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Ernst Simmel 1882-1947

Robert Fliess

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IN MEMORIAM

Ernst Simmel

1882–1947

On November 11, 1947, Dr. Ernst Simmel died in Los Angeles at the age of sixty-five. His loss to us is incalculable, and the loss is sustained by many. The science of psychoanalysis has lost an ingenious worker, and the development, expansion and diffusion of psychoanalysis has lost the exponent of a policy without scientific compromise. Students have lost an inspiring teacher, and all who ever had contact with Ernst Simmel will mourn the man who so impressively influenced educators, medical men and lawyers in consultations, in meetings and in court.

Modest and unassuming but firm, patient and humorous, a theoretician possessed of convictions not always attainable by the slow process of thought, Simmel usually prevailed when a dialectician would have failed.

Outstanding though his written contributions were, it was Simmel, the clinician, the conversationalist, whom one most vividly recalls. He blended humor and its melancholic complement in such a fashion as to produce a mixture of serenity, liveliness and reticence, peculiar to him. The colloquial brevity of his expression, the incisiveness of his softly spoken sentences, his pensive approach to a problem, and the denouement—frequently after a reflective pause followed by a sudden resolution of the matter under discussion—gave the listener a rare experience. His understanding of his patients was so complete, the objective of his therapeutic endeavor so vivid, the recounting of interviews with his patients so dramatic, that when he made clinical reports the sickroom became a stage and he a performer whose inimitable impersonations were at once tragic and comic.

More than two decades have passed since, in the Berlin Psychoanalytic Society, Dr. Simmel sat for the first time in the

presidential chair left vacant by Abraham's death. The Society had been founded only six years previously by Abraham, Eitingon and Simmel. Before that, World War I had found him as an army physician, employing cathartic hypnosis for the symptomatic treatment of traumatic neuroses with the help of the famous 'dummy' of his invention upon which the traumatized soldier was allowed to discharge his aggression in the climactic phase of the treatment. Current methods of treating 'battle fatigue' can, in part, be looked upon as scientific descendants of those previously developed by him.

In the second year of his presidency of the Berlin Society, in 1927, Simmel established a psychoanalytic clinic and sanitarium, 'Schloss Tegel', the first institution devoted to applying psychoanalytic principles to the treatment of crippling neuroses, perversions, addictions, borderline disturbances, and psychosomatic disorders. It was here that Simmel realized, however briefly, his concept—formed under the influence of Georg Groddeck—of the analytic physician. But, strong as Groddeck's impact was upon Simmel, Freud's influence remained stronger. Instead of opposing training and intuition, Simmel subordinated his personal ways of working to the theory of the transference, and thought of nursing and medication, admission and discharge from the institution, physiotherapy, and occupational therapy as therapeutic 'acting out' to be applied to the management of the analysis of the bedridden, or socially incapacitated patient.

It was in this sanitarium that Simmel made and published his penetrating observations on addicts, first studied alcoholism, and had the opportunity of deepening his knowledge of the subject closest to his heart, the analytic investigation and treatment of organic disease.

In 1934 Simmel emigrated to this country, accepting the invitation of a group in Los Angeles to start a training center. With the help of others, he developed the Los Angeles Study Group into a Psychoanalytic Society. During these years he wrote his important study, Self-Preservation and the Death Instinct, which combined acuity of observation with sincerity

of scientific endeavor, and which attempted to emend and, as he saw it, to complete Freud's theory of the instincts. There is invaluable material in this study, and even those not in complete agreement with his revision of theory will find in reading it that they have clarified their own positions. He edited Anti-Semitism: A Social Disease, a book containing his noteworthy paper, Anti-Semitism and Mass Psychopathology, which many readers may find the outstanding contribution in the collection. His analysis of the cliché, 'Some of my best friends are Jews', and his etymological interpretation in the term 'Jew-baiting' of the unconscious instinctual aim of the anti-Semite, are typical of the effective employment by Simmel of freudian thought. These are but two of many examples of his published productivity during his residence in America.

His bibliography, although extensive, contains but a fraction of his erudition. A few years ago, on the occasion of one of his last visits to the East Coast—a climate and scenery more closely resembling his native land than the West—shown a desk in the glass-enclosed corner of a country house on a high bluff, Simmel interrupted the conversation, looked across the desk through the windows to the waters of the bay, breaking along the coastline fringed with wild cherries, and smiled pensively: 'This,' he said, 'is where I would like to write my posthumous works . . .'. These works may still be written by students of Ernst Simmel, now living or yet to come.

ROBERT FLIESS

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Alcoholism and Addiction

Ernst Simmel

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ALCOHOLISM AND ADDICTION

BY ERNST SIMMEL, M.D.

We may expect as an aftermath of World War II the same psychological sequelæ which followed World War I. After the first World War there was noted an enormous increase in character disorders, particularly in addictions. Postwar mental disorders document the failure of the 'war ego' to reconvert into a 'peace ego' because of a shattering of ego and superego relationships. In war superego functions are disrupted, ego regressions enforced, and barriers of repression thus removed. If no neurotic or psychotic mechanisms are evoked as defenses, criminality results as the direct continuation of the war ego in civilian life.

During the war, working and fighting for victory was the common goal for civilians and soldiers alike, serving as a collective ego ideal, counteracting the blunting of the individual superego. Postwar disillusionment with the ideal of victory robs it of its significance and effectiveness as a stabilizing factor within individual psychological systems, thus depriving the individual egos of the supporting superstructure of a community spirit. The unified nation again disintegrates into dissenting groups with disparate aims of self-interest. The cessation of armed conflict is a narcissistic trauma for all; deprived of the protective participation in an inspiriting brotherhood of man, no longer able to identify himself with the nation as a whole, the disenchanted citizen finds that the bitter fruit of victory is a return to individual, social, and economic insecurity.

The less the individual ego is capable of reconstructing itself by a withdrawal of aggressive energies (increasingly precipitated by frustration), the greater the need that the nation as an entity undergo a process of structuralization. Failing this, the individ-

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Alcoholism and Addiction was written in 1947 for this QUARTERLY at the instance of the Editor. Dr. Simmel did not quite complete the manuscript before his last illness. His notes outlining the last few pages of his conclusions have been included.

ual forms or joins groups which provide him with a new protective communion of spirit with a common goal for the discharge of aggressive energies.

Addictions offer a perfect subterfuge for the postwar ego which finds itself hopelessly entangled in a conflict between frustrating realities and impulses—particularly aggression—from the id, the controlling power of the superego having been rendered incapable of intermediating. In addiction the ego finds a way of denying painful reality by re-establishing the infantile pleasure principle, as a release from superego prohibitions, through artificial pharmacotoxic elation. Pharmacotoxic elimination of superego interferences spares the ego the mental expenditure of energy involved in neurotic or psychotic defenses, and in genuine addiction under certain conditions serves also as a preventive against criminality.

Since in the United States the sale of narcotic drugs is prohibited and drug addiction is a crime punishable by law, and because alcoholic drinks are generally socially approved, alcoholism becomes the common American addiction.

The psychoanalytic psychiatrist differentiates between genuine addiction to alcohol, which makes the individual asocial, and other forms which, by substituting other ego-impairing defenses, keep up or renew periodically the individual's contact with society. Such differentiation is of theoretical interest as well as of practical therapeutic importance. It helps to determine whether psychotherapy other than treatment of individual alcoholics is at our disposal, to treat alcoholism as a mass social disease.

The experience that some alcoholics can be successfully treated through any of a variety of approaches, while others cannot be influenced by any, is very often considered justifiable evidence for classifying alcoholics as mild or severe cases. However, amenability to treatment is by no means a criterion of the severity of this mental disorder unless the degree and quality of the disintegration of the ego of the alcoholic are taken into consideration; moreover, it must be determined whether the

disintegration of the ego is the cause or the result of the alcoholic's chronic consumption of liquor.

That the need to drink alcoholic beverages serves one person as a means of escape from reality, whereas it serves another as a means of mastering reality, proves that the biochemical effect of alcohol is not the decisive factor for its use but the psychological effect which the ego derives from it. Our first effort, therefore, must be directed towards a psychodynamic classification of alcoholic mental disorders before we study alcoholic addiction in greater detail.

From observing alcoholics for many years, some in a hospital, some as ambulatory patients, I have differentiated four classes of chronic drinkers: the social drinker, the reactive drinker, the neurotic drinker and the alcoholic addict.

In each of these four interrelated categories the consumption of alcohol serves as a means of balancing an impaired mental equilibrium. In the first two groups, alcohol defends the ego against the mental impact of external circumstances; in the last two groups, it defends the ego against the threat of inner unconscious conflicts which only secondarily impair the ego's capacity for coping with reality.

By 'social drinker' I refer to those who are chronically *dependent* upon the consumption of more or less moderate amounts of liquor, without which they cannot enjoy association with people. They cannot converse with others without having a drink, or cannot do business without drinking or offering drinks to those with whom they must deal.

From the standpoint of group psychology it is, briefly, my opinion that this kind of social drinking is a by-product of our civilization. People are capable of living together and submitting to common standards of ethics only by renouncing a certain amount of individual instinctual gratification. Such renunciation, without sufficient opportunity to achieve instinctual sublimation, is what Freud called 'living beyond one's mental means' from which is derived the feeling of 'discontent' in our civilization. The social drinker seeks in the effect of alcohol a means of disposing of this feeling of discontent, which

he feels particularly strongly when in the company of his fellow men.

Drinking helps make congenial and convivial people who would otherwise dislike each other because of their mutually imposed instinctual renunciations. The perception of common discontent—sometimes felt only as common boredom—is substituted by and shared as a common feeling of alcoholic elation. If people are absolutely dependent upon social drinking in order to be convivial, we must conclude that there is something wrong not only with civilization, the collective character, but also with the individual characters. The superego obviously has not appreciably augmented its power, as a result of instinctual renunciations of the ego, which it should do in the normal process of sublimation. The sensation of increased self-esteem is not cherished if it has to be derived from diminishing returns of instinctual satisfactions. It is a minus of spirituality which must be compensated for by a surplus of spirits.

The reactive drinker is not necessarily a neurotic individual either, and it is not the demands of community life that promotes his need for release from stress; it is his personal life which imposes too much deprivation from suppression of instinctual desires: for instance, someone who suffers from an unhappy marriage, or from an unhappy work situation which he is unable to change. For him drinking is an escape from unbearable reality. It helps him temporarily to forget; to suppress what he cannot repress, and to find a substitutive happiness in the artificially elated condition of drunkenness. Since such individuals are forced to live psychologically beyond their means, their habitual drinking excesses—by rendering powerless any still possible functioning of the superego—provide them with the possibility of balancing their mental budgets through temporarily unrestricted discharges of pent up aggressive or erotic instinctual energies. The underprivileged of society belong in this group. They feel, however correctly, unjustly treated by society. Under the influence of alcohol they find an artificial happiness which they cannot achieve in

reality. Under the veil of drunkenness they find a way to discharge their aggressions against the frustrating world, and eventually they become criminals. Such people do not commit crimes because they are drunk; they get drunk in order to commit crimes. Freud must have made reference to the reactive drinker when he stated that 'alcohol does away with sublimations'.

Of particular interest to the psychoanalyst is neurotic alcoholism. Freud's statement that alcohol disposes of inhibitions applies specifically to the alcoholic neurotic.

The neurotic alcoholic drinks not because he is entangled in an insoluble conflict with his environment, but because he is in need of an escape from himself, although he quite often believes that it is his unhappy life situation which drives him to drink. His is the neurotic character which, under the spell of the repetition compulsion, recreates endlessly the same conflicts with people. For him drinking is not an escape from realistic unhappiness but from self-inflicted neurotic misery. It depends on the extent of his neurotic disturbance, on the morbidity of his ego, whether alcohol helps him to find an artificial adaptation to external reality, or whether his ego is doomed to disintegrate regressively and to lose its superego guidance in a clash between infantile instinctual cravings and the demands of reality. For these neurotic characters the business of living, loving, working, always has an unconscious connotation which brings an irrational trend into their pursuit of happiness. Ultimately, the unfulfilled infantile instinctual urges derive from the œdipus conflict which they are still striving to gratify in their adult lives.

Instances are numerous of a man whose drinking begins either when his wife becomes pregnant or gives birth to his child. In becoming a mother, the wife approaches the unconscious image of his mother and tends to become sexually taboo. He feels anxious because unconsciously he is haunted by incestuous guilt and fear of castration. He feels estranged from his own child because to his unconscious this child is his brother or sister. Alcohol dissolves the anxiety and triumphs over the

interference of his superego, liberating him from his sexual inhibition, possibly restoring his potency. For others drinking proves to be the opportunity for fleeing from the threatening female by bringing them into the community of fellow drinkers of men only.

For these neurotic alcoholics the self-induced sensation of elation through drinking has an unconscious autoerotic connotation. It revives and replaces orgastic sensations previously experienced in infantile or adolescent masturbation. The wish to bring about the alcoholic elation has become a compulsion because it is dominated by and has been elaborated upon by the processes of the unconscious. It is a substitute for the repressed infantile wish to enjoy autoerotic pleasure which once served as a defense against insoluble conflicts by providing release for pent-up instinctual energies withdrawn from the objects.

It is striking how often we find that the struggle of the alcoholic with himself or with his environment in combating or indulging the forbidden enjoyment of drinking is an actual repetition of his original fight for or against masturbation. A patient who always made resolutions that today's drink would be the last, kept a book in which he made notations on the frequency of his taking drinks in a vain attempt to reduce the frequency to three times a week. He had kept a similar book when he once tried to cut down on his masturbatory activities, and still had the book in his possession. After some interval of abstinence, two of my patients felt impelled to start drinking again 'in order to prove' to themselves that they could stop—the identical way in which during puberty they had rationalized their relapses into masturbation. The way an alcoholic lies to his wife or his father, the way he hides the bottles (particularly in the bathroom), is very often an exact repetition of the way he used to hide his masturbatory enjoyments against interference by a parent.

Neurotic alcoholism appears to be a mixture of a compulsion neurosis and a perversion. With the latter the alcoholic has in common the achievement of being able to gratify infantile sex-

ual demands by excluding the danger of castration; but because the symptomatic drinking is a degenitalized masturbatory substitute, it is much closer to a compulsion neurosis in which the symptom at the same time is a substitute for and against infantile masturbation. The alcoholic's one great advantage over the compulsive neurotic is that his ego has also found a way to eliminate its fear of the superego. In the struggle of the alcoholic ego between the id and reality, the superego does not take sides in favor of reality and against the id; on the contrary, it helps subordinate the demands of reality to those of the id. The reason for this is that from the standpoint of reality, drinking alcohol is a socially acceptable enjoyment, and from the standpoint of the id the superego is inclined to favor this infantile satisfaction because of the characteristics of the parents, the prototypes of the alcoholics' superegos. The parents of most alcoholics I have studied, father or mother or both, were usually emotionally immature, unstable persons. They permitted themselves indulgences and enjoyments which they prohibited their children. For such parents it is a kind of ego defense against their own superego protests to suppress in their children manifestations of instinctual reactions which they themselves are unable to repress. They themselves may indulge in temper tantrums but strictly prohibit an outbreak of temper in their children. The mother may betray all the signs of indulgence in anal erotism by being sloppy and careless in conducting the household, but be tyrannical in enforcing the cleanliness of her children. The most severely traumatic effect on the children in creating a two-faced superego which sometimes prohibits, at other times encourages the same instinctual gratifications, comes from parents who combine attitudes of manifest incestuous seductiveness towards their children with an overpuritanical education in sex matters. Such parents, directly or indirectly, attempt to derive sexual gratification from their children, but if the child responds by showing signs of sexual excitement or reacts to stimulation by masturbation, the parents will punish it severely.

The stepmother of one of my patients, considerably younger

than her husband, would regularly allow her four-year-old boy to caress her leg from the foot up to near the vagina, but she would beat him and threaten him with castration when he wet his bed, or when she found him playing with his penis. The father of a woman patient, himself an alcoholic, would attack sexually all the female members of the family, including this daughter, but he beat her whenever he found her playing with her genitals. When, in adolescence, she made her first attempts to get away from him by having dates with boys, he forbade such 'indecency', and punished her drastically for overstepping his prohibitions.

It is no wonder that such parental prototypes help to create multiple superegos which can be opposed to instinctual demands of the id but can also be bribed by it.[1] This, as I once called it, is a form of resexualization of the superego relationship, a return to the once more or less latently incestuous parent-child relationship within the ego.[2] The ego is thus enabled to bribe the superego into indulgence, in this way giving it a share of its id gratifications. There is much truth in the facetious statement that has become current to the effect that 'The alcoholic's superego is soluble in alcohol'.

Alcoholic euphoria, as degenitalized sexuality, constitutes a great triumph in the psychic economy of a neurotic. It is the successful transformation of the painful experiences accompanying infantile masturbation (fear of castration, anxious feelings of guilt) into pleasurable feelings which re-establish the orgastic sensation once denied in infancy.

An actor felt compelled to overcome his stage fright by becoming inebriated. Drinking resolved his inhibition. This proved to mean to his unconscious that acting on the stage (dependence on the applause of the audience) was the equiva-

[1] Dr. Robert P. Knight referred explicitly in a paper to the multiple superego of the alcoholic. In his cases he found that what was mainly responsible for people becoming alcoholics was a constant disagreement between the parents concerning the instinctual education of the child.

[2] Simmel, Ernst: *Zum Problem von Zwang und Sucht.* Bericht über den V. allgemeinen ärztlichen Kongress für Psychotherapie in Baden-Baden, 1930, pp. 26–29.

lent of exposing and playing with his penis in front of his mother in the hope of seducing her and winning her love. Acting for him was 'acting out' infantile incestuous demands, which were taboo to his superego. The actor was unconsciously afraid of re-experiencing the rejection and the threat of castration he had once experienced when he attempted such 'acting' in front of his mother. In enjoying his alcoholic elation, his 'reality function' had not only become erotized, but it had also become degenitalized and thus freed from the impending doom of guilt and castration by his mother, displaced to the fear of being rejected by his audience.

The alcoholic ego's achievement of degenitalizing activities which have latent infantile sexual connotations is of fateful consequence. The character of this mechanism of ego defense determines whether the potential alcoholic can remain a neurotic or whether he must become an alcoholic addict; for the defense of degenitalization is a mechanism of infantile regression to pregenital stages of ego development. If the ego regresses beyond the phallic, the anal and the oral stages to its earliest pre-ego stage (which I have termed the gastrointestinal stage [3]) the alcoholic becomes an addict. Then the structure and dynamics of alcohol addiction are no different from any other pharmacotoxic drug addiction. It is understandable that the degree of premorbidity of the ego, due to pregenital fixation, is decisive for such an outcome; however, it is certainly true that the psychotoxic effects of alcohol or other drugs can push an ego on the path of these regressions if reality is too difficult to comprehend or too painful to bear. It is, as always in psychopathology, 'a complemental series of external and internal factors' (Freud) which determine the final outcome of an instinctual conflict.

The artificially created sensation of elation re-establishes the infantile pleasure principle within the *conscious* mind of the alcoholic. This weakens the ego's object strivings and contributes to throwing it back to the level of secondary narcissism,

[3] Simmel, Ernst: *Self-Preservation and the Death Instinct.* This QUARTERLY, XIII, 1944, pp. 160–183.

to the developmental stage of the infant that has discovered its ego and is in love with it—which explains much of the attractive charm of the autoerotic alcoholic personality. From here the way is open to a regressive splitting of this narcissistic self-love into partial erotic demands on the object. As we know, the process of instinctual regression is associated with the process of instinctual defusion, with an increasing subordination of the erotic instinct to the destructive instinct. This defusion is (as I have described it[4]) nothing but the process of regression itself: a gradual retreat from the genital stage to the gastro-intestinal stage at which the mouth appears to be the only mediator between the instinctual demands of the pre-ego and the world of objects. The urge for sexual contact with the object is transformed into the desire for inner contact with it by devouring it. Love is replaced by hate; the process of identification reverts to a tendency towards actually devouring. The drink itself becomes interchangeable with the hated object, well expressed in a drinkers' joke: 'I hate that stuff [liquor]. I seize every opportunity to get rid of it—by swallowing it.' In accordance with the impulse to devour, this joke appears to tell the true meaning of alcoholic addiction. In addition, the physical incorporation (devouring) replaces psychological repression because it makes the object disappear from outer perception.[5] The alcoholic addict in drinking strives ultimately for oblivion: the repression of reality.

I wish to state in connection with the example of the actor that in treating addicts it became clear to me what determines the neurotic-acting-out quality of a professional activity. Such professional activity is not the sublimation of a surplus of instinctual energy but is neurotic acting out if this activity is discovered to represent repressed infantile masturbatory fantasies.

In the stage of developing its object relationships, masturbation may be regarded as the infant's first social activity. For through this activity the child withdraws from the disappoint-

[4] *Ibid.*
[5] *Ibid.*

ing object which rejects its love and stimulates aggressive destructive reactions. In its own body, the child finds a substitutive gratification for the narcissistic trauma, replacing the object by its own genital as an object, and finding in itself a way of discharging object-directed erotic and aggressive tendencies. It has thus renounced direct instinctual gratification from the real objects, but keeps an ideational relationship with them in masturbatory fantasies. Through masturbating the child begins to resolve its instinctual conflicts within itself without, I might say, bothering the objects; but it is forced again secondarily into conflict with them if the parents interfere with this masturbation which is the child's struggle for a pleasurable release of instinctual tension. I have found in psychoanalyses that the child is often caught and interrupted in the midst of an orgastic elation; its reaction against the intruder is rage and hatred. The introversion of this hate and its destructive energies sets the individual on the path of self-destruction as a direct consequence of the latent masturbatory conflict.

One of my alcoholic patients, who became completely inhibited and unable to fulfil his professional duties as a physician, remembered that when he was four years old he once put in his mouth a cigar stolen from his father, and played with his penis, thinking of his mother. When he was just 'feeling fine', his father trapped him, shook him and shouted literal threats that he would castrate him. It is understandable that such individuals experience a triumphant feeling of happiness when, by drinking, they can recapture this infantile 'feeling fine'. This pleasure reconciles them with an object world which was violently hostile to their reasonable instinctual needs in childhood; but, as happens too often, it eventually causes narcissistic withdrawal from objects because infantile masturbatory activities and fantasies, prohibited at the genital level, have acquired pregenital regressive aims. These masturbatory fantasies then strive to satisfy instinctual demands from the anal and oral or gastrointestinal (aggressively devouring) stages of libidinal development. The chronic alcholic progressively loses his grip on objects and reality of which he had maintained a semblance

as a neurotic character by transferences, and by pleasantly dulling his sensorium through the toxically induced equivalent of infantile masturbatory elation. Eventually he develops the single craving to act out these infantile masturbatory fantasies directly. This acting out of unconscious infantile masturbatory fantasies is incorporated into his daily life and acquiries the character of rebellion and protest against a frustrating world, repeating his protest against the unbearable conflict between the œdipus and the prohibition against infantile masturbatory relief. In bouts of drinking he becomes again a baby with yearnings (anal, oral, gastrointestinal) for *one* object only: his mother.

There is a typical way in which such a chronic alcoholic starts his sprees, and how he ends them. He stays away from his home, and starts with the resolve to have only a few drinks; however, progressively he loses self-control and seems to come to have the one aim of becoming *insensibly* drunk. In this condition, he is dragged home by friends or strangers, having squandered all of his or other people's money, and losing all his valuables in the process of getting drunk. He is mentally and physically in a most deplorable condition, dirty and unkempt. Completely helpless, he must be taken care of by his wife or other members of his family, or in a sanitarium. He stops drinking for a while, voluble with good resolutions that this will never recur; and then he starts it all over again. During the abstemious interludes, he is quite aware that he is torturing his relatives and destroying himself, but he cannot prevent it.

In his sober intervals the alcoholic cannot hold any job because unconsciously he does not want to earn his living, wanting to remain dependent upon his mother or her equivalent. I have known several alcoholics who made all arrangements in advance for ending their drinking in a typical fashion. One of my patients cultivated a relationship with a nurse who always had to live with him in a hotel room to sober him up, to 'wean' him from liquor by feeding him milk, and clean him up. Another of my patients always secured a prostitute for the same purpose as a mother substitute.

In my sanitarium [6] one of my patients was brought in on a stretcher in a state of stupor, cyanotic, unkempt and filthy to an extreme. He made a quick physical recovery, under the loving care of friendly nurses who bathed him and fed him warm milk. When he was completely sober, he readily agreed not to get any liquor, but he begged for a sleeping potion in the evening. I first sought to deny this, arguing that he would only be substituting one toxin for another. Finally I agreed to put it at his disposal, for him to use at his own discretion in the event he could not do without it. I filled a liquor glass, such as he was accustomed to using, with sleeping medicine and put it on his night table. The feeling that he could have it, that this mother substitute was within his reach, was enough to make him feel secure and he slept soundly without taking it that night, and, similarly, on three successive nights. The fourth day, sober, clean and well-fed, he left the sanitarium, declaring himself cured of alcoholism (an opinion which I did not share).

The alcoholics called dipsomaniacs have drunken sprees only sporadically, sometimes periodically, with relatively long intervals of pseudonormality. Their orgies begin like the others, but they often remain away from their homes for weeks or months and, remaining drunk, engage in all kinds of activities until they wind up in the routine desolate state of helplessness in accordance with the established custom of alcoholics. The dipsomaniac, however, has a complete amnesia for what happened during the preceding weeks or months of inebriation. One of my patients, after creating all kinds of embarrassing inconveniences for his older brother, used to travel through the country by train, always arriving sooner or later in the city in which his married sister lived. It was this sister, who during his childhood had substituted for his mother, to whom fell the task of sobering him up and caring for him. The addict thus acts out his pregenital masturbatory fantasies by returning in effect to his mother as her baby to be nursed and taken care of.

The pharmacotoxic effect of liquor psychologically re-establishes the dipsomaniac's infantile masturbatory elation of 'feel-

[6] Schloss Tegel, Berlin, Germany.

ing fine' by releasing barriers of repression which allows unconscious infantile impulses access to motor innervations. Dipsomania is a sort of alcoholic somnambulism, the effect of the alcohol protecting 'sleep'. The superego takes no part in these regressive symbolic actions of the alcoholic because the ego has temporarily regressed to the stage when the prohibitive authority (superego) was still an external object. Being a sick, helpless, dirty infant seems the only possible means of acquiring the kind of love he seeks, or of aggressively dominating the world around him.

In treating addicts, particularly under observation in a sanitarium, I have found that almost everything connected with acting out their addiction has a symbolic meaning: for instance, drinking his liquor from a *glass* or from a *bottle* has a specific meaning to the addict. One of my patients, upon missing his whiskey, would lie in bed crying bitterly, repeating over and over: 'I want my bottle, my bottle'. Another reported a compulsion to drain his bottles of whiskey to the last drop, recalling the while that he was imitating what he had once long ago seen his baby brother do when being fed from a bottle by their mother.

Addiction to beer rather than to whiskey often has the special meaning of being especially the drink of the urethral erotic—giving him, as it does, the opportunity to fill himself with great quantities of liquid with the special pleasure of discharging them exhibitionistically, often in competition with other men. The substance he drinks sometimes has an equivalence to urine itself. Two of my alcoholic women patients, in states of abstinence under treatment, developed the compulsion to drink their own urine which brought about a condition of inebriation as from drinking alcohol.

For others, alcohol is unconsciously equivalent to their own feces. These people drink liquors of disgusting flavor, or abhor the taste of what they drink; they perform a real ceremonial in preparation for forcing themselves to swallow each drink. The pregenital masturbatory fantasies which these addicts strive to

satisfy are what I once called 'reciprocal autoerotism'.[7] In these fantasies the various erogenous zones of the body serve to satisfy each other for want of satisfaction from the mother. These are wishful fantasies of urinating or defecating into one's own mouth.

For one of my patients, liquor signified castor oil which his mother used to force down his throat. The money which alcoholics squander has a symbolic meaning; also the habit of many drinkers of getting away without paying for their drinks I have found, on several occasions, to be unconsciously determined. To them, the bartender is a mother image from whom they want to get something (milk) without giving anything in return (feces). For one of my patients, drunken staggering invariably reminded him of the time when he had difficulties in learning to walk and held on to his mother's hands.

The few examples suffice to illustrate the most important trauma at the root of every addiction: the mothers, for whom these addicts long, provided them with no security whatever. They are mothers who indulged themselves without consideration for the child's needs. Such mothers may overindulge the child during the process of nursing and become tyrannically strict about toilet training and cleanliness. Mothers of three of my patients were hypocritically kind, never punishing the children themselves, but briefing the fathers to do the beating. One mother, to impress her husband, the father, enacted suicide by putting poison in a glass of liquor, inviting the boy to die with her. Such a child wants to love his mother, but she will not let him; therefore he must hate her. All my alcoholic patients had deeply seated hatreds for their mothers. This hatred is deeply repressed as an impulse to incorporate, to destroy by devouring the mother.

All addictions, and especially alcoholic addiction, are protections against depression (melancholia). The melancholic has introjected a disappointing object of love (basically his mother) and tends to attack and destroy the introjected object within

[7] Simmel, Ernst: *Die psycho-physische Bedeutsamkeit des Intestinalorgans für die Urverdrängung.* Int. Ztschr. f. Psa., X, 1924, p. 219.

himself. The alcoholic addict has only pseudo object-libidinous relationships with people, his drink increasingly representing his only external object. In his struggle for and against abstinence, he fights an endless, indissoluble object fixation and conflict: to draw life (love) from his mother by devouring her; to murder the one person on whose very existence his only hope for security depends.

The feelings of guilt and despair which torment the alcoholic after he has become sober may be partially the pharmacotoxic effect of alcohol, but it is essentially and much more significantly a clinical depression (melancholia) which follows the alcoholic mania. I always considered it progress in the psychoanalytic treatment of alcoholism when the consumption of alcohol not only ceased providing this manic effect, but produced instead misery, depression and guilt. That the alcoholic can react with a hangover during drinking instead of afterwards proves that the psychoanalytic process has succeeded in unmasking alcoholic elation as a defense against depression, although there are some alcoholics who have this depressive reaction while drinking without treatment.

The unconscious conflicts of the wish to destroy the mother on whom he depends, and the need to hate when he wants to love, are of the deepest significance to the alcoholic addict's fight for and against his drinking. By his alcoholism he tortures those who care for him, tending to destroy them, and with them, to destroy himself. His addiction is chronic murder and chronic suicide.

Identification with his mother within the ego is substituted by drinking as the physical introjective prototype of incorporation.[8] By drinking her, as it were, he becomes one with her and thus approximates psychologically a return to her womb. Death has a great attraction to his unconscious; it signifies Nirvana, pre-existence in the mother's womb, complete oneness with her, where love and hate do not exist. The alcoholic drinks himself into oblivion, the mental state of prenatal Nirvana; emergence

[8] Simmel, Ernst: *Self-Preservation and the Death Instinct. Loc. cit.*

from this stupor is a rebirth, with mother in attendance ready with milk to nurse him back to life.[9]

In psychoanalyzing patients in my sanitarium, I observed a form of supplementary and two forms of substitutive addictions. In the first, the alcoholic addict is impelled to seduce others into sharing the addiction with him. This was only seemingly determined by the wish for companionate enjoyment of elation. Unconsciously, the intent was to destroy the other person as he destroys himself: to drink him, to drink from him, devour him, and drown together in the same element. An alcoholic who consulted me had lived with a woman several years his senior—an obvious mother image—both doing nothing but mutually drinking themselves into destitution. His mother had to support them. The young man rejected my suggestion that he separate from the woman with signs of great anxiety. I asked him why. He answered: 'She helps me. She gives me drinks and drinks with me.' By drinking with someone the alcoholic addict achieves just what the social drinker seeks to avoid by the same means: mutual, orally aggressive, introjective, destruction.

A secondary, substitute addiction, I observed, was an identification addiction. The addict, under psychoanalytic treatment and abstinence, develops the compulsion to imitate others, particularly of course his psychoanalyst, often very clearly with the intent of doing damage to the person whom he imitates. One of my patients was seriously offended because I did not entrust him with the management of my sanitarium when I went on vacation. This same patient went on a drinking spree, after a period of abstinence, and landed in a café close to the sanitarium. There he gave a big speech to an audience of fellow drinkers, telling them his name was Dr. Ernst Simmel, chief of the sanitarium for the cure of alcoholism. This patient revealed to me the deeper meaning of this hostile identification

[9] Of all the addictions, the alcoholic addict shows most clearly that the addicted ego tends to realize the same unconscious regressive psychological strivings as the psychotic ego, an indication that an addiction may be a last defense against a psychosis. A study of alcoholic psychoses might provide more insight into this speculation.

in a state of abstinence. He found a cat which he kept in his room. The cat slept with him, and regularly he fed it milk from a bottle, even at night, thus demonstrating how a good mother should love and feed him. But that he was also an evil mother (his own mother he hated), he proved by the way he would talk to the cat: 'Now be a good baby; first you get milk, later on you will get coffee—and then liquor'. The 'good baby' gets poisoned by a hostile mother. In identifying himself with the hostile mother, he consumes his hatred towards her but, being the baby, he also destroys himself. This patient, in periods of abstinence, used to consume enormous amounts of coffee.

In one instance, I was able to observe directly and in *statu nascendi* the transformation of the process of identification into its physical prototype, incorporation, and vice versa. A young alcoholic, in the course of psychoanalysis, had reached in his regressive transference a stage of passive feminine submission to me. He tried to ward off castration anxieties resulting from unconscious passive feminine fantasies by a very aggressive rebellious attitude. His continuous attempts to provoke my counterhostility and counteraggression failed. Eventually his anxiety reached the proportions of panic and he shouted that he wanted to run away from the sanitarium and drink. I told him that drinking would do him no good but that no one would prevent him from doing what he thought he must do. He rushed out of doors through the park to the gate leading from the grounds of the sanitarium where he broke down writhing in pain with abdominal cramps. He was carried back on a stretcher and was brought to the treatment couch. Here he raged against '. . . the pain you brought upon me'. He pounded his painful abdomen with his fists, exclaiming, 'This goddamned thing in here prevented me from getting my drink. This is you. Now I have you in my stomach.' And, after a while, pounding his head, 'Now I have you in my head too—twice'. Later when I saw him, he said to me solemnly, 'A strange thing has happened to me; for the first time in many years I can think and ponder about drinking, and I really think it is no good'.

It is clear to me that the patient had demonstrated his aggression from the fantasy of devouring an object to identifying himself with it. Instead of being identified with the mother who submits to the father, he regresses to infancy when he wanted actually to devour his mother, thus attempting to consume his hatred against both parents; then, after having transmitted the introjected parental object from the somatic to the psychic ego, he restructuralizes it by elevating the somatically introjected parental object into his superego. The 'aggressive energies withdrawn from the object, introjected and made over to the superego' (Freud), enabled his ego to put restrictions upon itself, to interpolate the processes of thought and judgment between impulse and action.

The third substitute observed to occur, during a state of abstinence under psychoanalysis in a hospital, substituting the addiction to alcohol or drugs, was an overt suicidal addiction or an overt addiction to homicide.[10] During this stage the addict's only compulsion is to kill: himself or others. Usually he does not rationalize this urge; he just wants to die or, at other times, he just wants to kill.

In observing the process of becoming a compulsory killer under the influence of abstinence, we find a striking difference between the alcoholic addict and the reactive alcoholic; for the reactive alcoholic becomes homicidal only when he is intoxicated because then his superego is paralyzed and the barriers of suppression and repression are released. The alcoholic addict, however, would kill when he has to refrain from drinking because he is failing then to satisfy his homicidal impulse symbolically through drinking. One of my patients, in a state of abstinence, once exclaimed: 'I must kill people—I hate them —or I must drink; then my hate is gone'.

[10] I have noticed a difference between the alcohol and morphine addict with regard to these obsessional impulses to kill or commit suicide. The morphinist appeared to be more driven by the impulse to commit suicide, whereas the alcoholic addict is more driven by the impulse to commit homicide. It seems to me that the consumption of alcohol keeps the addicted ego longer object-related in its destructive tendencies than the consumption of morphine, possibly because alcohol is a socially accepted mother surrogate, whereas morphine is socially taboo.

It is beyond the scope of this paper to discuss under what conditions committing murder can be a compulsory defense against suicidal depression, a re-extroversion of the object to be killed outside instead of inside the ego. What is germane to the discussion of alcoholic addiction is the apparent identity between the depression and the elation of the alcoholic, and the self-destructive significance of both.

This psychological constellation throws some light on the senseless and yet tragic fact that the alcoholic addict must drink in order to rid himself of his feelings of guilt caused by drinking. When after a period of contrite sobriety the alcoholic relapses into drinking, the world shrinks for him to one object: drink. This drink unconsciously symbolizes his mother at the time when he was afraid of her, and when she still was the external prototype of his superego. He relapses into drinking from a crushing feeling of guilt towards the mother (or substitute) who takes care of him. He devours in drink this re-externalized superego and thus disposes of his fear of punishment (infantile feelings of guilt). In thus condensing crime and punishment into the one act of drinking, the alcoholic addict achieves what he was denied as a child when he was prevented from introverting his aggression and converting it into the pleasurable 'autoplastic' act of masturbation.

That the crime and punishment are identical for the alcoholic addict, and that drinking is the crime of enjoying self-punishment was proven to me by a typical recurrent dream of the majority of my patients: dreams of drowning. In these dreams the alcoholic drowns himself, is drowned, or struggles to rescue someone who is in danger of drowning with him. Let me cite such a dream of an alcoholic being treated by psychoanalysis.

> 'I was on trial for murder, accused of having attempted to poison myself. I felt amused [cf. 'feeling fine'] and was not at all coöperative with my defense counsel. Finally, I was sentenced to death by drowning. I was taken to a large pool and ordered to jump into the water, which I did. My body went to the bottom of the water and I intentionally opened

> my mouth to fill my lungs with water. I wanted to hurry the process of drowning, but I had to cough and I expelled water which caused me to come back to the surface. This process repeated itself several times until I was finally ordered to get out of the water because it seemed impossible for me to drown myself.'

It is interesting to note that this dream directly represents the phenomenon of repetition compulsion. I think the fact that someone 'orders him to stop' the repeated suicide by drowning does not make it less so, because the drinker repeats his debauches again and again in order 'to be ordered' to stop, thus repeating the interferences in his masturbatory activity by his parent. Of course, the man in the dream who interrupts this chronic self-punishment is the psychoanalyst. The analyst's therapeutic task is to interrupt the vicious cycle by combining psychoanalytic therapy with temporary initial indulgences, satisfying the deepest instinctual needs of the addict, and then lead him into occupational therapy, based on metapsychological principles with special outlets for aggression, and so back to mature reality. Without some such interruption, the alcoholic will compulsively follow his regressive trend (also symbolized in dreams of drowning) and drown himself in liquor, returning to the mother's womb, to the stage of primary narcissism and complete oblivion.

CONCLUSIONS

Having completed the theoretical discussion of the psychopathology of alcoholism, we turn to the practical question of how to meet the danger which the chronic consumption of alcohol signifies for the individual, as well as for public mental health. As an aftermath of war, alcoholism has become a social disease and therefore has not only psychological but also sociological implications which must be taken into consideration, but whose correction is beyond the domain of the psychotherapist. However, a theoretical basis for improving therapy for the individual might help to understand and to further attempts at group treatments which already exist. I am of the opinion that the prog-

nosis for the individual alcoholic may become most favorable if we select our psychotherapy in accordance with the proper classification of the case.

The alcoholic addict needs hospital care during psychoanalytic treatment. It should be combined with occupational therapy based on metapsychological principles which, for example, gives the patient an opportunity to discharge his aggressive, destructive tendencies before he is able to sublimate them in constructive activity. What these patients need, in addition to psychoanalysis, is the concerted therapeutic effort of the entire hospital personnel, which aims at rebuilding and reconstructing the alcoholic's ego,[11] gradually restricting his hostile, introjective, devouring impulses in favor of an ultimate healthy identification. Psychotherapy in a hospital furnishes a sound basis for a process of maturation of the ego because it begins with the active aim of remedying the fundamental narcissistic wound of the addict's ego: compensation for the loss of the drink, and its symbolical value, by gratifying the patient's unconscious infantile need for the loving and understanding care of a nursing mother. In the process of becoming sober, the alcoholic is 'reborn'. From then on, by psychoanalysis combined with careful management, he must be helped to develop a mature ego to replace the infantile narcissistic pleasure principle with the reality principle.

The neurotic alcoholic can be treated psychoanalytically without hospitalization; however, it seems advisable here also to intersperse periods of psychoanalytic treatment under hospital supervision. This becomes necessary when a tendency to relapse into drinking is precipitated by transference difficulties, or by impulses to maintain repression of emergent unconscious material sensitized by the psychoanalytic process. Expe-

11 The sanitarium, Schloss Tegel, in Berlin, Germany, had no closed wards, no locked doors. Any time an alcoholic seemed unable to endure his abstinence, and showed signs of breaking away to some bar, the entire personnel was informed of this situation and whoever saw the patient about to leave the hospital grounds was instructed to talk to him, induce him to stay within the grounds, and call his doctor immediately. The aim was to instigate and keep alive an inner mental conflict in the patient before he relapsed.

rience has taught me that a phase of withdrawal symptoms under abstinence can yield very productive analytic results. For such temporary hospital treatments, the psychoanalyst should have access to the same facilities as other specialists have in treating their patients. There should be small hospital units in cities where alcoholic patients can be placed temporarily with adequate care and supervision. These units should have psychoanalytic treatment rooms.

The reactive alcoholic is not in need of a specific psychotherapy. He benefits from psychotherapeutic aid based on factual help and a metapsychological understanding of his unsolved inner and environmental conflicts. The reactive alcoholic needs supportive psychoanalytic therapy. It is mainly the preconscious which must be made conscious and integrated in his ego. He must become aware of and verbalize his conflicts and thus learn to interpolate thinking, instead of drinking, between impulse and action ('experimental way of acting'—Freud).

One last question of utmost practical importance remains to be discussed: does our theory, derived from psychoanalytic research, provide any possibility of application to the therapy of groups of patients to meet the universal danger which alcoholism signifies for the mental health of the country? The answer is affirmative because, strangely enough, it has already been applied intuitively and successfully in a mass psychological experiment—Alcoholics Anonymous.

In studying a pamphlet of Alcoholics Anonymous, I was struck by the fact that the therapeutic principles employed in its psychotherapeutic endeavor correspond basically to psychoanalytic findings. This is not surprising because Alcoholics Anonymous was created by alcoholics for alcoholics and therefore originated from an unconscious awareness of the latent id drives in alcoholism, and the tendency of the alcoholic ego to preserve itself against them. It cannot be a mere coincidence that the creator of Alcoholics Anonymous was a doctor who found a cure for himself by helping a fellow alcoholic to get cured.

The therapy of Alcoholics Anonymous is based on three fundamental principles:

1 The alcoholic is treated by an exalcoholic not only in order to be cured but also in order to cure others.

2 Through being cured and becoming a healer, the alcoholic becomes a member of a society of exalcoholics in which, in contrast to our so-called 'normal' society, alcohol is socially not accepted, but taboo.

3 The alcoholic must become capable of accepting two beliefs: one, which introduces the treatment; the other, which brings about the final curative achievement.

The first belief is for the alcoholic to accept the fact that he is powerless against alcohol. It is useless for him to struggle against it because he is forced to drink by an inner compulsion. The second belief is that there is a 'Power greater than himself' in the Universe; if he submits to this Power, his compulsion will be broken. The first belief is easily accepted by the alcoholic because he realizes it is the first basic step in every cure. For the first time in his life of neurotic misery, the alcoholic finds himself understood, and by this learns to understand himself. His therapist is not a professional man, but his helper just because he is an exalcoholic. Before this experience,

'The clergyman has said: "Your drinking is a sin".
The employer: "Quit this monkey business or get out".
The wife: "Your drinking is breaking my heart".
And everyone: "Why don't you exercise some will power—
and be a man?" '

He knows he cannot exert sufficient will power to counteract the overwhelming driving power which emanates from his unconscious. 'But', the alcoholic whispers in his heart, 'no one but me knows that I must drink to kill worry and suffering too great to stand'. To achieve belief in a Universal Power which, if accepted emotionally, is capable of expelling the alcoholic compulsion, is the essence of the treatment. This achievement is based on what is called a spiritual experience,

and he learns to see clearly 'that he must have a spiritual experience or be destroyed by alcohol'.

> 'This dilemma brings about a crisis in the patient's life. He finds himself in a situation which, he believes, cannot be untangled by human means. He has been placed in this position by another alcoholic who has recovered through a spiritual experience. This peculiar ability, which an alcoholic who has recovered exercises upon one who has not recovered, is the main secret of the unprecedented success which these men and women are having. . . . Under these conditions, the patient turns to religion with an entire willingness and readily accepts without reservation a simple religious proposal. He is then able to acquire much more than a set of religious beliefs; he undergoes the profound mental and emotional change common to religious "experience". Then, too, the patient's hope is renewed and his imagination is fired by the idea of membership in a group of exalcoholics where he will be enabled to save the lives and homes of those who have suffered as he has suffered.'

It is always stressed that the core of the therapy of Alcoholics Anonymous is religiosity but not religion. The exalcoholic brotherhood consists of 'Catholics, Protestants, Jews, near-agnostics, and near-atheists'. It is emphasized that 'the core of the technique by which Alcoholics Anonymous has worked . . . is not religious, but spiritual . . .'. It is 'the recognition of a power higher than man . . . the Creative Spirit over all. The name is immaterial . . . it will simplify matters to use the familiar terminology employed in the Christian religion, calling this Power "God" . . .' The alcoholic gets hold of this Power 'by a simple "act of faith" '. In order to give this faith the power to revolutionize the mental self of the alcoholic, he must have a 'spiritual experience' which 'reaches the inner man'. 'It is surrender to the Higher Power. . . . In non-religious terms, the experience is like the realization that sometimes comes to a person who has never appreciated good music or good books, and who all of a sudden "gets" the idea of the pleasure, the value to be found in them. Thenceforth he

proceeds with delight to enjoy that in which he formerly had found no charm, no meaning.' It is 'the recognition of human helplessness and complete reliance on the Supreme Power as the one way out'.

'These exalcoholics frequently find that unless they spend time in helping others to health, they cannot stay sober themselves. Strenuous, almost sacrificial work for other sufferers is often imperative in the early days of their recovery. This effort proceeds entirely on a good will basis. It is an avocation.'

'A missionary with what a difference! What missionary to the savage was ever a savage?'

The formal typescript ends at this point. Following are Dr. Simmel's notes written in longhand on the last page of the manuscript. (Ed.)

Alcoholics Anonymous is a defense and a substitute formation. It is a new community spirit in a different but artificial society. It is a society not only of nondrinkers, but also a society of healers.

The alcoholic's psychopathological formula of destroy and be destroyed is changed to save and be saved.

The spiritual experience serves to undo wrongs, resolve guilt. Reinforcement of the superego, externally (prohibition) and internally (religion, introjection). Verbalizing preconscious material (ego-building).

The cure aims at becoming a healer through identification. Substitution of identification for addiction during abstinence makes the formation of this new society possible. Devouring is replaced by identification with the group.

Possibilities for Alcoholics Anonymous from the collaboration of psychoanalysts.

How much can be achieved for the increasing number of addicts by psychoanalytic therapy alone?

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Comments on the Correlation of Theory and Technique

Sandor Lorand

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COMMENTS ON THE CORRELATION OF THEORY AND TECHNIQUE

BY SANDOR LORAND, M.D. (NEW YORK)

Freud's basic principles of therapeutic technique, which were evolved from clinical experimentation, have remained the fundamental guide in present day analytic therapy. But his theoretical formulations and those of his early co-workers concerning technique and therapy were gradually subjected to re-examination as time went on, by Freud himself, as well as others. Attempts at re-examination began on a large scale in 1924 with Ferenczi's *Entwicklungsziele der Psychoanalyse.* In 1936 at the Marianbad International Congress there was a symposium which dealt with the interrelationship between theory and therapy. The contributions of the symposium are well known, as are the participants; however, contrary to expectations, this wide-scale discussion brought little clarification to the problem. It did make plain, however, that there were many questions in the minds of the analysts, and differing views on the relationship between theory and technique. One important contribution of the symposium was to bring to the foreground of attention the necessity for discussing these problems. From that date, we more frequently find in analytic literature attempts at fresh orientation, and trials at finding and formulating new correlations between technique and theory. It became apparent in these publications that although there was agreement on many basic principles, there was sharp disagreement about various others.

We are all familiar with the comprehensive work pertaining to the problem done by the Institute on Psychoanalysis in London, edited by Edward Glover, entitled: An Investigation of the Technique of Psychoanalysis. The volume represents an attempt to systematize and correlate knowledge and opinion on the technique of psychoanalysis. Glover hoped as a result

Presidential address to The New York Psychoanalytic Society, October 1947.

'That problems requiring further investigation [would] be made to stand out more clearly'. The book was intended also as a stimulus for further investigation in order to settle both old and newly arising problems of technique.

The questionnaires from which the book was compiled brought into the open comparatively wide differences in the application of analytic principles which obtained mostly among British analysts, but in my opinion apply to analysis wherever it is practiced. In summarizing the information contained in the replies, Glover pointed out that the answers justified the view held by many analysts that it was 'very desirable to make fresh investigations of technique from time to time'. Scattered throughout the book are references to various theoretical differences which interfere with standardization of technique. The answers to several questions showed that many analysts are concerned about the relation of theory to practice. Glover grouped the replies according to marked differences of opinion, resulting in twenty-one headings, with an addition of nineteen individual opinions which did not fall into any of the twenty-one categories.

In general, the belief that there was need for reformulation of various subjects was expressed by many authors and several members of our Society made contributions towards the solution of the problem, among others Zilboorg's paper, The Fundamental Conflict with Psychoanalysis,[1] and Kubie's work entitled, A Critical Analysis of the Concept of a Repetition Compulsion.[2]

In 1943 Oberndorf published a report of his investigation, using the questionnaire method, of the results of psychoanalytic therapy. Replies to the questionnaire received from eighteen established psychoanalysts, each having more than twenty years' experience, revealed a disconcerting divergence of opinion on such topics as the type of case considered most favorable for analysis, criteria for termination, percentage of patients who discontinued analysis, etc. In 1946 in a paper entitled, Con-

[1] Int. J. Psa., XX, 1939, Nos. 3–4.
[2] *Ibid.*

stant Elements in Psychotherapy,[3] Dr. Oberndorf stated that '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, explanations and analytic interpretations, and . . . further investigation of these elements will lead to a broader . . . application of freudian principles in psychotherapy and psychoanalysis to the innumerable medical conditions affected by or consisting of the psychic attitude of the patient.'

In the short symposia held during our Society's meetings in 1946 the need for re-examination, clarification and reformulation was expressed by Hartmann, Eidelberg, Kris, and Waelder. Hartmann, Kris and Loewenstein, in a paper entitled Comments on the Formation of Psychic Structure,[4] drew attention to the fact that there was a lack of adequate communication among various groups of analysts. They brought out the fact that because of this situation students are not adequately informed about the development of various hypotheses and formulations. They further emphasized the need for verification in many areas of theory and construction.

Spitz discussed theoretical assumptions concerning melancholia in a study called Anaclitic Depression.[5] He examined the concept of early depression in the literature and offered some critical remarks on Melanie Klein's theories. Van Ophuijsen's paper, The Psychoanalytic Rule, presented in the spring of 1947, brought to the fore a discussion of various views on free association in therapy.

All the papers and discussions cited point to the fact that interpretation of fundamental rules, both of theory and technique, varies considerably. There is need for organizing and bringing into harmony various opinions regarding basic technical proceedings. A sharper, clearer, more detailed definition of them is needed. This can only be done if differences of

[3] This QUARTERLY, XV, 1946, pp. 435–449.

[4] *The Psychoanalytic Study of the Child,* II. New York: International Universities Press, 1946.

[5] *Ibid.*

opinion in therapeutic procedures, which are arrived at through one's clinical observation, are compared. The comparison of therapeutic progress in types of cases which present basically similar problems might conceivably be used ultimately to verify the various claims of needs for reformulating theory. It may lead finally to a more useful formulation and to a greater uniformity in the application of theoretical concepts.

Freud's explorations and theoretical formulations gave us the basic scientific explanation for the understanding of neurosis. This theoretical understanding in all its ramifications is essential to acquiring skill in therapy and in bringing about the dynamic alterations in the neurotic conflict. But theoretical considerations may be overemphasized and may lead to error in judging the dynamic structure of the patient's symptom. We all agree that the theoretical orientation of the analyst may influence his therapeutic work. It may lead to preconceived ideas which may enter into the manner of conducting analysis. The therapist may hastily interpret unconscious material and unconscious conflicts, but if they are not recognized by the patient as a part of his unconscious struggle, it will be no more effective than naming or describing something to the patient of which he cannot conceive. An analyst can discuss and interpret developmental phases, the meaning of drives and fixations, but may fail, if he gets lost in theoretical concepts, to link the developmental phases with present behavior of the patient.

Finding out and informing the patient that something went wrong in his early psychological development has no therapeutic influence unless it is connected with the patient's affects in analysis in the transference, and referred back from the actual analytic situation to the repressed affects of the early developmental period. Emphasis on theory may give the patient superficial knowledge but too often interferes with therapeutic progress. Guiding one's self solely by theory can create uncertainty in the analyst, and prevent the proper handling of transference and resistance. It interferes with objectivity and intuitiveness, both of which are so important in therapy.

The first theoretical constructions of Freud were derived empirically through clinical experience and many analysts are prone to do likewise, namely, to form their own theoretical ideas as a result of their individual experiences. This is perfectly understandable, but it is important that such views be exposed to general review and criticism in order to evaluate them properly. Working methods of one analyst may differ slightly, or to a great degree, from other analysts. Ferenczi was of the opinion that analysts fall into two groups, one to whom therapy is more important, who consider psychoanalysis a branch of medicine, and the analyst as a medical healer; for this group theory is a by-product. The other group consists of those who look upon analysis as a research laboratory in which they can prove some psychological truth or the existence of some unconscious factors. For the latter, the exploring of the unconscious and testing of scientific findings is of primary importance, therapy being looked upon merely as a concomitant of research. Many clinicians feel that having a favorite theory may result in a tendency to mold observations to fit the theory. In this connection Glover says, 'The pure clinician will maintain that theoretical orientation is a fertile source of mistakes due to bias'.

In the course of many years of analytic work, I have had the opportunity to observe, in working with younger colleagues who are in the process of being trained, the influence upon them of the changes of training programs, expansion of subjects and also the shifting of their theoretical orientations. With students or patients who have transferred from another colleague, one often meets ideas which differ from one's own and from those generally accepted. Sometimes an analyst favors a particular theoretical point of view and repeatedly refers to it. An analyst may be led on by scientific interest to prove the validity of a concept to which he feels a predilection. In some cases it can be an emotional attitude based on 'training transference' which causes an analyst to overemphasize one viewpoint.

It is essential to theorize a certain amount but one must beware of the danger of neglecting the clinical aspects. Since

theoretical orientation may determine procedure, there is always the possibility that preconceptions will be the guide in technique.

The following short example is given to illustrate the misguidance of therapeutic effort because of adherence to a favorite theory. A student in supervised clinical work happened to be treating an artist, with whom he worked into a long-lasting period of resistance and stagnation of analysis, as a result of interpreting the unconscious factors in the artist's creations and his neurosis entirely on the basis of theory. He wanted to prove that his patient's artistic productions were projections into his art of early introjected objects. It was true that the patient's basic problems were connected with scoptophilic tendencies, but in the analyst's opinion, these tendencies resulted in introjection of the external world by oral destruction. He believed that looking was equated with devouring, being very much impressed by that bit of theory, which was Fenichel's construction. Fenichel extracted the idea from Ella Sharpe's paper, Certain Aspects of Sublimation and Delusion,[6] in which she expressed her belief that representation of objects in artistic creation is primarily an unconscious attempt at 'making reparation' for criminal fantasies and tendencies. In her opinion the work of art aims to reanimate persons whom one has killed with his omnipotent thoughts. The killing having been effected by introjection, the introjected object is projected into art and thus reanimated.

This young analyst pursued his therapeutic goal entirely through one avenue of approach. There were abundant, obvious factors in the complicated neurosis of the artist which should have been interpreted and followed up, but the therapist chose the most remote as a result of his attraction to a particular theory. In other words, his clinical evaluations were based mainly on theoretical considerations.

We are all inclined to place emphasis on some aspect of therapy and theory, this emphasis depending more or less upon

[6] Int. J. Psa., XI, 1930.

our personality. But if one of us wishes to present a new discovery or a new theory which he considers superior to a previous formulation, and especially if he is in a position to indoctrinate younger colleagues, then it is time to investigate these private views and compare them with the accepted ones.

I do not mean to suggest systematizing therapeutic technique in analysis. It is hardly feasible. But the teaching of technique of analysis should be better organized and systematized. The logical step at which to begin reorienting ourselves in the teaching of analysis would be objectively to review the subject matter and our method of teaching it. An evaluation of both comes to us indirectly occasionally through seminars and supervised clinical work with students. It is not enough in teaching to emphasize the importance of analyzing resistances. For instance, properly timing the analysis of the resistances and the interpretation, and even the correct expression and wording of interpretation, are of equal importance. This topic requires further detailed study. Not enough has been written in concrete terms about methods of interpreting. Very little has been said on the form of interpretation or about content, which is of paramount importance. Should one place the greater emphasis on the pregenital phase, as in the English school? When should interpretations be given? What are the drawbacks of interpreting in terms of particular developmental levels, a practice with which one still meets.

The meaning of the term 'deep interpretation' also has to be clarified. Glover's questionnaire sought opinions regarding it, and the replies indicated that to most analysts deep interpretation connoted theoretical description, topography. But the term is also frequently used in reference to dynamic interpretation. Efforts to give deep interpretation we often see in younger colleagues who overlook the obvious, it seems so easy, and reach for the far-fetched, sometimes obscure interpretation. In Glover's book he actually refers to 'deep groups': those who feel that anything but deep interpretation is ineffective. For instance, for states of anxiety they would consider reassurance or gradual interpretation ineffective; furthermore,

this group believes that reassurance can become a handicap in analysis.

Younger colleagues are sometimes afraid to interpret because the interpretation may serve also as reassurance, or carry some suggestion to the patient. They are not quite aware of the fact that the analysis of the transference relationship always contains suggestions; moreover, they consider interpretation to be generally the same for all cases, whereas our clinical experience, which is now much greater than it was when fundamental rules were established, warrants various attitudes about interpretation in special cases. Observation of the technical handling of compulsion neurosis, for instance, points to the fact that the greatest progress is made in therapy through proper interpretation of the transference. But in this instance also, various views are held about the line of therapeutic approach. Comparison and discussion of empirical observation by a number of analysts is needed because observation of technical procedure has not been adequately and sufficiently described, and in their courses of study our younger colleagues have little chance to hear about it in detail.

There are many and varied theories about the interpretation of transference. Some analysts advocate interpretation of transference only when original emotional situations are being relived and re-experienced in relation to the analyst. Opinions are divided concerning the handling of early phases in the development of transference, and the fully developed transference. Fenichel referred to 'silently developed' transference. Some immediately interpret the patient's feelings about the analyst and analysis in early sessions. Others believe that early interpretation of the transference may help the patient to hide and repress the relationships to the real objects in early life and cause him to dwell on the interpreted transference of analytical relationship. The interpretation of transference on the basis of introjected and projected objects of the pregenital phase is also open to much criticism.

In my opinion, the most favorable time to start interpretation is when sufficient material has been produced by the

patient to convince him of the validity of the interpretation. Interpretation which includes the patient's productions reassures him, whereas badly timed and nonspecific interpretations may be upsetting. By proceeding without haste, step by step, affects in interpretation will be relived and the emotions produced by the interpretations will become dynamic. Through it, the analysis of early patterns of emotional reaction is made possible. Love, hate and anxiety related to the transference and to reality situations will be easily connected with the patient's childhood pattern of reaction. The practice of giving anamnestic interpretations, of relating everything to the patient's childhood, is of little value unless the interpretation is dynamic (related to the present). I feel that it is important to emphasize the emotional reactions to the analyst or to the analysis and then interpret the pattern of reactions which brings about such feelings in regard to analysis.

In the teaching of analysis some way must be found of correlating the various views to avoid theoretical indoctrination which lead to confusion—to interpreting what seems theoretically correct but misses the obvious. We find too often in supervised clinical work a lack of up-to-date knowledge of the progress of theory. The students work with theories based on early concepts of Freud and have not enough information about additional material or changes of those early views; for whenever clinical evidence called for modifications, Freud altered his earlier concepts.

I frequently encounter young colleagues who will not analyze dreams which are fragmentary. If there are parts which the patient does not recall, instead of asking for associations to the remembered parts, they ignore the dream entirely. In response to my inquiries into the origin of this attitude, I have received the reply that Freud said that many dreams are untranslatable. But Freud also said[7] that untranslatable dreams can be of use for introducing thoughts and evoking memories, even if their manifest content cannot be interpreted; also, that one can at

[7] Freud: *Bemerkungen zur Theorie und Praxis der Traumdeutung,* Int. Ztschr. f. Psa., IX, 1923.

least draw conclusions as to what the dream wish is. This, these students do not know.

The four methods of starting dream interpretation described by Freud are:

1 Associations in accordance with the manner in which the dream is presented, which he terms classical technique.

2 Selecting one part of the dream which seems important and starting associations from it.

3 Starting the dream work with the day's residue without taking the manifest content into account.

4 When the patient knows enough about dream interpretation, leaving it to him to begin his associations as he chooses.

Freud stated that it was up to the analyst to decide which of these techniques was the most suitable for the situation at hand. He further stated that if the dream resistance was strong, resulting in fragmentary dreams or forgetting of parts, one must be satisfied with interpreting some symbolic meaning (symbol translation).

The teaching of dream interpretation is another area where varied opinions must be brought into closer harmony.

In 1936, in an address entitled, The Future of Psychoanalysis, which was delivered to the Vienna Psychoanalytic Society, Jones said,[8] in referring to interpretation: 'What I look to is rather a steady progress in thoroughness, a greater polish and accuracy leading to far more sureness than we now possess. Special studies are needed on the precise criteria for the trustworthiness of our interpretations and also on the extraordinarily difficult subject of the correlation between technique and theory in psychoanalysis.'

Theoretical formulations reached through practical clinical experiences may serve as a hint, but not as a definite guide for therapeutic practice. Individual cases demand special treatment at times, quite apart from one's theories. Theory can always identify the mechanism of the neurosis, but it cannot be the sole guide in therapy. This fact must be constantly emphasized, especially in teaching and training.

[8] Int. J. Psa., XVII, 1936.

Masochism is another important problem which has given rise to much discussion and needs to be clarified. It was discussed from a seemingly new theoretical angle in the spring of 1947 by Dr. Berliner [9] at the meeting of the American Psychoanalytic Association. Freud's concept of primary masochism as being connected with death instinct is not applicable in technique. The workable hypothesis is his earlier view expressed in Three Contributions to the Theory of Sex wherein he showed that masochism is the result of sadistic drives turned against the ego. His early paper, A Child is Being Beaten, is based on clinical observation: the fantasy of being beaten follows the wish that the hated rival should suffer. In our clinical work we also find aggression turned against the ego, and carrying with it sexually charged drives.

Dr. Berliner elaborated his concept that masochism is a deep plea for affection. He endeavored to prove that masochism represents chiefly the person's wish to bear pain in order to attain pleasure and that the masochist's suffering has as the deepest aim the re-establishment of the unconscious wish to get attention from the beloved person who in the past caused him pain; further, that it originates in the oral stage of development. Certainly one of the aims of masochism is the securing of love, but to claim as Dr. Berliner does that all masochism originates on the oral level is giving undue emphasis to one factor, and theoretically substantiating something which clinical experiences do not, on the whole, bear out. Masochistic fantasies, as we all know, can originate in any developmental level.

Eidelberg [10] is of the opinion that masochistic mechanisms permit the individual to render frustrations harmless by creating some active frustration himself instead of tolerating them passively. According to Eidelberg, this mechanism belongs with those of projection, introjection, repression and reaction-forma-

[9] Berliner, Bernhard: *On Some Psychodynamics of Masochism.* This QUARTERLY, XVI, 1947, pp. 459–471.

[10] Eidelberg, Ludwig: *Beiträge zum Studium des Masochismus.* Int. Ztschr. f. Psa., XX, 1934, pp. 336–353.

tion. He found masochistic perversion least amenable to scientific research and therapy in isolation but when present with other neurotic difficulties therapy is more fruitful. He also emphasized the importance of the rôle of childish megalomania and strong aggressive drives in cases of masochism.

The controversial aspects of the problem of sado-masochism are far from clear theoretically; however, in therapy we are fairly well able to cope with masochism through the understanding of its relation to general aggression. The puzzling fact that fantasy and reality are so peculiarly mixed in masochism and that it seems contrary to pleasure-seeking tendencies led to numerous attempts on the part of various analysts to clarify the problems of theory involved, but no one has been completely successful. Fenichel, one of many who studied the problem, described four mechanisms, all of them valid but yet not constituting a comprehensive explanation of the phenomenon. To try to simplify the problem theoretically and to teach it that way will not advance progress in understanding of it, as he himself pointed out. The solution lies in clinical case studies. Theoretical formulations should be appraised in the light of clinical findings in a variety of cases.

However, one cannot fit a patient into a category formed from ideas drawn from the analysis of other patients or from the writings of other authors. We can use theory and the findings of others to guide us in situations where it is necessary to formulate an idea as to the trend in which we are likely to be led by the patient or to explain some structure in the patient's neurosis. But we must wait for material from the patient which will tell us whether or not we have been correct in our hypothesis. Theoretical formulations will help us to schematize and keep in mind the relationships in the personality structure and the variety of factors entering into that structure. Thus it will be of help in describing the analytic process or changes which have to take place in the different parts of personality as a result of therapy. But in teaching, the greater emphasis must be put on what takes place in the thera-

peutic process. Then one can check his theoretical knowledge by his findings in treatment.

It is advisable that an analyst be well oriented in theory, but he should guard against trying to rediscover and apply in all his work some specific theoretical ideas. One can be a good analyst by adhering to fundamental principles and bearing in mind the fact that the analytical process is an affective one permitting elasticity in the application of rules, and that it is not chiefly an intellectual process.

The progress of technique, the evaluation of data, and further knowledge gained by practical experience necessitate new formulations and the reformulated theories can be applied with greater precision to the therapeutic technique than they now are. Rather than substitution of the old theory, there should be reconstruction of the old on the basis of new clinical and therapeutic experiences. We are now in a better position to do that than in past years because of the greatly increased number of analysts and the number and variety of cases which can be compared. Technique has of course run ahead of theory, and attempts towards clarification of their mutual relationship has to be undertaken from time to time.

What we find in the majority of cases is that such new theories and formulations often obscure rather than clarify. They attempt to replace the old theory without having sufficiently substantiated new hypotheses and methods. The missing factor is testing on a large scale, which can only be done through a comparison of clinical results.

The theory of instincts is another important topic which many have attempted to explain and which still requires more comprehensive interpretation. Therapy aims to reorganize instinctual drives towards more harmonious functioning. This is accomplished indirectly by re-establishing the original line of functioning, biological in origin, which we feel was disturbed by environmental influences. What we can observe are the effects of the instinct; hence so much speculation about the nature of the instinctual energies.

The last reference to instinct made by Freud is to be found

in a paper entitled, An Outline of Psychoanalysis [11] (translated from his unfinished work which was started in 1938). In this paper Freud stated that the instincts represent the somatic demands upon the life of the mind, and that with regard to the specific instinctual factor, there is a discrepancy between theory and experience; moreover, 'The gap in our theory cannot at present be filled'.

There have been many attempts, if not to fill, at least to narrow the gap. Loewenstein, in 'The Vital or Somatic Instincts' [12] re-examines the classification of the instincts. He emphasizes a distinction between sexual and somatic instincts. Fairbairn,[13] in a series of involved papers attempted a complete revision of the theory of mental structure and instincts. He proposes to replace Freud's classical theory with his own, and begins by examining the classical libido theory of pleasure seeking. According to Fairbairn, libido is object-seeking and the libidinal aims which Freud describes in terms of erotogenic zones to him are not libidinal aims but modes of dealing with objects: 'The zones in question should properly be regarded not as the dictators of aims, but as the servants of aims'. He changes instinct to instinctive tendency, declares that Freud's ego, id and superego are not dynamic structures, that his (Fairbairn's) psychic structure includes all energies in contrast to Freud's psychic energy. Fairbairn's entire theory is based on Melanie Klein's hypothesis of good and bad objects. His revision of the theory of instincts and mental structure presents a very obscure picture when one tries to think of its possible application to therapeutic work. It is perfectly obvious that pleasure-seeking tendencies in therapy are always attached to objects, and the libidinal aims themselves which are attached to erotogenic zones are always directed towards objects. Fairbairn's theoretical formulation seems rather twisted and certainly it would be difficult to prove its validity in clinical application.

11 Int. J. Psa., XXI, 1940.
12 *Ibid.*
13 Int. J. Psa., XXV, 1944, and XXVII, 1946.

At the meeting of The American Psychoanalytic Association in 1947, Dr. Kubie, in a paper on Instinct and Homeostasis approached the problem from a more clinical angle. Following is his own short abstract of the paper.

> We find that in discussing instincts Freud made two important points which have been largely neglected, partly by himself, and in part by other workers:
>
> (a) that a classification of instincts must rest on a physiological rather than a psychological basis;
> (b) that instincts represent the demand which the body makes on the mental apparatus.
>
> Our discussion supports Freud's position.
>
> All instincts consist of (a) the direct or indirect expression of biochemical body processes, through (b) inherited yet modifiable networks of neuronal synaptic patterns, which (c) are molded in turn by superimposed, compulsive and phobic mechanisms. These are seen to operate in normal psychology as in psychopathology. The relative rôles of the three components of instinctual activity vary in different instincts and in different species. Therefore, it is impossible to make any absolute distinction between instinct and drive (*Trieb*). The differences are quantitative rather than qualitative, and are due to the different rôles played by the three components mentioned above.
>
> In many of the instinctual processes the biochemical source of energy is converted into behavior through deprivation because deprivation synchronizes the continuous asynchronous flux which in states of rest goes on in body tissues. The biochemical processes, however, are linked to warning mechanisms, which under ordinary circumstances come into play before any actual tissue deprivation occurs; therefore, in higher animals, instinctual patterns are triggered off by warning mechanisms rather than by tissue hungers; therefore, on the psychological level, instinctual aims and objects are also built around the warning mechanism.

This paper points the way to a more profound clinical observation of the derivatives of instincts, the observation of which

may enable us to form clearer ideas about the way instincts work.

At a recent meeting of the New York Psychoanalytic Society, Dr. Hart expounded some ideas in relation to the problem of narcissism. He spoke about the concept of narcissistic equilibrium and its therapeutic aspects, and discussed the disturbing effect of the various id drives upon the equilibrium, maintaining that they can gradually be repaired by the substitution of sublimatory equivalents.

To return to the main point of this paper: we are all agreed that the interpretation of fundamental rules varies considerably. Freud, in Recollection, Repetition and Working Through,[14] writes: 'It seems to me not unnecessary constantly to remind students of the far-reaching changes which psychoanalytic technique has undergone since its first beginnings.' In a paper published in 1938 dealing with technical rules he mentions a type of patient who must be analyzed like a child because he cannot be made to adhere to rules. 'Many neurotics have remained so infantile that in analysis too, they can only be treated like children', and 'the amount of influence which the analyst may legitimately employ will be determined by the degree of inhibition in the development of the patient'.

When we think of fundamental rules in the technique of psychoanalysis we should bear in mind such changing attitudes of Freud himself, who advocated even such extreme elasticity in their application. Fundamental rules cannot become rules of theory but must be thought of always as fundamentals for technique. To treat is more important than to adhere to specific rules and theoretical concepts. The technique should be adapted to the patient, not the patient to the technique. Some patients cannot comply with rules, and we still have to treat them.

Dynamic interpretation is ineffective unless it carries feelings which concern both reality situations and transference, which means that practical problems must be discussed objectively by

[14] Coll. Papers, II, p. 366.

the analyst and the subjective feelings of the patient in relation to his problems must be tested.

One may question to what extent the early biography of the patient enters into the creation of the neurosis. One may argue as to just when the œdipal phase is in progress and at what age the superego organization begins. The exact course of the early object development of the individual may also be a ground for disagreement among analysts. However, I do not deem it of great importance to determine the exact date of development of definite object relationships. Our ability to study infantile development is considerably limited. Descriptions of these very early stages are mostly theoretical hypotheses. We cannot arrive at an accurate appraisal of the psychic apparatus of the infant. In my opinion the oustanding importance of this early period is that it forms the basis for identification through object relationships and within it is to be found the origin of conscience.

The early object relationships are the ones which are emotionally reactivated in the transference relationship, enabling unconscious impulses to be brought into consciousness. To be sure, there are diversities in technique, but if the difference arises from an emotional bias or a bias in favor of a particular theory, it will prove to be a source of trouble. We know that therapeutic results were achieved even when theories about etiological factors in neurosis were changing. During that time the therapeutic process served a second purpose as well, that of research, and as more knowledge was gathered about technique, the theory was reformulated in conformity with it. The best example of an extreme change in theory is to be found in Freud himself. He originally warned analysts to be cool and detached in observing the patient, acting as a mirror, merely reflecting to the patient his own actions and feelings. Later he made the above-mentioned statement in regard to treating certain types of patients as children—the extreme of elasticity. Therefore, many of us advocate pooling our therapeutic results in order to formulate new theories about treatment. New

theories which survive objective examination will be utilized in practice.

Another important phase of treatment which would profit greatly from a comparison and re-examination of therapeutic results is the matter of the final aim of analytic therapy. Criteria of degree of adjustment attained through therapy differ. Some analysts are inclined to overestimate therapeutic possibilities, others to underestimate them, especially in certain types of neuroses; hence the growing tendency toward specialization. There are analysts who will treat only certain types of cases, others while accepting all types will always have greater success with a particular kind of neurosis.

As to criteria of results in therapy, some therapists emphasize improved object relationship, others improvement in social contact and elimination of anxiety. Still others consider sexual adjustment of primary importance as a criterion of well-being. Such differences of opinion may be influenced by theoretical orientation. Clinical evidence must be lined up so that we can arrive at some kind of uniformity in our theory as to when termination is at hand.

In clinical conferences and in supervised clinical work one receives the strong impression that criteria for and method of termination are outstanding problems for the young analyst. In the answers to his questionnaire, Glover found broad disagreement regarding termination of analysis. He saw an urgent need for 'a detailed list of the practical indications for terminating an analysis, a list that will allow for variations in the clinical type of case'.

Etiological views play a part in the various opinions held regarding length and thoroughness of analysis. These marked divisions of opinion undoubtedly enter into our teaching and they must be reduced if we want better therapists and to improve our therapeutic results.

The impression is inescapable that the handling of the final phase of treatment is entirely an individual matter. Since very little has been written on the subject, young analysts have nothing to guide them except the manner of termination of

their own analyses, or they are reduced to experimenting with their patients.

I do not underestimate the need for theoretical knowledge. It is necessary for scientific research and in varying degrees every therapeutic process contains some elements of research. But the usefulness of hypotheses can only be judged by adequate description of the phenomenon investigated. The various forms of neuroses, mechanisms which are common to particular types of cases, differences in technique, modifications by individual analysts, all should be subjected to detailed study and comparison.

I believe that many discrepancies among the various formulations can be eliminated. In the process, theories can be substantiated or changed through observing effects in practice, for it is undeniable that in psychoanalytic work practice influences theory.

After all, it was interest in technique of therapy which led Freud to therapeutic experimentation, the results of which ultimately yielded the theory of the unconscious, with all its dynamics, as we know it today.

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Feminine Significance of the Nose

Leon J. Saul

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FEMININE SIGNIFICANCE OF THE NOSE

BY LEON J. SAUL, M.D. (PHILADELPHIA)

A physiological relationship between the nose and the female genitalia has long been recognized *(1)*. Endriss *(2)* published in 1892 a review of similar observations since 1835. W. Fliess's book *(3)* on this subject appeared in 1897 and has been confirmed by later work. Oberndorf *(4)* in his review of this literature quotes Emil Mayer's *(5)* treatment of dysmenorrhea by applications to the nose. Certain cases of epistaxis have been described as vicarious menstruation *(6)*, particularly since the observations of MacKenzie *(7)* in 1884. Recent work shows certain changes of the nasal as well as of the vaginal mucosa during the ovulation cycle, and is briefly surveyed by Mortimer, Wright and Collip *(8)*. Atrophic rhinitis has been treated by œstrogenic hormones *(9, 10)*.

It is to be expected that this connection between the nose and the female genital would reflect itself in the mental life. A review of the psychoanalytic literature shows, however, that whereas the nose is commonly recognized as a representative of the phallus, its use as a representative of the female organ is either only alluded to or very briefly noted. Thus, Abraham *(11)* and Jones *(12)* have pointed out that the nose is commonly a phallic symbol. Abraham attributed certain cases of nasal congestion in women to the displaced wish for the penis and states that some cases of conjunctivitis have a similar neurotic basis. The nose appears primarily as a representative of the phallus in Freud's Wolf Man *(13)*, particularly during his period of analysis with Brunswick *(14)*. Oberndorf observed the nose to be primarily a phallic symbol in his paper, Submucous Resection as a Castration Symbol. He describes the sniffling in his male patient as an expression of masculine heterosexuality and also as a suckling equivalent. As to the

Read at a meeting of the Chicago Psychoanalytic Society, March 4, 1939.

receptive feminine utilization of the nose, Fenichel *(15)* mentions briefly its bisexual nature and points to its anal feminine significance. He describes inspiration as an unconscious symbolic incorporation. K. Menninger *(16)* refers to transposition of masochistic feminine tendencies to the respiratory tract. The author *(17)* has reported observations which show a connection of the nose with oral and feminine receptive wishes. Jones *(18)* refers to mythological concepts of impregnation through breath, and he and Ferenczi remind us that in respiration the nose is both receptive and eliminative, while in olfaction it is receptive, acting as a sense organ by taking in minute particles. The receptive function of the nose is implied in Freud's Wolf Man who used inhalation to take in the Holy Spirit and exhalation to avoid identification with cripples and to be rid of evil spirits.

The dreams of a patient of mine showed the connection between the nose and female organs with such clarity that it seems worthwhile to report them. A further connection with the anus is also clear and is to be expected in view of the common origin of the vagina and rectum from the cloaca. This patient was a middle-aged man who suffered from occasional attacks of sinusitis, and from a severe pruritus ani which bothered him only at night when it occasioned mild diarrhœa. He often picked his nose. He sought analysis because of difficulties in establishing and maintaining human relationships and a lack of interest in women. Although never overtly homosexual, he was consciously attracted to young men. He was the son of a driving, rather terrifying father, and of an extremely dominating, possessive mother who prevented him from going out with girls and did everything she could to keep him bound to her. The mother was also seductive and would get the patient to help her dress even when he was in his thirties. During analysis his passive feminine wishes towards the analyst were immediately apparent through his thin defenses. For example, his second current dream was of having detachable genitals under which was a cavity. At the end of

two weeks he dreamed of the analysis as a strip tease act by a young man, who was himself, and shortly thereafter brought two frank dreams of fellatio with himself in the oral rôle. His dreams were full of phalli and phallic symbols. Intercourse with men was always represented as fellatio or mutual genital relations, and never anal. His identification with his mother is illustrated by the third dream of the analysis. In this dream he has hair on his neck, to which he associated his mother's pubic hair, shaving, and a woman's bare hip. In the fourth dream, the female pudenda are not at the neck, but are represented by the nose.

> 'I am walking with a man looking for privacy. We walk in subterranean caves. I see a man crawling. He has a stick with a flexible end. I fear him. Then I have the stick and I hold the man off by pointing the tip of the stick at the man's nose.'

To the stick, the patient associated penis. Privacy brought thoughts of homosexuality, the patient's dislike of being seen undressed, and his feeling that his penis was too small. To nose, he associated his reading of a case in Krafft-Ebing's *Psychopathia Sexualis* in which a man is married to a woman with a very big nose which the man tries to utilize for sexual relations. Other associations are omitted since we are interested in only one aspect of this complex bisexual dream and not in its detailed analysis. The essential point for our present discussion is that the nose is frankly represented as a female organ. In the associations the patient identified with a woman who has intercourse with her nose as vagina. The patient's bisexuality and partial feminine identification were clearly apparent throughout the analysis, as illustrated by other dreams. Near the end of his analysis, one and a half years later, the patient reported the following dream.

> 'I am lying on this couch and doctors are operating on my nose, removing obstructions and sticking in long probes. It was not unpleasant.'

Doctors recall to the patient that when he had sinus trouble, at the age of about twenty, an operation was advised. But another doctor who was consulted put a long probe into the patient's nose, with an opiate to deaden the pain, and then squirted water up and down the passages. He then told the patient to pay and get out; that he did not need to have his sinuses scraped. To nasal, the patient associated anagrammatically, 'anal, nasal, anus', and went on facetiously, 'Does the patient want a penis in his nose? Cork in anus. Cannot defecate without removing it. Cancer of anus. If one died of it, he would escape the scourge.' To obstruction, he associated making a hole, making the patient into a woman. He then mentioned people who always feel that they are attacked and therefore must attack others.

Without recording the complete analysis of the dream, it is apparent that the nose again appears as the female sexual organ. The patient was reacting to the ending of the analysis which he anticipated with regret and resentment. In the dream he expressed his feminine wishes quite frankly. He could not quite admit his passive enjoyment of analysis, but stated that he came only because it was a necessary medical procedure, an operation. He reacted against the feminine wish with the paranoid mechanism of hostility which was projected and turned against himself, thus adding castration fear to the castration wish. The site of the conflict was his nose.

One more dream is of interest in this connection. It occurred a few weeks before an interruption of the analysis. It was one of a series of three dreams as follows.

1. 'There is a hole in the hedge; wind is blowing through it and this keeps objects from going in.'

2. 'I hurt my father's back and he may die.'

3. 'I forget everything about this dream except that I was with Aunt H [an elderly woman].

We are concerned only with the first dream of the series. To hole, the patient associated vagina, and a wind which keeps the penis from coming in; a defense against the penis; air in caissons to keep out water; pumps in mines to blow out poison gases.

This dream is included although it does not mention the nose because the defense against the feminine wishes is so clearly expressed in terms of air. The link between anal and nasal (mines, poison gas) is evident in the associations to the dream. Exhaling is here a direct defense against feminine wishes. Associations to the second dream of this series were of castration as a punishment for hostility to the father; and to the third dream, a wish to regress from the homosexual conflict to a secluded dependent relationship with the mother. This patient's unconscious passive feminine wishes apparently played a rôle in his pruritus ani, his habit of picking his nose, and possibly in his sinusitis, although this could not be clearly determined. I have seen another patient with a closely similar picture of the psychological problem and the organic symptoms. In a female patient of Dr. Helen V. McLean, and in a male patient of mine, conjunctivitis was clearly correlated with repressed feminine desires, as well as with phallic ones, as described by Abraham.

Another male patient had a dream in which his sister was blowing her nose, which the patient felt to be offensive. To this he associated urination, defecation, enemas which the patient had had, and, suddenly, abortions; and he went on to speak of his sister's miscarriages. Again, the nose represents the vaginal and rectal canals. These observations would bear out the point stressed by Ferenczi *(19)*, that in all true symbolism there is some underlying biological or physiological connection.

The physiological connection between the nose and the female genitalia makes it appear that biological tendencies not genitally expressed can utilize the nose. These tendencies are of course psychologically reflected. This raises the question of the relationships between analytic concepts of symbolism and the underlying physiological processes. There are other physiological relationships similar to that between the nose and the vagina. One recalls the 'gastric spots' of the nasal mucosa.

SUMMARY AND CONCLUSIONS

Since Freud pointed it out, we are well acquainted with the bisexual nature of symbols and of psychogenic organic symptoms. Three dreams of a man whose central problem was latent homosexuality show the use of the nose as representing a vagina; also a connection of both these organs with the anus. This is in accord with the well-known physiological relationship of nose and genital, and presumably reflects in the psychological sphere this physiological relationship. In this case the connection between nose and vagina is frankly expressed in dreams. This suggests that this patient's unconscious feminine wishes were a factor in his pruritus ani, and possibly in his sinusitis, in this particular case.

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Walter Bromberg

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DYNAMIC ASPECTS OF PSYCHOPATHIC PERSONALITY

BY WALTER BROMBERG, M.D. (RENO, NEVADA)

At the present stage of the development of psychiatry, the concept of psychopathic personality is neither well defined nor is its etiology well understood. From a clinical point of view, however, the vagueness of the concept does not prevent fairly accurate recognition of psychopaths from their anamneses and behavior. Clinical criteria of instability, impulsiveness, egocentricity, antisociality, callousness, in addition to the all-important one of unmodifiability by punitive, corrective or therapeutic means, have been held to justify a diagnosis of what Henderson *(1)* calls the 'psychopathic state'. Yet, whenever the need for formulating an etiological hypothesis appears, either as a requirement for psychotherapy or in the interests of psychological theory, the apparent unity of the concept fades.

The ambiguity of terms like 'constitutional psychopathic inferior', 'constitutional inadequacy', 'criminal psychopath', 'neurotic character', and a host of others indicate the lack of unanimity. Preoccupation with a 'constitutional' basis for the psychopathy has not proven fruitful in understanding this group. More recent thinking, which points towards defense mechanisms developed early in life in response to instinctual fixations, has brought psychopathic personality into closer relation with more thoroughly explored personality disturbances *(2)*. This approach, moreover, has invited a dynamic attitude towards the condition under discussion.

Psychoanalytic study *(3* to *7)* has shown the effect of emotional factors in the early environment on the ego structure of the psychopath. Specific constellations in parental relationships determined the form of subsequent defenses in the character structure of the individual psychopath. There is an

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additional emotional influence operating to fashion and solidify character defenses, that functions currently as well as in the early phases of the psychopath's life: the unconscious biases and feeling derivatives constantly exerted by society towards maladjusted persons. The shallow object relationships of the psychopath, his impulsiveness and asocial actions, are conspicuously related to the overt prejudices and unconscious reactions of the individuals of the society in which he lives. Society, on whom the depredations of the psychopath are visited and whose sensibilities have long been alerted to this variety of personality disorder, maintains an attitude that is not without its reciprocal effect. One purpose of this inquiry is to seek the sociopsychological factors which develop and maintain defensive traits of character which socially are recognized as psychopathic.

The influence of current social attitudes on psychiatrists has not been inconsequential in psychiatric nosology. Psychiatrists, like other citizens, are identified with the cultural trends of the society in which they live, and their judgment about behavior which affects social welfare is consciously or unconsciously swayed by environmental influences. Historically, changes in the concept of psychopathic personality provide a measure of the strength of social biases in psychiatric thinking. Sociopsychological concepts in the period of descriptive psychiatry forced 'alienists' into accepting legalistic standards of 'insanity' and criminal 'responsibility' *(8)*. This influence was reflected in the emphasis on diagnostic terminology: moral imbecile, homicidal mania, irresistible impulse; moreover, the physician's moral and authoritarian position in the social hierarchy made him particularly susceptible to the pressure of moral influences. 'Moral insanity', Lombroso's 'criminal man', and 'constitutional inferiority'—all indicated the accent on moral judgment in psychiatric phenomenology. Psychiatry in the nineteenth century preserved the religio-philosophic dichotomy of 'good' and 'evil' in estimations of human behavior. Psychiatrists still preserve a measure of moral judgment towards psychopaths; indeed, to make psychiatry socially intelligible

its practitioners still tend to conform to conventional social standards of desirable or undesirable, good or evil behavior.

Evidences of psychopathic behavior achieve their most striking representation in delinquency and criminality. The evolution of criminal law is the embodiment of society's ambivalences, unconscious hostilities, and feelings of guilt in legal and penological codes. How, then, do these prejudicial social trends, embodied in social institutions, aid in developing ego defenses in 'undesirable' or 'antisocial' psychopathic personalities?

Respect for the law, common to most citizens, represents the successful resolution of each individual's conflict with his unconscious hostilities to authority. The transformation or repression of antisocial instinctual impulses is accompanied by compliance with the prevailing moral standard. Such compliance is accomplished by a complex series of transformations of primary primitive instinctual strivings in each individual, including mechanisms of sublimation, reaction-formation, repression and others.

Current social attitudes towards wrongdoing constitute a virtual historical recapitulation of the evolution of social sentiments about criminal acts during civilization. The primary attitude of the law-abiding citizen towards the criminal is one of rage accompanied by an immediate impulse to talionic revenge. Gradually, the direct impulse to retaliatory feelings is displaced to the state whose laws eventually achieve retribution for transgressions. There is a sense of satisfaction from the anticipation that justice will prevail through action of the law. After the emotional gratification consequent to the law's eventual triumph (revenge) is realized, there often arises a curiosity about the reasons impelling the particular criminal act, extending to the over-all problem of crime as a human failing. Pity and sympathy bring in their train a wider interest in the criminal as a human being, with humanitarian urges to succor or solace the offender. Combined with sympathy are reflections on the need for correction of the offender's 'unfortunate' nature through penitence.

The belief that penitence would relieve the criminal's guilty

feelings springs, in part, from the motive of unconscious retaliation, in part, from similar criminal strivings in each of us. The intense public interest so continually demonstrated about crime and criminals is based on an unconscious participation in universal unconscious criminal feelings experienced by all members of society. Covered by maturer altruistic motivations, the repressed drive for retaliation is still powerfully active. If the erring criminal will confess his guilt, accept punishment and repent, the emotional needs of the law-abiding citizen are satisfied by his vicarious participation in crime, punishment and redemption. With this gratification, the emotional participation of the public in a crime ordinarily ends.

The psychopathic personality is intuitively aware of the unconscious hostility which lies behind efforts to reform or treat him. He distrusts the analyst or psychotherapist as he distrusts society. He senses that society allays its anxiety in compartmentalizing its own aggressive antisocial tendencies through projection to certain individuals viewed as structural or constitutional deviates. The wish to see evil vanquished in the world represents an idealized construction which serves to neutralize anxieties developed in the social ego. Social welfare depends upon the persistence of reaction-formations of idealism in conduct and ethics. Such psychological mechanisms effectively keep evil aggressive tendencies from view and therefore establish criteria for successful social adjustment.

This mechanism is illustrated by the experience of psychiatrists in civil and military prisons. Recently the writer, in attempting psychoanalytic investigation and treatment of a series of psychopaths in a large naval establishment, encountered strong open resistance among officers handling such personnel who insisted there was 'no use' trying to modify psychopathic behavior. Such attitudes, hiding behind traditional clichés, are protective of deeper anxieties which can be paraphrased: 'You cannot cure criminals. Don't try it. They require punishment. In analyzing evil, you will disturb us and the whole system by evoking our guilty feelings and anxieties.'

This view of the immutability of antisocial characters is shared by the psychopaths themselves. Whether attempts at treatment are in the form of active humanitarian management or the relative passivity of psychoanalysis, psychopaths react to the unconscious prejudices which society entertains towards them. The psychopath acts throughout life as society unconsciously wishes him to, by remaining irretrievably maladjusted, the carrier of society's antisocial feelings. He reacts to therapy defiantly.

This psychological interaction between the psychopath and society imparts a characteristic clinical tone to the therapeutic relationship with a psychopath: if he coöperates at all, he is playful often with elements of grimness. Whether he be openly antagonistic, apparently compliant, or even courteous, he is not 'in' the relationship. He plays at being treated for a short time, quickly losing interest. The game for him has long since been lost. The playful attitude is a regressive defense against the threat of transference. He cannot risk reliving in a transference neurosis developmental affective tensions which had aroused intolerable anxieties. With detachment, he regards the therapist as representing a state of security denied him. The fear of betrayal, should he seek the security for which he yearns through dependence again on a parent, is re-enacted by impulsive flight or aggressive behavior. After one or two sessions, the psychopath abruptly discontinues treatment or becomes hostile and unproductive if, as in an institution, there is no means of escape.

The psychopath's distrust has the basis in reality that he was treated badly as a child. The hatred of his parents comes to include all society. If the psychiatrist return the hostility by inner contempt or anger, however unconscious, with the notion that the psychopath is a characterologically 'deficient' person, the psychopath's highly sensitized intuition places the therapist among his enemies.[1] In the psychopathic patient's feelings, hostility towards the parents who did not give him

[1] Cf. Staub, Hugo: *A Runaway from Home.* This QUARTERLY, XII, 1943, pp. 1–2. (Ed.)

the security he needed when he was helpless and dependent becomes fused with reaction against the hostile attitude of society towards him. If the psychiatrist be passive in his attitude, the patient flees from the danger of the transference. If he acts as a member of society, by virtue of his connection with a court, prison or welfare agency, with its implied moral judgment, the patient becomes aggressive and uncoöperative.

The intolerance of the psychopath to developing a transference comes from the unconscious perception that the therapist might serve as a father, which arouses anxiety lest the patient be deprived of his right to remain antagonistic, his only defense following his unconscious acceptance of his position as society's scapegoat. His society is and always was a hostile one. It has never helped him and remains an ever-present threat; hence his rebelliousness to every adult standard of conduct. Criminals often designate their position in the social order by referring to their victims as 'citizens'. The individual and collective characteristics of perpetual rebelliousness, consolidated in an antisocial code, permit psychopaths to remain emotionally comfortable by warding off anxiety.

The peculiarity of the psychopath's insecurity, in contrast to that of neurotic individuals who may suffer from feelings of inferiority and masochistic attitudes, is the fact that the former's feelings are joined with those of other psychopaths in a specific ideology. The *Weltanschauung* of antisocial persons characterized by rebelliousness and reversal of standards of mature adjustment supports the individual's self-esteem, allays his anxiety and provides masochistic gratification through identification with the 'evil' life.

Defenses against individual masochistic expressions, and the inner fear of endangering essential narcissistic supplies, prove too strong a psychological reality to the patient approaching therapy. Transference depends upon a capacity for object love formed on the pattern of early love relationships with parents, which tends to repeat itself throughout life *(9)*. Individuals who remain strongly narcissistic have a limited capacity for object relations, a clinical fact readily seen in many psycho-

paths. The influence that is probably responsible for the narcissistic fixation in this group is the inadequate receipt of security in being loved in the precœdipal phases of ego organization. The histories of psychopaths feature actual or virtual lack of parental love whether through orphanges or from aged, neurotic, mentally ill and sadistic parents. The sensitivity of this group of individuals to lowered self-esteem (although hidden from superficial view) is based on the investiture of persons in authority with the prototype image of denying parents.

Bergler *(10),* in discussing the mechanism of orality as it stimulates criminal behavior, has pointed to the overwhelming feeling of helplessness derived from the precœdipal stage when the offender felt no one believed him capable of taking revenge. In compensation for this helplessness towards mother (later society), the criminal commits a 'herostatic' act. Although Bergler feels that every criminal action is evidence of a resolution of this nature, the essential point is that a masochistic mechanism is undeniably present in the criminal who attempts to revenge himself on the unjust and orally denying mother or her surrogates. It seems probable that the helplessness is unconsciously representative of oral starvation and therefore is a threat to existence *(10,* p. 27). The hostility towards society of the psychopath, with its masochistic consequences, is a form of moral masochism, related to the unconscious need for punishment *(11).*

These observations of the reactions of psychopaths to psychiatry are based on experiences in a criminal court and in penal institutions of varying types, where diagnostic analyses were the paramount aim. Many of the reactions were displayed in interviews which were ostensibly not therapeutic. There is a need for developing a technique which might foster a rapport of such a nature as to allow psychoanalysis of such individuals. Such a technique has several theoretical requirements. One is that the therapist be neither completely identified with society and its moral evaluations, nor

completely passive in relation to the affective tensions of the patient. Another is that authority must be exerted to keep the patient under treatment until the psychopath's confidence in the analyst becomes established.

The psychopathic patient as a matter of experience in reality does not believe that anybody in his environment is truly permissive towards him; furthermore, strong feelings of guilt are aroused by displacement from the parents of unconscious hostile impulses which arouse anxieties to the point of impulses to flight. An attitude of authority in the analyst decreases feelings of insecurity, especially in the youthful psychopath, encourages the development of feelings of dependency, hitherto denied by the patient, and gives an affective meaning to the therapeutic relationship. The fusion of the analyst as authority with society as punitive agent relieves guilt feelings and paves the way for acceptance of security through masochistic mechanisms. The approach to be adopted then is one in which the analyst deliberately participates in an authoritative position. The use of such an approach was reported in a previous publication *(12)*. This same case is presented here to illustrate some of the points raised in this paper.

A youth of nineteen of average intelligence was referred to the psychiatric clinic of a naval activity by prison officials. He had a long record in civilian life of truancy, incorrigibility and criminality from the age of ten years. His condition had been repeatedly diagnosed Psychopathic Personality, Emotional Instability by several competent observers. While in military service, he was imprisoned for desertion and theft. During incarceration he was wildly aggressive, refractive to simple routine, threatening to officers and guards, mutinous, destructive and unmanageable. After a preliminary interview, the patient was ordered to come for daily analytic treatment, lying on a couch. He was compelled to attend, and punishment and reward as well as his daily activities were under the control of the analyst.

The subject was the oldest of four children. The next

sibling, a brother, was in the merchant marine; a younger brother and sister were adolescents. The parents were divorced when the subject was ten years old, and the family was cared for by welfare agencies for many years. During the greater portion of his boyhood, he was in the care of his paternal grandmother, frequently without supervision. His mother was described by social workers as markedly erratic and 'terribly involved' in her domestic troubles. The father, described as irritable and intolerant of criticism, drank excessively, worked irregularly, and was periodically confined in a house of correction for alcoholism, fighting, and petty offenses. When the patient was eighteen, his mother remarried, but he had never met his stepfather. The father's contacts with the children after the divorce were sporadic, and usually during an alcoholic episode.

The patient came for treatment rather unwillingly but complied with the analytic rule. During the first month he continued to have periods of rage, at times destroying the fittings in his cell, at times openly defying the institutional regulations. He complained loudly of being ordered to the clinic for treatment. Some of this attitude was obviously a considered reaction to taunts of fellow prisoners and guards at his being given special attention by the 'psycho' doctor. His manner with the analyst was tinged with embarrassed impatience and supercilious irritation accompanied by gruff humor.

Early productions took the form of fantasies of physical injury to the guards whose faces and bodies he wished to cut, smash and crush. Against older authorities his anger was often veiled in humor. The older men he wished to humiliate, the younger ones to maltreat physically. 'The gold braid have lived their lives; all they do is sit back, smoke cigars and control people's lives.' In this vein he would enlarge the group of father-figures to include the naval service, all governmental officials and the nation at large. 'I want to be a man without a country . . . I would steal their money and let them cry their eyes out.' He reported details of his knowledge of crime, his

affiliations with gangsters, his admiration of their calloused attitudes. In a boyish way he described techniques of killing he had learned in civil prison and firsthand information he had gathered about Dillinger and Babyface Nelson and other notorious criminals. He once related having met his father in the house of correction as a fellow prisoner.

During this early period a fresh flurry of infractions resulted in the destruction of the toilet bowl and cot in his cell. The analyst withheld the punishment required by regulations. His reaction to this was the appearance of manifest anxiety accompanied by dreamlike hallucinations of '. . . zombies look right through you', and '. . . were out to take me with them'. With this appeared fears of bodily destruction, of being considered insane, and complaints about empty, lonesome weekends spent in his cell.

Periods of compliance and active dislike towards the analyst alternated for the next three weeks. Once he threatened the life of the analyst with a dagger which he had clandestinely fashioned from a screw driver and secreted in his sleeve when he came to the session. This serious infraction was disregarded, no punishment meted out and the analysis resumed. This and similar behavior was interpreted to him as attempts to stimulate further punishment. Hostility towards the guards continued. He was particularly irritated by their constant surveillance which was a refusal to trust him. He sarcastically belittled their adherence to regulations, and had fantasies of retaliation: 'If they were in trouble, I would stand before their cell and just look . . . they would feel sorry'.

At the end of the second month he related a dream.

> 'I found myself wrestling with a werewolf in a playful way, like you would fight with a brother, playing grab-ass. I am home, everyone sits around the table eating but I am under the table with the werewolf. They are not worried, and no one has seen it but me. Then I have a sharp instrument with two points and I am supposed to stick it in a vein to poison myself. A man shows me what vein to go into but I fool him and squeeze the poison and blood out of the vein.'

He was reminded of his next younger brother who was thrifty, diligent and well-behaved. He described the extreme conditions of poverty in his early life with periods of insufficient food because of his father's irresponsibility. He complained again of impoverishment in infancy because of the birth of a brother. He said he was homesick, wished to see his mother and 'new' stepfather.

Latent homosexual elements on the basis of which the transference was developing were evident in the dream. The masochistic nature of his attitude towards the analyst were represented by the werewolf and the needle. While the patient's siblings were eating at the parents' table, he was fed poison (medicated affection) through a (doctor's) needle. His resentment against his mother prevented him from accepting the emotional nutriment he so desperately craved: 'Food [love] cannot be for me; for me there is only death'. It is probable that the two-pronged needle represented the patient and his brother and the solution of his sibling hostility: death to both. In this connection it is noteworthy that the patient frequently stated, as in the episode of the threat to stab the analyst, 'I'm not going out of this place alone; two or three are coming with me'. The depth of his conviction of ostracism from the family and society is represented by placing himself under the table with the werewolf.

Shortly he reported another dream of which he remarked humorously, 'Now, don't let's diagnose this one'. In the dream he was in bed and suddenly his right calf blew up like a vein. 'Then, wham, a corkscrew went into it. I woke up and my leg was all right.' The patient was embarrassed when associations to this dream were asked for and refused to go on. During the following days he discussed his avoidance of marriage and his worry about contracting syphilis from casual sexual contacts.

The analyst maintained control of his privileges and changes in his prison classification. In the analytic room he was generally uneasy but productive. He playfully speculated about how he would act should he meet the analyst in later life, and related that he defended the analyst from slurs of fellow

inmates because of his continued treatment. During this period he brought magazine articles and pictures concerning psychiatry in the movies, and particularly stories of women psychiatrists.

The treatment was terminated when the analyst returned to a civilian status. In reaction the patient incited another prisoner to riot, became destructive and viciously threatening to the prison personnel, was punished by the prison administrator, and continued misbehavior resulted in his being sent to a federal penitentiary of maximum security.

The technique which utilized an avowed affiliation with authority by the psychiatrist produced for the patient a combination of the possibility of punishment and the demonstration of understanding and love. This attitude, new in the experience of the patient, permitted gratification of yearnings for security and a diminution of feelings of guilt.

The antagonistic psychopath wants to submit to authority and thus reach a source of security, but anxiety aroused by his masochism must be calmed and his instinctual primitive aggression tolerated. The possibility of discipline from the therapist absorbs some of the excessive hostility with the result that eventually identification with authority (superego) and formation of new ego ideals occur. The self-esteem of the patient is increased through narcissistic gratification which aids in the development of transference.

Such a technique as outlined is suitable only in institutions or with psychopathic offenders on probation. Whether analysis can be completed successfully in such cases is not yet demonstrable.

SUMMARY

The dynamic psychopathological substratum of the so-called psychopathic personality is similar to, if not identical with, the basic defects in the structure of the ego found in the neurotic character and in 'impulse neurotics' (Fenichel). The structure of the psychopathic character rests upon the same defenses against strivings for forbidden instinctual gratifications from

the early oral phases of infantile development as those found in the neuroses. The presence of anxiety, feelings of guilt, repression of instinctual urges and substitutive gratifications makes it difficult to view the psychopath as dynamically dissimilar to symptomatic neurosis. Theoretically, psychopathic personality should be a remediable condition. However, the ever-present attitudes of society towards psychopaths requires recognition in psychotherapy. The defenses of society are so strongly intrenched, so infiltrated with punitive attitudes, and such infinite patience and resourcefulness are required of psychotherapists, that spectacular results cannot be expected in the treatment of this neurotically ill group.

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Clifford M. Scott

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A PROBLEM OF EGO STRUCTURE

BY W. CLIFFORD M. SCOTT, M.D. (LONDON)

The problem of the nature of the 'reality ego' in contrast to the 'pleasure ego' is of interest chiefly for three reasons: first, it is related to attempts to clarify our conception of early development and the implications of early development on all stages of later life; second, such a problem furnishes, I think, a fruitful field for coöperative research among embryologists, neurologists, psychiatrists and psychoanalysts; third, and most important reason for discussing this problem, is my increasing conviction that a new orientation to what has been previously formulated as the relation between the bodily and psychic egos is necessary. No attempt is made to discuss id or superego problems in any way. There has been a gradual enlargement of the psychoanalytic views of the importance of what is unconscious and of what can become conscious. We have created difficulties for ourselves by trying to clarify a relationship between the psyche and the soma, between the body and the mind, between the psychic ego and the bodily ego almost as if this relationship is real in the same sense that the relationship between one ego and any other ego is real. I have come to the conclusion gradually that more progress may be made if psychoanalysts attempt to view this division between the psychic ego and the body ego as symptomatic of a splitting which may not necessarily be egosyntonic.

During our lifetime the conceptions which determine our view of the world and what happens in it have altered markedly. As part of that world we believe that there is a relationship between the unconscious forces in the discoverer and the discoveries which he makes of forces in the world, and in this I, of course, include the forces in human beings; nevertheless, as yet, we have made little use of these altering con-

Slightly altered from a paper read at the Conference of European Psychoanalysts at Amsterdam, May 25th, 1947.

ceptions of the world in improving our conceptions or formulations of the reality of what individual states of consciousness and individual lifetimes are. The work in genetics, with regard to mutations and the effects of environmental influences on characteristics previously considered to be determined by inheritance, the work in embryology which has greatly expanded the concepts of integration and differentiation and has pointed to the complexity of prenatal behavior, biochemistry which has greatly altered our view of the importance of food and nutrition, and the work of physicists and mathematicians, who have provided new conceptions of the universe and more especially new conceptions of the integration of space and time, must all be related sometime to what the individual is able to be conscious of immanently, immediately and nonsymbolically. To think of a space-time continuum, with the unit of experience called an 'event' with its space and time, is certainly as big a step in symbolism as was the introduction of Arabic numerals which made figuring extremely simple compared to the difficult task presented when only Roman numerals were available. Perhaps, similarly, when the problem of what is the nature of a 'reality ego' at any stage of development is before us, whether this stage be infancy, childhood, maturity or senescence, we see the effect of dysfunction or the development of what is called 'good' or efficient function. We use our senses to match our beliefs to a patient's to decide whether he is deluded, and we use our concept of the nature of external reality, of the nature of the body, of the relationship of the body to the psyche, etc., to evaluate his concepts when we are considering the nature of his development, his health or psychopathology. The value or uselessness of our concept of his 'reality ego' is seen most when we use it not only with normal and neurotic individuals but when we apply it to infants, psychotics and patients with degenerative neuronal diseases. In dealing with these on the one hand, and with patients recovering from some types of disorganization on the other hand, the traditional concepts of a soma-psychic split has in my experience proved a handicap.

In seeking a solution, and especially in attempting to explain a possible solution to others in any general sense, one has to use terms—a new term invented by oneself, a term taken over from a patient, or a term in current use to which a new meaning is given.

In this paper I have adopted the course of extending the meaning given to 'schema' and am using the term 'body schema' to denote that which will be defined and elaborated in this paper. Terms like 'life schema' or 'lifetime schema' were discarded as not emphasizing the central rôle the immanent body plays in the 'body schema' which I would gladly discard for a better term. In this discussion the body boundary and phenomena related to this boundary have a central and not a peripheral position with regard to all those aspects of the body schema which deal with distinctions and connections between the inner and outer worlds and distinctions between and relations among individuals.

The following is an example of the words with which a patient spontaneously describes what is meant by body schema. In a first interview, a married male teacher of thirty-five, who has a son of six months, complained that intercourse with his wife was interfered with by fantasies of sexual experiences with either boys or girls aged from two to fourteen. He stated that during the past ten years, despite the presence of this complaint, he had generally improved in other ways. Reared as a Catholic, he had ten years ago 'lost his soul'. He had ceased to need to feel that all experiences were not included under what he called his body and his mind. He felt that an increase in his abilities to teach and to cope with children and adults occurred five years previously when he ceased to believe in any essential difference between body and mind. When I asked what name he gave to what he was conscious of when he ceased to be interested in any personal difference between soul, body and mind, he said, 'me', or 'my enigma—the enigma of growth and development'.

In such a patient who has shown progressive development of ego functions the nature of the previous splitting into body,

mind and soul will, of course, enter into any analytic treatment, but to deal satisfactorily with and to do justice to the type of ego integration which can develop the concept of body schema put forward here may prove useful.

In many spheres of science, there is at present considerable interest in attempts to invent adequate integrating concepts. In our science the concept of the superego has been valuable and it is a concept which is used in the patient's own terms in the analysis of every patient. Similarly and indeed earlier, the concepts of ego and id became invaluable and no one doubts that they will remain so. In each individual analysis we deal with the material in the patient's own terms, including the terms the patient will use to discuss the parts of the ego which become from time to time unconscious. A division between psychic and body ego is usually almost taken for granted, both by analyst and patient and very rarely, and then only when abnormalities of the psychic ego or body ego are present, does the distinction come into analysis. Perhaps, when the distinction does come into analysis, more of the possible dynamics of this distinction as a split and by no means always as an egosyntonic split may become conscious, both in the patient and analyst.

Before discussing this concept in detail a tentative attempt at definition should be made. The body schema refers to that conscious or unconscious integrate of sensations, perceptions, conceptions, affects, memories and images of the body from its surface to its depths and from its surface to the limits of space and time. I am referring to a conscious or unconscious integrate of sensations, perceptions, conceptions, affects, memories and images of the body, etc., but this is not all. This integrate deals with a spread of content from a surface boundary outwards to the limits of space and time and inwards to the depths of one's inner life and to the limits of memory and anticipation. In other words, part of the body schema is a continually changing world scheme, the extended limits of which have to deal with what can only be called the limits of space and time,

and with a continually changing lifetime scheme of memory and anticipation.

Several types of criticism may be anticipated. First, the criticism that what is called bodily function is being emphasized at the expense of psychic function. I do not believe that is so. In any integrated conception the *quantitative* and *qualitative* aspect or problem of what was previously considered only psychic will still exist and have to be solved in any given patient and in any given situation, even though it is seen in a somewhat different setting. Secondly, it may be said that the concept of body schema is something too large to be of practical use; that it is only another term for 'personality' or 'character'. To answer this criticism fully would entail a long discussion of the changing uses of the concepts, 'personality' and 'character'. Personality has never been a useful day to day concept of psychoanalytic practice or of metapsychology, and when it has been used it has been used almost as much in contrast to the bodily ego as has the concept 'psychic ego'.

The neurological concepts of the 'body image' or 'body schema', etc., the psychological conceptions of 'schema', etc., and the psychoanalytic conceptions of ego, imago, internal and external objects, etc., can all be related, as far as their genesis in the individual is concerned. An attempt can be made to relate their development up to the present to the present state of functioning, both with regard to activity related to the present and with regard to planning for future functioning.

Recent work by Gesell (1946) and others on the development of behavior during the second half of prenatal life greatly extends our knowledge of prenatal motility and behavior. Trunk movements, limb movements, facial movements, breathing movements, sucking movements are active for such a long period before the usual birth that the origin of the body scheme and the regressive phenomena of psychotics and deteriorations must be linked to such discoveries. Coghill (1946) concludes that there are no primary reflexes which become integrated into more general or more comprehensive

patterns, and that reflexes are secondary and are developed by individuation within a total behavior pattern of primary integration. What Coghill states with regard to reflexes must be tested out with more complicated phenomena of development.

Neurologists have almost been forced to accept the concept of a dynamic unconscious to explain disorders of movement and sensation. The concept introduced by Head and Holmes (1911) of a schema which is continually being built up and is being continually altered by new activity and new stimulation on the one hand, and is being constantly used for reference in accurately placing new sensations and in correctly initiating new movements on the other hand, has proved most fruitful. The phenomenon of phantom limbs following amputations and the presence of phantoms following plexus or cord lesions without amputations has led to extensions of the concept.

Neurologists studying the recovery from posttraumatic confusional states, and in studying anosognosia in which the patient denies that he has lost a function, such as sight or the use of his limbs, have led to conclusions that there is a close functional interrelation between the ability to build up a scheme of the outer world and a scheme of the body. Many neurologists were stimulated by the work of the late Schilder (1935) who suggested that a spatial and temporal aspect were inherent in every sensation and perception. Schilder did not discuss the implications of this conception in the development of the body ego and psychic ego, both of which he took for granted. What I suggest is that every content of consciousness has a temporal and spatial aspect.

Psychiatrists and neurologists have both been presented with problems of polyopia (seeing objects as multiplied), autoscopia (seeing oneself outside oneself), metamorphosia (objects and people change shape, size, etc.), and have suggested that the body scheme concept should be enlarged to allow seemingly diverse phenomena to be brought down to a common denominator. Nevertheless I have found no reference suggesting that this common denominator is unconscious or conscious in

each patient and that many diverse ego and body symptoms may be the result of abnormal differentiation.

Parapsychologists also discuss the relation between the psychic ego and the body ego for reasons which psychoanalysts come up against repeatedly in dealing with psychoses. The parapsychologists who say that unconsciously there are no boundaries between different psychic egos seem to me to be saying that the psychic ego is almost, if not, infinite in size. Of course, omnipotence regarding extension as well as other functions is common knowledge in psychoanalysis.

Psychologists, especially in work on memory, have elaborated the concept of *schema* even further than the neurologists, but have paid little attention to it in a genetic sense. Northway (1940) puts forward the suggestion that the notion of a schema suggests a means of evaluating achievements and the extent to which development is reaching desired ends. Nevertheless this attitude is more that of giving the observer a new standard of reference than that of discovering something new in the unconscious or conscious of the person observed.

Freud (1915) came, I think, nearest to discussing the body schema concept when he stated that the ego '. . . can abolish external stimuli by means of muscular action, but is defenseless against those stimuli that originate in instinct. This antithesis remains sovereign above all in our intellectual activity and provides research with a fundamental situation which no amount of effort can alter.'

Later (1923) Freud wrote: 'In the last resort the quality of being conscious or not is the single ray of light that penetrates the obscurity of depth-psychology. The body itself, and above all its surface, is a place from which both external and internal perceptions may spring. It is seen in the same way as any other object, but to the touch it yields two kinds of sensations, one of which is equivalent to an internal perception. . . . The ego is first and foremost a body-ego; it is not merely a surface entity, but it is itself the projection of a surface.'

Riviere (1927) annotated this last sentence thus: 'The ego

is ultimately derived from bodily sensations, chiefly from these springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body, besides, . . . representing the superficies of the mental apparatus.'

Here are brought together two problems: (1) the problem of the perception of the body or body-ego—I cannot distinguish between these—and (2), what I think is almost the same problem, the relationship of the unconscious and conscious body ego to 'mind' or 'mental apparatus'. Freud's designation of the ego as a mental projection from the surface of the body is the nearest I can find to a metapsychological formulation of what I consider one of the earliest splits in the ego—or splits in the body schema—between (1) the body and all that which can become conscious as integrated to form the body or body ego and (2) the mind—the psychic reality—the inner world—the psyche as opposed to the soma.

Freud (1927) described in The Future of an Illusion the psychoanalytic facts regarding beliefs concerning the 'soul' within man, and the abode of Gods, devils, and the souls of the unborn and the dead in the world outside man. He described the reasons why people consider these something *apart from* and not a *part of* the mind of man. When a mind has lost the need for a soul it gains conscious access to and control of all that had been, at an early period of life, split off and disowned for many reasons. Similarly when a patient in analysis loses the illusion of needing a psychic apparatus separate from all he has called his body, his world, etc., this loss is equaled by the gain of conscious access to and control of the connections between the superficies and the depths, the boundaries and solidity of his body schema—its memories, perceptions, feelings, images, anticipations, etc.—which had been given up at an earlier period in his life when the duality, soma-psyche, began. Not infrequently in a patient whose first complaint is a fear of 'losing his mind', the desire to lose his mind and regain the feeling of a previously integrated state but in a new form soon becomes apparent.

Melanie Klein (1946) has stated that the early so-called wish-

fulfilling hallucination of a good object is only a partial memory and should be related to a coincidental denial of a destroyed or injured or fragmented similar object. She wrote: 'The main processes which come into play in idealization are operative in the hallucinatory gratification, namely, the splitting of the object and the denial both of frustration and of persecution. The frustrating and persecuting object is kept widely apart from the idealized object. However, the bad object is not only kept apart from the good one, but its very existence is denied as *is* the whole situation of frustration and the bad feelings (pain) to which frustration gives rise. This is bound up with denial of psychic reality. The denial of psychic reality becomes possible only through the feeling of omnipotence—an essential characteristic of the early mind. Omnipotent denial of the existence of the bad object and of the painful situation is in the unconscious equal to annihilation by the destructive impulse. It is, however, not only a situation and an object which is denied and annihilated—it is an object relation which suffers this fate; and therefore a part of the ego, from which the feelings towards the object emanate, is denied and annihilated as well.'

The implications of the last sentence should be specially noted and elaborated, namely, it is both the object relation and the part of the ego which is a part of the object relation which are annihilated. For example, in infancy the frustrated immanent mouth has to be denied, separated, annihilated for the hallucinatory oral gratification to be effective. The memory of previous oral gratification may be conscious in the hallucination, but if this is so the hallucinated, satisfying mouth is separated from the immanent but frustrated, desiring mouth. A wish-fulfilling hallucination (an infant's dream or hallucination of the breast) has to be related to the place where the hallucinated breast is, how it is kept away from the mouth, in other words, how it is kept static in order to prevent anxiety. Anxiety might develop by remembering the phase of a past experience which was unpleasant (a previous frustration) or by fusing the hallucinated object with an immediate sense

perception of frustration which cannot then be tolerated (as when the breast reaches the mouth the dreamer may wake with sensations of oral frustration). Such wish-fulfilling hallucinations in adults can be linked to a denial of unconscious perception of the world as it would be if the hallucination did not cover, blot out, the adult external world of reality. In other words, a bit of the immanent world as well as a bit of the immanent superficies of the body have equally to be denied to allow hallucinosis. The study of the factors governing these denials may turn out to be quite as important as the already discovered factors governing the content of the hallucination. Not always is a bit of the external world fused with or identified with the content of the hallucination. Often rather a part of the world has to be unconsciously denied for the hallucinatory content to take its place. For some time I have noticed that the most difficult hallucinations to discover are those which occur in a place where an object similar to the content of the hallucination is. Of course, normal perception and normal recognition of objects is related to this process, but not infrequently the projection is of an emotionally much more significant object. Freud (1911) mentioned facts allied to this in describing how in the early stage of paranoid delusions some basis in fact may exist. Often it is found that the description of the delusion is in terms near to, but not identical with, those the patient would use to describe the external situation had it no important significance for him. This problem is similar to the neurological problem of a phantom limb which is much more difficult to describe or detect when the real limb is still present.

Tausk (1919) related the libido, at the early stage to which the schizophrenic regresses, to a developmental stage of the psyche in which the object, to which the libidinal cathexis occurs, is in fact a part of the individual's body but is still regarded as a part of the outer world: 'His psyche is the object of stimuli arising in his own body but acting upon it as if produced by outer objects'. From this results the development of 'a unified whole under the supervision of a psychic unity',

narcissism and autoerotism. In this view there seems to be a more or less conscious relationship between a narcissistic bodily ego and something within: the psyche. The point to which regression occurs is considered by him to be the end of fœtal existence. He states: '. . . the development both of the ego and of the libido may become arrested and may set up goals of regression at as many points as there are primary, secondary, tertiary, (etc.) factors of relationship and development. The entire problem is further complicated by the elements of time and space and so made insoluble.' Such pessimism has been proved unwarranted, and I think it has been proved so by a gradually increasing awareness of the relationship of the whereness and whenness of instinctive impulses and derivatives. The view which he expressed that stimuli—hallucinated stimuli—memories—thoughts was the sequence of development is, I believe, a partial truth. Other facets of the truth regarding many hallucinations, memories and thoughts are the unconscious denial, destructive scotomization of the conflicting effects of past and present experience. In other words, hallucinations, memories, thoughts have been found to be less simple phenomena than previously considered, but an acceptance of this complexity has led to a much more than descriptive analysis of their genesis. Tausk's paper shows the same attitude to schizophrenia as some more modern authors do to the organic psychoses. He describes what has happened in a psychosis as the so-called 'psychotic process' develops, but nothing of the psychotic in the complicated psychotic type of transference situation. I think it is only by attempting to understand in greater detail the countertransference effects of the need to maintain a differentiation between psychic and body ego and the countertransference effects of the ability to integrate bodily and psychic ego, that more psychoanalytic advances will be made in the study of ego development in children, defectives, psychoses and organic deteriorations. If the body schema, as described, is used as a frame of reference for describing conscious and unconscious ego functions I think many problems may be simplified.

If such a body scheme is unconscious in all patients, and if the division between the psychic ego and the body ego is almost a universal cultural split, and if perhaps it is also a development due to the present stage of human evolution and, consequently, common among psychoanalysts, it will not easily be recognized unless in personal analysis the dynamics of the genesis of the split between the body and psychic egos has been well elucidated.

In conclusion I wish again to stress that I have not discussed the id or superego and have not in any way tried to add to or alter the usefulness of these concepts. In this brief abstract of views to be published much more extensively later, I have only tried to draw attention to the possibility that the commonly accepted primary divisions between the external world, the body ego and the psychic ego (or mind) may be considered quite as symptomatic as the further divisions (now accepted as symptomatic) into soul, heaven, hell, etc. A structural concept of a 'body scheme' to describe the conscious and unconscious integration which exists before the split into external world, body and psyche occurs has been suggested as useful. This concept is helpful in giving a general description of what happens in individual analyses as the illusions of the previously rigid boundaries between mind, body and external world are given up and new and more useful ways of living develop. Such a concept may be useful in linking psychoanalytic theory more closely to developments in related sciences—neurology, psychiatry, psychology, etc.

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The Influence of Unrecognized Difficulties

Richard L. Frank

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THE INFLUENCE OF UNRECOGNIZED DIFFICULTIES

BY RICHARD L. FRANK, M.D. (NEW YORK)

I wish to point out in this paper that healthy functioning may be interfered with by nonpsychological phenomena which have existed in the individual's past and that these interfering processes may fail of conscious recognition by everybody, and interfere with therapy in much the same way as they have disrupted adaptation in daily life.

I was introduced to this problem while working with hard-of-hearing children. Parents, teachers and physicians seemed to have the greatest difficulty in recognizing a loss of hearing and in accepting its immediate and commonplace implications. Trained medical men seemed to evaluate it as poorly as did the average citizen.

Later, in practice and in the army, I found many case histories from which similar pictures emerged. Various defects and diseases of the patients had been seriously misinterpreted. Among these were allergies, diabetes, chorea, rheumatic fever, epilepsy, defective intelligence, confusional states and a multitude of other conditions.

To compound the confusion was the apparent ready acceptance by the suffering individual of the mistaken judgment of those in authority. For example, the hard-of-hearing child would tell you that the reason he did not come when mother called, or did not hear the teacher, was that he was not paying proper attention. He would often say that he did it because he was angry or disinterested. In fact, he would agree with almost anything that he had been told with sufficient emphasis by those over him; and when objective tests showed the presence of organic defects, in themselves sufficient to explain the difficulties, anxiety often proved an obstacle to giving subsequent relief. This anxiety was mainly in terms of threatened interference with relationships to parental figures.

That there are profound unconscious factors in such situations is well known. It is not my purpose to discuss so much the reasons for this development as it is to consider the consequences. The consequences extend into the personality of the patient, into the development of symptoms, and they profoundly affect his human relationships.

Certain types of defect seem to be particularly disturbing for the individual since they interfere with functioning and also prevent effective handling of the relationships with others; thus, anything involving reality testing, considered in the broadest sense, can be expected to produce deep-seated anxiety and reactions designed to deal with the situation. Disturbances of functioning of sense organs, of sensation or of orderly mental activity are of this nature.

One of the most effective tools for bringing about a good working relationship between persons in authority and an individual is the phenomenon of understanding. We have become accustomed to think of it in terms of empathy and of an inner knowledge of feelings; but it is obvious that a knowledge of the actual situation plays an equally important rôle.

Our own preverbal experience forms a background for our appraisal of understanding. The care that an infant receives is partly guided by the mother's intuition. It is, however, made effective by the mother's knowledge and experience and the facility thus acquired in correcting the causes of the discomfort. A vague feeling that something is wrong and a desire to help cannot, in itself, automatically correct distress and overcome pain. The pangs of hunger can be rendered more tolerable by cuddling, but it requires feeding to stop the pain. Likewise, a pin sticking in an infant is not rendered less painful by feeding the infant. Understanding the situation is as important as sensing the pain.

As the infant matures it depends less on magical communications. It develops or acquires skill in directing the adult to the source of its pains. This is a significant step in adaptation. The adult likewise tries to combine intuition and skill. Anything that causes an abandonment of this development and a

return to magical solutions is a step toward maladjustment and illness.

The perception by an individual that those around him are disturbed because of a particular difficulty revealed by him may represent the point at which he abandons his efforts to get realistic help. Both adult and child have great difficulty in distinguishing between the rejection of a trait or a bit of behavior, and being rejected as a person.

Holding to the promise of necessary help from those upon whom he is dependent becomes a paramount issue if that help is threatened. The child may be completely unable to change a physical trait which it knows exists, but it can offer to change its behavior. The issue becomes diverted from the correction of the defect to a false struggle with behavior.

In every person's life history may be found periods when things have gone wrong. At different times those close to the individual have not perceived the true nature or extent of difficulties. If the general feeling of strength within the individual is adequate, and if the confidence felt in those around is sufficient, the ensuing disturbance is weathered without too prolonged a dislocation of relationships, nor are the symptoms maintained over an extended period. Various factors such as the duration of the misunderstanding, the measures used for handling the individual, and the degree of incapacitation induced by the disturbance, play a part

For example, many children develop chorea and, as Wilson puts it, 'Someone has said that a choreic child is punished thrice ere his condition is recognized—once for general fidgetiness, once for breaking crockery, and once for making faces at his grandmother'.[1] If finally, the true nature of the disease is established, everyone is contrite, all is forgiven and under favorable conditions, the child resumes his normal way of life. But, if the acute phase of the illness does not appear, and the cause of the earlier misbehavior has not been diagnosed, those around the child may continue to bring pressure. Lasting

[1] Wilson, S. A. Kinnier: *Neurology*. Baltimore: Williams & Wilkins, 1940. Vol. I, p. 612.

disturbances may then ensue. Along similar lines are the continuing upsets incident to minor encephalitic changes or to unrecognized epilepsy. Defects of brain functioning are particularly productive of anxiety, are not obvious since they can be concealed or circumvented, and are particularly subject to denial of their very existence by all concerned. Frequently they can be revealed only under special conditions of testing. Since cases with this type of difficulty illustrate particularly well some of the points I am trying to make, I shall draw my illustrations from among them.

A twenty-three-year-old soldier was brought into a medical ward with what, at first, was thought to be a coronary thrombosis. It was rapidly evaluated as an acute anxiety state. The patient became sick when transfered from a protected special service job to one of danger requiring skilled muscular coördination. He had struggled to make the adjustment but became anxious in a relatively short time. He was an only child of socially ambitious parents. His father was an educator. The boy had reached the middle of his fourth year at college when he was drafted. Ostensibly he had a high I.Q. but differential testing revealed a persistent inability to deal with spatial configurations, number and letter reversals and confusion. In addition, he was astoundingly clumsy and could hardly identify right from left. He had failed in geometry five times, and had finished his third college year only by dint of persistent study to the exclusion of all social life. Superficially, he was devoted to his parents. His opinion of himself was that he had again failed them from 'lack of guts', application and ambition. In similar terms he assailed himself for having let down the army officers who had believed in him.

His initial reaction to being told that his cardiac symptoms did not mean invalidism was relief, immediately followed by severe depression. When, eventually, he became aware of the basis of his confusional state he felt much better for a time, but gave expression to a tremendous amount of hostility toward his parents and others in authority for what he rightly felt was their failure to understand the reality of his difficulties. Re-

educational methods succeeded in showing this man the direction that his rehabilitation could take and proved an effective aid in the removal of his anxiety and of the symptoms associated with his hostility. It is noteworthy that this case showed a catastrophic type of reaction [2] when he was presented with tests which brought his confusion to the foreground.

Now, it has not been the intention in this paper to dwell specifically on problems of cerebral dominance, confusional states, etc. Let me be prompt to deny that all cases of intellectual disturbances are organic in origin. Sometimes the interferences in intellectual functioning are mainly psychological.[3]

Nor do I wish to give the impression that I consider all cases of psychological illness to be based on underlying organic substrates which have remained unobserved. I do wish to emphasize the converse of this. Long continued organic obstacles to functioning may lead to psychological illness. This is particularly true when the nature and reality of the difficulty is not recognized and overcome, and when the defective functioning of the individual is dealt with essentially as a moral or behavioral issue.

The problem of dealing with nonpsychologically determined symptoms has been a difficult one for psychoanalysts. All have been aware of the long and involved struggle to convince the medical world that physical symptoms often are the direct expression of psychological conflict. Analysts, themselves, have had to fight back their own fears of the mysterious world of the mind and to resist the constant temptation to find a 'real' cause for symptoms. To complicate the matter further, there has always been the tendency of the patient in treatment to

[2] Goldstein, Kurt: *The Organism.* New York: American Book Co., 1939, Chapter I, *cf.* pp. 35–61.

[3] I cannot confirm, however, Blau's thesis that disturbances of laterality are only a special manifestation of negativism. It seems more in accordance with the clinical observations to consider the negativistic reactions seen in these individuals as part of their defensive maneuvers. These are consistent with their feeling of intrinsic helplessness and of their fears of what they interpret as threatening surrounding figures. *Cf.* Blau, Abram: *The Master Hand.* Research Monograph, No. 5. New York: The American Orthopsychiatric Association, Inc., 1946.

use physical symptoms as a weapon against the final relinquishment of primitive defenses. Physical illness could always be brought forth to tempt the therapist out of his shadowy rôle into a situation where he must play the physician. And in demonstrating to the patient the relationship between psychic conflict and physical symptom, the disappearance of the symptom has always been one of the most convincing experiences.

Psychoanalysis has traditionally been concerned with those cases where trauma might have exerted an initial effect which was then perpetuated for psychological reasons. Kardiner,[4] in a case where an organic substrate continued to exert its effects currently, reported some therapeutic results, with methods designed to re-establish effective ego functioning.

When patients sense difficulties in ego functioning and the therapists do not, difficulties in the therapy must be expected. Much of the deeper awareness that not all is well internally is extremely difficult to verbalize. It sometimes communicates itself in some indefinable way to the therapist, but where unrecognized, certain changes in the relationship with the therapist are inevitable.

The relationship to the therapist depends fundamentally on the establishment of a bond between patient and doctor. The ability of the therapist to communicate his understanding of the patient's situation to him forms the keystone of therapy. The understanding which the patient demands is founded on the models of former relationships. Infinite expectations and demands for magical help are familiar. We are accustomed to work these out in the transference. Our purpose is to reorient the patient to a more realistic series of expectations and to secure the use of more effective techniques of functioning. It is obvious that to be successful in this the therapist's view of the situation must, itself, be realistic and factually oriented.

There are many similarities in effect between inexact interpretations in therapy and inaccurate explanations in early

[4] Kardiner, Abram and Spiegel, Herbert: *War Stress and Neurotic Illness.* New York: Paul B. Hoeber, Inc., 1947. Chapt. VI, pp. 152–157; Chap. VII, pp. 219–223.

life. The mistaken appraisal of the situation in real life may have either convinced the individual or coerced him into the use of the affected organ. If the period of use enables the individual to preserve functioning until spontaneous healing has taken place or enables him to develop methods of circumventing the difficulty, an increase in self-confidence may ensue; and an increased confidence in the coercing individual may also develop, based on the objective results obtained and on the feeling that it was all done for his own good. But, if the task required is beyond the ability of the individual, or if the anxieties become too great, the results may be far different. The task may be tackled ostensibly but substitutive symptoms such as illness or involvement in social difficulties may serve to prevent functioning.

Glover [5] has pointed out that inexact interpretation may do a very similar thing. The patients displace and repress their symptoms. Artificial substitutive symptoms may be produced and apparently take the place of the original symptoms. If the analyst misunderstands and misdirects his efforts in the same way that others have done in the patient's life, we can see similar types of defensive functioning expressed either in the transference or in the form of acting out.

The particular point which I wish to stress in this paper involves the course of those cases where the initial cause of disturbed functioning remains current and unrecognized. The derivatives of the difficulty are analyzed. The disturbances in present relationships are traced back to early experiences in life. The patient learns that current figures are not identical with the figures surrounding him in childhood. The ineffective nature of the defensive reactions becomes obvious to the therapist and the patient. Symptoms shift, relationships transiently improve, but something keeps interfering with the completion of the treatment.

Resistance is analyzed out on different levels and in the transference. The various symptomatic methods of telling

[5] Glover, Edward: *The Therapeutic Effect of Inexact Interpretation. A Contribution to the Theory of Suggestion.* Int. J. Psa., XII, 1931, p. 400.

his problems are considered. The multitudinous dramatic, coercive and evasive maneuvers are worked with. The patient improves. Difficulties in functioning are analyzed in relation to their emotional connections but at some point the patient continues to complain of something being wrong. The analyst may have an uneasy feeling that all is not well with the patient. But the previous examinations have revealed no organic pathology. The analyst fears that he is looking for an excuse for his failure, in seeking an organic cause for the persistent difficulty. The patient, too, confirms this feeling by revealing how his difficulty is intensified by anything which puts him under emotional tension. He reveals anxiety over his inability to meet the demands of getting well. He gets spells of depression and of irritability in his efforts to control himself and in response to his resentments. The more these are analyzed, the more the patient tends to take refuge in techniques designed to show the analyst how hard he is trying to be good or to demonstrate the hopelessness of the struggle. Passive aggression becomes a frequent manifestation. In less anxious individuals, the defiance may become more overt and the demands for immediate help direct. Some of these patients take the logical step of leaving treatment when the help they seek is not forthcoming. The problem is often easier to see in therapy with children and is indeed easier to handle. I should like to present a simple case history as an illustration.

Roger was nine, the eldest of three children, with sisters two and four years younger. He was reared in a large city in the middle West. His early childhood had been without incident. There were no serious illnesses or accidents, except a tonsillectomy at seven. Feeding had been no problem, training in cleanliness was uncomplicated, sleep undisturbed. Social relationships had been good. He was under the care of one nurse until he was about seven and a half. The family moved to a new neighborhood when he was eight with a resulting change in schools. Problems began to come to the foreground at this time. He disliked school and his new group. There developed increasing jealousy of one sister and resentment toward

what he considered unfair handling by both mother and father. He had numerous colds and minor illnesses. There were spells of stubbornness, tantrums, episodes of talking back to parents, maid, and teachers, and unfriendly relationships with children.

When seen, he presented the picture of a tense, irritable, unhappy boy who needed help. The parents were friendly, interested, coöperative, but it seemed obvious that they represented the crux of the problem. The father had had an unhappy childhood beset by failure in a conventional school, followed by success when taught individually. He was resolved that his boy would not suffer the sense of frustration he had suffered with his parents. He had made himself a boon companion to the patient, coaching him in sports and in his studies. Actually, he had become a highly competitive older brother to the boy. One sister, who was bright and winning, attracted a large part of the mother's time and interest.

A period of analytically oriented play therapy was initiated and marked improvement was shown after a fairly short time. His sibling rivalries decreased, his relationship to his parents seemed easier and there was less sullenness at school. The material was appropriate to the situation and treatment seemed satisfactory, but progress tapered off. At the end of the school year there was great tension. He was in danger of failing in arithmetic, and the father's attempts to bring him up to grade by tutoring were met with resentment and a revival of feelings of being under too much pressure and of being misunderstood.

Despite several previous intelligence tests, a new series of psychometric tests were done, at ten and a half years, as was a Rorschach. In general the boy did very well on verbal material: Terman Vocabulary I.Q., 120; Stanford Binet, 121. He did very poorly on concrete material (Ferguson Form Boards), below eight years. He was nervous, jerky and unrhythmical. He had trouble finding underlying principles but little difficulty in applying them when once found. The interpretation by the psychologist was that the difficulties were

due to interference with concentration because of emotional factors. From the Rorschach came a number of pertinent statements: '. . . marked emotional insecurity—great deal of tension, unhappiness and suffering . . . nature of conflict seems fairly well known to the boy, annoys him greatly and intermittently depresses him. Problem probably sexual. . . . Has inhibited fantasy life. Emotional responses less inhibited. Drive for achievement not so strong as would be expected at his age. Boy seems to protest against demands which are made of him and which he considers unfairly great. . . .' Since the tests seemed to confirm what was already known, treatment was continued along the same lines as previously. The relationship with the therapist continued to be warm but there was increasing veiled resentment.

With the help of his father's intensified tutoring the boy completed his school year. He had a fairly good time at camp. Upon his return to school and to treatment he often complained about the unfairness of what he was required to do. About a month later his parents came in to demonstrate some of his attitudes and showed a letter he had written from camp. To my amazement the letter was full of reversals, transformations, misspellings and other evidence of profound specific disability. The parents then revealed that this had been of long standing and had seemed to them of no particular moment. Special retesting was done and the obvious situation confirmed. An interesting side light was the revealing of a similarly veiled difficulty in the father.

Several points of importance can be seen here. First, that a fairly obvious problem could be missed by parents, several good schools, a competent and alert psychologist, and by the psychiatrist. That the problem was obscured by his high intelligence, his unusually keen powers of observation together with the consistant help at home, as suggested by the second tester, does not alter the fact that it was missed. One other important point must be noted: that the psychologist's interpretation of his tests had been seriously warped by the interjection of

thinking borrowed from the psychiatric field. Goldstein's[6] observations on the catastrophic reactions in test situations of the injured brain show that the emotional reaction is often the result of the individual's feelings in respect to a situation with which he can not cope adequately, and can not be adduced as the cause of the lowered test scores. Both are manifestations of the underlying difficulties, as they proved to be in this case.

When the results of the tests were reviewed with the boy, a profound anxiety reaction ensued. 'Everyone', he said, 'is trying to tell me I am dumb; now, my father won't be willing to help me anymore'. Depressive features came to the foreground: 'What is the use? I can't hope to be any good. I don't have the guts to go in for a long period of retraining.' His depressive maneuvers were devoted to attempting to get proof that he would not be abandoned. As with his emotional reactions to most real situations, these too proved transient. Remedial tutoring was initiated. The response of the patient to finding that there were real difficulties for which he could, in fact, be helped was marked. With improved performance, he became less tense and more outgoing. He sought out companionship of both sexes. He became vice-president of his class and captain of his football team. Family relationships became far easier, and as the source of his feelings of being misunderstood became apparent, he was able to accept the situation easily and directly. The sexualization of the problem, which had appeared causative previously, proved secondary and, in good part, a sugar coating for what had seemed an inescapable deficiency. This cleared rather easily. The improvement in general functioning had, in itself, a marked curative effect. A follow-up, four years later, revealed a happy, popular, well-functioning boy. There remained some residue of the profound rivalry with the father, but this was not caus-

[6] Goldstein, Kurt: *The Significance of Special Mental Tests for Diagnosis and Prognosis in Schizophrenia.* Amer. J. Psychiatry, XCVI, 1939, pp. 575–588. And, *cf.* footnote 2.

ing noticeable interference. His specific disabilities, while improved, were not completely corrected.

I do not believe that the recognition and correction of his specific disabilities would have, of themselves, helped this boy without psychotherapy, but I do believe that without the handling of this situation psychotherapy would have become increasingly ineffective.

It is not surprising that confusional states should be potent sources of disturbance since interference with scholastic achievement is only one phase of the problem. Social graces and athletic prowess are often involved.[7] That a difficulty interfering in mental, physical and social spheres could prove a potent source of conflict seems reasonable, but even apart from any possible specific rôle of the confusional states, re-educational measures can be used as an adjunct to psychoanalysis in adults where evidence of a basis for disturbed functioning is found. In cases of traumatic neurosis, Kardiner[8] has pointed out, this has been an essential measure. I believe that with an awareness of the problem many occasions will be found where a prompt use of properly trained clinical psychologists, physiotherapists, and educators will result in the avoidance of interminable analysis. Thus far in analysis, patients have been referred to other specialists for specific organic complaints or for clarification of diagnosis. The tendency to use such auxiliary aid has been greater on the part of doctors working in institutions where investigations are a matter of institutional routine. In individual practice the danger of giving the patient some basis in reality for developing the fantasy of having an organic disease which he may use as a defense has to be given careful consideration.

Specific disturbances of mental functioning have been considered the domain of the neurologist or the educator. Analysts have taken an interest in the treatment of stuttering;

[7] Orton, Samuel T.: *Reading, Writing and Speech Problems in Children.* New York: W. W. Norton & Co., 1937.

[8] *Cf.* footnote 4, Chapt. VII, p. 173 and 219–223.

child analysts have shown an interest in the correction of the so-called habit disorders; but, by and large, analysts of adult patients have been more content to investigate the psychological mechanisms surrounding the disturbance in mental functioning than to devise techniques for dealing with them.

The problems presented in conjunction with the traumatic neurosis and the various brain disturbances incidental to war have stimulated fresh interest in this. It is my impression, however, that the most fruitful field for working out the necessary techniques will prove to be in the cases of less complicated neurosis. The study of a large number of differential psychometric tests in cases in my practice and in the army has shown that many cases of neurosis continue to have current disturbances of mental functioning. It has been possible to treat this directly in childhood and in certain adolescents. From the type of response seen in the transference, I am convinced that the results are not purely suggestive. At the very least, a better contact with the patient has been possible. Facilities for dealing with this same problem with adult patients in office practice are found with difficulty. Realistically directed treatment, designed to help overcome the physical basis for various symptoms can prove successful. It does not cause the patients to avoid making efforts to overcome their psychopathological symptomatology; if anything, it reinforces their efforts.

SUMMARY

Underlying disturbances of both physical and mental functioning can exist unnoticed, and can be prejudicial to psychotherapy. These disturbances can be brought to light and treated by direct methods with benefit to psychoanalytic therapy.

This communication is presented to attract attention to the technical problems involved. It is hoped that a pooling of experience will enable us to find methods of overcoming this type of obstacle to successful therapy.

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In Memoriam

A. A. Brill

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IN MEMORIAM

Richard H. Hutchings

1869–1947

Following his voluntary retirement from the New York State Hospital, June 30, 1939, after forty-seven years of active, conscientious and outstanding service, the pupils, co-workers, and friends of Richard H. Hutchings dedicated to him a number of the Psychiatric Quarterly (XIII, No. 4). My contribution to it was entitled Richard H. Hutchings, Friend of Psychoanalysis. It was the kind of a volume that the French call a *mélange,* and the more pretentious Germans a *Festschrift.* The word *mélange* means a mixture, and thus expresses that the volume is made up of a number of papers on problems and topics that are of interest to the honored scholar, while the word *Festschrift* implies, in addition, that the publication of such a volume carries with it something solemn and festive. Whatever its characterization, such a dedicative volume signifies that the dedicatee has perceptibly influenced his co-workers both as a teacher and active contributor to some branch of science. It was in this spirit that I wrote, and I quote some of the thoughts I expressed at that time because they are still as appropriate as they were in 1939.

> 'The degree of narcissism in our civilization is so high that no matter how well one performs his life's tasks, he usually gets little credit therefor. Our contemporaries expect us to march in line with them in the familiar, well-trodden paths which were laid down by former generations. . . . But in the course of history, it sometimes happens that through some unconscious overdetermination there arises now and then some genius, who deviates from these familiar paths. The horde invariably becomes dismayed by his behavior and calls him revolutionary; he is looked upon with suspicion and efforts

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Read at the meeting of the New York Psychoanalytic Society, December 9, 1947.

are made to thwart him, for he speaks a tongue which is comprehensible only to a few.'

Hutchings belonged to the few who understood Freud when he first appeared on the American psychiatric scene. Hutchings sensed the value of psychoanalysis when few if any state hospital physicians gave any thought to it.

Shortly after I entered the New York State Hospital service in 1903, I was attracted by a notice in one of our neuropsychiatric journals which stated that Hutchings had been appointed superintendent of the St. Lawrence State Hospital. I would have surely forgotten this notice if it had not been for the fact that years later, while I was busy with the translation and exposition of Freud and his theories, I received an encouraging letter from Hutchings in which he told me that he was fully convinced of the theories and values of psychoanalysis. Speaking here to you, an audience composed mostly of young psychoanalysts few of whom knew the deceased, I cannot express to you what this message meant to me. When I introduced Freud's theories in this country I made a special appeal to state hospital psychiatrists. Having been one of them I wished to convince them first, but it was a futile effort. Hutchings' letter, as you may imagine, was a real tonic to me.

Richard H. Hutchings was born in Clinton, Georgia. After completing his academic education in a military school, he studied medicine in the old Bellevue Medical College, where he received his M.D. in 1891. For a year he interned in the Almshouse Hospital at Blackwell's, now Welfare Island. In 1892 he entered the Manhattan State Hospital, Ward's Island, and remained in the state service until his retirement in 1939. I shall not attempt to enumerate his many beneficial and useful activities during his long and honorable career in the state hospitals. Others better qualified than I will speak of that elsewhere. Here I merely wish to recall with gratitude his conscientious efforts in behalf of psychoanalytic psychiatry.

Having gone into psychiatry at a time when the specialty

was not so highly rated, Hutchings strove hard to raise it to a higher level. All his contemporaries spoke of him as a student actively in quest of practical and theoretical ways for the advancement of psychiatry. Long before the New York State Psychiatric Institute rose to its present scientific status, before Adolf Meyer became the director of the Pathological Institute on Ward's Island, the staff of the Institute was headed by Van Giesen, Sidis, and Levine. These workers investigated all sorts of neuropsychiatric problems, neuropathology, biochemistry, suggestion and hypnotism, even crystal-gazing. While on Ward's Island, Hutchings worked there whenever his regular hospital duties permitted. Hutchings was not satisfied with the routine activities of the state hospital physician; he was an active innovator as one can see by reading the New York State Hospital publications.

From 1908 he taught psychiatry in the School of Medicine of the Syracuse University, and from time to time he contributed papers and discussions to current psychiatric periodicals. His last paper, Psychoneuroses and Our Changing Times, which appeared a few days after he died (Memorial Issue to Smith Ely Jelliffe of the Journal of Nervous and Mental Disease) is typical of his broad interests in psychiatric problems.

In 1930, he published the Psychiatric Word Book, of which over twenty thousand copies have since been sold. Speaking to me before publishing it, he deplored the fact that earnest workers in the field of neuropsychiatry often make serious mistakes in the use of words which have definite meaning. Few realize the amount of effort Hutchings expended in making this an authentic work.

Since 1935 Hutchings functioned as the editor of the Psychiatric Quarterly, which he raised to one of the best periodicals in the field of psychopathology. I know that he always welcomed papers on psychoanalytic psychiatry, and his editorials were always interesting, direct, and at times provocative.

Hutchings became a member of the American Psychoanalytic Association which was formed soon after the New York Psy-

choanalytic Society for those who lived outside New York City. When the American Psychoanalytic Association was later reorganized to include all members of all the groups—by this time there were four—the original members of the American Psychoanalytic Association joined the group nearest them, and Hutchings then became a member of the New York Society.

I have been in friendly communication with Dr. Hutchings since 1912. I discussed with him everything that took place during my active work in the psychoanalytic movement, and often asked for his help and support. He was of the utmost help to me in founding the Section of Psychoanalysis in the American Psychiatric Association when some members of this society foolishly opposed it. It was Hutchings, Chapman, White and other psychiatrists who stilled the critical voices of Bernard Sachs and many others who were horrified at the idea of a section of psychoanalysis in the American Psychiatric Association. I was pleased when Hutchings followed me as chairman of this section (1936–1937); for Hutchings was highly regarded in the American Psychiatric Association whose president he was in 1939. You may not now know that there was a time when psychoanalysis was surrounded and assailed by hostile forces and needed support from orthodox psychiatrists. Yes, there was such a time, and we owe much to Richard H. Hutchings for having been a friend in need. He not only gave direct help to me, but his indirect influence on the advancement of psychoanalysis among the more progressive old timers can hardly be estimated. His assistants and pupils were all indoctrinated in psychoanalytic thinking. Dr. Lehrman, your former president, came to me directly from Dr. Hutchings; Dr. H. L. Levine, another former assistant of Hutchings, also became an analyst.

Like every mortal, Hutchings had to pass on. In June 1947, I spent two days with him at a conference in the Willard State Hospital. I saw that his body was weakening, but his mind was unchanged. When we parted we both talked as if we would soon meet again. I received a letter from him a month before

he died, but never saw him again. Richard Hutchings lived a full life with all its trials and vicissitudes, and passed away following a cerebral hemorrhage which rendered him unconscious to the end.

I have lost another friend and co-worker. You may think of him with gratitude as a pioneer American freudian who worked with full conviction for the advancement of our science.

A. A. BRILL

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War Stress and Neurotic illness. By Abram Kardiner, M.D. with the Collaboration of Herbert Spiegel, M.D. Second Edition of The Traumatic Neuroses of War. New York: Paul B. Hoeber, Inc., 1947. 428 pp.

Nathaniel Ross

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BOOK REVIEWS

WAR STRESS AND NEUROTIC ILLNESS. By Abram Kardiner, M.D. with the collaboration of Herbert Spiegel, M.D. Second Edition of The Traumatic Neuroses of War. New York: Paul B. Hoeber, Inc., 1947. 428 pp.

The vexing problem of the traumatic neuroses, unquestionably of prime theoretic significance for all psychopathology, has long claimed the attention of the senior author of this book, so that his views are familiar enough to the informed. Whatever the heat which has been generated by his critique of the libido theory, which he by no means simply discards, and by his concept of urges and action-systems, it cannot be denied that Kardiner's contribution is distinguished by a clinical clarity and a depth of conceptual awareness which makes it outstanding in its field. An added chapter, on battlefield psychiatry, by Dr. Spiegel, is executed with poise and precision.

We must be grateful to Dr. Kardiner for having been so bold as to make a sharp dichotomy between the traumatic neuroses proper, and the numerous elaborations which have confused so many observers. Should such a distinction prove somewhat oversimplified after a time, it nevertheless seems an absolutely essential step at present to introduce order into a subject in which the worst kind of nosological chaos has prevailed. In any event, the concept of a specific traumatic neurosis, as distinguished from other neuroses, has already stood the test of time. There is a kind of monotony in the symptomatology and a poverty in the content of the traumatic neurosis which gives the impression of a high degree of specificity.

Kardiner's opinion that many who write about the traumatic neuroses of war burst into print too soon, is entirely justified. To him, much of the nosological confusion has been the result of not waiting long enough for the stark syndrome to emerge from the welter of defenses at first thrown up to ward off the massive blow to the personality. The thesis recommends itself for its simplicity, and a careful reading of the closely reasoned process by which the author has managed to separate the wheat of the trau-

matic neurosis from the chaff of its addenda, leaves no doubt about the clarity of his views.

Illustrative of a prevailing tone of cautiousness is the author's estimation of predisposition. He is not convinced by any of the attempts made thus far to establish adequate criteria. It is not sufficient to dismiss so many of those who developed traumatic neuroses during the war as having had 'normal' personalities before they fell ill. Considering the enormous difficulties and the desperate urgencies attendant upon war psychiatry, one cannot now accept the common negative findings, although they may turn out ultimately to be valid. What is necessary is a vast, well organized peacetime investigation; also, we simply do not know enough neurophysiology. Among others, Klüver has investigated the inhibitory functions of the cerebral cortex with respect to perception. Whether this is the mechanism which ordinarily protects the organism against massive onslaughts of stimuli, precisely how it operates, what are its psychological concomitants, how one can prophylactically detect its weaknesses, all these are problems of the psychopathologist who studies the traumatic neuroses. The implications of integrated endeavors of this nature for the understanding of the early development of the ego are fascinating. Perhaps the reason why Kardiner's speculations on the psychodynamics of the traumatic neurosis do not seem sufficiently rich or productive is that we do not yet have a sufficiently developed neurophysiology, upon which they depend to crystallize the argument. For the rest, one is not certain whether he gives adequate consideration to the libidinal accompaniments of his cherished drive towards mastery.

The case histories and the discussions, the chapters on treatment and differential diagnosis, and the lucid account of forensic issues, all bespeak the seasoned worker in a difficult discipline. There is none of the intoxication over the use of drugs in war psychiatry, to which we have become unfortunately accustomed, but a sound and altogether proper emphasis on a knowledge of psychodynamics in treatment as absolutely primary. It would seem indispensable to know this book as a requisite to an understanding of the traumatic neuroses.

NATHANIEL ROSS (NEW YORK)

FREUD: ON WAR, SEX AND NEUROSIS. Edited by Sander Katz with preface and definitive glossary by Paul Goodman. New York: Arts and Science Press, 1947. 288 pp.

This volume contains nine of Freud's papers, all of them published in the Collected Papers edition of the Hogarth Press. Evidently something has happened to the copyright to permit such a reprinting. Comparison with the authorized English edition shows that the original text, including editorial notes, is followed; but only about one half of the case of Dora is reprinted, as far as the part headed 'Analysis of the Second Dream'. The glossary is for a low-level public; it explains 'De motuis nil nisi *bene*' [*sic*] and 'J'apelle un chat un chat', as well as terms to be found in the official International Glossary. The preface is a superfluous journalistic exercise.

B. D. L.

PROBLEME DES SELBSTMORDES (Problems of Suicide). By Fritz Schwarz. Berne: Medizinischer Verlag Hans Huber, 1946. 128 pp.

This short but extremely meaty book represents eleven lectures given to a lay audience by the Professor of Legal Medicine at the University of Zurich. It deals clearly and simply with the main and knowable facts relating to suicide: how it can be definitely recognized, difficulties in diagnosis, the legal and insurance aspects, and the facts that are revealed by comparative statistics, with cautions as to the use of this method of approach. There follows a discussion of the 'personality' of suicides: they are classified as psychotic, psychopathic and normal with special attention to suicide in the young. Considerable space is devoted to the description of preparations and means, including double and multiple suicides, and the final lecture gives autopsy findings. As far as the book goes it is substantial and authoritative. One misses any reference to psychoanalytic ideas. Ten 'on the spot' photographs worthy of the Grand Guignol theater and of our tabloids decorate the general sobriety of the narration.

B. D. L.

SINN UND GEHALT DER SEXUELLEN PERVERSIONEN—Ein daseinsanalytischer Beitrag zur Psychopathologie des Phänomens der Liebe (THE MEANING AND CONTENT OF THE SEXUAL PERVERVERSIONS—A Contribution to the Psychopathology of the Phenomenon of Love by Means of Existential Analysis). By M. Boss, M.D. Berne: Medizinischer Verlag Hans Huber, 1947. 130 pp.

Dr. Boss is one of the outstanding members of a Swiss group who have in recent years been interested in what they term 'existential analysis' (*daseinsanalyse*). In his discussion of the perversions Boss contrasts his theories with the psychoanalytic concepts and also with the so-called 'anthropological' theory of perversion. The exponents of the latter theory emphasize the nature of man (anthropos) as a total entity. They aim to study the human being in relation to his place in the 'objective' world, eliminating 'subjective' evaluations as much as possible. Gebsattel, Straus, Kunz, et al. believe the aim of perverse behavior to be the gratification derived from aggression against, and destruction of, the established ethical standards upon which 'normal' culture and interpersonal love relations depend. This concept is highly theoretical, and, according to Boss, not substantiated even by their own clinical data.

Boss's position most closely approximates L. Binswanger's who, with Jasper and others, has formulated a theory of love based upon the Platonic myth that primordial man was cloven into masculine and feminine halves by divine wrath. These two parts are then in perpetual search of each other, trying to re-establish a union through love and a sense of integration with the structure of the real and metaphysical world.

According to Boss, the love-life of man is to be considered as an entity rather than as a composite of many infantile and adult instinctual drives. He is evidently well versed in psychoanalytic theory, although he carefully avoids the use of psychoanalytic terminology in any of his formulations whenever possible. However the clinical material makes it evident to the reader that he makes full use of his psychoanalytic knowledge in order to evaluate the patient's 'existential' position. Although Boss does not actually deny this, he strives to formulate his theories entirely in terms of the conscious experiences of the patient and in somewhat vague cosmological phraseology: 'the transcendental quality of love', the

dissolution of the time-space concept by the eternal power of love, and the like.

He comes to the conclusion that sexual perversion is, in each case, the only possible means by which love can break through the otherwise impenetrable barriers previously imposed upon the personality development by the environment. No matter how divergent from more normal love impulses, the perverse act itself is regarded as an attempt on the part of the patient to re-establish a positive affective relationship with the outside world and with other human beings even when it is manifested in so remotely displaced a fashion as in fetishism.

In the discussion of psychoanalysis, Boss confines the argument to the early writings of Freud as exemplified by the libido theory and does not at any time refer to the more recent contributions of psychoanalysis in relation to ego psychology. There are occasional references to the publications of Horney, Alexander, et al. His whole orientation is opposed to any psychoanalytic concern with the specific meaning of perverse acts as an expression of partial drives. He attempts to make a sharp differentiation between the perversions and compulsions, and/or addictions, and disregards the unconscious byways by means of which the patient develops his particular perversion. The emphasis is on the gross pathology of environmental influences, on the restrictions imposed on the erotic impulses by fear, shame, and disgust, and on the ultimate breaking through of love in a fashion peculiar to the needs of the individual as a whole. Boss differs with the so-called 'anthropological' psychologists in their explanation of the perversions as 'a destructive reaction' (Gebsattel), or as 'a depreciation and deformation of accepted ethical values' (Straus). He does not consider hate as antipodal to love, but assigns this rôle to '*Angst*'. (This cannot be translated directly by the term anxiety, since Boss makes no differentiation between fear and anxiety.)

The clinical implication of Boss's findings is not in itself new to American psychiatrists and psychoanalysts since it is based on something akin to psychobiology, and to that type of understanding of the deformation of the ego with which most modern psychoanalysts are fully conversant. However, an alien type of ideology is introduced by the ease with which established facts are merged with the transcendental.

From the point of view of practicable therapy, Boss's shift of

emphasis from the derivative origin of the perversion to its economic usefulness to the patient seems to have considerable validity. He regards the perversion as the patient's only means of contact with his own love impulses and the only way he has to break through those barriers which prevent him from sharing emotional experiences with other human beings. The perversion is therefore regarded as an attempt at restitution and an abortive effort to re-establish contact with reality and to wring some gratification from it, no matter how minimal. However, Boss further insists that this gratification is not purely somatic-erotic, related to the finite everyday world, but that it involves a supramundane emotional reunion with the cosmos.

Boss's well presented cases of fetishism, coprophilia, kleptomania, voyeurism and exhibitionism, sadomasochism, and homosexuality, several of whom were treated psychoanalytically by the author, raise many questions in the mind of the psychoanalytically informed reader. To mention only a few of these: How much of this 'existential' information could have been obtained by Dr. Boss without the use of his psychoanalytic knowledge? Are any other than psychoanalytic concepts necessary for the full understanding of this clinical material if it is permitted to speak for itself? And, finally, if Dr. Boss is as familiar with the concepts of the œdipus complex, the castration complex, and the phallic mother, as he gives evidence of being, why does he so completely disregard the feminine identifications of his male patients, and defense by denial, which are so evident in his clinical data? The case material does not appear to present any unconscious mechanisms which cannot be understood readily according to present-day psychoanalytic theory of which ego psychology is an integral part.

BETTINA WARBURG (NEW YORK)

PROGRESS IN NEUROLOGY AND PSYCHIATRY. Volume II. Edited by E. A. Spiegel, M.D. New York: Grune and Stratton, 1947. 550 pp.

In this volume an attempt is made to review the progress made in neurology and psychiatry during 1946. It is divided into four parts: Basic Sciences, Clinical Neurology, Neurosurgery and Psychiatry. Part IV gives psychiatry one hundred seventy-five pages or about one third of the entire volume. There are some new chapters on such topics as forensic psychiatry, mental hygiene,

psychiatric nursing, occupational therapy and alcoholism. All the valuable contributions abstracted in this book are too numerous to discuss here. Chapter 34 on Psychoanalysis is edited by Franz Alexander and Gerhard J. Piers. A number of valuable articles which have appeared in this QUARTERLY, American Imago, American Journal of Orthopsychiatry, Psychoanalytic Review, and other journals is reviewed. The reader who wishes to keep up with the literature and who is unable to cover the entire field will find this book valuable for information and reference.

CHARLES DAVISON (NEW YORK)

MILITARY NEUROPSYCHIATRY. Edited by Franklin G. Ebaugh, M.D., Harry C. Soloman, M.D., and Thomas E. Bamford, Jr., M.D. Baltimore: The Williams & Wilkins Company, 1946. 366 pp.

Four years ago, when the war was very real, The Association for Research in Nervous and Mental Diseases held a symposium on Military Neuropsychiatry. This book, their twenty-fifth publication, reports the best of the papers delivered at this meeting with the accompanying discussions. There are forty-seven contributors. The content of these papers, as might be expected when an endeavor to satisfy all tastes is attempted, varies from the boring to the brilliant for the individual reader.

The papers on the Organization and Functioning of Psychiatric Programs are among the boring ones, especially when there is no war on. However, the one on the Mental Hygiene Unit by Louis L. Robbins is well done and interesting, even in retrospect. His stressing of the fact that the mechanisms of defense of the ego are so much tied up with the proper occupational classification of the recruits struck a sympathetic chord in the reviewer who well remembers the tremendous difficulties encountered by him while overseas when he attempted to pull round pegs out of square holes.

The most original and spectacular contribution to the development of psychotherapy during World War II was that of Grinker and Spiegel. Not only were drugs, mainly sodium pentothal, used for abreaction and reintegration, but the cases were classified and treated from a dynamic and analytic point of view. Grinker's paper, A Dynamic Study of War Neuroses in Flyers Returned to the United States, was up to his usual standard of interest and is of particular importance now that we are seeing his predictions

bearing fruit: '. . . the majority of the men who are being admitted to our VA Hospitals have developed their incapacitating symptoms after being exposed to what was previously the normal stress of civilized life'. He feels that they are altered personalities in the direction of regression who tend to break down under minimal stress and that this is an ominous indication of what may be expected in future years. The outstanding paper on Therapy is that of Kubie and Margolin on The Therapeutic Rôle of Drugs in the Process of Repression, Dissociation and Synthesis,[1] in which they discuss how and why drugs may be used in dynamic psychotherapy to circumvent resistance. Following this paper, there is a discussion of Grinker's idea that the reproduction and discharge of the affective component of the war neuroses with pentothal is a very effective therapeutic procedure even though the intellect does not adequately integrate it. Regardless of what is meant by 'adequate', it has certainly been the experience of those working with the more chronic war neuroses that this is not so and that drug abreaction is only of use in working through material, outside of its use as outlined by Dr. Kubie.

The thirty-three papers in this book are so exceedingly variable in scope and value that it is obviously impossible to discuss many of them. New diagnostic aids discussed are, among others, The Electroencephalogram in War Wounds of the Brain by Roseman and Woodhall, and Modification of the Rorschach Method for Large Scale Investigation by M. R. Harrower Erickson. This modification of a valuable test certainly should be useful if too much is not expected from it as it is still impossible to predict just how those diagnosed as 'neurotic' and 'psychopathic' will make out during wars. The reviewer well remembers many cases seen in consultation who had made valuable contributions for many years in the service and were able to return to a full duty status and perform satisfactorily although the Rorschach said they should have been hospitalized on a locked ward. In the discussion following his excellent paper on Methods of Recovery in Combat Fatigue and the Influence of Therapy, Captain George N. Raines mentions the fact that the entire personnel of one destroyer were 'Rorschached' before combat experience. These results should be interesting as it is presumed that many of the crew developed functional disturbances following the experience.

[1] Abstracted in This QUARTERLY, XVI, 1947, pp. 140–41.

Psychiatric Contrast in the Two World Wars, by Strecker and Appel, is a fascinating, succinct, and complete presentation which points out clearly the little differences between the two World Wars aside from minor refinements in techniques due to the enormous number of men involved and the new idea of total war. In connection with the previous paragraph, it is of interest that they found that the foreign literature of World War I states that as a group psychological patients served as long and as well as the average soldier, that many men with psychoneurotic predispositions recovered rapidly and returned to units. Concerning these statements, it is a pity that so few adequate studies were made. The employment of the Harrower Erickson version of the Rorschach might be a step in this direction provided it is utilized for an unprejudiced study and not for the support of preconceived notions. In connection with this, John Whitehorn, in his paper, Changing Concepts of Psychoneurosis in Relation to Military Psychiatry, mentions how impossible it is to be sure that the occurrence of a clinically recognizable type of psychoneurotic reaction incapacitates one for military life, and points out clearly the fallacy of inventing diagnostic labels indicative of situational factors, such as, Flying Stress, Combat Fatigue, Operational Fatigue, instead of diagnoses based on personality factors; how, as it were, the concept of 'shell shock' lived on in a kind of second life in the notion of psychological trauma. He realizes that it is wise to evaluate the situation and the personality but feels, and who can not heartily agree with him, that the general level of psychiatric practice is not up to the point where it can adequately evaluate both, and there is little more than 'illogical and sentimental vacillation between one set of oversimplified descriptive terms and another set of oversimplified situational terms'. It is of interest that in the new VA set-up cases are now being considered and diagnosed from the point of view of the three sets of factors that he feels demand consideration: (1) the situation to which the neurosis is the person's reaction; (2) the reaction descriptively and dynamically stated; (3) the personality. It is very heartening to hear the comments and see the looks of amazement on faces of residents trained in the dynamic and analytic methods when they are confronted by consultants of the Old School who pay lip service to these concepts but have no real understanding of their nature and use.

Among the miscellaneous are two papers of great interest. Psychiatric Reactions to Amputation, by Randall, Ewalt and Blair, is excellent as far as it goes, and is particularly interesting in the the finding that injuries of the upper extremities are much easier to adjust to than those of the lower extremities, that personality changes in the form of anxiety, emotional instability, aggressive acts and alcoholism, occur in a surprisingly large percentage (eighty percent) of these men, and that there is considerable difficulty in sexual adjustment; however, one has the feeling that material of such interest should be investigated psychoanalytically. Personality and Psychosomatic Disturbances in Patients on Medical and Surgical Wards, by Mittelmann, Brodman, Wechsler and Wolff, tabulates in statistical form what has been suspected for a long time: of four hundred fifty routine admissions to medical and surgical wards, twenty percent can be classified as having mild, and ten percent as having severe neuroses arising from their difficulties in connection with the threat to their bodily safety, frustration of dependency needs, hostility, sexual problems, and failure to live up to high standards of achievement.

This book is extremely interesting from a historical point of view and well worth reading inasmuch as it is representative of not only what was accomplished during World War II but also what was missing. The problems in connection with weeding out, treating and utilizing the neurotically handicapped, and the problems of morale, war and peace, and the efficient handling of men en masse appear not only inextricably interwoven but woefully in need of research and study.

WILLIAM F. MURPHY (CAMBRIDGE, MASS.)

PERSONALITY DISTURBANCES IN COMBAT FLYERS. By Major Norman A. Levy, M.C. New York: Josiah Macy Jr. Foundation, 1945. 89 pp.

This book must be considered from the perspective of the author and the times. It is the fourth of five volumes dealing with personality disorders occurring in the Army Air Force flying personnel exposed to hazards of combat duty. It was written for the most part in the heat of combat when cases were so much more pregnant with meaning and emotional significance and when the author was exposed to the hazards of having to keep up with the brilliant work of the dynamically alerted and analytically oriented neuro-

psychiatric unit of the Air Force headed by Colonel John M. Murray. The cases are extremely well presented and show in detail the development of the various anxiety states, phobias, depressions, conversions, and psychoses among the flying personnel engaged in bombing. They show particularly the great rôle played by social forces in the shape of feelings of group solidarity and mutual responsibility in increasing or decreasing the individual's capacity to withstand the anxieties engendered by his constant proximity to bodily mutilation and destruction. However, the chapters on the etiology, dynamics, and therapy of the war neuroses have been presented before more adequately and in much greater detail, and the book has little to offer aside from a number of interesting and graphic case reports.

WILLIAM F. MURPHY (CAMBRIDGE, MASS.)

BRAIN AND INTELLIGENCE: A Quantitative Study of the Frontal Lobes. By Ward C. Halstead. Chicago: University of Chicago Press, 1947. 206 pp.

This volume is a result of extensive investigations on approximately two hundred and fifty patients with neurosurgical conditions, normal control individuals, normal individuals under experimental stresses, neuropsychiatric patients and individuals with closed head injuries. In these investigations a battery of twenty-seven behavioral indicators was developed and employed for the first time. Mr. Halstead presents a new conception of adaptive intelligence, which differs considerably from the theories on which standard intelligence tests are based. He has combined new instruments and quantitative methods with the techniques of factor analysis to isolate the basic factors of higher mental processes.

On the basis of his studies, the author evolves a four-factor theory of biological intelligence. It consists of (1) a central integrative field factor *C* which represents the organized experiences of the individual. It is a region of coalescence of learning and adaptive intelligence. (2) A factor of abstraction *A* which the author considers the fundamental growth principle of the ego. This factor concerns a basic capacity to group to a criterion, as in the elaboration of categories, and involves the comprehension of essential similarities and differences. (3) A power factor *P* which reflects the undistorted power factor of the brain. It

operates to counterbalance or regulate the affective forces and thus frees the growth principle of the ego for further ego differentiation. (4) A directional factor *D*, which vector, according to Halstead, constitutes the medium through which the process factors are exteriorized at any given moment. On the motor side it specifies the 'final common pathway', while on the sensory side it specifies the avenue of modality of experience.

With the aid of these four factors, the author draws the following inferences, which to the reviewer do not seem exactly new. (1) Biological intelligence is a basic function of the brain and is essential for many forms of adaptive behavior of the human organism. While it is represented throughout the cerebral cortex, this representation is not equal throughout. Its maximal representation is in the cortex of the frontal lobes. (2) The nuclear structure of biological intelligence comprises four basic factors which, in unified fashion, enter into all cognitive activities. Their dysfunction, the result of brain damage, may yield progressively maladaptive forms of behavior or 'biological neurosis'. (3) The frontal lobes are the portion of the brain most essential to biological intelligence.

The author has undoubtedly attempted to investigate the subject thoroughly and has done much work. To the reviewer it seems that he has evolved a rather complicated number of factors by means of which he has arrived at conclusions, whether accepted or not, that are already well known.

CHARLES DAVISON (NEW YORK)

FUNDAMENTALS OF CLINICAL NEUROLOGY. By H. Houston Merritt, M.D., Fred A. Mettler, M.D., Ph.D., and Tracy Jackson Putnam, M.D. Philadelphia and Toronto: The Blakiston Co., 1947. 289 pp.

THE ANATOMY OF THE NERVOUS SYSTEM, ITS DEVELOPMENT AND FUNCTION. By Stephen Walter Ranson, M.D., Ph.D., and Sam Lillard Clark, M.D., Ph.D. Eighth Edition. Philadelphia and London: W. B. Saunders Co., 1947. 532 pp.

This new general introduction to the clinical problems of neurology by three members of the staff of the New York College of Physicians and Surgeons discusses concisely the methods of neuro-

logical examination and the anatomy and diseases of the nervous system. It is especially intended for the general practitioner who needs to know something of neurology. History taking and the notation of findings are briefly discussed and there follow sections on examination of cranial nerves, motor system, sensory system, speech, and higher cerebral functions. Examination of the comatose patient is discussed in one chapter. Gross and microscopic anatomy of peripheral nerves, spinal cord, and brain are briefly described, and short descriptions given of the common diseases of these parts. One valuable chapter is devoted to cerebrospinal fluid.

This small volume is probably as good a brief introduction to its subject as can be found. Emphasis is strictly on matters of clinical importance; theoretical discussions are absent, while some important practical details are here treated more fully than in most larger textbooks. The chapter on cerebellum especially deserves praise for presenting clearly and simply a subject often obscured. The book cannot supplant larger reference works, and will be most useful to the student who is reviewing neurology. The practicing psychiatrist may, however, find it useful when confronted by an occasional neurological problem, for the concise discussions of syndromes in this book should facilitate reference to the larger standard texts.

The eighth edition of the familiar textbook on the anatomy of the nervous system is the first revision prepared for the press not by the late Dr. Ranson himself but by his designated successor in the task, Dr. Clark of the Vanderbilt School of Medicine. Much of the book has been rearranged and some parts rewritten. These changes result in improvement by making the book more readable. The section on cranial nerves, for example, seems simpler and easier to follow. The discussions of thalamus and of blood supply are more thorough and supplemented by new illustrations, and other new material has been inserted throughout the book.

This textbook of neuroanatomy remains the most valuable in its field for reference by the physician as well as for study. It is accurate, clear, and constantly kept up-to-date. So well known is it that it needs no new praise, but one can say that its new editor has made still better a standard work.

GERARD FOUNTAIN (NEW YORK)

HANDBOOK OF CORRECTIONAL PSYCHOLOGY. Edited by Robert M. Lindner and Robert V. Seliger. New York: Philosophical Library, 1947. 691 pp.

Forty-six authors—whose background of experience is unspecified —offer articles that vary greatly in value. Textually and bibliographically some show expert knowledge of their subjects; others are very simple commonsense contributions. Despite the title of the book and the editors' assertion that it deals with problems encountered in institutions for detention and custody, other aspects of delinquent and criminal behavior are considered, and psychology is by no means always featured. Several deal sketchily with general medical work in prisons, dentistry, eye, ear, nose and throat ailments, sedative measures for mental patients, gastric neuroses, etc.—all acknowledged to be much the same as extramural practice—interspersed with such articles as one on Essentials for Helping People, which has nothing to do with offenders. The longest and best documented chapter is on Sugar Metabolism in its Relation to Criminology which concludes by allowing that many investigations will be necessary to establish the validity of a relationship.

The editors, granting that there are omissions in this book, feel that it covers what 'is perhaps sufficient for present needs'. The reviewer's experience leads him to insist that a very grave omission, indeed, is the slight and only incidental discussion of the psychological effects of punishments and disciplinary regimes in institutions. Attitudes engendered by these forms of treatment are often of vital import for the current and future behavior of offenders. To be sure, Knight contributes some ten pages of sound ideas on The Meaning of Punishment, but this is confined mainly to the rearing of children. In addition to four excellent articles about 'psychopathic personalities', there are many other scattered comments on this type of offender. In the regrettable absence of an index, it is not easy to check, but it is evident that the general theme is pessimistic.

Quite interesting is the highly theoretical contention of Bergler that conflict in the oral, precœdipal phase of development determines criminosis. There are other secondary factors, variable with each individual, but this constant factor is the real underlying mechanism of crime. The starting point is the feeling that the precœdipal mother is unjust and denying. The young child cannot

force the mother to acknowledge his ability to take revenge, but later, to representations of the mother in society he can exhibit by delinquency or criminality that he is not so helpless. There is not much else of psychoanalytic interest in the book. Oberndorf contributes some Sidelights on Criminality, but in his short article hardly seems to have done himself justice. Lindner of course describes his 'hypnoanalytic' technic. Group treatment is well covered by Curran. Some other phases of psychotherapy are briefly considered.

WILLIAM HEALY (BOSTON)

SCIENCE AND FREEDOM. By Lyman Bryson. New York: Columbia University Press, 1947. 191 pp.

More than a quarter of a century ago when the present reviewer was attending Janet's classes, a professor at the Sorbonne summed up the then current attitude toward Freud in the words, '*Certes, l'amour est important*'. Dr. Bryson refers to love only once, to say, 'The doctrine of love is much too hard . . . to live by' and 'the next best thing . . . is the rule of sportsmanship'. Freud is mentioned four times in the text of Science and Freedom. Once Dr. Bryson suggests indirectly that Freud was a poet rather than a scientist. Once he lumps Freud together with Pareto in a perjurious context. Twice he grudgingly admits that 'hints from Freud' may have a certain usefulness in a discussion of 'the use of the scientific method in understanding human behavior'. The longest reference is the remark that 'we can certainly understand behavior better because of the insights of psychologists and anthropologists who have taken hints or leadership from Freud'. Those enumerated are Bateson, Mead, Gorer, L. K. Frank, Lasswell, Kardiner, Benedict. The amount of space devoted to the work of Freud himself (and of those who have taken from him more than hints or even leadership) is significant only because Science and Freedom is in one important respect an anti-freudian tract. It amounts to an argument, admittedly unscientific, in support of the thesis that direct application to the social sciences, including psychology, of the methods of modern physical science—on the one hand abstract and symbolic, on the other hand quantitative, statistical, taxonomical—is the royal road to the creation of a 'good society'.

With Dr. Bryson's definitions of his social goals, few liberal

progressives will quarrel. The 'good society' is a social structure of individuals free to use fully their creative powers, and of institutions allowing differences, divergences, pluralisms of all sorts, yet fostering unified action. Processes will be sacrificed to persons, individuals will be saved without destroying kinds. Conditions will be created as will best keep and develop the creative powers of man, and all the other creative factors of nature that man has access to.

But the moment Dr. Bryson turns from freedom to science, it becomes clear that he uses the word, creative, as coterminous if not identical with the word, productive. In a particularly revealing analogy between a man and a bar of steel, each 'complex' and 'unique', he argues that, 'Men can make progress . . . by making use of abstract, generalized, and often numerically expressed scientific facts about persons and institutions'; and 'the social and cultural structures by which a good life can be made possible will be more swiftly and surely built if some of our thinkers and workers deal with relevant general ideas and forget that each man is unique'. The subject matter of a science of human behavior in Dr. Bryson's sense is not a human being but an abstract entity called a 'person' defined as 'a pattern of habits with a marginal capacity for change, held together by memory'.

Nevertheless, Dr. Bryson who makes a great point of clear definitions, tries his hand at behavior elements usually associated with the psychological personality of the human being. For example, on the subject of emotional drives, he writes, 'Man can learn to behave in such a variety of ways that we almost believe him to have sophisticated or obscured in himself whatever there is of original nature'. Of instincts, he says, 'Man . . . has practically none'. Of mind, 'I obviously mean active consciousness and the possibility of active consciousness'. Dr. Bryson admits that from his man-as-steel-bar taxonomical viewpoint almost nothing is known about instincts, emotions, etc. The unconscious is never mentioned and irrationality ('foolish behavior') arises from a failure to shift attention from irrelevant to valuable loyalties, which 'persuasion applied by leaders or teachers' can remedy. And, even on consciousness, Dr. Bryson comments a bit sadly that 'there is no knowledge to which I have found access that can be univocally described and quantitatively observed'. Undismayed, however, Dr. Bryson insists 'the problem is not to find a new scientific mode

but to find the entities in human behavior that can be scientifically used'.

This resolute discipline by subtraction runs through the entire argument. All that does not fit into Dr. Bryson's quantitative scheme of things has little value in a scientific approach to human behavior. 'Statistics are dull but more reliable [than insight]' and, failing the statistics, away with the insights. 'We can', he concludes, 'think about men as we have thought about other embodiments of human energy. We can think about things abstracted out of the observation of human behavior that will be as real as atoms.' The final note which might be expected to be a rising one, goes *decrescendosi*. 'No one can say how much this way of thinking . . . will increase our powers. It may not make as much difference in the management of men as it has in the management of things . . . Man's toughest problem is himself.' There is little quantitative about that, the last sentence in the book. And one may comment, 'Yes, indeed, tougher than a bar of steel'.

PERCY WINNER (NEW YORK)

THE REACH OF THE MIND. By J. B. Rhine. New York: William Sloane Associates, Inc., 1947. 234 pp.

One of the major difficulties of the science of psychic phenomena, latterly known as parapsychology, has been the enormous resistance provoked by its unfamiliar subject matter. As with resistance to the less threatening aspects of the unconscious in psychoanalysis, resistance to the basic facts and propositions of parapsychology takes a variety of forms, all more or less easily rationalized, all fundamentally phobic and irrational. Of all the façades readily utilized by resistance, the presumption of chance is the most difficult to resolve from the purely logical point of view.

The only way out of this difficulty is to set up a system for observing the hypothesized event in which the factor of chance is known completely and in advance. Thus if a subject is asked to guess the first card that will be turned up from a well shuffled pack of ordinary playing cards, the probability of a correct hit will be 1 in 52. If in 5 runs through the deck he makes 13 hits instead of the expected 5, it can easily be calculated that the probability of this occurring by chance is about 1 in 5,000. If a perfect cubical die is used, the subject's chance of correctly calling the face that will turn up in any random throw is 1 in 6. If the

subject gets 11 hits in 24 throws, the probability is about 1 in 10,000 that chance was responsible. In neither case is chance excluded; all we can say is that in a situation in which a known probability factor applies, we have gotten certain deviations from an expected average. We are merely assessing the significance of these deviations in terms of accepted mathematical rules and have made a formal statement about our evaluation in numerical language.

Now the remarkable thing about this system of evaluation is its predictive usefulness. If we set up an experiment which is a closed probability situation in that the total number of possible events is known, and we wish to find out what the chances of occurrence of any given one or more of these events will be—like the turning up from a shuffled bridge deck of a king of hearts and a three of diamonds in the 16th and 17th places respectively—we have merely to make an arithmetical calculation to learn how many times we may have to repeat the experiment before such an event can be expected to happen. If we then actually do the experiment, the results will tally very closely with the prediction, and the more often we do it the closer the correspondence becomes. Why this is nobody knows, but such is the reliability of this system of correspondences that all of science has come to depend on it.

The calculus of probabilities was first applied to experiments in telepathy in 1884, but comparatively few significant investigations were made until Dr. J. B. Rhine began his now well-known work at Duke University in 1930. Since then Dr. Rhine and his staff of young co-workers have turned in an amount of statistically significant experimental work that is nothing short of staggering, and to no one more than to Dr. Rhine belongs the credit for having put parapsychology squarely, obtrusively and unavoidably within the sights of general science. Resistance still continues, of course, and is scarcely less violent than before; but it is much more difficult now to be complacent about rejecting a mass of evidence that equals any empirical findings in chemistry or physics in scientific validity; moreover, any serious critic is welcome at any time to participate in or repeat Rhine's experiments and check the processing of his data.

The story of the earliest investigations of the Duke group was

told in Rhine's New Frontiers of the Mind which appeared in 1934. The storm of criticism which this evoked led to a general tightening up of the experimental and mathematical techniques utilized so that by 1940, when Extra-Sensory Perception after Sixty Years was published (Rhine et al.), it was possible to deal once and for all with thirty-five counterhypotheses which had been offered in criticism of some or all of the work to that date. Since then there has been practically no informed criticism of the major experimental or mathematico-statistical techniques or results, and the parapsychologist has finally emerged from the defensive to a confident take-it-or-leave-it position.

In the earlier books, the telepathic and clairvoyant hypotheses were adequately covered from the standpoint of their mathematico-statistical foundations, while the concept of precognition was barely introduced. In the present volume, which is paced for the cultivated general public, Rhine deals more fully with the investigations at Duke and other research centers of this most fantastic and inherently incomprehensible hypothesis: that it is possible for the mind to perceive a future event before it has occurred and on a basis precluding any known means of rational prediction or calculation. The phenomenon of accurate prediction of complex future events has been known for a long time to occur in waking, trance and dream states, but it has always remained one of those eerie curiosities whose implications well-balanced people have preferred to dodge. To find that it is susceptible to the same kind of rigid experimental verification as anything else in the realm of science seems to be more disturbing to our philosophic calm than any other single fact of nature. We have somehow always managed to get along on a sort of double standard in which our scientifically professed determinism is limited to a forty-hour week. After five and on week ends we live, think and plan in terms of a careless, open-ended indeterminism without which life for all but the most dogged Spinozists would lose its zest and a great many of its peculiarly human qualities. The fact of precognition would seem to lead inescapably to an absolute determinism, regardless of what we do with the concept of time; but few people can bear to think of themselves as puppets whose main function is to actualize the latent absolute, or of history as the unfolding of an unalterable destiny. Our narcissism rebels at such thoughts.

Rhine himself gives ground only after a hard struggle with the (to me bewildering) concept of partial determinism, and is still far from reconciled to the implications of his data. But the data stand.

For many people the concept of psychokinesis is scarcely less revolutionary than that of precognition, although it does not seem to terrorize the logicians and philosophers who are able withal to keep their cosmic households fairly tidy. Psychokinesis, or PK, is the capacity of the mind to exert force and do work on matter independently of any known means of sensorimotor interaction. The concept of PK, like telepathy, clairvoyance and precognition, is probably as old as mankind but its empirical basis has rested on data much more elusive. Still, what evidence for its occurrence exists has convinced many scientific investigators, including some of the ablest physicists of our era, that PK is a reality and not simply a groundless superstition or, as we analysts all too one-sidedly tend to think of it, an illusory external projection of deeply lying endopsychic trends. In the latter part of the nineteenth century research interest in the phenomenon was stimulated by the still inexplicable (except on the PK hypothesis) performances of several exceptional physical mediums, and thirty years ago an Irish engineer did some brilliant experiments on the mechanics of the force under conditions of the most rigorous independent supervision. What remained was to test the phenomenon under conditions which would admit of standard, open and shut statistical processing.

This problem appeared to the Duke group as a natural corollary to the one of clairvoyance where, too, some kind of as yet unknown interaction had to be postulated between mental and physical processes—an interaction, that is, on a clearly nonneural or neurochemical basis. Investigations were first begun on PK in 1934 where subjects *willed* certain die faces to turn up after a roll. As the results of the early exploratory experiments seemed clearly beyond chance expectation, more and more variations were introduced into the test conditions to rule out successively all counterhypotheses to that of PK. Mechanical throwers were used, procedures to insure perfect initial randomicity were brought in and up to 96 dice were thrown at one time. To obviate the question of faulty dice, each of the six die faces was given a turn as target. As more and more experiments were run off with num-

bers of subjects, the statistical significance of the work gradually established itself as beyond question. But the surprise finding which stole the show was the discovery that the rate of decline of scoring from the beginning to the end of the test runs was itself so consistent as to be expected only about 1 in 100,000 times on a chance basis. The significance of this decline effect led to a reanalysis of the earlier data on telepathy and clairvoyance, not only of the Duke work but of the statistical work done at other centers as well. Practically identical curves were found. In other words, a purely mathematical critique has yielded some of the strongest independent evidence on record for the existence of what Rhine, following another investigator, now calls psi capacities.

Publication of these results was withheld for nine years until controversy over the earlier work on telepathy, clairvoyance and precognition had died down. Since the first publication of the Duke PK results in the Journal of Parapsychology in 1943, excellent confirmatory experiments have been done at other centers.

Following his chapters on telepathy, clairvoyance, precognition and psychokinesis, Rhine has a chapter on How Normal Are Psi Capacities? As yet we have no definite answers to the several aspects of this question since the study of the relationship between psi and the total personality has only comparatively recently become a topic of research interest. Provisionally, however, it may be stated that under the most favorable conditions a fairly large percentage of the general population seems able to score above chance in the Rhine type of test, and that physical and mental health and well-being seem conducive to high scoring. Rorschach and other projective tests seem to indicate fairly definitely so far a positive correlation between scoring success and healthy personality integration.

In his last two chapters, Prospects For Application and Consequences For Relations Among Men, Rhine cuts loose with some speculation that may make many readers wish that he had stuck to statistics. In the first of these, Rhine considers what would happen if psi capacities were to become subject to conscious control. There is no need here to outline his specific inferences from this assumption since any imaginative reader who has read this far can probably think up his own consequences to such an eventuality; the only hitch is in the primary assumption. I myself feel that there is about as much likelihood of bringing psi

under conscious control as there is of bringing the vegetative nervous system under such control, and that the results would be just about as fatal. There have been instances, of course, of rare individuals who have had a comparatively high degree of conscious control of their telepathic and clairvoyant capacities, but such a development on a large scale could only mean unmitigated chaos. As it happens, the trend toward biological economy and the whole course of evolution would not seem to favor such development. At any rate, this type of speculation is at present so far beyond our empirical moorings as scarcely to warrant discussion; and for the time being a consideration of the prospects of the application of our newer knowledge toward a sounder world picture and toward filling in the many gaps in our science would probably be much more to the point.

As to the consequences of our knowledge of psi for interpersonal relations, I am again somewhat reluctant to follow Rhine's rather sanguine speculations. Rhine seems to feel that parapsychological research has tapped something close to the core of man's spiritual (or better) nature, and that future knowledge and application of this elusive thread in the fabric of things will go far towards achieving for man that peaceful utopia that has always been his highest dream. At best this leaves me with a yes or no feeling. Yes possibly on the ground that knowledge of any aspect of man's nature may ultimately lead to a betterment of his conditions of life; and even this I hold honestly debatable. No, certainly, if Rhine thinks (as he seems to) that psi capacities are on a higher plane (i.e., freer mainly from aggressive and destructive components) than any other human capacities. Such optimism, I fear, comes from the artefact introduced largely by the rather de-emotionalized conditions of laboratory study that constitute Rhine's field of observation, and from the relatively motivationless frame of reference within which his tests are set up. If, and when, more psychoanalysts begin to observe the workings of psi with their unique method, it will be found, I believe, that psi is no more spiritual than respiration, temperature regulation, or thought itself, and that along with these homeostatic functions it may be just as much in the service of hate as of love. Where we go from there is anybody's guess.

This is Professor Rhine's third book on a most provocative subject. Due largely to his efforts, ignorance can no longer be a

valid excuse for a parochialism that in high places, at least, begins to look more and more like sheer morbid disinterest. Science will soon have to take a stand one way or another on its most challenging data, and it behooves the student of psychology, regardless of his initial bias, to lead the way.

JULE EISENBUD (NEW YORK)

THE SCIENTISTS SPEAK. Edited by Warren Weaver. New York: Boni and Gaer. 1947. 369 pp.

This is a compilation of the ten to fifteen minute talks given through several years during the intermission at the Sunday afternoon concerts of the New York Philharmonic-Symphony and broadcast over C.B.S. The speakers were all outstanding experts in their fields; the topics covered are extraordinarily varied, in general comprise pure and applied sciences of all kinds, and are distinctly up-to-date. A good 'refresher' for anyone.

B. D. L.

HUMAN DESTINY. By Lecomte du Noüy. New York: Longmans, Green and Co. 1947. 289 pp.

This is one of the latest books in the long series that reconciles an author's religious views with his scientific knowledge. In this case it is chiefly a matter of harmonizing theories of evolution and a belief in God. Dr. du Noüy attacks modern materialism with scientific arguments. Our present day physics and chemistry are based on assumptions of the operation of pure chance among atoms and elemental bodies. It is mathematically impossible, he states, that pure chance should have produced even so simple a substance as a protein molecule, much less life itself; and at this point he invokes 'anti-chance', special creation, God. Similarly, man with his moral sense implies another jump, another direct intervention of the deity. This tour de force evidently arises from the author's conception of 'science' as a statement of ultimate truth about the invisibility of matter, and 'religion' as a statement of ultimate truth about the mind. Many simpler, more flexible, less arbirary solutions suggest themselves readily; in fact, thousands have been suggested by many scientists who have seen the trees as well as the woods, and who appreciate the existence of those facts that can be ranged, more or less systematically, somewhere between the electron and the soul.

B. D. L.

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A Contribution to the Study of the Masturbation Fantasy. Ludwig Eidelberg. Int. J. Psa" XXVI, 1945, pp. 127–137.

H. W.

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ABSTRACTS

A Contribution to the Study of the Masturbation Fantasy. Ludwig Eidelberg. Int. J. Psa., XXVI, 1945, pp. 127–137.

Eidelberg presents the sadistic and masochistic pathological masturbation fantasies of four analytic patients and then gives the unconscious structure of each of them from the material which appeared in their analyses. In a subsequent discussion the author compares the structure of these fantasies to those in normal masturbation and those in a phobic fantasy. He also attempts to answer two questions: why the material of these fantasies is conscious while similar material in other patients remains unconscious, and why the fantasies are accepted by the total personality and not treated as 'a foreign body' and rejected as are other fantasies which constitute defense mechanisms. He finds (in essence) that 'these fantasies are the result of an unconscious defense by the ego and the superego against an infantile wish from the id'; that they represent 'a denial of an infantile narcissistic mortification suffered in infancy'; and that these unconscious satisfactions lead to conscious genital stimulation ending in orgasm. This masturbation produces a feeling of independence of external objects and of control. They are accepted because they differ in several important points from the structure of a phobic fantasy and 'because patients who accept them belong to the narcissistic type'. Finally, he says, 'They resemble the acts of perverts in being ego-syntonic, but differ from them in respect of their independence of an external object'.

H. W.

Primitive Emotional Development. D. W. Winnicott. Int. J. Psa., XXVI, 1945, pp. 137–143.

This is a 'preliminary personal statement' of Winnicott's theories on the emotional development of the infant during the first year of life based on his clinical experience with children and psychotic adults. Patients suffering from ambivalence can be treated along classical psychoanalytic lines; those with hypochondria and depression have a different fantasy about the analyst: instead of the analyst's work being done out of love it must be understood by the analyst as being done 'to some extent [as an effort] to cope with his . . . guilt and grief resultant from the destructive elements in his own (the analyst's) love. Finally 'the patient who is asking for help in regard to his primitive, predepressive relationship to objects needs his analyst to be able to see the analyst's undisplaced and co-incident love and hate of him'.

At about five or six months, the infant realizes for the first time that it has both an inside and an outside and assumes that its mother has an inside, and it begins to know itself and others as a whole. Before this time three processes start: (1) Integration and (2) personalization, (which occur together) followed by (3) realization (appreciation of time and space and other properties of reality). All of these processes are incomplete in psychosis.

Primary unintegration is assumed; disintegration of the personality is well

known. Integration is the feeling of wholeness and unity separate from the outside world and continuous through varying emotions. When integration is incomplete a series of dissociations arise. When day dreams are remembered and related to someone, dissociation is lessened.

'Contact with external or shared reality has to be made, by the infant's hallucinating and the world's presenting, with moments of illusion for the infant in which the two are taken by it to be identical, which they never in fact are.'

The primitive ruthlessness of the 'stage of preconcern' must be acted out in a child's play with its mother or it will have to get expression in a dissociated state.

Winnicott ends with a note on thumb sucking which he considers 'an attempt to localize the object (breast, etc.), to hold it halfway between in and out: a defense against loss of object in the external world or in the inside of the body. I should say, against loss of control over the object, which occurs in either case.'

H. W.

Some Aspects of Fantasy in Relation to General Psychology. Marion Milner. Int. J. Psa., XXVI, 1945, pp. 143–152.

By 'General Psychology' Milner means psychology as it is understood by an academic psychologist. She discusses a book with this title (by W. J. H. Sprott, 1937) with reference to his understanding of psychoanalytic theory. Milner feels that general psychology often has misgivings about the form in which psychoanalytic concepts are presented rather than about their content. She questions whether, 'when the general psychologist talks of sentiments [attitudes] and the psychoanalyst of internal objects we may not in fact be talking about the primitive form of the same thing'.

In an attempt to answer this question the main body of Milner's paper is an investigation of the use of fantasy and the image, 'the question of the form which . . . first knowing takes before experience is verbalized'.

The image has two functions: 'the primitive knowing or interpreting experience and the primitive substitute for action'. But the former must be subdivided into that referring to subjective experience and that referring to objective experience. The wish-fulfilling function and that of interpreting objective experience are barely recognized by academic psychology. What is still less understood is the concept of introjection and the function of fantasy and imagery as an expression of our manifold subjective experiences in our attitudes toward introjected objects and their reprojected forms. Milner clarifies each of these functions with the help of clinical material and at the same time attempts to show that the content behind the form of expression of the academic psychologist and the psychoanalyst are similar but that academic psychology had simply not gone far enough. She ends with a plea: 'It seems to me that it is in connection with the mental phenomena included under the term fantasy that the general psychologist and the psychoanalyst can most fruitfully meet. Thus if the psychoanalyst, with his special instrument for the study of fantasy, and the general psychologist, with his greater

knowledge of techniques for studying overt behavior outside the consulting room, could combine their findings, then surely the understanding of human behavior would be greatly enriched.'

H. W.

Prohibitions Against the Simultaneous Consumption of Milk and Flesh in Orthodox Jewish Law. M. Woolf. Int. J. Psa., XXVI, 1945, pp. 169–177.

In this exhaustive study Woolf makes a real contribution to our understanding of the primitive unconscious origins of certain compulsions incorporated in Jewish religious law. Searching for the origins of the prohibition against the simultaneous consumption of milk and flesh he first investigates the historical development of the night of the Passover festival and concludes that it celebrated three events:

(1) 'The spring festival of El, the Sun-God, with large offerings of the first-born of men and beasts, a feast dating from the very beginnings of the Nomadic Age. (2) The festival of the mercy of God, who has renounced the sacrifice of children and allowed their redemption by the lamb. (3) The liberation of the people and their release from slavery, the return to national freedom and independence (with a reinterpretation of rites and customs) and the resumption of former national habits and customs, and of the old national religion.'

From this festival, which in its deepest strata represents the eating of a child (much as it is practiced today among the nomads of Central Australia), Woolf goes on to investigate the cooking of a kid in its mother's milk. (The kid, of course, represents a baby and any meat, by association stands for the kid or baby.) 'Cooking a kid in its mother's milk was part of the cult of Astarte, worshipped by the Canaanite Phoenicians as the goddess of fertility and love.' Since the worship of Astarte was the religion of the agrarian peoples surrounding the nomadic Jews, the Hebrew prohibition against such practices was on the first level 'a juristic precipitate of the religious and national struggle between Jewish monotheism and heathenism'. This prohibition existed among many other primitive pastoral tribes and thus 'At a lower level it is an echo of the historical struggle of the peoples of the earth, including the Semites and, especially, the Israelites in the days of their wanderings, against the superior, but hostile, agricultural civilization of their neighbors'. Finally in the deepest unconscious stratum the prohibition is one against gestation—the child in the mother's body—clearly shown in that '. . . seething the kid in his mother's milk became the symbol of fertility in the worship of Astarte. . . . This matriarchal right the Bible veto apparently seeks to destroy. The son belongs not to the Astarte mother, the goddess of fertility and love, of the earth and its crops, but to the paternal, omnipotent Sun-God, El. . . . this prohibition reflects the conflict between the matriarchal and patriarchal forms of society.'

Woolf's argument is well thought out and richly documented.

H. W.

Concerning Art and Metapsychology. Adrian Stokes. Int. J. Psa., XXVI, 1945, pp. 177–179.

Stokes pleads for a broadening of the psychoanalytic metapsychological theory relating to the rôle of the reality principle in its substitution of the pleasure principle. Heretofore in this substitution, external reality was considered mainly as a source of frustration and control. What has been overlooked, Stokes states, is that in the whole world of artistic creation and enjoyment this substitution produces untold satisfaction. 'It can at least be argued', he says, 'that art is a parable of the over-all aim of human activity to force by substitutions of every kind the completeness or externality of death to serve the purposes of Eros until we die'. Not mentioned is Hartman's exhaustive study [1] of the function of reality.

H. W.

The Approach to Reality. Henry Harper Hart. Psa. Rev., XXXIII, 1946, pp. 285–305.

From the beginning, reality is too much for us and without a deep belief in the pleasure-giving quality of the real world, man would not be able to succeed in his adjustment. The initial mastery of reality is rendered possible through strong libidinal object relations. Later, perceptive contact with reality becomes a synthetic process involving instinctual gratification. Artistic creation and scientific achievement result from a large capacity for mastering reality, while in the neurotic the attempt does not lead beyond fantasy.

There are many references to psychoanalytic literature on the subject of reality, followed by a theoretical discussion of its relations to the ego, repression, rationalization and narcissism.

CAREL VAN DER HEIDE

The Extension of Basic Scientific Laws to Psychoanalysis and to Psychology. L. Bellak and R. Ekstein. Psa. Rev., XXXIII, 1946, pp. 306–313.

The basic laws of modern science can be applied in psychology and most naturally in psychoanalysis. The principle of causality, the law of conservation of energy (libido theory) and the biogenetic law (phylogenetic aspects of psychosexuality) are the most important elements in the biological foundation of psychoanalysis.

CAREL VAN DER HEIDE

The Analysis of a Dream Occurring During a Migraine Attack. Sidney Tarachow. Psa. Rev., XXXIII, 1946, pp. 335–340.

Tarachow distinguishes two ways of neurotic interference with action, both leading to somatic symptoms. During total inhibition ('utter defeat') there is collapse of tension with corresponding physical phenomena, whereas partial inhibition results in anxiety accompanied by somatic overmobilization. Hemi-

[1] Hartmann, Heinz: *Ich-Psychologie und Anpassungsproblem.* Int. Ztschr. f. Psa. und Imago, XXIV, 1939, pp. 62–135.

crania, thought to be a state of cerebral vasodilatation, is a psychosomatic disorder of the first type. This is exemplified by the occurrence of migraine at times of a sudden drop of tension.

A dream following an attack of migraine is reported. It presents, in a condensed way, the chief emotional conflicts of an inhibited, male analytic patient. Characteristically, his aggressions were borrowed from father images. The brief case report shows beautifully the elements of intellectual attack—'the mental castration turned against one's own head', e.g., the concept of migraine as introduced by Fromm-Reichmann.

CAREL VAN DER HEIDE

An Ill-Bred Child. Editha Sterba. Psa. Rev., XXXIII, 1946, pp. 341–352.

Sterba treated a delinquent eight-year-old girl by 're-education based on psychoanalytic knowledge'. Dispositional factors (both parents of 'instinctual character') and constantly changing poor environment had caused a pseudo feeblemindedness and an arrest at the autoerotic stage. Sterba states that without child-analysis, but by her specific (permissive) behavior alone, she 'made possible the belated formation of a superego' by incorporation. Treatment extended over three months, four sessions weekly; results were most satisfactory and a normal development was observed over ten subsequent years. It is pointed out in conclusion that this kind of therapeutic method offers much as a prophylactic measure against juvenile delinquency and that at any time the relation can be carried over into a real child-analysis.

CAREL VAN DER HEIDE

On a Particular Form of Resistance in the Transference. Robert Fliess. Psa. Rev., XXXIII, 1946, pp. 359–364.

The specific factor behind this parapraxia in hearing is an oral destructive impulse. The latter is mobilized by castration fear in the transference relation and resistance is expressed as a refusal of incorporation. Acoustic scotomization and distortion result from the auditory displacement of an originally oral-aggressive response to the analyst's spoken word.

CAREL VAN DER HEIDE

Report on Some Emotional Reactions to President Roosevelt's Death. Richard Sterba. Psa. Rev., XXXIII, 1946, pp. 393–398.

Five male analysands, all Democrats and admirers of the late President, reacted to the latter's death with dreams with the following specific content: a symbolic representative of the primal father is slain or castrated, and in one case, orally incorporated. It is pointed out that the patients were unable to relate their dreams to the death of the President because of the strong repression of hostile feeling towards this father-figure.

CAREL VAN DER HEIDE

Use and Misuse of Analytic Interpretations by the Patient. Edmund Bergler. Psa. Rev., XXXIII, 1946, pp. 416–441.

No matter whether correct and dynamically effective, interpretations given by the analyst are often misused by the patient for purposes of resistance. Bergler

presents his technique of dealing with this common phenomenon and offers twenty-one rules for its management. Though the discussion of these rules necessarily is kept on a general level, analysts will find valuable clarifications and suggestions in this review of daily experience with the protest against analytic cure.

CAREL VAN DER HEIDE

Masturbation Fantasies. Géza Róheim. Psychiatric Quarterly, XX, 1946, pp. 656–673.

Róheim describes in great detail the analysis of a schizoid young man with strong mother attachment, fixation on urinary erotism, and castration fears referring to the mother which were acted out in later relationships. Because of his schizoid disposition his masturbation fantasies and other unconscious trends were easily admitted to consciousness and presented in interesting detail.

BERNHARD BERLINER

Five Aims of the Psychoanalytic Patient. Edmund Bergler. Psychiatric Quarterly, XX, 1946, pp. 684–700.

Every analytic patient enters analysis with (or develops partly during analysis) five aims. One is conscious and four are unconscious: (1) (Conscious) I suffer and want to rid myself of my neurosis. (2) I want to live out and materialize repressed wishes. (3) I want to eliminate feelings of guilt. (4) I want to strengthen unconscious defenses without change in the displacement of guilt upon a 'lesser crime'. (5) (Developed during analysis) I want to maintain my neurosis although I am willing to give up, under pressure, a few trimmings. These aims are demonstrated in several cases. Of particular importance is the displacement of guilt and the resistance against having it reconnected with its original source.

BERNHARD BERLINER

The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy. (With Discussion.) John Nathaniel Rosen. Psychiatric Quarterly, XXI, 1947, pp. 3–37.

Rosen reports on remarkable therapeutic results with 'direct analytic therapy' in thirty-seven cases of deteriorated schizophrenia. By direct analytic therapy he means a procedure in which instinctual manifestations underlying the schizophrenic symptoms are directly interpreted and most frankly discussed with the patient. This method, generally considered contraindicated in non-psychotic persons, is possible and successful with the schizophrenic because his pathogenic id processes are not unconscious. They lie open to his conscious and can be made understandable to him if the therapist knows how to speak the language of the psychotic. The therapist converses with the patient in this language, meeting him on his own level of regression, and interprets the 'unconscious' to him at every available opportunity. He thereby establishes a workable transference based upon the figure of a good, understanding parent who is free of hostility towards the patient.

Rosen's patients were observed, and the results verified, by other psychia-

trists, including the editor and three other members of the editorial board of the Psychiatric Quarterly. In the discussion of the paper valuable contributions were made by Paul Federn, Paul Hoch, Jule Eisenbud, Melitta Schmideberg, Joseph Meiers, and Hyman Spotnitz.

This paper is of extraordinary importance. As its details are beyond the scope of an abstract it should be read in the original.

BERNHARD BERLINER

The Treatment of Hysterical Deafness at Hoff General Hospital. Andrew D. Rosenberger and James H. Moore. Amer. J. of Psychiatry, CII, 1946, pp. 666–669.

Sodium pentothal narcosynthesis was found to give 'spectacular' results in the treatment of hysterical deafness, while malingerers were refractory. The narcosis was strongly supplemented by suggestive therapy on a superficial level. No follow-up studies after discharge from the hospital are available but the authors indicate that the present report is merely preliminary.

MARK KANZER

Furlough Psychosis. George F. Sutherland and Milford E. Barnes. Amer. J. of Psychiatry, CII, 1946, pp. 670–673.

Twelve cases of acute schizophrenic reactions which developed during furloughs lead the authors to surmise that the episodes were provoked by the sudden release from military authority upon which the patients had become emotionally dependent.

MARK KANZER

Personality Studies of Marijuana Addicts. Sol. Charen and Luis Perelman. Amer. J. of Psychiatry, CII, 1946, pp. 674–682.

Sixty addicts were studied at Fort McClellan. Forty-one cases were seen because of behavior problems rather than for primary drug addiction. Narcissistic tendencies were dominant in nearly all. 'The common story of these men was that the army failed to understand them, and there was a childish, sullen resentment to regulations and discipline.' There was a remarkably high proportion of Negroes among these soldiers, of whom fifty-one percent came from undesirable home environments. No less than sixty-three percent came from broken homes, in sixty-eight percent the personality of the father was marked by outstandingly undesirable traits, while sixty percent had mothers who imposed strict standards of morality reinforced by severe punishment. The authors suggest that 'parental strife, resulting from the opposing characteristics of father and mother, laid the foundation for inner conflict in their sons'.

Psychopathic traits in childhood were common, as were poor records of school and work adjustment. Delinquent and criminal behavior were prevalent but were attributed to the underlying personalities and not the drug addiction. The addicts preferred the society of their own kind, showing polymorphous perverse sexual activities and recognized each other by a jargon of which interesting samples are given. None of the men had any desire to be cured.

MARK KANZER

Irrelevant and Metaphorical Language in Early Infantile Autism. Leo Kanner. Amer. J. of Psychiatry, CIII, 1946, pp. 242–246.

Kanner, in a highly interesting article, describes peculiarities of language in children 'whose extreme withdrawal and disability to form the casual relations to people were noticed from the beginning of life'. Frequently these children say things which seem to have no meaningful connection with the situation in which they are voiced. Kanner was able to ascertain that some of these irrelevant remarks were meaningful in terms of earlier experiences and were of metaphorical significance in the later situation. The irrelevance of the child's remarks results only from the narrow and individual meaning of his words and phrases and his inability to communicate his personal symbols to the social group. Kanner further calls attention to other peculiarities of autistic speech, particularly to the confusion of 'I' and 'you', and comments on the significance of these observations from the standpoint of understanding schizophrenic language.

This study of autistic language will readily recall the formulations of Freud in tracing the unconscious processes underlying speech, especially his comments on schizophrenic thought in The Unconscious (1915). Kanner's observations represent a valuable contribution which points the way to further research into these problems.

MARK KANZER

The Concept of Culture and the Psychosomatic Approach. Margaret Mead. Psychiatry X, 1947, pp. 57–76.

Mead asserts that psychoanalytic theory has failed to recognize the rôle of culture in the production of psychosomatic disease. The physician has always regarded the particular type of cultural molding that he sees about him as *human nature,* but it is essential to recognize that man's biological potentialities can only be inferred from observing the effects on human beings of many kinds of cultural pressures. A culture selects certain biological potentialities for elaboration while ignoring or even suppressing others. During the process of socialization a certain pattern of behavior is built into the developing organism which has a determining influence on structure and functioning. It is this process which produces the character structure typical for a given culture. Every human being is so profoundly molded by his culture that even the most basic life processes are subjected to systematic patterning. Everyone pays a definite psychosomatic toll for adjustment. Hence, in every culture, even the most homogeneous, are to be found consistent slight pathologies and systematic somatic modifications. In individuals with greater constitutional vulnerability, or those subjected to unusually severe stresses, there is to be expected an aggravation of the consistent pathology. In heterogeneous cultures, the greater prevalence of persistent character strain or psychic conflicts may result in an exuberance of somatic expressions. Also during periods of rapid cultural change when the usual cultural means of reducing personality tensions have been swept aside, these tensions are exacerbated. In all these circumstances, the individual is forced to work out his psychic conflicts on his own body, or his immediate environment—especially his family and children.

The proper recognition of the cultural factor has profound significance for preventive medicine because cultural forms might be developed to ease somatic strain.

S. GABE

Changing Concepts of Homosexuality in Psychoanalysis. Clara Thompson. Psychiatry X, 1947, pp. 183–189.

Thompson discards Freud's libido theory and with it his formulation of the nature of homosexuality. She contends that 'homosexuality is not a clinical entity, but a symptom with different meanings in different personality set-ups'. Among the meanings she has encountered in patients analyzed by her she mentions fear of the opposite sex, fear of adult responsibility, a need to defy authority, a flight from reality, a symptom of destructiveness of oneself or others.

S. GABE

Psychiatry in France. Pierre D. Fouquet. Bulletin of the Menninger Clinic, X, 1946, pp. 173–179.

Fouquet is a French psychiatrist and a member of a French commission formed to revise the laws of France affecting psychiatry. He was sent to the United States by the French Ministry of Health to study our methods.

In this paper he gives a brief historical review of French psychiatry. He points out that until the end of the nineteenth century, French psychiatrists—though prominent in their field—were mainly of the descriptive school. At the beginning of the twentieth century French psychiatry began to decline and remained far behind that of Germany. Nevertheless, in this period Binet formulated the first intelligence tests, and Toulouse established the first attempts at mental hygiene. At the present time French psychiatry still tends to remain essentially somatic in its orientation.

The problems confronting the French are very similar to those in this country: there are too few psychiatric hospitals, there is a tremendous increase in juvenile delinquency, etc.

The French differ from us in the care of their psychiatric patients in one important respect: their psychiatric hospitals are organized in small units, each having a medical director assisted by residents. The patients are placed according to the intensity of their disturbance and are housed in small units arranged like a town rather than a hospital.

RALPH R. GREENSON

Modern Concepts of War Neuroses. William C. Menninger. Bulletin of the Menninger Clinic, X, 1946, pp. 196–209.

Menninger cites as the important factor in combat exhaustion, failure on the part of the ego to control the unconscious aggressive impulses. In order to bear the new pressures of army life, the soldier must establish a positive father relationship to the leader of his group, and in addition, an *esprit de corps*. Finally, he must regress to an earlier developmental stage in order to accept a dependent, passive rôle.

Menninger then goes on to describe the development of what he calls a 'neuropsychiatric' reaction in combat. In discussing the psychodynamics of combat exhaustion, he states that combat dreams do not relieve the traumatic neurosis because the dream process is unconscious and is not permitted physical expression. Thus 'what was originally stimulated by an external threat becomes internalized, and without help may become an insoluble vicious cycle'.

The author states that his paper is oversimplified and condensed. The rôle of aggression is the only factor emphasized. The rôle of external danger, deprivation and guilt feelings are hardly mentioned.

RALPH R. GREENSON

Neuroses Occurring in Soldiers After Prolonged Combat Exposure. Alfred O. Ludwig. Bulletin of the Menninger Clinic, XI, 1947, pp. 15–23.

Ludwig describes a special type of war neurosis which occurred after long combat experience. The clinical picture was characterized by slowly mounting anxiety culminating in a clinical syndrome in which apathy and emptiness were in the foreground. Ludwig stresses the psychodynamic importance of leadership, personal pride, guilt, and political orientation. He does not stress deprivation specifically as the most significant factor in this type of reaction.

RALPH R. GREENSON

Some Factors Found Valuable in Maintaining Morale on a Small Combatant Ship. Morton E. Bassan. Bulletin of the Menninger Clinic, XI, 1947, pp. 33–42.

In this very interesting paper, Bassan describes and analyzes the high morale of the men on the U.S.S. The Sullivans, a 2200 ton destroyer, which took part in many exhausting combat campaigns in the Southwest Pacific.

The name of the ship itself helped these men feel a warm team spirit. Their first Captain who was exacting and demanding but extremely efficient, left a well-trained group of men with poor morale. The new Captain, pleasant and easy going, made it possible for these men to withstand severe combat stress and deprivation by his use of friendliness, rewards, good food, and equal sharing of the good and bad between officers and men. The men of this ship were able to maintain an extremely healthy psychological equilibrium. In twenty-one months of combat duty only one officer was evacuated as a neuropsychiatric casualty.

RALPH R. GREENSON

Psychogenesis and Psychotherapy of Ulcerative Colitis. J. Groen. Psychosomatic Med., IX, 1947, pp. 151–174.

Groen describes six cases of ulcerative colitis. Special attention is paid to the character structure of the patients and to the emotional conflicts that preceded the outbreak of the disease. It was demonstrated that every onset or recurrence of the disease was preceded by an emotional trauma which had produced a specific internal conflict, viz., a painful loss of love which was also felt as a humiliation, so that the patient seemed inferior as a man (or woman). None of the

patients had been able to solve his (or her) conflict and had persisted in grieving. Groen suggests that the presence of this specific type of unsolved emotional conflict in patients of this character is the cause of the disease. Four of the six patients improved rapidly after a simple form of supportive psychotherapy.

The patients were studied with a method called 'biographical amnesia'. The psychological material so obtained is convincingly described even though at times intuition substitutes for analytic evidence. This paper—especially if contrasted with previous papers dealing with similar methods—is a worthwhile contribution, showing the limitations, but also the potentialities, of nonanalytic research in psychosomatic fields.

MARTIN GROTJAHN

Variations in Adolescent Adjustment of Institutionally Raised Children. William Goldfarb. Amer. J. of Orthopsychiatry, XVII, 1947, pp. 449–457.

As a sequel to earlier studies on the harmful effects of institutionalization on personality development during the first six months of life, Goldfarb seeks in the present study 'a program to counteract the effects of the privation process'. He found little encouragement from attempts to adjust such children in foster homes during adolescence and is of the opinion that traditional methods of therapy are inadequate. He calls for 'bold experimentation' in this field, but the nature of such experimentation is not indicated.

MARK KANZER

The Implications of Culture Change for Personality Development. Margaret Mead. Amer. J. of Orthopsychiatry, XVII, 1947, pp. 633–646.

Mead examines the concept of normal personality and finds in case histories a tendency to assume that changes in the environment have a significant bearing on character formation, and tacitly, that most people are raised in a homogeneous and unchanging culture. The contrary is so true that that part of the population which is brought up in a really stable background is so small that they actually represent an abnormal fraction and 'are placed in a position so deviant that it becomes a liability through its unusualness'. Mead goes on to discuss the impact of cultural changes on various types of immigrants and in conflicts between different generations and social classes. Where transition occurs from a stable homogeneous culture, two stages may be distinguished. In the first generation, the old cultural realities undergo forms of amnesia, distortion and confusion; the goals and standards become inconsistent and the second generation is raised with a 'tentative' approach to life and with a fragmentation of the personality which becomes particularly marked under conditions of stress. It is this second generation which has become 'the expected personality type for the world today'. Modern American culture has developed a variety of self-corrective devices, including emphasis on progressive education, which allows freedom for development of new, integrated, cultural forms.

MARK KANZER

Psychosis During Withdrawal of Morphine. A. Z. Pfeffer. Arch. of Neurology and Psychiatry, LVIII, 1947, pp. 221–226.

Pfeffer investigated the effects of withdrawal of drugs upon five hundred morphine addicts and found that only in six were there manifestations of a psychosis. Since morphine addiction represents an extremely severe neurosis, it is surprising that such a small percentage of psychotic reactions accompany withdrawal.

RALPH R. GREENSON

Vitamin E in Treatment of Mental Disorders. Stanley T. Michael and Arthur H. Ruggles. Arch. of Neurology and Psychiatry, LVIII, 1947, pp. 351–356.

Michael and Ruggles studied the effects of vitamin E on thirty-five psychotic and psychoneurotic individuals chosen at random among hospitalized patients. The findings indicate that vitamin E stimulates some psychomotor activity resulting in clinical improvement in twenty percent of the subjects and in intensification of symptoms in forty percent.

RALPH R. GREENSON

Sodium Amytal in Treatment of Aphasia. Louis Linn. Arch. of Neurology and Psychiatry, LVIII, 1947, pp. 357–358.

Linn demonstrates the fact that many patients suffering from organic aphasia can be helped by the use of intravenous sodium amytal. The drug makes it possible to explore the emotional overlay, otherwise not readily accessible to psychotherapy.

RALPH R. GREENSON

A Note About Teaching Psycho-Analysis. Martin Grotjahn. Samiksa (Journal of the Indian Psychoanalytical Society), I, 1947, pp. 39–49.

Scant attention has been paid in psychoanalytic literature to the important problem of how best to conduct analytic training. There is general agreement on the necessity for a personal analysis as a prerequisite for further training, but no generally accepted criteria of pedagogical methods have been developed for the conduct of supervised analysis, case seminars, or lecture courses. Granted that for the predictable future the teaching of psychoanalysis will remain largely individualistic, still the interchange of experiences and opinions about objectives and techniques cannot fail to contribute to the skill of the training analyst and to improve the results of training.

To remedy the situation, Grotjahn advocates papers discussing the methods, principles and technique of teaching psychoanalysis. By way of opening such a discussion, he submits his experience in teaching a seminar on Freud's Wit and Its Relation to the Unconscious. He does not confine himself to generalities but details faithfully the procedure of every session in the seven-hour seminar: the literature reviewed and discussed, the rôle of the mentor, the extent of participation by the students, the different facets and ramifications of the subject pursued. From the material presented it becomes possible to form an independent opinion on how near such a seminar

comes to realizing the analyst's aim of 'helping his students to experience and see the interrelationship between the analysis of wit and the analysis of dreams, symbols, symptoms and other manifestations of the "Creative Unconscious" '.

S. GABE

Les phénomènes hallucinatoires passagers causés par la captivité (Transitory Hallucinations Due to Captivity). Les phénomènes hallucinatoires persistants des psychoses de captivité (Persistent Hallucinations in Psychoses Due to Captivity). Maurice Bachet. Le Bulletin Médical (Paris), LIX, No. 18, August 21, 1945.

In assaying mental illness which appears during imprisonment, Maurice Bachet makes a distinction between transitory (usually auditory) hallucinations which occur as a result of chronic anxiety and exhaustion, and the persistent hallucinations observed in a psychiatric syndrome. The author looks at these phenomena as different steps in the disintegration of personality.

RAYMOND DE SAUSSURE

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Notes

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NOTES

On December 16, 1947, the New York Psychoanalytic Society and Institute dedicated its library to DR. A. A. BRILL, designated by and in honor of his name: THE ABRAHAM A. BRILL LIBRARY. Dr. Sandor Lorand, President, presided, and the dedicatory address was read for Dr. Clarence P. Oberndorf.

'Mr. President, Dr. Brill, Members and Friends of the New York Psychoanalytic Institute:

'Today we are gathered together to dedicate a library. It is exceptional among the libraries of learning in that almost none of the books which it shelters—some fifteen hundred volumes—could have been written fifty years ago. It is the precious heritage of man which distinguishes and dignifies him above all other species in that he enjoys a capacity to think and the ability to grow and change in his thinking. The chatter of monkeys has probably remained the same since first they swung freely from branch to branch in the primeval forest. The sweet note of the skylark has not changed since the first skylark poured forth its "full heart in profuse strains of unpremeditated art". But man's expression is not static. What he perceives or how he perceives it and the progression of his thought have been recorded in the written word—itself one of the most remarkable achievements of his ingenuity and thinking. These thoughts are preserved for us to ponder, from the Rosetta Stone and the papyri of the Egyptians, the scrolls and bound manuscripts of medieval times, to the printed books which Gutenberg's press made possible since the fifteenth century. From that time, the results of thought became accessible to an ever increasing number of people for their instruction, enlightenment and entertainment, and libraries multiplied.

'With every new thought a pattern of controversy repeats itself between those who are willing to examine and test the new and those who find safety and reassurance in the old and familiar. The right to heresy has ever been challenged and the originators and protagonists of the new have often suffered and were often destroyed with the books which were the fruit of their thinking. This, too, became the fate of Sigmund Freud whose disturbing revelations concerning our inner selves at first brought upon him ridicule, insult and condemnation. But gradually his unorthodox works found a place in the private libraries of a discerning few and were reviewed with favor in Europe and America.

'The earliest notice of Freud's psychological work in this country which has come to my notice is of the Psychopathology of Everyday Life reviewed by Boris Sidis in 1906. It was about this time that A. A. Brill, a recent graduate of Columbia University, College of Physicians and Surgeons, not content with the routine psychiatric approaches at one of the regulation New York State hospitals, journeyed abroad to study at the mental hospital of Burghölzli in Zurich, at that time intensively engrossed in the investigation of psychopathology by the new psychoanalytic methodology. The story of young Brill's quick appreciation of the possibilities of psychoanalysis as a therapy and diagnostic aid is well known to all of us. Returning to America, he became the most insistent champion of Freud's discoveries, the most energetic

and boldest protagonist of them, the founder of the first psychoanalytic society in America here in New York, and the official translator into English of many of Freud's books. To these translations he added and is still adding numerous distinguished works of his own on psychoanalysis and psychiatry.

'Indignation at psychoanalysis, levelled principally at Freud's sexual theories and interpretation of dreams, found immediate expression in medical circles in America. Brill bore the brunt of much of the attack and so skilfully and courageously that now, after forty years, psychoanalysis has become accepted and respected in American medical circles.

'Fifteen years ago evil days fell upon freedom of thought in central Europe, and books were burned in the streets. They burned the books of Heine, one of the sweetest poets who ever lived; and they burned the books of Freud because of his philosophy and his race—as though monstrous men in Berlin could destroy thinking and thought by burning books even if there had been no other libraries in the world to safeguard them.

'Perhaps no one has done quite so much to spread and preserve the work of psychoanalysis in English as A. A. Brill. His colleagues and friends felt that these services could best be recognized and honored by dedicating our library to him and by unveiling in it a bronze bust of Dr. Brill. Our good friend finally agreed to sit and we were fortunate in finding as the sculptor, Mr. Olem Nemon who also executed the statue of Freud in this institute. Mr. Nemon has captured Brill in a characteristic pose in which anyone who had the pleasure of hearing Brill reply to adversaries in the old days of psychoanalytic controversy will perceive what I mean.

'It is indeed a fitting and deserved tribute that in this Institute of Psychoanalysis, to whose establishment Dr. Brill's efforts and unflagging zeal have contributed so much, there should be a bronze portrait of him and that the Library should be called by his name, the Abraham A. Brill Library. In honoring him we express our appreciation and honor ourselves.'

DR. A. A. BRILL:

'Mr. President and Friends: On an occasion of this kind one is at a loss for words. The only idea that runs through my mind is that I highly appreciate the great honor you have just bestowed upon me in dedicating your library to me. I was deeply impressed by Dr. Oberndorf's address which was read by Dr. Lehrman because Oby was unable to leave his home on account of a bad cold. Dear old Oby has been a faithful friend and steadfast collaborator throughout all the years of our psychoanalytic struggles. He and I are the only ones left of the charter members of the New York Psychoanalytic Society, which was officially formed on February 11, 1911. Unofficially we had met regularly since 1908, usually in my home, sometimes in the back of Rudolph's beer saloon, where we discussed the new theories and practice of Freud's psychoanalysis.[1])

[1] Following the formation of the International Psychoanalytic Society, ours was the fourth group to be admitted to it. The Berlin Society, consisting of nine members under the presidency of Karl Abraham, was admitted in March, 1910; the Vienna Society of twenty-four members under the presidency of Alfred Adler, in April; the Zurich Society of nineteen members, under the presidency of Ludwig Binswanger, in June. All these societies existed before

'As I now stand here and look at you, mostly youthful and middle-aged, interspersed with some old friends like Federn and Wittels whom I first met in 1907–1908, on my first visit to Vienna, a long panoramic review of my psychoanalytic life passes before my mind's eye. I could talk about it for a long time, but I shall be brief. Everything that comes to my mind naturally revolves on pleasant, some not so pleasant, recollections of the history of our society.

'From 1911 to about 1936 I was conspicuously active in the affairs of this society. I was the prime mover in its organization and years later in starting the institute, and naturally bore the brunt of criticism for everything. But as the years went on, the younger generation grew up and we did not always agree on matters of policy. I realized that a change in the attitude and manner of the society was at hand. Bert Lewin, one of the leaders of the younger generation, whose honesty and ability I have always admired and respected, discussing the situation with me frankly said that the younger members found it hard to work with me because, as he put it, 'There is no second generation in the society. You have no sons, we are really your grandsons.' I felt that he was right. The only member of the society that I could have called a son was Lehrman, who as I told you (*cf.* p. 100) came to the society years before the new group of young analysts after World War I. I thereupon reviewed my aims and activities in the society, and came to the conclusion that I had accomplished everything I had set out to do, except the formation of a clinic, which your records will show I was very anxious to do. When Lewin and others assured me that this could not be done at the time I decided to retire from the society. Lewin then urged me to function in an advisory capacity, but I did not consider it feasible. After being in the van of all activities for so many years I feared that my continued presence in any office of the society might raise some difficulties. Judging by the history of the society and institute since 1936, I feel that I made the right decision.

'It was not easy to forego all the pleasures, tribulations and excitement of leadership, but once I made my decision I abided by it. From time to time I am invited to participate in some special function of the society or institute which I have always been pleased to do. You have honored me before, and of late I have also received honors from nonanalytic regions: in

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the formation of the International Psychoanalytic Society. The president of the International, Dr. C. G. Jung, from whose report I am quoting (*Jahresbericht 1910–11, Zentralblatt für Psychoanalyse, II,* p. 233) called these societies the foundation of the International, and said that it started 'as a very tender plant', but he added, 'I can affirm with great pleasure and satisfaction that during the past year our society has developed a very solid existence. In February, 1911, the seed sown in American soil developed sprouts. A society of twenty-one members was formed under the presidency of Dr. Brill. . . . In March, a society of six members was formed in Munich under the presidency of Dr. Seif.' Jung then continued: 'The Zurich members are deeply indebted to Freud's scientific stimulation. But the debt of gratitude which weighs so heavily on us becomes lighter when we can point to the fact that the founders of the Berlin, Munich, and New York Societies were former members of the Zurich school.'

I add this footnote for the enlightenment of a younger generation which knows an entirely different Jung.

November 1947 I was elected an honorary member of Phi Beta Kappa, and I am just informed that I have been elected an editor of the American Journal of Psychiatry. This is indeed a recognition coming as it does from an orthodox psychiatric journal to a rank psychoanalyst. I have always been glad to contribute my services to scientific literary work, but frankly I am not much thrilled by these honors. I need not tell you however how extremely pleased I am by what you have just given me. Books were always more valuable to me than anything else in this world, and your records will show you that I started this library as soon as we established a home for the society and institute in West 86th Street. Since then the library has grown apace, and as Dr. Oberndorf so nicely put it, this library is unique because most of the fifteen hundred volumes which it houses could not have been written fifty years ago. And just imagine how exciting it was for me watching it grow, for there were only about half a dozen of Freud's books in print when I first came on the psychoanalytic scene.

'My friends, in dedicating to me this imposing and well equipped psychoanalytic library, you have amply recompensed me for the little I have done to advance Freud's views here. May this library, which is an inspiration to us, continue to be of service to students of the mind of the oncoming generations. I thank you.'

From the minutes of the Forty-Eighth Meeting of the AMERICAN PSYCHOANALYTIC ASSOCIATION, Hotel Pennsylvania, New York City, May 17, 18, 19, 1947 the following items are reported.

The results of a multiple ballot sent to the membership on February 26, 1947 were reported. The members voted: (a) approval of the application of the Baltimore Psychoanalytic Society (175–5); (b) approval of revision of the 1938 resolution against the future training of lay analysts (162–20); (c) revision of Article V of the new By-Laws modifying election of Councillors so as to insure adequate representation of affiliated societies on the Council (181–3); (d) revision of Article VI of the new By-Laws in relation to composition of nominating committee; (e) revision of Article VI of the new By-Laws permitting mail balloting in election of officers; (f) approval of a proposal to appoint a committee to work out the problem of relationship of the American Psychoanalytic Association with the International Psychoanalytic Association; (g) disapproval of modification of Article I Section 2 of the By-Laws defining the purposes of the American Psychoanalytic Association; (h) disapproval of modification of Article III Section 2 which would permit voting by proxy at annual meetings; (i) disapproval of modification of Article IX Section 1 pertaining to method of selection of the Board; (j) disapproval of modification of Article IX Section 3 that would permit voting by proxy by members of the Board of Professional Standards.

Dr. Lewin reported on correspondence with Dr. Jones in relation to reorganization of relations between the American Psychoanalytic Association and the International Psychoanalytic Association. After considerable discussion in the council, the President appointed a committee consisting of Drs. Lawrence S. Kubie, Robert P. Knight, Heinz Hartmann, William C. Menninger and

Leo H. Bartemeier, of which Dr. Kubie is chairman, to continue the exchange with the International. The consensus of the council was that: the membership in the International, or affiliation with the International be through the American Psychoanalytic Association rather than by individual society affiliation; representation on the Board of the International be proportional to membership for the American and for all other societies affiliated with the International; the old International Training Committee be abolished. A suggestion was made by Dr. Bettina Warburg that representation in the International could be through the Council of the American Psychoanalytic Association. On motion of Dr. Lewin, seconded by Dr. Bartemeier, the foregoing three points were approved by the council.

Dr. Kubie moved, and Dr. Bartemeier seconded a proposal that the American Psychoanalytic Association have a historical account of the rôle and contribution of psychoanalysis and psychoanalysts to military psychiatry prepared. The council approved and the President appointed Dr. R. L. Frank as Chairman of a committee to further this project.

On motion by Dr. Bullard, seconded by Dr. Bartemeier, the Council recommended that the annual meeting of the Association again be held in conjunction with the May 1948 meeting of the American Psychiatric Association in Washington, D. C. Drs. Menninger and Lewin pointed out conflicts in schedule of the American Psychoanalytic Association and the American Psychiatric Association, and the limited time available for presentation of scientific papers. The Council approved a proposal by Dr. Bartemeier that the mid-winter meetings of the association be resumed. It was recommended that three-day meetings rather than two-day meetings be held in the interest of fuller programs. A committee consisting of Dr. Bartemeier, Chairman, Drs. Daniels, Knight, Maeder and Wilson was appointed to work on the problem of conflicts between spring meetings of the American Psychiatric Association and the American Psychoanalytic Association.

Dr. Kubie raised some question as to the matter of privileged communication between analyst and patient in connection with wartime and current investigations of patients' political leanings. It was moved by Dr. Kubie, seconded by Dr. Knight, that this question be referred to legal counsel for advice. This motion was passed.

Dr. Knight pointed out the increasingly burdensome and time consuming nature of the secretaryship of the Association and the need for some permanent office space for storing of files and records of the Association. On motion by Dr. Knight, seconded by Dr. McLean, the Council approved appointment of a committee to study and report on this problem. Drs. Knight and Weinstock were appointed members of this committee with Dr. Mohr as Chairman.

Dr. Bartemeier presented to the Executive Council a resolution recommending appointment of a special committee to wait on representatives of the several faiths and churches to plan conferences and investigations in areas where joint research between such groups and psychoanalysts is indicated. It was the consensus of the Council that this was an aspect of the larger problem of public relations. In this connection, the additional need of services to prepare appropriate press releases in connection with the scientific meetings of the

organization was pointed out. On motion of Dr. McLean, seconded by Dr. Wilson, the Council approved appointment of a committee on Press and Publicity to investigate and, with respect to the press, to act in behalf of the Association. The President appointed to this committee Dr. Mohr, Chairman, Drs. Bartemeier, Kubie and Romm.

THE INSTITUTO BRASILEIRO DE PSICANALISE was founded in Rio de Janeiro in November of 1947 for the following purposes: to serve as a training center for doctors interested in the practice of psychoanalysis; to offer psychoanalytic training to professionals in other fields in which such training is to the interest of the community; to contribute to the psychoanalytic treatment of needy patients in the interest of social welfare; to provide for and stimulate cultural interchange on a national and international scale through a program of lectures, courses and fellowships; to interest specialists in and provide for the additional training required for the psychoanalytic treatment of children; to establish a library, library service and facilities for bibliographical research; to facilitate the training of special nurses; to organize and publish in pamphlet, prospectus, report, or monograph form, research and statistical information, which may, if judged convenient, constitute the subject matter of a periodical to be published by the institute.

The constitution of the Brazilian Institute of Psychoanalysis has thirty-seven sections which adhere to the most exactingly high standards of psychoanalytic practice and training. The only deviation from the requirements of the American Psychoanalytic Association is the admission to membership of candidates without medical training.

All medical doctors graduated from a Faculty of Medicine recognized by the institute and other professional and laymen adjudged by the committee to have adequate scientific preparation are eligible for the status of active member-in-training. Active members-in-training will be admitted only on proposal by two members, subject to acceptance by an absolute majority of the Board of Directors. All persons presenting evidence of qualification by the Instituto Brasileiro de Psicanalise or by any other institute recognized by the International Psychoanalytic Association are eligible for active qualified membership.

To fulfil its aims the institute shall establish and maintain the following departments: Psychoanalytic Training and Courses; Psychoanalytic Therapy; Library and Bibliographical Research; Cultural Interchange and Publicity; Fellowships and Scholarships.

The following are the minimum requirements for admission to psychoanalytic training which must always be in accord with the prerequisites established by the International Psychoanalytic Association: graduation from a Faculty of Medicine recognized by the institute; presentation of two recommendations as to the character, intelligence and seriousness of purpose of the candidate; satisfactory interview with at least two members of the Committee on Admissions; presentation of satisfactory evidence of ability to read English, French or German (at least one of these languages); acceptance by the candidate for admission of the obligation not to use the title of Analyst until formally qualified; acceptance by the candidate for admission of the obligation to

devote one third of his working hours to the practice of psychoanalysis in collaboration with the institute.

The following are the minimum requirements for qualification as a psychoanalyst by the institute: completion of personal analysis with an analyst of the IBP; satisfactory completion of the supervised analysis of two patients chosen by the institute; satisfactory performance on written, oral and practical examinations covering the lecture and seminar work of the candidate; presentation and defense of a thesis; presentation of satisfactory evidence of ability to read and translate English, French or German.

The training program of the institute will be inaugurated upon the arrival in March 1948, in Rio de Janeiro, of Dr. Mark Burke of London.

Communications should be addressed to Dr. D. Arruda Camara, R. Alves de Brito 12, Rio de Janeiro, Brazil, or to Dr. J. J. Barbosa Quental, R. Torres Homen 1082, Rio de Janeiro, Brazil.

Dr. D. Arruda Camara recently completed a trip to Europe, visiting psychoanalytic centers and colleagues in England, France, Germany and Switzerland. Plans for the institute were discussed by him in detail with Dr. Ernest Jones in London.

The annual conference of the CHILD STUDY ASSOCIATION OF AMERICA, held March 1, 1948, in the Hotel Roosevelt, New York City, was a symposium on The Problem of Human Aggressions: How They Develop? Must they Lead to War?

Roots of Aggression—In the Family, in the Community. Chairman: Mary Fisher Langmuir, President, Child Study Association of America; Professor of Child Study, Vassar College. Speakers: Lawrence S. Kubie, M.D., Clinical Professor of Psychiatry and Mental Hygiene, Yale University School of Medicine; Justine Wise Polier, Justice of the Domestic Relations Court, City of New York.

The Price of Peace—Management of Aggressions. Presiding: Mary Fisher Langmuir, President, Child Study Association of America. Chairman: Goodwin Watson, Professor of Education, Teachers College, Columbia University. Speakers: Franz Alexander, M.D., Director, Chicago Institute of Psychoanalysis; Norman Mackenzie, staff of The New Statesman and Nation of London, Visiting Professor of Government at Sarah Lawrence College.

Conflicts in our Present-Day Culture—Can Education Meet the Challenge? Chairman: Malcolm W. Davis, Acting Director, Carnegie Endowment for International Peace. Speakers: Sarah Gibson Blanding, President, Vassar College; Cord E. Meyer, Jr., President, United World Federalists; Harold Rugg, Professor of Education, Teachers College, Columbia University.

THE WORLD HEALTH ORGANIZATION, Interim Commission, is coöperating in a United Nations study for the prevention of crime. The purpose of the study is to provide a plan for international action. To enable the Social Commission to initiate its program with a minimum of delay, it is intended that the study should be based mainly on the collection and analysis of existing

opinion and research, rather than on original scientific inquiries. Two members of the UN Secretariat, Department of Social Affairs, taking part in this study are Adolph Delierneux, Belgian sociologist, assistant director of the Department's Social Activities Division and Benedict S. Alper, American criminologist. Dr. Leon Radzinowicz, Director of Criminal Research at Cambridge University, England, is the fourth member of the group. Dr. Manfred S. Guttmacher, chief medical officer of the medical service of the Baltimore Supreme Bench, has been appointed consultant psychiatrist. He will take part in planning the study, but his specific work as representative will relate to heredity as a factor in the causation of crime; prevention of crime by giving attention to the early social adaption of children; psychiatric factors in the genesis of early criminal careers; psychiatric methods for the treatment of juvenile and adolescent offenders; psychiatric care for the treatment of adults in penal institutions.

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