended by representatives of psychoanalytic groups from the United States, England, France, and Russia, and telegrams of congratulation from all over the world were read by the Chairman, August Aichhorn.

At a meeting of the TOPEKA PSYCHOANALYTIC SOCIETY held October 26, 1946, Dr. Sylvia Allen, Vice-President, presiding at the business session and the scientific meeting, Mr. Erik Homburger Erikson of San Francisco read a paper on Psychoanalytic Treatment of Children and Adolescents.

The Council of the AMERICAN PSYCHIATRIC ASSOCIATION has launched a campaign to correct conditions in State Hospitals. The membership of the Association is urged in a circular letter to inform the 'people of the country' who are the only ones 'who hold the means of solution of this problem'.

'For more than a century the membership of the American Psychiatric Association has been deeply interested in winning for the mentally ill of the United States and Canada the best possible care and treatment.'

'Scandalous conditions have come to light . . .' recently and have been brought to the attention of the public by courageous and determined individuals through the medium of books and the lay press.

It is hoped that such exposures will continue until all hospitals for the mentally sick everywhere are continuously operated in accordance with the most civilized, scientific and humane standards. That the energy for this effort has to be multiplied in this country by forty-eight—once for each legislature that controls the welfare of the mentally sick patients in the hospitals of its State—is an unfortunate and anachronistic reality.

To the members of the American Psychiatric Association, its president, Samuel W. Hamilton, M.D., has written in part: 'The Association at its meeting in Chicago congratulated the large body of faithful, earnest workers who continue to struggle—against enormous odds—to provide even a decent measure of kindly care to the mentally ill in the poorer public institutions, to say nothing of scientific treatment. The Association urged these devoted men and women to keep up their courage and assert the need of necessary resources and facilities that only the State Legislatures can provide. The Council of the Association went on record as ready to support any medical superintendent who acts to inform the public of his patients' needs, and every member of the Association is urged to arouse the public conscience in his own area.'

The PEOPLE'S COMMITTEE FOR MENTAL HYGIENE is a voluntary citizens movement founded October, 1945 by Ellen C. Philtine, author of They Walk in Darkness,

for the purpose of securing better care and treatment for State mental patients. From a handful of interested people it has grown to thousands, including forty-two important welfare and civic organizations, numerous psychiatrists and allied professional and non-professional workers, ministers, lawyers, artists, writers, etc. All are voluntary workers who pay their own expenses and work for the improvement of conditions in State mental hospitals in order to bring more humane care and scientific hope to all mentally sick people. The Committee fought for this cause all through the 1946 session of the New York State Legislature. In 1947 it will fight again for an enlightened and adequate program for State hospitals in New York State. For literature and membership application address: People's Committee for Mental Hygiene, 154 Nassau Street, Room 1007, New York 7, N. Y.

The NATIONAL INSTITUTE OF SOCIAL RELATIONS, INC. is a new undertaking in social psychiatry, instituted by one of the Army's former mental hygiene consultation service psychiatrists, Dr. Julius Schreiber. It is a non-profit organization which was organized early this year. Dr. Schreiber has a group with him who, during the war, planned and prepared the Army orientation program discussion material. This program was designed to assist the American soldier to understand the issues of the war. Now they are attempting this same general program on a civilian basis. Group workers, educators, and civic minded citizens are making profitable use of Talk It Over discussion guides published by the National Institute of Social Relations, 1029—17th Street, N.W., Washington 6, D. C. The guides deal with vital issues of the day. Although they are prepared primarily for the use of discussion leaders, trained in their own communities by the Institute's Field Service Staff, they are available at cost to other local and national organizations and interested individuals. The guides are based upon exhaustive research and study of each of the areas under consideration. They are factual and documented; they present, as fairly as possible, all sides of a controversial issue; they are easily understood; and, because of their clear and specific instructions and notes, are easily used by group discussion leaders. Subject matter of the Talk It Over series varies widely—ranging from problems of Youth, Veterans, Women, Labor, Housing, Health, Unemployment, Discrimination, Education, Propaganda, Community Planning to Atomic Energy and other national and international issues. The Institute's Board of Consultants includes Brig. General William Menninger, Mr. Philip Murray, Bishop G. Bromley Oxnam, Mr. Quentin Reynolds, Dr. Channing H. Tobias, Dr. George S. Stevenson, Mr. Walter F. Wanger.

The NATIONAL COMMITTEE FOR MENTAL HYGIENE held its thirty-seventh annual meeting in New York City on October 30 and 31, 1946, and its scientific sessions were devoted to the following subjects: Strengthening the Hand of Medicine; Experimental Attacks on Fascism; Mental Hospitals and Advancing Psychiatry; The Mental Health of State and Nation.

The Twenty-Fifth Anniversary meeting of the CENTRAL NEUROPSYCHIATRIC ASSOCIATION was held in Denver on October 4th and 5th, 1946. The scientific program of the Association, limited by custom to presentations by the members of the host city, was presented by the Denver and Colorado members and their colleagues. The next meeting will be held in Galveston in October, 1947. Officers elected for the coming year are: Dr. Clarence E. Van Epps, Iowa City—President; Dr. Jack R. Ewalt, Galveston—Vice-President; Dr. William C. Menninger, Topeka—Secretary-Treasurer; Dr. A. E. Bennett, Omaha—Counselor.

The Ninth Annual Louis Gross Memorial Lecture was delivered under the auspices of the MONTREAL CLINICAL SOCIETY at the Jewish General Hospital, Montreal, on Wednesday, October 23d, 1946 by Dr. Roy R. Grinker of the Michael Reese Hospital, Chicago, on the subject, Psychiatric Objectives of our Time.

The annual meeting of the AMERICAN GROUP THERAPY ASSOCIATION will be held in New York City in January, 1947. The program will include a session on group therapy in private practice; a session on the parallel treatment of a group of preschool children with a group of their mothers; also there will be a session given to research in group therapy and a report on a training program for workers in group therapy.

The Secretary of Welfare of the Commonwealth of Pennsylvania announces the establishment of twelve positions for research in psychiatry and related fields at the WESTERN STATE PSYCHIATRIC INSTITUTE AND CLINIC, PITTSBURG. At the Institute numerous clinical and teaching activities, the latter in collaboration with the University of Pittsburgh, have already been initiated. The Institute is the teaching and research hospital of the Pennsylvania mental hospital system which includes twenty-one hospitals and institutions with an average of 40,000 patients where, it is expected, will be trained psychiatrists, social workers, psychologists, nurses, occupational therapists and others for hospital and private fields. These new positions provide for the appointment of properly qualified senior and junior research workers in psychiatry, internal medicine, biochemistry, neuropathology, neurophysiology and clinical psychology. In some instances research at the Institute will be coördinated with teaching at the University; in such cases the applicant for appointment, and his qualifications, must meet also with the approval of the Dean of the School of Medicine. Interested persons may obtain further information by writing to the Director of the Institute, Grosvenor B. Pearson, M.D., O'Hara and DeSoto Streets, Pittsburgh 13, Pa.

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: (1946) Index, The Psychoanalytic Quarterly, 15:4, 563-578, DOI: 10.1080/21674086.1946.11925660

To link to this article: https://doi.org/10.1080/21674086.1946.11925660

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Books Received

To cite this article: (1946) Books Received, The Psychoanalytic Quarterly, 15:4, XX-XX, DOI: 10.1080/21674086.1946.11925661

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