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A. A. Brill

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Abraham Arden Brill

October 12, 1874

March 2, 1948

A. A. BRILL

Abraham Arden Brill spent his student days and entire professional life in New York City and was the intimate friend, and often the mentor, of the older members of the New York Psychoanalytic Society. The influence of his long sustained efforts and scientific contributions has had a profound effect upon all, including the younger group who had not the privilege of close association with him. Medical historians in the future may well regard the time of Brill's passing as marking the full ripening of an era in psychiatry in America to which he himself referred as the freudian epoch and in which he assumed distinguished leadership.

The factual data of his life will serve as an armature about which we may build the full statue of the man. He was born in Kanczuga, Austria, on October 12th, 1874 and arrived in New York in 1889, a boy of fifteen, alone, almost penniless and friendless. In this new, bewildering country he was thrown upon his own resources and entered the school of hard work, long hours and rough competition. This small, eager youth, who struck out for himself in the maelstrom of New York's east side, must have been exceptionally sturdy, tireless, industrious and alert. He worked during the day at all sorts of jobs open to a youth in his teens but by diligent application to books of knowledge at night, he rapidly acquired sufficient preliminary education to enter the College of the City of New York. He studied there for two years before he was compelled to discontinue his studies because of lack of funds, a situation which repeated itself during his medical studies. Eventually he was graduated a Ph.B. from New York University in 1901, and from the College of Physicians and Surgeons of Columbia University in 1903, at the age of twenty-nine, a Doctor of Medicine. He then became an assistant physician in a New York

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Read at the Memorial Meeting for Dr. A. A. Brill at the New York Psychoanalytic Institute, March 30, 1948.

State Hospital at Central Islip where he remained for four years.

With his insatiable and restive mind always seeking new knowledge, he went abroad in 1907, first to the famed neurological clinics of Paris, which disappointed him, and then following the suggestion of Dr. Frederick Peterson, to the hospital at Burghölzli at Zurich. Here he came into contact with Eugen Bleuler, Carl Jung, and Karl Abraham who were applying Freud's still unaccepted theories to the study of the psychoses. Brill immediately discerned the importance of this new dynamic approach, called psychoanalysis, to the study of mental disease. Retrospectively it threw light on some of the enigmatic utterances and actions of the patients he had observed at Islip. He embraced enthusiastically these innovations and departures from the then current descriptive psychiatry which had in its time contributed much to prognosis and treatment through classification.

Upon his return to America, Brill married K. Rose Owen in 1908 who, with two children, Gioia Bernheim and Edmund, survives him. To Mrs. Brill, his devoted wife, he dedicated one of his most recent books as the one 'who unwittingly inspired my quest for Freud's psychoanalysis, and whose patience and encouragement sustained me in the struggle to establish it in this country'.

About this time he established himself in private practice in New York City and from then until his death Brill remained a vital and dominant force as a proponent of the psychoanalytic theories in America and internationally as well. He has left an entertaining account of this phase of his professional contacts and impressions in his book, Freud's Contribution to Psychiatry, based upon the Salmon Lectures which he delivered in 1943.

Freud received his formal introduction to America at Worcester, Massachusetts, in the fall of 1909 under the auspices of Dr. G. Stanley Hall and Professor James J. Putnam of Harvard University. However, it was really Brill and his early associates who demonstrated the substantiality and clinical correct-

ness of Freud's teachings and their tangibility and successful applicability to the cure of mental illness and its physical derivatives. Further, Brill made the knowledge of psychoanalysis available to American medicine through the translations of Jung's Psychology of Dementia Præcox (1909), Freud's Selected Papers on Hysteria (1909), and Freud's Three Contributions to the Theory of Sex (1910). This constituted a challenging task, for Freud's writings introduced a new vocabulary, intricate structure and a complicated, unaccustomed ideology. He succeeded in this difficult undertaking so well that Freud entrusted him with the translation of most of his subsequent works.

In addition Brill himself is the author of Psychoanalysis, Its Theory and Practical Application (1912), and Fundamental Conceptions of Psychoanalysis (1922); and after a lapse of twenty years he wrote Freud's Contribution to Psychiatry (1944), and Lectures on Psychoanalysis and Psychiatry (1946). The first two books served as authoritative résumés of psychoanalytic theories and were intended primarily for the education of physicians. Furthermore, he produced well over a hundred and fifty papers which illuminated a wide variety of scientific problems, especially psychiatric and psychoanalytic, or amplified psychiatrically topics of general or popular interest. These include Mental Adjustment in Jews, Tobacco and the Individual, Piblokto or Hysteria Among Peary's Eskimos, Reflections on Euthanasia, and An American Precursor of Freud—a few chosen from many titles to indicate the diversity of Brill's curiosity and interests. We may also mention that he edited and translated Bleuler's Textbook of Psychiatry (1923), and The Basic Writings of Sigmund Freud (1938).

Dr. Brill founded the New York Psychoanalytic Society in February, 1911, was active in the formation of the American Psychoanalytic Association a few months later and was honored with the Presidency of both these Associations on several occasions. To enumerate the scientific societies of which Dr. Brill was a member would be to list practically all the important

psychiatric associations in the state and nation. Many of these organizations elected him as their president, including the New York Neurological Society, the New York Society for Clinical Psychiatry, the New York Psychiatric Society, and The Section of Neurology and Psychiatry of the New York Academy of Medicine. When psychoanalysis attained sufficient respectability to force academic recognition, Brill was selected to be lecturer at Columbia University on psychoanalysis and psychosexual sciences and Clinical Professor of Psychiatry at New York University. Shortly before his death Phi Beta Kappa conferred upon him an honorary membership.

Brill's profuse contributions to literature did not surpass the influence he exerted through the spoken word in the spread and defense of psychoanalysis so often under violent attack. He seldom missed and often created the occasion to speak on the topic at scientific or other gatherings, and he was an indefatigable, almost religious, attendant at medical meetings. Although it had become a frequent experience for him to be chosen as the speaker of the evening in distinguished medical groups, he did not refuse, even in his later years, to respond to a call involving an inconvenient train trip or a dreary ride to a distant section of New York City to address obscure societies of general practitioners. Most of these speeches were extempore with the aid of a few guiding notations.

The early struggles in boyhood and young manhood when Brill had to fend for and defend himself proved an invaluable experience in the fight he was destined to lead for psychoanalysis. The concepts which Brill had early chosen to endorse and champion in America were repellent and offensive to many and his manner of presenting them was never cushioned by indirection or a softening of his appeal. He did not hesitate to jeopardize his reputation and even the possibilities of a successful career by opposing the established and influential authorities in neurology and psychiatry who resented theories in which the unmentionable sex impulse played such an important rôle and which denied man's complete mastery of himself.

In debate Brill found no difficulty in maintaining his position. He would not be dissuaded, discouraged, terrified or intimidated, for the faith of his convictions was solid. He yielded ground to no one and pugnaciously returned to resume the contest. When aroused, Brill spoke with provocative candor and flashes of temper, but his anger and resentments did not linger.

Notwithstanding his unconventional bluntness, Brill made few permanent enemies. Perhaps it was his integrity, his sincerity, his honesty and forthrightness which eventually reconciled bitter, elder opponents to respect and even admire the outspoken younger man whose ideas had nettled them. Indeed Brill had an unusual number of friends who could depend upon his aid and loyalty, and who will ever miss his geniality, hospitality, enthusiasm and warmth. I am privileged to have been one among them.

The story of Brill's life follows in the pattern of the Horatio Alger ideal of the American boy of fifty years ago: from poverty to prestige—an American saga. It is a narration of rise to greatness through pluck and perseverance, through work and wisdom, through fortitude and faith in self. And Brill loved the land which gave to him equal opportunity to develop his talents, which placed so few artificial barriers in his path, which had no official censors to confine or crush his original thinking. He showed his appreciation realistically. In the first World War he discontinued his practice to serve with a psychiatric unit at Plattsburgh, New York, and again in the recent war, although seventy years old, he volunteered as consultant in psychiatry to the Selective Service System. No more conscientious or competent physician worked with that group.

In conversation and with his friends Brill was witty, quick at repartee, entertaining and gay, often enlivening his remarks with a well-told anecdote or joke—sometimes having an earthy flavor. Often when stirred, he became fervid, impetuous and impulsive, and thoughts seemed to explode from his mind.

But first and foremost Brill's thought and heart lay in clinical

medicine notwithstanding his many other interests in music, the classics, languages, ornithology, sociology, education. His lifework was that of the devoted physician, helping and healing those suffering from disturbances of the mind, quite as painful as those of the body which in turn they so often affect.

Brill exemplified the type of physician whose ideals for the advance and improvement of his specialty never falter. He was always sufficiently realistic to discard theoretical ideals for sound factual procedures when he decided that the occasion demanded it. Sometimes he would cast aside all professional considerations to give liberally to the afflicted one from his rich fund of human kindness. And so he has left not only a profound impact and permanent impression upon those aspects of medicine and sociology which are influenced by psychiatry but also the more precious heritage of the gratitude and tender affection of a large number of patients and colleagues who have benefited by his generosity and his instruction and have been inspired by his example.

Dr. Brill bore his distinctions lightly; in his tastes and habits he remained simple and informal. Certain often quoted stanzas of the poet, Tennyson, seem particularly appropriate to the spirit and philosophy of our friend:

> 'Sunset and evening star,
> And one clear call for me!
> And may there be no moaning of the bar
> When I put out to sea.
>
> Twilight and evening bell
> And after that the dark!
> And may there be no sadness of farewell
> When I embark.'

C. P. OBERNDORF

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A. A. Brill in American Psychiatry

Philip R. Lehrman

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A. A. BRILL IN AMERICAN PSYCHIATRY

As the first American psychoanalyst, Brill was deeply esteemed as the teacher of two generations of psychiatrists and psychoanalysts. First to bring Freud's monumental discoveries to this country—and by his translations of Freud's major works to the English-speaking world—Brill's place in the history of twentieth century psychiatry has been fully acknowledged here and abroad. At seventy-two, he dedicated his Lectures on Psychoanalytic Psychiatry[1] 'to the State Hospital Physicians who bear the brunt of curing and alleviating mental ailments; in whose ranks I served and to whom these lectures were first addressed'. He continued to serve in the 'ranks' until his death, March 2, 1948.

I have counted it a privilege to be one of his many students. I listened to his lectures on numerous occasions and when I first began the study of psychoanalysis it was Brill who functioned as my 'psychoanalytic institute' because there were no organized and well-staffed psychoanalytic institutes as there are today.

A. A. Brill had a special talent for conveying to the reader of his works, and to the listener of his lectures or informal talks, the distilled essence of an impressive accumulation of sound observations in the science of the mind. He was a profound scholar and his clinical presentations were always alive and brilliantly interlaced with a critical digest of the heterogenous storehouse of psychiatric and psychoanalytic literature.

At the beginning of this century, American psychiatry was slowly emerging from its barrenness. The psychiatric curriculum in the best medical schools consisted of about a dozen lectures and demonstrations of mental diseases. The young physicians were either overawed by the mysteries of the mentally sick, or repelled by the chronic 'dementias' which frightened

[1] Reviewed in this QUARTERLY, Vol. XV, No. 4, 1946, pp. 509-510.

them away. If a few drifted into the State Hospital services their interest in the mentally sick was soon blocked by the prevailing apathy. Pathological anatomy occupied those who continued their scientific bent, but it threw no light on the turbulent eruptions in the living patients. Psychiatry was dry and monotonous, and twenty years later some patients who had been admitted in 1885 had meager histories with the three-word follow-up note of 'Dull, Stupid and Demented'. The permutations of these three words seemed to occupy the state psychiatrists of that time and, for variation, a new doctor would note merely that the patient's condition was 'as noted above'.

When A. A. Brill entered American psychiatry in 1903, the year he obtained his M.D. degree from the College of Physicians and Surgeons, Columbia University, the most advanced work in psychiatry was of the descriptive German school, notably Kraepelin, whose two nosological entities—dementia præcox and manic-depressive psychosis—represented a distinct advance. Adolf Meyer had been recently appointed director of the New York State Pathological Institute on Ward's Island, and when he started the custom of asking all the New York State Hospitals to send selected members to the Pathological Institute for courses, A. A. Brill was in the first group to take the course of three months intensive training. During his four years of residence in Central Islip State Hospital, Long Island, New York, he thoroughly mastered the psychiatric knowledge of that day, served as pathologist in Central Islip for two years and was the first to organize the pathological laboratory there.

He grew tired of pathology after two years, and eager to work in clinical psychiatry he followed Adolph Meyer's abstracts in writing the case history. Two years of classifying patients, making diagnoses and prognoses, and then 'nothing to be done except watchful waiting' left him dissatisfied. While still at Central Islip he sought therapeutic enlightenment at the Vanderbilt Clinic, but the 'tonics and sedatives' for 'dopey and nervous' patients appeared illogical to him.

Extramural psychiatry was equally dispiriting. Though the

majority of the patients seeking treatment in the neurological clinics consisted of neurotics, the main attention was directed toward neuropathology. The armamentarium of sedatives, hydrotherapy, physical therapy and, in some instances hypnotism, did not appeal to Brill.

At thirty-three years of age, Brill was eager to enter private practice in his chosen field but felt the need to observe the work in Europe. In 1907 he journeyed to Paris. French psychiatry was uninspiring and once again neuropathological studies occupied him. He speculated about the possibility of abandoning psychiatry for some other branch of medicine (otolaryngology!). He was, however, dissuaded by Frederick Peterson and was advised to go to Burghölzli in Zurich, Switzerland. There Eugen Bleuler and his co-workers had become actively interested in Freud's discoveries and were experimenting with the new science of psychoanalysis.

For the first fourteen years of Freud's psychoanalytic work (1893–1907) he stood alone surrounded by a hostile and skeptical world. This period of isolation in which Freud formulated his theories of the neuroses served him in good stead as he was able to observe his findings and test out his formulations without interruption. Most neurologists and psychiatrists of his time were either completely unaware of his epoch-making discoveries or on superficial examination of his work were derisive and hostile. The one exception was Bleuler of Zurich, who in 1907 communicated to Freud that in Burghölzli his group of scientific workers had been studying and applying Freud's principles with remarkable results.

Appointed an assistant in Burghölzli, Brill remained there about one year. Having translated Jung's book into English, he met Freud a few months later and arranged to be his translator. When Brill returned to New York and began his practice of psychoanalysis in 1908, that was the beginning of psychoanalysis in the United States. Some psychiatrists here had delved into the association experiments of Wundt in a superficial way, but the catatonic will either not answer or will persevere in his

associations. The Zurich investigators had the object of determining whether Freud's theories of instinct were true and whether there really was an unconscious. They were not merely interested in what the patient said, but in what the patient *meant*. That was the beginning of the era of psychopathology and interpretive psychiatry with which Brill was closely identified to the end of his career.

During the years 1908–1910 when Brill was the only psychoanalyst in New York, he had two pupils[2] who have left an indelible impression on American psychiatry. During the winter of 1909 and 1910, Professor James J. Putnam of Harvard University came to New York about two or three times a month to spend a few hours with Brill 'discussing Freud's theories', to remain a staunch freudian 'in his own New England manner for the rest of his life'. The other pupil was Smith Ely Jelliffe, to whom both Brill and Freud gave due credit for being the father of psychosomatic medicine. From a letter which Brill received from Jelliffe April 2, 1943, the following quotation is memorable.

> 'As to my part in the various movements, I count myself specially fortunate in getting in contact with you on your return from Bleuler that year Peterson was away and you and I ran his service in the Neurological Institute. Our walks through the park started something in me of inestimable value and I shall never be able to tell you what they did for me in the way of assembling and crystallizing a large background of general medical experience. I felt that bottom rock had been reached and we could then build with confidence. I had been reading Freud, but you made it vital and real to me. It was a "forge" into which things could be plunged and then hammered out into shape. This you helped me to do, and your help was generous and unstinted. Your genuine and intrinsic honesty, as well as your good sense, made me cleave to you as a brother I never really had and supplemented my contacts with White [William A.] that had been so invalu-

[2] *Cf.* Brill, A. A.: *Psychotherapies I Encountered.* Psychiatric Quarterly, XXI, October 1947.

able. I had something to give him also, thanks to you. Many an issue or conception vaguely grasped previously, stood out clear and precise after discussion with you, and White further simplified these for general use. It really was always Jelliffe, White and Brill from that time onward. Yet, you never lost your individuality and never will.'

Brill who was a tireless practitioner nevertheless found time in his various hospital and university appointments to teach the medical staffs who eagerly awaited his 'rounds'. He was Clinical Professor of Psychiatry at New York University, College of Medicine; lecturer on psychoanalysis at the College of Physicians and Surgeons, Columbia University; and consultant to the psychiatric departments of Bellevue Hospital, the Veterans' Administration Hospital on Kingsbridge Road, and Manhattan State Hospital on Ward's Island. He continued active in the psychoanalytic training program of the New York Psychoanalytic Institute.

On Sunday, October 12, 1947, Dr. Brill and his wife motored to Westport, Connecticut to share his seventy-third (and last) birthday with the writer whose birthday falls on the same date. Though it was Sunday and Columbus Day he nevertheless had to return to his office to keep an evening appointment with a pupil whose clinical work he was supervising at the time.

Brill was firmly identified with psychoanalysis for forty years and through his translations, writings, discussions and lectures he 'fought for it extra- and intra-academically'. When the Section on Psychoanalysis of the American Psychiatric Association was formed in 1933 in Boston, he was its first chairman and it marked the formal integration of psychoanalysis with American psychiatry. Ten years later he was selected the Salmon lecturer and was particularly moved by the introductory words of his 'first teacher of psychiatry', Dr. Adolf Meyer who came from Baltimore to the New York Academy of Medicine for the occasion.

In 1934 Dr. Brill received a Medallion from New York University as an outstanding graduate. He was honored with the

presidencies of the New York Psychiatric Society (1939–1940) and the New York Neurological Society (1941–1942). In 1939 he received the New Orleans Trophy from Z.B.T. Fraternity, and in 1947 he was elected an honorary member of Phi Beta Kappa. Best of all, however, he was pleased with the dedication to him of the 'Abraham A. Brill Library' of the New York Psychoanalytic Society and Institute on December 16, 1947[3] at which time a bust cast in bronze, the work of the sculptor, Olem Nemon, was also presented to him and placed in the library. Present were his wife, children, and grandchildren, and the members and students of the American Psychoanalytic Association, the New York Psychoanalytic Society and the New York Psychoanalytic Institute. Brill's closing sentence in his response of acceptance was: 'May this library, which is an inspiration to us, continue to be of service to students of the mind of the oncoming generations'.

PHILIP R. LEHRMAN

[3] *Cf.* this QUARTERLY, XVII, 1948, No. 1, pp. 138–141.

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Curriculum Vitae A. A. Brill

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CURRICULUM VITAE A. A. BRILL

1874	Born Kanczuga, Austria, October 12, and received public school education in Austria.
1889	Came to the United States. (Naturalized July 3, 1899.)
1892	Graduated Public School No. 4, New York City.
1892–1896	College of the City of New York.
1896–1898	College of Physicians and Surgeons, New York. Had to interrupt study due to lack of funds.
1901	Graduated Ph.B. from New York University after a Scholarship, Academic Department of New York University.
1903	Graduated M.D. having resumed medical studies at College of Physicians and Surgeons. License to practice medicine July 20, 1903.
1903–1908	Central Islip State Hospital.
1903–1904	Courses with Dr. Adolf Meyer, under whom he was prepared for the position of Neuropathologist of the Central Islip Hospital of New York State.
1907	Worked in the Neurological Department, Hospice de Bicêtre, under Professor Pierre Marie in Paris, France.
1908	Entered Clinic of Psychiatry at Zurich, Switzerland, where he held the position of Third Assistant Physician for about nine months. During this time, he met Professor Sigmund Freud of Vienna and decided to become his translator.
1908	Married to Dr. K. Rose Owen, May 21, 1908.
1908–1914	Clinical Assistant in Department of Neurology and Psychiatry, Vanderbilt Clinic, New York.
1908–1911	Assistant in Nervous and Mental Diseases, Bellevue Hospital, New York City.
1909	Appointed Chief of the Neurological Department, Beth Israel Hospital, New York City. Resigned, 1910.
1909	Appointed Assistant Physician, Department of Public Charities, New York City.
1909–1911	Assistant Physician in Neurological Hospital, Blackwell's Island (now Welfare Island), New York City.

1911	Appointed Chief of the Department of Neurology, Bronx Hospital and Dispensary. Resigned, 1917.
1911	Founded and was elected President of the New York Psychoanalytic Society. Re-elected president in 1912.
1913–1914	Chief of Clinic of Psychiatric Department, Vanderbilt Clinic, New York.
1913–1922	Secretary of the New York Psychoanalytic Society.
1913–1920	Lecturer on Abnormal Psychology and Psychoanalysis at the New York University School of Pedagogy, Washington Square, New York.
1913	Became a member of the American Medico-Psychological Association, now the American Psychiatric Association.
1914–1918	Assistant Professor of Psychiatry, New York Post-Graduate Medical School and Hospital.
1917	Appointed Associate Visiting Consultant, Division of Neurology and Psychiatry in the New York Department of Correction.
1918	Commissioned Captain, U. S. Army, M.R.C.
1919	Commissioned Major, U. S. Army, M.R.C.
1919	Consultant Psychiatrist, U. S. Veterans' Facility Administration, No. 81, New York.
1920	President of the American Psychoanalytic Society.
1921–1925	Member of the Board of Alienists attached to the Psychopathic Department, Bellevue Hospital.
1922	Consulting Psychiatrist, Manhattan State Hospital, New York.
1925–1934	President of the New York Psychoanalytic Society.
1927	Lecturer in postgraduate Department of Nervous and Mental Diseases, College of Physicians and Surgeons, Columbia University, New York City.
1929–1935	President of the American Psychoanalytic Association.
1932	Appointed Honorary Consultant, Police Department, New York City.
1933	Resigned Commission in U. S. Army Medical Reserve Corps.
1933	Honorary Consultant, British Psychoanalytical Society.
1934	Medallion from New York University.
1939–1940	President of New York Psychiatric Society.

1939	New Orleans Trophy, Z.B.T. Fraternity.
1941–1942	President of New York Neurological Society.
1943	Salmon Lecturer.
1945	Clinical Professor of Psychiatry, New York University.
1945	Consultant Neuropsychiatrist, Bellevue Hospital, New York City.
1946	President, New York State Hospital Alumni Association.
1947	Phi Beta Kappa, Beta Chapter, New York University.

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THREE TRIBUTARIES TO THE DEVELOPMENT OF AMBIVALENCE

BY EDMUND BERGLER, M.D. (NEW YORK)

Bleuler's technical term 'ambivalence', later accepted and made famous by Freud in his studies of obsessional neurosis, denotes the presence of two contradictory psychic strivings toward the same person at the same time. As time went on, the term was applied to all neuroses and became the typical description of practically all contradictory feelings. First it meant the conflict between love and hate, anal submission and aggression; then it came also to mean the conflict between masculine and feminine tendencies in the same person; to being at the same time a 'good' and a 'bad' boy; or between being dirty and meticulous. Some analysts apply the term to the contrasting introjected images of the 'good' and the 'bad' mother in all its consequences; some, to quick shifting between introjection and projection. Freud spoke in later years of ambivalence as the struggle between the instincts of life and death. Freud's last statement on the subject, in 1926, was to the effect that we do not know why ambivalence plays such a decisive part in obsessional (compulsive) neurosis.[1] Since ambivalence in no other neurosis is so pronounced as in obsessional neurosis, the study of that neurosis gives the best promise of yielding an understanding of the symptom.

In my opinion, the problem of ambivalence in obsessional neurosis cannot be explained without taking into account the interconnections between the oral and anal phases of development. It has been repeatedly demonstrated, by Abraham and others, that oral and anal instinctual strivings are psychologically and biologically closely related. It has not, however, been sufficiently stressed that the child repeats in both these phases of development, though not at the same time, similar

[1] Ges. Schr., XI, p. 52.

passive experiences. Some children perceive breast or bottle feeding as acts of maternal aggression—for some children, at least, something like being pierced. Affectionate kindness is perceived as maternal aggression. That conception seems at first glance to agree with the well-known observation of English colleagues that the infant believes the mother to be cruel, sadistic, devouring, her milk poisonous—all as the result of the infant's projection of its own aggression upon her.

My conclusion pertaining to the infant's misconception that being nursed is having its body aggressively penetrated places it at a time preceding these projections, and assumes disturbance of the child's fantasy of omnipotence. I doubt that this strange distortion of reality has much to do with the maladroitness of mothers and nurses who sometimes push the nipple too forcefully into the baby's mouth. The infant originally believes that the breast and its equivalents are parts of its own body (Freud, Ferenczi). Sometimes the infant becomes aware that these objects are separate, outside itself and therefore uncontrollable, frustrating, in the last extremity aggressively intrusive. The child feels passively victimized and retaliates by biting the breast, refusing to take it, spitting, vomiting, crying. Usually, the libidinous gratification from sucking and nourishment prevail, and the infant satisfies both. Adult clinical psychopathology leads, in analysis, to these reconstructions of infantile experience in a circuitous way.

A young man of twenty-one sought treatment for impotence. In an amusement park two years previously he had picked acquaintance with a chambermaid, and tried directly to seduce her. She refused, and he forced her to begin to masturbate him in a dark street, threatening to choke her to death if she refused. Thoroughly frightened, she broke away and ran. He overtook her and started to strangle her. The girl's screams led to their arrest. The young man pretended that the girl wanted to rob him. The girl told the true story, with some

exaggerations, and the young man was released because the girl had a police record, and because the young man was from 'higher social circles'. The motivations for his criminal reaction are unimportant here.[2] He had repetitive dreams in which, suspended head downward, his feet bound together to the ceiling, an enormous ball, sometimes a stone, was pressed into his mouth. As no associations were given, the strongly presumptive connection with the breast could not be mentioned to the patient. However, one day he entered 'by chance' the room in which his landlady's daughter was nursing her baby. He withdrew with apologies and thought, 'It looks as if she would choke the baby with her enormous breast'.

A man was persuaded by his wife to seek analysis because, having been a radio actor who became too apprehensive to face a microphone, he had to abandon his profession and accept work in a poorly paid position. He had originally established himself as an actor in the theater. He developed increasing stage fright, was afraid of forgetting his lines, and entered the radio field where he could read his lines. He dreaded the advent of television, which would deprive him of that advantage. After analyzing some scoptophilic components of his anxiety, he recalled the 'flash of an impression' he had suppressed for years since the beginning of his stage fright. 'It occurred to me one night,' he related, 'while on the stage and waiting for my cue. Looking up at the darkened galleries of the theater, they reminded me of an open mouth ready to swallow me up.' While learning an acting rôle during that phase of analysis in which he was able to resume his career as a radio actor, he reported: 'While studying my part, I had the impression that somebody was forcing something down my throat, and I was resisting violently'. This proved on analysis to be a disguise for the fantasy that 'digesting' his part

[2] *Cf.* Bergler, Edmund, *Suppositions About The 'Mechanism of Criminosis'*, Case 9. J. of Criminal Psychopathology, V, 1943, pp. 215–246.

was having his 'bread and butter' 'forced down his throat' by the 'cruel' analyst in the transference.

A professional writer, in analysis because of an inability to write, lasting years, in addition to the typical reasons for such an inhibition,[3] had the symptom, when attempting to write, of vomiting. His father had been a scholar, and his step-father was a writer. His mother pushed the patient, first indirectly, later directly, into becoming a professional writer, in part because of her antagonism to her second husband who patronizingly denied that the 'boy' had any literary ability. Gleefully, she displayed the patient's first book to her skeptical husband as if it were her own. Her triumph increased with the success of the book. The patient's inability to continue writing was an unconscious defense against his masochistic attachment to mother's alleged oral refusal. The patient's vomiting proved to represent an unconscious refusal of 'food', in this instance equated with learning and writing which, with much justification, he felt was forced upon him. His primitive oral aggression was corroborated by his recollection of an anecdote told by his mother some years before her death, to the effect that he had been a strange infant: he 'was such a strong child' that either he refused to nurse or he bit her nipple once so firmly that his father had to force his mouth open to free it. In later life, the patient became an exquisite gourmet. Much of his quarreling with his successive wives centered around the preparation of food. While in analysis he dreamed he was in a hospital in which the patients were treated by the doctor, a woman, who, with a long rubber hose attached to the patients' penes, pumped in a fluid which distended their stomachs. The dream led directly to associations

[3] Bergler, Edmund: *A Clinical Approach to the Psychoanalysis of Writers.* Psa. Rev. XXXI, 1944, pp. 40–70. Also, *Psychoanalysis of Writers and of Literary Productivity,* in *Psychoanalysis and the Social Sciences,* edited by Géza Róheim. New York: International Universities Press, 1947. Also, *Further Contributions to the Psychoanalysis of Writers.* Psa. Rev., XXXIV, 1947 and XXXV, 1948.

of stories of a sadistic punishment called the 'water cure', employed to subdue rebellious Maoris. The equivalence of the penis and breast in the patient's unconscious had been established from the analysis of other of his dreams. The rubber hose represents the breast, the fluid, milk. Especially characteristic is the transference in which the patient reacts to the analyst as to a maternal aggressor who 'forces' him, makes him feel (orally) passively victimized.

These and additional similar observations, over a period of years, gradually overcame my doubts about the conclusion that, for these patients, nursing in infancy was experienced as an act of maternal aggression. Supporting this conclusion were clinical observations in cases of psychogenic ejaculatory impotence.[4] For some of these patients who are incapable of ejaculation despite protracted intercourse, it is the unconscious fantasy that ejaculation is a destructive explosion, like a bomb. In not ejaculating they protect themselves and the woman from being blown to pieces. That aggression is, however, already a defense against deeper embedded masochistic fantasies. The well-known equating of breast with penis, and of semen (urine) with milk, is a comparably inhibiting, equally bizarre, infantile distortion. These patients, who as infants perceived being fed as maternal aggression, misconceived bowel training in no less a fantastic way. It appeared to them as being 'drained', as something powerful, uncontrollable and overwhelming forcing them to expel a 'part of my body'; once more, as being passively victimized.

Here is a traumatic connecting link between the oral and anal phases of development in certain individuals: first, a fantasy of aggressive oral penetration; second, the trauma of weaning (oral castration); third, being forced to expel feces (anal castration)—all passive experiences. Normally, the child

[4] Bergler, Edmund: *Further Observations on the Clinical Picture of 'Psychogenic Oral Aspermia'*. Int. J. Psa., XVIII, 1937, pp. 196–234.

actively combats passive suffering which dispels its fantasies of omnipotence. The infant boy counteracts the trauma of weaning by finding pleasure in his penis which he equates with the breast: instead of being a passive recipient of milk, he becomes the active bestower of urine (later semen). Through these narcissistic channels, the infant male counteracts feelings of passive suffering which otherwise become fixed as masochistic traits of character, perpetuated by the repetitive compulsion.[5] A classic example of a child's aggressive anal fantasy is recorded by Karl Abraham.[6] A little boy threatens his governess: 'If you make me angry I'll ka-ka you across [the other side of the river]'; to which Abraham adds, 'According to the child's view the way to get rid of a person one no longer liked was by means of defecation'.

The specific conflicts of obsessional neurotics, in my opinion, are more complicated than is usually assumed. The problem hinges on the differentiation as to whether the aggression displayed in obsessional and compulsive patients is primary or defensive.[7] Many analysts will state they 'feel' that much of the aggression they observe in obsessional neurosis is pseudo-aggression. All analysts are familiar with aggression mobilized as a defense against passivity which Freud described for paranoia in the case of Schreber; however, it is nowhere stated in the literature that this mechanism is the central feature of obsessional neurosis. In the analyses of obsessional neuroses, aggression is too often taken at face value, the formulation of anal-sadistic regression being too literally considered. I do not claim to have discovered the importance of pseudoaggression in obsessional neurosis, but I wish to emphasize it because it has not previously been expressly stated.

[5] Bergler, Edmund and Eidelberg, Ludwig: *Der Mammakomplex des Mannes.* Int. Ztschr. f. Psa., XIX, 1933, pp. 547–583.

[6] Abraham, Karl: A Short Study of the Development of the Libido, (1924) in *Selected Papers,* Int. Psa. Library No. 13. Hogarth Press, London, 1927, p. 427.

[7] Bergler, Edmund: *Two Forms of Aggression in Obsessional Neurosis.* Psa. Rev., XXIX, 1942.

Male obsessional neurotics labor under a continuous unconscious conflict regarding their passivity. The danger of the passive craving is warded off by an aggressive reaction-formation, as if to say: 'I am not passive; on the contrary, I am extremely aggressive'. But the aggressive position becomes equally intolerable—because of guilt and fear of retaliation—and forces a retreat again into passivity.[8] The wish to be anally penetrated by the father is not only the result of the inverted œdipus and of fear of castration, but is also the refuge from an oral conflict secondarily projected onto the father. The child escapes from the threat of castration connected with the positive œdipus into the passivity of the negative œdipus. Why the œdipal fear of castration in these cases is so effective, is the old allurement of oral-anal passive experiences. What the anal regression expresses is the old fantasy of being orally penetrated.

Not enough attention has been given to the fact that the concept of an anal penis is but an autarchic attempt to negate the dependence on the breast, and later, as a substitute for the paternal penis.[9] This does not contradict the importance of the fear of castration which leads to the regression. The unconscious reasoning runs something like this: 'It is not true that I want to be penetrated (anally) like mother by my father's penis (repetition of the mouth-breast conception of being pierced); rather, I have an anal penis of my own'. This, I believe, is the narcissistic wish to derive anal pleasure from bowel functioning as a defense mechanism against passive submission to oral-anal aggression. The inverted œdipal wishes are a later compulsive repetition of the oral masochistic fantasy.

The first tributary of the stream of ambivalence is then the conflict between the autarchic defense mechanism (I want to play autarchically with self-produced feces rather than be orally [maternal breast] and anally [paternal penis] passively

[8] *Ibid.*

[9] *Cf.* Bergler, Edmund: *The 'Leading' and 'Misleading' Basic Identifications.* Psa. Rev., XXXII, 1945.

penetrated.') and the regressive wish to be passively orally-anally penetrated.

The second tributary to ambivalence is a pseudoaggressive attempt to ward off passivity. The narcissistic infantile overevaluation of its feces seems at first corroborated by the interest of mothers and nurses in regularity, amount, color, odor and the like. Later the same anal products become taboo. The obsessional child utilizes this contradiction as a weapon against the superego; it tries repeatedly to prove the hypocrisy and inconsistency of external and internalized authority.[10]

The third tributary to ambivalence is utilization of pseudo-aggression against oral-anal submission through narcissistic gratification. Obsessional neurotics employ four unconscious mechanisms of teasing the superego, or reducing it to absurdity; 1, inner contradiction of all 'compulsive rules'; 2, direct disparagement of the superego; 3, relative crudity of the compulsion; 4, 'guided miracles'. Details of these mechanisms have been described elsewhere.[11] By twitting his superego, the obsessional neurotic preserves a measure of narcissistic omnipotence, proving to himself that he is not passively helpless. Even in obsessional indecision, the illusion of narcissistic control is paradoxically maintained despite the inner reality that unconscious conflicts compel the victim to endless doubt.

SUMMARY

Ambivalence is the presence of two contradictory feelings toward the same object at the same time. Three tributaries to the mechanism are described. The common basis is a conflict between inner passive cravings and the fight against them by means of autarchic fantasies. The infantile sense of omnipotence of some infants is traumatically disrupted by the distorted perception of suckling as maternal aggression, as being

[10] Bergler, Edmund: *Hypocrisy*. J. of Criminal Psychopathology, IV, 1943, pp. 605–628.

[11] Bergler, Edmund: *Bemerkungen über eine Zwangsneurose in ultimis. Vier Mechanismen des narzisstischen Lustgewinns im Zwang.* Int. Ztschr. f. Psa., XXII, 1936, pp. 238–248. Partial translation in *Two Forms of Aggression in Obsessional Neurosis, loc. cit.*

passively pierced. Bowel training is later similarly misconstrued as being passively victimized. Against these misconceptions, aggressive and libidinous counterdevices are normally set in motion. Where these countermeasures do not suffice, ambivalence develops, especially in children regressing to the anal stage. Ambivalence is the outward manifestation of a desperate unconscious struggle between the wish to be orally and anally penetrated and an anxious denial of this dangerous wish by pretending aggressively that autarchy is preserved.

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THE CONCURRENT ANALYSIS OF MARRIED COUPLES

BY BELA MITTELMANN, M.D. (NEW YORK)

This paper is a study of complementary neurotic reactions as revealed during continuous treatment of a husband and wife by the same analyst.

A thirty-two-year-old woman sought analysis because of obsessive thoughts, of three years duration, of cutting her child's throat. She felt worthless because she had experienced clitoral but never vaginal orgasm. It became clear after about six months of analysis that during ten years of marriage the wife was always disappointed in her husband's sexual performance but out of considerateness never said anything to him about it. His ejaculations occurrred within about thirty seconds after intromission. Seven years previously the patient had seen a child run over by a streetcar and had become so emotional that people thought her child had been killed. During six months of anxiety and depression that followed, the patient wanted no sexual intercourse. The husband agreed out of considerateness, and then assumed that he was much more potent than his wife.

Being told of his sexual difficulty, the husband consented to treatment after a period of reluctance. A capable architect, six years his wife's senior, he was periodically moody, feeling that he had failed his family by not earning more, and at such times his sexual potency diminished. The wife, meanwhile, had been relieved of her obsessive thoughts, had partly acknowledged her disappointment in her husband, and had become somewhat more self-assertive. She now insistently raised the question whether she would be capable of vaginal orgasm if her husband were adequately potent. The analyst agreed to

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suspend her treatment until the husband's potency became adequate, and this was accomplished in six months. The wife, however, still experienced no vaginal orgasm, felt at times repelled by her husband, and had obsessive fantasies of taking men's infected penes into her mouth. She resumed treatment with great reluctance and discomfort, despite evidence from her husband's improved functioning that her own analysis could be successful.

Her analysis came to a standstill about eight months after resumption. She began each hour by relating in an affected voice incidents and dreams she had prepared for the hour. When the analyst commented about her lack of spontaneity, she first felt hurt at being 'criticized', then agreed, and finally admitted she was afraid of the breaking up of her marriage. A divorce would prove her final worthlessness, having failed in her occupational ambitions, and in her relationship with her parents and with her child, now six years old. She was told that her implacable ideals and dependent needs interfered with the investigation of her sexual frigidity as well as of her disappointment in her husband, of whom she demanded compensation for all the disappointments of her life.

The husband talked shyly and wept occasionally, but was unable to give vent to his emotions or to associate freely. In discussing his defensive attitude he too expressed catastrophic fear that the marriage might terminate.

After a year and a half of analysis, the husband began openly to voice objections to interpretations not to his liking. He also began to experience and at times to voice anger towards his wife when she declined to have sexual relations, or if she was unreasonably critical of him.

The analyst believed the husband was justified in complaining that the wife, although in a gentle way, was always critical and never gave him credit for anything; furthermore, he felt that in her reluctant complaints about her husband's shortcomings she so colored the stories as to make him appear in the wrong. A trivial but characteristic incident made this

clear. In early summer, they rented a bungalow. Each week end, the husband dragged two heavy suitcases to and from the train. The wife reluctantly told the analyst that the husband objected to carrying the suitcases—showing thereby his passivity, lack of responsibility and of manliness. The husband independently told the analyst that the suitcases could be sent by express except for his wife's objection. In reply to a casual question in her next interview, the wife stated that she was sure the express company would not accept the suitcases, or that if they did they would not be delivered on time. The analyst remarked that there would be no harm in trying it once. Two weeks later, the husband related laughingly that the express company had accepted the suitcases and regularly delivered them in time. The wife mentioned nothing about this but, in reply to a casual question by the analyst, confirmed the story.

The analyst then began consistently to point out to the wife that she always had to be right in any difference of opinion with her husband, and that she disparaged him in order to feel superior to him. This feeling of being right and superior, the analyst suggested, was one of the ways in which she escaped feelings of utter worthlessness. He made these constructions by selecting relevant material from the patient's spontaneous productions, or he used them as the basis of approach to the patient's defenses when the trend of her associations was obscure or she was detached. Occasionally he asked questions to clarify some incident she related but did not quote her husband's version.

The patient at first reacted with self-condemnation, then she attacked the analyst for destroying the last vestiges of her self-esteem. However, the analysis started to progress. She was made aware that although her feeling of being superior saved some shreds of her self-esteem, the effects were pernicious. It made her feel guilty because of her severe conscience, and deprived her of the affectionate and manly husband she needed to compensate for the kind of parents she had always missed.

It increased her sexual rejection of him and led her to fear abandonment and retaliatory genital injury. Her attitude constantly undermined his feelings of competence and masculinity, damaged his sexual potency, and thus she deprived herself of what she most wanted. The resolution of these attitudes made the patient's infantile experiences more accessible to analytic investigation, and she reported two dreams.

> A man is pursuing two young boys, captures them and holds them as prisoners. One of them sits crouched in terror. He looks effeminate. The older one is stronger; he throws a knife at the man and kills him.

Her parents had quarreled from her earliest childhood. Her mother, she learned, often refused intercourse with the father. They were divorced when the patient was eleven years old. Her further associations led her to the recollection that her father used to tell the story of Bluebeard to the patient's sister, who would crouch in terror listening while the patient angrily asked him to stop. For the first time she spoke of having been 'left out in the cold' as a child. Her sister, two years younger, was pretty and everybody's favorite. Her brother, four years her senior, was sickly and received a lot of care. The patient herself was a 'miserable' child, with teeth missing, whom everybody teased.

> In the second dream, the patient is sitting at a table with her mother and her sister. The patient is afraid that people will see how her sister is behaving. She notices a pair of bloody and soiled drawers on the chair. She angrily reproaches her mother for having worn and soiled them.

The sister has a compulsion neurosis which the patient tries to conceal from everyone. This dream revived the memory from childhood of humiliating and frequent enemas, openly discussed before visitors. Both dreams tell the story of parental rejection and hostility, sibling rivalry, fear of destruction, wanting to be a male, blaming the mother for being a worthless, soiled, injured female and for failing to be an adequate

woman. She now spoke in the analysis with adequate affect about such topics and responded to the interpretation with further material and relief of distress. Her need to be right and to surpass her husband had to be elucidated recurrently when revived in new situations of stress or when new problems were approached in the analysis.

In the course of these developments the patient stated she had obsessional thoughts about the analyst during the analytic hours. She visualized taking his infected genital into her mouth, whenever he made a comment that she considered derogatory to her. It had been clear from the beginning of the analysis that she wanted the analyst to be a figure of omnipotence who would compensate her for all suffering, establish her worth-whileness and need to be loved, and would relieve her of all problems and satisfy all her wants. His interpretations implied to her exposure of her deficiencies and of her guilt and thus shattered her expectations; furthermore, when the analyst through his interpretations questioned her extreme ideals and goals of perfectionism she felt he threatened everything by which she had tried to gain self-valuation and affection. Her reaction to these threats and frustrations was anxiety, resentment and guilt which re-evoked infantile feelings of rejection by her parents, of injured self-love and of worthlessness. She reacted with a renewal of striving for perfection, and of having to be right, which had first appeared in her school years. These strivings included rivalry with her mother, her siblings, and penis envy. In her helplessness, however, she could not tear herself away from the analyst nor could she openly express those strivings; instead, as illustrated by the obsessional fantasy, she debased him, debased herself, but tried to obtain some satisfaction of her needs. The need to be right was one of the forces that made the patient oppose indirectly every interpretation offered during the most difficult period of the analysis. This opposition was further intensified by the idea that accepting the analyst's interpretations meant

that she was wrong and her husband was right. These attitudes were unrecognizable in the transference because of the patient's self-effacement, detachment and guilt. Simultaneous treatment of the husband enabled the analyst to recognize the needs in both relationships.

The husband's bitterness could now be brought into the open in his analysis, as well as the fact that he regarded successful treatment of his sexual difficulties, defeatism, and self-effacement impossible as long as his wife's behavior remained unchanged. His infantile and adolescent experiences became more accessible to analytic investigation, and he reported a dream.

> He is in front of some building in which a man had died and he feels he ought to know who the man was and what his affairs had been.

The associations led to the death of both parents. The patient's only memory of his father, who died when the patient was six, was a vague picture of him, dead, before the funeral. In his childhood and adolescence he felt that his life would have been happier if his father had lived. He was the youngest of five siblings. When he was twelve, his older brother attempted anal intercourse with him without penetration. The patient, feeling guilty, refused the second time. The mother worked hard to provide for the children, and the patient felt both pleased and guilty that she did not remarry being 'loyal to the father's memory'. He never dared to assert himself with his domineering mother and siblings until he decided to marry. They all opposed his marriage and called him ungrateful and disloyal. When his mother died not long ago, he experienced little grief. Thus the dream referred to the patient's harsh fate of losing a protective and strong father, of being exposed helplessly to the domination of his mother and his siblings, to his hostility and his œdipal conflict, his submissiveness, his unconscious passive (anal) homosexuality, and his guilt.

TYPES AND DYNAMICS OF NEUROTIC INTERRELATIONS

Oberndorf (2) analyzed nine married couples and found the procedure feasible and advantageous. He states that in narcissistic individuals the idea of the possession of another person persists instead of giving way to the mutual participation inherent in adult love. Wishes of this kind stem from the longing for a parent-child relationship which is revived in the masturbatory fantasies of adolescence continued into marriage. The narcissistic individual's need for acceptance is acutely exaggerated because of the limitation of his own capacity to give affection. While acceptance by the partner would seem to validate the esteem which the neurotic member has placed on himself, it essentially affords reassurance against his inferiorities, both physical and emotional. Expectations of the miraculous in marriage are doomed to partial disillusionment. Oberndorf concludes that intermarriage difficulties are caused by emotional immaturity, incest wishes and taboos, and identifications with parents of the opposite sex—all inherent in the unresolved œdipus complex.

In most prolonged neuroses, complementary reaction patterns develop between individuals in intimate relationships. In a previous paper (*1*), the author distinguished the following neurotic patterns: 1, one of the partners is dominant and aggressive, the other, submissive, passive, and masochistic; 2, one of the partners is emotionally detached, the other craves affection; 3, there is a continuous rivalry between the partners for aggressive dominance; 4, one of the partners is helpless, craving dependency and consideration from an omnipotent mate; the mate tries to live up to this expectation but periodically wants to assume the rôle of the dependent partner.

In all of these complementary patterns, both partners may obtain a measure of satisfaction and safety. Mutual identification between the partners can play a significant supportive rôle in the following ways: (a) both mates find security, satisfaction, and increased self-esteem through a mutual overidealistic approach to life; (b) in their helpless dependence

each considers the other a haven of refuge and by helping him helps himself. The feeling of safety for the dependent partner from the 'omnipotent' supporting mate is obvious. The supporting partner allays his own unconscious fear of helplessness, isolation, and abandonment by helping the dependent mate. The feeling of helplessness may, however, be renewed through identification with the helpless partner; also resentment is engendered when one partner does not live up to expectations and thus makes the other's deficiencies again evident; furthermore, the one assumes as his own those deficiencies that the mate manifests, and thus feels guilty and inadequate.

Fears of frustration, condemnation, abandonment, and attack arise from the one partner's own impulses of hostility, or submissive dependency needs, as well as from the partner's behavior. The reactions are likely to be most intense when the intrapsychic distortion and reality coincide; thus patients consider a partner's hostile overreaction as a proof of the catastrophic dangers of self-assertiveness.

The following types of relationships have been observed between the sexual attitudes of the two partners. First, both value coitus highly, and have relatively good potency in spite of otherwise serious problems. The genital relations then acquire considerable compensatory value for other difficulties and may become one of the important ties maintaining the relationship. Second, both partners have strong anxieties and guilt about sex, accompanied by impaired potency, feelings of inadequacy, and repressed infantile sexual strivings. If one or both of the partners blame the other for the difficulty, the feelings of frustration, hostility and guilt become intensified. Blaming the partner appears fully justified because of the other's actual difficulties. Third, both partners have strong masturbatory, oral, anal, or sadomasochistic impulses. Although these activities are followed by some guilt and feeling of inadequacy, the reactions are not intense, because through identification, they relieve each other's guilt. If, however, the reaction-formation against the partial impulse is

strong in one of the partners but absent in the other, or if the permissible partial impulses are different in the two partners, the difficulty can be serious.

The habitual attitudes of a spouse may contain clearly the reaction to a parent toward whom they were originally directed, or the attitudes may represent generalizations from infantile experience, for example, 'I was rejected by my mother and am being rejected by everybody; I have no hope in life'. The attitude may represent a longing that was frustrated or secretly gratified, or reactions against now repressed strivings either in the form of moral repudiation or defense; thus, the demand for gratification of frustrated longings for dependence may have persisted throughout the patient's life. Although without insight into its nature, extent, and unconscious motivations, it may dominate the patient's marital behavior. Similarly, sibling rivalry may lead to sustained aggressive competition or to passive homosexual trends.

The dominant symptoms and trends which develop out of the wide potential possibilities are determined in part by the mate's difficulties. The choice of a mate takes place on the basis of a limited knowledge of his or her functioning, and subsequent developments depend upon reactions of both mates to one another. Thus, it seems likely that the wife previously discussed would have developed a more adequate vaginal response if the husband had been potent. This, in turn, would have altered the development of her oral trends.

Husbands and wives may conform to infantile and pubertal images of parents and siblings that they transfer to each other. If a mate's behavior be the opposite, the complexity of the problem is illustrated by the couple described. The wife was superficially entirely different from her husband's domineering mother and siblings, but she was like them in her continuous criticism of him, and evoked comparable reactions in him; however, because of the subtlety of her behavior and his own self-effacing submissiveness, his bitterness and resentment were repressed. His defense was a false self-esteem

maintained by their mutual ego ideals, by his illusion of exceptional potency, and lastly by his feeling that, with utmost considerateness, he was looking after her needs.

Current attitudes of dependence, hostility, sexual needs, anxiety, guilt and infantile experiences are interrelated in complex complementary reactions. Rejection by the mate leads to anger, then to anxiety and guilt; this revives infantile helplessness and dependence, with fear of genital activity and reinforcement of infantile striving; this in turn reinforces current anxiety and guilt, and leads to anticipation of rejection.

TRANSFERENCE REACTIONS

Similarities and differences in the mates' behavior toward the analyst are equally instructive. Similarities were illustrated by the couple discussed. They both spoke quietly, could rarely associate freely, and lapsed into silence, unless the analyst made a comment, early in the hour. By contrast, one spouse may be taciturn and self-effacing, and the other friendly and talkative. Both partners may show boundless faith in, or superiority toward, the analyst or may manifest contrasting attitudes. Such observations enable the analyst to understand the mates' mutual reactions and to judge the reality of the problems they present to each other.

The following attitudes may arise in one or both married partners who are being treated by the same analyst: (a) concern as to whether the analyst agrees with one patient's overevaluation of the mate or whether he considers him or her as deficient; (b) the fear and accusation that the analyst is siding with the other partner; (c) the wish-fulfilment fantasy that the analyst will change the other mate by magic and thus save the patient the necessity of coming to grips with his own conflicts.

The following reactions may arise out of discussion of marital problems: (a) blaming the analyst for the assertiveness of the previously submissive mate, which may be combined with the complaint that the analyst deprived the complaining partner

of any defense against such attacks; (b) fear of divorce arising in connection with the liberation of repressed submissive or aggressive impulses; (c) complaints about the destruction of overidealized values attached to the marriage. The husband and wife previously discussed stated that if their 'ideals' of unlimited loyalty, considerateness and perfect harmony were questioned the marriage would lose all its value.

An important aspect of the concurrent analysis of married couples may be one patient's feeling that by changing the mate, the analyst alters a reality which presents insurmountable difficulties. The correction of these difficulties relieves the patient's helplessness, increases his confidence in the therapist, removes some of his most important rationalizations, and forces him to face inner and external problems.

TECHNICAL CONSIDERATIONS

The type of material presented by the patient and the comments made by the therapist do not differ essentially whether one or both of the mates is being analyzed. The advantage of the analyzing of both is that the analyst gains a more complete picture of the realities and of the complementary reactions of the two individuals. Information may be obtained from one that the other does not reveal or underplays to such an extent that the analyst might fail to recognize some crucial trends. Without the interpretation of these trends, the success of some analyses would be seriously limited; moreover, by gauging the relative risks involved in the changing reactions of one or the other, the analyst can increase or lessen the emphasis in his interpretations. The therapist can utilize knowledge gained from one by shifting his focus and selecting for comment relevant material from the other's associations. He may also ask casual questions about incidents of which he had been given a different version, or which had not been mentioned. Rarely, he may actually quote the mate or state what his opinions were about certain incidents. This last procedure requires careful judgment.

Occasionally it may be necessary to increase, by interpretation, a patient's rebellion against the mate's behavior. Although the mate may at first react with increased aggression or anxiety and guilt, without such rebellion he would never be forced to recognize his difficulties. On the other hand, when one of the mates is temporarily under severe external or internal pressure, a reassuring word from the therapist mitigates anxiety.

To Oberndorf's (2) statement that in the analysis of married couples the analyst has to maintain scrupulous impartiality toward both, the comment may be added that when one presses the therapist for a stand as to who is 'right' he may state that both parties have problems, and that his rôle is to help each one without taking sides. He may state that on certain points the grievances of one or the other are justified, *e.g.* if the mate cannot stand contradiction, pointing out, however, that the patient reacts to this justifiable grievance in accordance with his own problems. He may usefully add to this an explanation of the complementary nature of the difficulties, for example, how the patient's submissiveness fosters the partner's domineering behavior. If both patients color incidents in their own favor and the realities and dynamics of the situation are perplexing, the analyst should state that he does not understand the problem. Through the reactions of one or both the mates, the picture soon becomes clarified to the point where the analyst can interpret again.

As a rule both patients accept the confidential nature of the information they give to the therapist and are not afraid that he will divulge it to the mate, nor is it usual to ask for information about the mate, even when there are jealousies about possible infidelities. Both mates are best advised not to discuss their analyses with each other in order to avoid complications. Nevertheless, such discussions occur occasionally. If one of the mates asks questions about the meaning of the other's behavior it is best to state that the two analyses should not be 'mixed'.

Increased tensions may arise when they 'quote' the analyst to each other during periods of stress, although the tensions aroused may lead to insight into pertinent problems. Difficulties may arise if one of the mates has a negative therapeutic reaction, or terminates the treatment.

Concurrent analysis of married couples by the same analyst is practicable in the majority of cases. It may be inadvisable if one of the partners has paranoid traits or is very dependent and also if it is likely that the marriage will break up. In doubtful instances the trial period of analysis enables the therapist to decide whether one of them should be transferred to another analyst. In all instances included in this report, one of the mates started treatment at least one month before the other, the second coming for interviews after it was evident that he too had significant problems. By this time the first patient is sufficiently established in the transference to cope adequately with conflicting feelings arising out of the visit of the mate. The mate's anxious eagerness to turn to somebody for help or to vindicate himself makes him accessible to therapy.

CASE MATERIAL AND THERAPEUTIC RESULTS

The material discussed in this paper was based on the treatment of twelve couples. In four instances, husband and wife had daily analytic interviews over prolonged periods of time. Of these, two husbands have terminated their analyses, one because he improved adequately after two years of treatment. His wife is continuing her analysis. The other man stopped his treatment after deciding to divorce his wife, and has since remarried. In this instance, an exceptional procedure was followed. In the eighteenth month of the wife's analysis and the sixth month of the husband's, the analytic sessions of both were filled with recriminations against the mate, both of them coloring the stories entirely in their own favor, and making all interpretation ineffective. The therapist finally had two sessions with husband and wife together in which they related their contradictory stories. These two sessions were very

revealing of facts and complementary reactions with the result that the husband decided to divorce his wife. In so doing he liberated himself from neurotic goals that he had unhappily pursued through ten years of marriage to vindicate himself, retain his dependence and still to win a victory over his wife. The wife agreed to her husband's decision, and continued her analysis.

All of the analyses in this group have advanced far enough to be considered successful as regards disappearance of clinical symptoms, as having effected favorable changes of character, and elucidation of dynamics. In eight instances one of the mates came for analytic interviews, whereas the other received a minimum of two but not more than twenty treatments at intervals of one week to several months. Of these, in six instances there was sufficient change in the mate's reactions to make the relationship satisfactory for the patient. Three of these patients have terminated their analyses successfully.

With individuals who need or accept only infrequent interviews, it seems best to start with the comment that their attitudes will strongly influence the effectiveness of the mate's treatment. Utilizing knowledge gained, for example, from a wife in analysis, well-placed questions may elicit the husband's symptoms. This may accelerate the whole therapeutic process, or make therapy possible for an otherwise resistant individual who needs it.

The effectiveness of limited treatment of married couples even with serious psychopathology is illustrated by the example of a sixty-two year old man who was successfully analyzed for hypertension and anxiety hysteria. The wife was sufficiently paranoid to confide to the therapist that her husband 'has millions of women'. She was not cured of her paranoia, but the therapist's comments in the course of six interviews, to the effect that she would ruin her family unless she behaved differently, stopped her from watching and questioning her husband, neglecting her appearance, nagging and trying to run her children's lives.

The effects of a mate's uncoöperativeness, which occurred

in two of the eight couples, depend on the analysand's potential self-reliance. In one case, phobic symptoms and anxiety attacks of a forty-year-old dependent housewife recurred, after a year's improvement, from her husband's unresolved neurotic character. He always had to have his way; otherwise he became taciturn or made polite but biting remarks. He was reluctant to come for treatment, and spent the interviews vindicating himself. Amid distortions of the therapist's comments, he repeatedly decided to stop the treatment. In the tenth interview, the analyst told him that if he refused treatment from him or some other psychotherapist, the wife's further treatment would be futile. That evening the husband told his wife that the analyst intended to stop her treatment. She had a serious attack of anxiety continuing through the next day and did not return for treatment. It is at times difficult to judge how emphatic the therapist should be with an uncoöperative mate. With less emphasis both to the wife and to the husband, the effect of the failure might have been less overwhelming in this instance. The reaction of this dependent woman may be contrasted with another whose husband, it became evident after two interviews, had characterological difficulties as severe as his wife's, but was unwilling to undergo treatment. His wife, always self-assertive, decided to institute divorce proceedings. Following separation, her tension lessened and the treatment progressed smoothly. Relative economic independence favored this patient's ability to cope with an uncoöperative husband.

SUMMARY AND CONCLUSIONS

Treatment of married couples by the same analyst makes more concrete both the realities and the neurotic interactions between the mates. Current reactions of dependency, guilt, hostility, anxiety, and superiority are revealed in a clearer light, and at times one of the mates gives information about crucial trends in the other mate. These trends may be so underplayed by the other mate that they would not otherwise

be adequately recognized by the analyst, although their investigation is imperative for the success of the treatment. Light is thrown on the problem of why certain symptoms and trends develop out of the many infantile and pubertal possibilities, and to what extent the mates actually correspond to the infantile prototypes of parents and siblings. Transference reactions include concern about whether the analyst favors the other, whether he values the mate as highly or as poorly as the patient, fear of divorce or separation, and the defense of unattainable marital ideals. Increased tension may develop if the mates (mis)quote the analyst to each other during new situations of stress, or if one of the mates has a negative therapeutic reaction or stops treatment. Simultaneous treatment of married couples was successful in eleven of twelve instances, including two which ended in divorces satisfactory to both parties. In four of the twelve couples, both mates were analyzed, in eight, one mate was analyzed, the other received briefer psychotherapy.

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Problems of Psychoanalytic Training

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PROBLEMS OF PSYCHOANALYTIC TRAINING

BY MAXWELL GITELSON, M.D. (CHICAGO)

The problem of training in psychoanalysis which confronts us today is not a mere matter of pedagogical technique. How it is to be done, who shall do it, who shall be trained, and how many, are important questions. However, the basic questions are what do we want to teach, and to what end is our teaching to be directed? Unless we find common ground in the answers to these questions there can be no meeting of minds, no resolution of the other problems presented.

As one reads the minutes of various conferences on training and education which have been held since 1940, one is struck by the fact that there is a tendency to avoid the issues which arise from these basic questions. If we view the material of the minutes as we do the material of a psychoanalytic hour, we are impressed that the corporate patient is talking all around the point with only here and there an accession of something clear and explicit.

At the Richmond meeting of the Association in 1941, Dr. Helene Deutsch stated that '. . . an intuitive understanding of unconscious processes cannot be learned. A person who does not have this gift cannot become a good analyst.'[1] At the same meeting, Dr. Adolf Meyer said '. . . if one wants to belong to the analytic group one has to be capable of working with the unconscious. *One cannot only tinker with it.*'[2]

At the Boston meeting in 1942, Dr. French stated that '. . . students should know psychoanalysis historically. It is necessary that people know how to practice psychoanalysis but *I do*

Read at the forty-eighth meeting of the American Psychoanalytic Association, New York, May 17, 1947.

[1] Minutes of the Forty-third Meeting of the American Psychoanalytic Association, at Richmond, Virginia, p. 4.

[2] *Ibid.*, p. 6.

not care what they are taught if they know how to handle patients when they have finished their training.' Dr. French was therefore opposed to any definition of psychoanalysis. He felt that anything should be taught that anybody believes.[3]

At the Chicago meeting in 1945, Dr. Fenichel proposed that '. . . the Association should be a competent body to decide what is pertinent psychoanalytically and what is not';[4] Dr. Bibring '. . . felt the need of some group in which we could discuss our fundamental conceptions of what an analyst is, of what this Association considers as analytic and as healthy growth'.[5] At the same meeting, Dr. Alexander felt 'that it would be bad procedure for a scientific society *in a young field* to make a definitive statement to the effect that those who believe in this and that are psychoanalysts and those who do not are not psychoanalysts'.[6]

At the Conference on Postwar Problems of Psychoanalytic Training in 1946, the issues became a little clearer: 'Most opinions expressed at the Conference converged on the principle . . . . that high standards at this critical time should be strengthened rather than weakened'.[7] The general view seemed to be that the problem of increased numbers of candidates should be dealt with by an increase of the training load, 'if necessary up to fifty percent' by all qualified training personnel.[8] Dr. Kubie made a tentative and exploratory proposal that '. . . we put a student through two or three pieces of analytic experience with two or three people, a few months with each'.[9] Dr. Warburg reacted to this with the feeling

[3] Minutes of the Forty-fourth Meeting of the American Psychoanalytic Association at Boston, Massachusetts, p. 13.

[4] Minutes of the Joint Meeting of the Executive Council, the Council on Professional Training and the Special Committee on Educational Policy of the American Psychoanalytic Association, at Chicago, Illinois, p. 15.

[5] *Ibid.*, p. 18.

[6] *Ibid.*, p. 19.

[7] National Conference on Postwar Problems of Psychoanalytic Training, New York, February, 1946, p. 4.

[8] *Ibid.*, p. 19.

[9] *Ibid.*, p. 16.

that 'Dr. Kubie's suggestion would be very dangerous'.[10] Dr. Alexander, on the other hand, said: 'I do not think that these suggestions are radical but I think they are sound. We should give up the idea that every candidate needs the same kind of training analysis. I think that the material we get is very varied. We should train and analyze our candidates according to their needs. *There are many candidates for whom our goal is not to change their personality structure, but to familiarize them with the analytic process for their future work.* These candidates do not need a long period of analysis.' [11]

It was at this point that Dr. Bonnett raised the really pertinent question. She asked, 'What are we working towards in this discussion of standards? We say we must not lower standards, assuming that our standards are good enough now. We ought to look into our training in the past ten years and decide whether that training has been good enough. I would like to approach the problem of looking for great improvement in our standards.' [12]

Dr. Knight, in his comment on the report of his survey of criteria for the selection of suitable candidates stated: 'There was no agreement as to whether any one thing should disqualify an applicant for training. Some said there could be nothing absolutely disqualifying. . . On the basis of the replies, no set criteria can be used to qualify or disqualify an applicant.' [13]

One gathers from the discussion of Dr. Knight's report that there was a certain concordance of opinion. Candidates were not taken at their face value of apparent normality. The problem of pseudonormality as a defense was recognized. The problems of the orientation of the analyst towards his task were brought out.

'Everybody felt that psychological aptitude was the important

[10] *Ibid.*
[11] *Ibid.*, pp. 16–17.
[12] *Ibid.*, p. 17.
[13] *Ibid.*, p. 22.

thing to search for except Dr. Alexander.' [14] Dr. Alexander stated his position as follows: '*One of the natural faculties is the psychological grasp of another person,* and if a person has no neurotic tendencies nothing impairs the psychological grasp. The question is who will be good psychologists. The idea is to look for the negative criteria instead of saying "let's pick out the good points of the patient".' [15]

There appeared to be considerable doubt about the validity of preliminary interviews as a means of determining the suitability of a candidate. Dr. Lorand [16] and Dr. Blitzsten [17] agreed that the training analyst ought to have the courage to 'suspend the analysand in training' if this was indicated, but that 'as a result of his countertransference or empathy he lets them go through'. Dr. E. Bibring said: 'I certainly don't know what a normal person is. That is too vague. We are willing to change the training because "there are better people", "normal people". I don't know whether that refers to certain changes in their conscious adjustment. We must be more clear about the conceptions we use.' [18] Several of the conferees [19] were in accord with the general idea that every candidate needed a therapeutic analysis. The differences which were expressed on this point stemmed largely from practical considerations. Thus, Dr. Spitz felt that the transformation of the training analysis into a therapeutic analysis would clutter up the time of the training analyst, [20] while Dr. Bonnett thought that if the analyst who conducts the therapeutic analysis of a putative candidate is connected in the patient's mind with the issue of training, the analyst's therapeutic function is interfered with.[21]

[14] *Ibid.*, p. 22.
[15] *Ibid.*, p. 23.
[16] *Ibid.*, p. 25.
[17] *Ibid.*, p. 26.
[18] *Ibid.*, p. 27.
[19] Edward Bibring, Grete L. Bibring, Lionel Blitzsten.
[20] National Conference on Postwar Problems, *op. cit.*, p. 27.
[21] *Ibid.*, p. 28.

The Conference was informed in Dr. Warburg's Report on Applicants of the New York Institute [22] that the Admissions Committee asks itself: 'Is this man going to be an analyst who can treat patients adequately?' It is to be presumed that this meant: is he going to be able to institute and direct a process which moves towards the reintegrative ends envisaged by psychoanalysis? This is quite a different question from the one which confronts the nonanalytic psychotherapist. Certainly we cannot depreciate the widespread practical necessity for goal-limited 'adjustment' therapy; nor can we overlook the contributions which the science of psychoanalysis has made towards increasing the possibility of meeting this need. But speaking as psychoanalysts about the problem of training for psychoanalysis, the question which the New York Admissions Committee asks itself is relevant only to this assumption.

In an extension of this question Dr. Warburg asked about certain comfortable, well-balanced people whose horizons are limited and about whom one wonders whether their point of view is wide enough for them to do analysis. She said, 'It is questionable, even if you train them, whether they would be so pedestrian that they would not understand a lot of things'.[23] May there not be among these some of the very people who, it has been suggested, might require only enough personal analysis '. . . not to change their personality structure, but to familiarize them with the analytic process for their future work'.[24]

Dr. Bullard, speaking for the Washington-Baltimore group stated that '. . . some training is better than no training—older men . . . not identified with the psychoanalytic movement, tell patients they are doing analysis . . . if we are going to have that sort of thing, I think it is better to give them [such] training as we can, and the ones with integrity, the further they go the more training they [will] want. . .' [25]

[22] *Ibid.*, Appendix C.
[23] *Ibid.*, p. 31.
[24] *Ibid.*, pp. 16–17.
[25] *Ibid.*, p. 43.

Out of all of this arises the following issue: do we have the scientific obligation to continue to develop personnel capable of conducting definitive psychoanalysis of patients and of deriving relevant psychoanalytic data from their work, or, are we morally obligated to turn out psychotherapists, more or less trained, in as great numbers as possible, in the interest of some mass therapeutic goal? This is not simply a postwar issue. It is an issue for the entire future of psychoanalysis.

Psychoanalysts are in a dilemma. To the extent to which they have succeeded in empathizing with other human beings they feel impelled toward doing everything they can in their interest; however, to the extent to which they have freed themselves from fantasies of omnipotence and become capable of testing reality, they have reason to move with caution. A considerable part of the tendency of psychoanalysts to spread themselves thin is the result of a *real* conflict into which they are thrown by this dilemma. If we add to this those narcissistic attitudes which render them sensitive to their own criticisms and to those of others, we may gain some understanding of the reasons which tempt them to devise new techniques for carrying the burden.

This brings us back to the crux of the matter: what is analysis; what do we want to teach and to what end is our teaching to be directed? Some part of Zilboorg's comments at the Detroit meeting of the Society in 1943 is relevant.

> 'The various conflicting trends with which we are so familiar need not be dwelt upon in detail. Whether they stress the purely cultural, purely ontogenetic, purely physiological, purely reflexological, or purely current factors of human psychology, or whether they elaborate the points on which Freud was allegedly or actually wrong—matters little. They are various facets of the cultural crisis in which we are all engulfed.
>
> 'This does not mean that I would urge upon psychoanalysis the principle of static and uncritical orthodoxy. Just the contrary. Freud did not say the last word; he could not have and no one can or ever will, for no science has ever said the

last word. *But no science has ever survived or preserved its productivity if its postulates were rejected.* This is true of geometry or physics as much as of psychoanalysis. The greatest discoveries or revolutions in geometry or physics never overthrew their fundamental postulates. Psychoanalysis rests on individualism, empiricism, and the inductive method. Much in the libido theory will be revised, but its fundamental postulates will remain. It cannot be substituted by deductive constructions of disindividualized sociologies, or psychophysiologies.' [26]

If we accept the relevance of these remarks then we must ask ourselves whether there have been unequivocally established recent discoveries in psychoanalysis that would validate a radical change in the fundamental postulates of psychoanalytic instruction, and radical departure from established techniques.

In Analysis Terminal and Interminable, Freud emphasized that deepening analysis rather than shortening it must be the first consideration, and that this depends on the analyst's real mastery over the weak points in his own personality. In respect to this the analyst must be superior to his patient if he is to be an example of what the patient can hope for. However, Freud comes to the sad conclusion that 'analysis is one of the three impossible professions', the other two being parenthood and the government of nations. We cannot demand perfection from the analyst who is himself a human being and the training analysis is therefore of necessity incomplete. Nevertheless, Freud says, the training in analysis can accomplish its purpose if it (1) establishes a sincere conviction of the existence of the unconscious, (2) enables the person to perceive in himself psychic processes which are otherwise incredible, (3) provides a first hand glimpse of technique, and, finally, (4) sets up a process which does not cease with the last analytical session but continues to act so that ego transformation continues.[27]

[26] Bulletin of the Menninger Clinic, VIII, 1944, pp. 3–17.
[27] Int. J. of Psa., XVIII, 1937, pp. 373–405.

It would appear that the reason for the notion that a training analysis and a therapeutic analysis can be different is to be found in the fact that there is a tendency to dilute our understanding of what the psychic processes are. There is the inclination to believe that a 'glimpse of the unconscious' will really set up that final, continuously integrative process which Freud envisaged. We need only recall the patients who have left us free of symptoms after a hasty glance at these processes, and who continue glibly to parrot their awareness of the unconscious, to see how false this is. If we are really to enable the analysand to perceive in himself his psychic processes to the end that a real reintegration is set in motion, we are compelled in Waelder's terms to eliminate 'short-circuit interpretation in favor of an inching downward and backward from a broad base of character study with a view to arriving at more exact reconstructions of unconscious fantasies and of the whole process of the neurotic career. The ultimate technical ideal of this ego psychology is to actually transform the neurosis into its earlier stages, and finally into the precipitating conflicts—to roll the process of neurosis back along the path of its development'.[28]

This technical goal has been placed within reach through the elaboration of our knowledge of ego psychology, and this has had a very important effect on the technique of psychoanalysis with the consequence that we can no longer make a valid distinction between therapeutic analysis and training analysis. This seems to have been the basis for the indecision on this point at the Conference on Postwar Problems. Dr. Knight's questionnaire failed to reveal a consensus about what factors could be looked upon as explicitly invalidating the candidacy of an applicant for training. The argument was advanced that this was the case because we looked upon these

[28] *Present Trends in Psychoanalytic Theory and Practice*, read as a part of a symposium on this subject at the Detroit Meeting of the American Psychoanalytic Association, May, 1943. Printed in *The Yearbook of Psychoanalysis*, Vol. I, 1945, pp. 84–89.

factors psychoanalytically. But as psychoanalysts, how else can we look upon them?

The upshot of these considerations is that we find ourselves without an alternative to making personal analysis a prerequisite rather than an intrinsic part of training in psychoanalysis. We have then to remember what such an analysis must actually be. It must actually give the potential candidate a living experience of the psychic processes. Many will consider this to mean an analysis which is conducted according to the principles which have been cited. However, there are current trends in the direction of a so-called liberalization of psychoanalysis to which we must give attention.

It appears to be a hopeless task to set up normality as a basis for the selection of potential analysts whose training would be presumed not to take too much time. Psychoanalytically we are compelled to look upon 'normality' as a defense in so far as we are concerned with the person's capacity for empathy with his own and another person's unconscious processes. Often enough it is a defense by way of multiple or of rigid identifications and of 'adjustments' in the shallow sense of that common word. Such adjustments, when examined, are often seen to be examples of the mechanism of 'identification with the aggressor' which Anna Freud has demonstrated.

If there are any clinical criteria which might be used to appraise the possibility of a succeessful training in analysis, they are to be derived from an evaluation of what the person has made of himself despite his neurosis. We need to ask ourselves what has survived of creativity, of effective energy, of emotional flexibility and resonance, and of interpersonal interest—regardless of the formal diagnosis. We have to see what there is of native shrewdness, wisdom and of intellectual power. It is doubtful if there is much more that can be clinically determined from preliminary interviews. There is then nothing to do but to embark on the analysis and to let its actual outcome be the test of whether or not we have indeed succeeded in the initiation of a psychoanalyst. From this point of

view we may seriously ask whether or not we are warranted in saying to a potential candidate that we are first of all committed to what may be accomplished for his psychic health.

Whether we like it or not there is as yet no short cut. Those modifications of technique which have been proposed, such as selective therapeutic planning, denial of dependency, circumvention of the transference neurosis, dilution of the analytic schedule, and fractionation of the entire course of the analysis, have yet to demonstrate their psychoanalytic validity. These techniques involve such a degree of activity on the part of the analyst as to eventuate in the encapsulation of large quantities of the patient's psychic forces. They are tactics of penetration in contrast to a strategy of infiltration. They are deficient in that *sine qua non* of psychoanalysis—the process of working through. The patients may produce so-called material. Progress may apparently be made. But if one looks on the consequences in their formal aspects, as one must so often do to understand the function of a dream, one cannot avoid the conclusion that the patient has often borrowed from the analyst the means with which to come to terms with him; and this later manifests itself in the magic-making attitudes of the student towards his own patients.

No one will be unduly disturbed by the fact that under the circumstances of the actual pressure to which physicians are subjected, we are compelled on occasion to make technical compromises which may be practically necessary and symptomatically useful. It is a different matter when the goal is the training of an analyst. Here we cannot compromise. Even if his purpose be utterly practical the scientific practitioner must be able to operate with freedom of choice and decision. For us this means that the personal analysis of a potential analyst must be comprehensive and thorough. It must take as long as it takes to expose the narcissistic core of the neurosis. There is danger that otherwise we shall propagate and perpetuate the kind of analysts of whom Freud said: 'It does look as if a number of analysts learn to apply defense mechanisms

which enable them to direct the conclusions and requirements of analysis away from themselves, probably by applying them to others'.[29]

Didactic work with candidates should begin only when we are convinced that the analysand is indeed a candidate for training. This does not mean that we have to await the resolving stages of the analysis. But it does mean that we have to be certain that the candidate has made a bona fide contact with his unconscious libidinal conflicts, with some resolution and integration. Even when an applicant for training wishes earnestly to be analyzed the narcissistic stake in his neurotic system may prove to be a primary obstacle. For a longer or shorter time the transference will involve all of the characterological defenses with which he has lived previously—including his interest in psychiatry and psychoanalysis. So long as this still characterizes the analysis the patient is not yet capable of the reality testing which actual training involves. There is danger, when the analysand is from the start considered to be undergoing a training analysis, that the issue of training befogs the defenses in the transference for both him and the analyst.

At the Marienbad meeting in 1936, Glover said: 'To judge from earlier psychoanalytic controversies it would appear that whenever differences of opinion exist in psychoanalytic circles, two safe generalizations can be made: first, that the original views put forward by Freud on that particular subject are still the best available and second, that as a result of more recent work, these original views are capable of, indeed require, more detailed correlation. I should like to add that in most cases the first of these two generalizations is the more valuable.'[30] I think that this is a fair statement. I believe that many of the so-called 'new ideas' are verbal derivatives of earlier psychoanalytic work. It is not enough to say that 'students should know psychoanalysis historically'. This by

[29] Int. J. of Psa., *loc. cit.*

[30] *Symposium on the Theory of the Therapeutic Results of Psychoanalysis.* Int. J. Psa., XVIII, Parts 2 & 3, April–July, 1937.

itself may simply mean that psychoanalysis becomes a tolerated guest in its own house. Students should be taught *psychoanalysis* and there should be no doubt in their minds that its derivatives are only practically necessary and possible applications of a basic science. Students must learn the meaning of transference in all its ramifications and depths; they must become familiar with its manifestations in their own transference neurosis; finally, they must acquire an earnest respect for its technical implications in the conduct of analyses. I think this is the atmosphere in which institutes of psychoanalysis should teach.

It would appear to be in the best interests of both the student in training and the patient whose supervised analysis he undertakes that this ought not to be recommended until the student's analysis is in the stages of resolution or is satisfactorily ended. Experience shows that a student's work with patients tends to reflect what is happening currently in his own analysis, and that he may utilize his patient's conflicts as defenses in his own analysis. There are students who do not begin to have more or less objectivity about their analysands until they have undertaken the second or third case. For that matter, even in their didactic work, many good students experience a temporary inhibition of learning for reasons related to their own analyses. While there are clinical situations in which the analyst finds technical reasons for advising or permitting a student to undertake a supervised case before the ending of his analysis, such permission may sometimes be dictated by extraclinical considerations.

It seems to be a fact that many students are permitted to choose as initial patients for supervised analysis cases which are far too complex for beginners. Cases need to be chosen with due regard for the psychic readiness of the student and this means that the student's analyst ought to be consulted in the assignment of at least the first case—especially if the student analyst is still in analysis. Supervision should be focused on the student and cannot concern itself alone with the patient whose

treatment is being supervised. This is true whether or not the student is still in analysis. The supervising analyst is not intruding on the student's analysis when he calls to notice the bare facts of the student's relationship to his case. And when the student is no longer in analysis then it is still more the responsibility of the supervising analyst to be alert to obvious unresolved countertransferences of the student.

It is a difficult but unavoidable fact that training in psychoanalysis is from its nature an individualized matter of preceptorship. It needs to follow individual indications as to tempo and technique, like the student's analysis itself. We cannot hope to make the schedule of training as academic as convenience and urgency might sometimes lead us to wish.

The case seminars are a final consideration. It is a puzzling fact that, in a field in which the defensive process is of such outstanding importance, the tendency is to emphasize formulation. All of us must have noted the penchant of students to turn to schematization and diagrammatics and how difficult it is to enlist their patience in a study of the analytic process. While individual supervision may counteract this to some extent, nevertheless it would seem that the continued case seminar or group control has been neglected as a means of further coping with this tendency to foreshorten in the interest of seeming mastery. The single presentation of large blocks of analytic work fosters the trend toward facile and tendentious dynamic reconstruction.

This discussion from the beginning has had no possibility of introducing anything really new. Its only justification is the continuing necessity to remind ourselves that psychoanalysis is not a mere clinical technique but the basic science of man's mental life. Our knowledge of the forces of the unconscious and of their ramifications in the ego is far from exhausted. As Hanns Sachs once said, 'Our deepest analyses are no more than scratching the earth's surface with a harrow'.[31]

[31] Cited by Glover as a footnote to his part of the Symposium referred to in footnote 30.

Psychoanalysis still occupies a vanguard position. In deference to this responsibility it must move slowly and cautiously. No current exigencies should be permitted to compel us to give up its refined capacity for discovering, testing, and verifying the new directions which the applied mental sciences can safely and profitably follow.

I have presented a vulnerable point of view which is at present subject to the frequently heard stigmatization: dogmatic orthodoxy. Is it not possible that the reverse is the case —that we are tending to fly into the study of epiphenomena, and into therapeutic improvisations, which we call liberalized psychoanalysis, as an expression of that need for compliant belonging which characterizes our generation?

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Boswell: The Biographer's Character

Edward Hitschmann

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BOSWELL: THE BIOGRAPHER'S CHARACTER

A PSYCHOANALYTIC INTERPRETATION

BY EDWARD HITSCHMANN, M.D. (CAMBRIDGE, MASS.)

The increase in appreciation of psychoanalytic knowledge is most evident in biography, especially when neurotic traits in the personality of famous productive individuals need to be understood or at least labeled. The uncertainty of biographers in such circumstances is often admitted.

Despite the enormous volume of literature about him, the character of Samuel Johnson, the most popular Englishman of the eighteenth century, is understandable only by psychoanalytic interpretation.[1] Not to stop with describing a character, but to understand it by tracing it back to inborn instincts and their transformations by the ego, and to the influence of parents and early events in life, is legitimate and scientific characterology which is the most important part of a biography.

Interest in the character of James Boswell has mounted rapidly in recent years. J. W. Krutch, who in 1944 published a biography of Samuel Johnson, describes Boswell's personality and asserts: 'No doubt his (recently published) Private Papers will some day be used in an attempt to psychoanalyze their author'.

In a similar vein, C. E. Vulliamy wrote in his book on Boswell (1932): 'The ultimate assessment of character—if such a thing is possible—lies outside the true province of biography, and would only be attempted by means of frigidly scientific analysis of mental components and of personal permutations'. Vulliamy continues elegiacally, 'Biography used to be a vehicle for noble sentiment or profitable moralizing. The good biographer brought his work to a close with gentle harmonies or approval or with pious meditation. Now we are more accus-

[1] Hitschmann, Edward: *Samuel Johnson's Character, A Psychoanalytic Interpretation.* Psa. Rev., XXXII, 1945, pp. 207–218.

tomed to reviews of neuroses and complexes and all the rest of the psychological paraphernalia.' Because he finds 'the grapes too sour' for his limited knowledge of psychoanalysis he predicts ironically, 'Those who are not yet tired of playing at psychoanalysis will find in the history of Boswell most promising material for their pastime'.

'This mind of Bozzy has never been analyzed or studied', said Percy Fitzgerald in 1912; but he used 'analyze' in the general sense of the word. Growing respect for scientific characterology no longer allows acceptance of a personal opinion about anybody as correct because the man who expressed it was a polyhistor. Macaulay, the famous historian, expressed an opinion of Boswell which hindered future generations from being objective. Macaulay's own character made him unable to understand Boswell's quite different nature. His judgment that '. . . logic, eloquence, wit, taste . . . were utterly wanting to Boswell . . . that he was a dunce, a parasite and a coxcomb', certainly does not do justice to Boswell. It is meaningless abuse to call Boswell '. . . a fool, who could write the finest biography in English because he was a fool'.

George Mallory in his book, Boswell, the Biographer, (1912) emphasized the importance of Boswell's relationship to his hard and dogmatic father, who did not understand or appreciate his son. Mallory acknowledges Boswell's genuine interest in human character, and his warm attachment and devotion to Johnson.

Vulliamy detects the feminine qualities of sensibility and responsiveness in Boswell, and calls his attitude towards his father that of a 'frightened child'. He makes the assumption 'that the story of Boswell, of this unfortunate man, is the story of one who was doomed by a nameless, incurable and persistent malady of the mind. If there is a moral here, it is a purely eugenic moral in favor of exogamous marriages.' 'It is important', Vulliamy asserts, 'that Boswell was the first child of cousins-german, that one of his own children, Euphemia, was mentally deranged and that his brother John, the second son of Lord Auchinleck, was taciturn to a degree bordering upon

actual insanity'. Louis Kronenberger, in his book, Portable Johnson and Boswell (1947), goes so far as to call Boswell 'schizophrenic', a layman's diagnosis with which we are not at all impressed.

Boswell was, in fact, a very gifted, ambitious and learned man, who was for years happily married, a beloved member of society, and who wrote, in addition to remarkable books and essays, the greatest of English biographies of his fatherly friend Johnson, whose friendship he '. . . had the honor and happiness of enjoying . . . for upwards of twenty years'. Was this eminent biography Boswell's merit alone owing to his special gifts, or was it the fortuitous result of a happy combination of external influences? One certainly could not have found a more exceptional subject than Johnson who, moreover, delighted to exercise in company his wisdom, originality and vivacity. Boswell wrote proudly to his friend Temple: 'It will be without exception the most entertaining book you ever read'.

Conscious of the enormous influence of Johnson on Boswell's technique, on his choice of material and the completeness of the biography, it is true that Boswell 'thought after Johnson's pattern and said some sentences almost as Johnson would have said them' (Fitzgerald). Boswell was in time so pervaded by Johnson's personality that he imitated him habitually, even copying his loose clothes and fidgety manner. Boswell, who was not always reliable in acknowledging quotations, must certainly have read Johnson's essay, On the Dignity and Usefulness of Biography, published in The Rambler of October 13, 1740. We find that Boswell's biographical principles are indeed the same as Johnson's. 'I, who was taught discrimination of characters by Johnson', asks the pupil, 'should I have omitted his frailties?' 'If I delineate him without reserve, I do what he himself recommended both by his precept and example.' Boswell had resolved, 'to adopt and enlarge upon the excellent plan of Mr. Mason, in his memoirs of Gray', but he far surpassed that or indeed any other model.

Johnson's essay on biography had recommended the inclusion of domestic privacies and minute details of daily life.

Johnson praises Sallust who wrote of Catilina that 'his walk was now quick, and again slow'. More knowledge of a man's real character may be gained '. . . by a short conversation with one of his servants than from a formal narrative', said Johnson, condemning 'uniform panegyrics'.

In his instructive book, The Development of English Biography, Harold Nicolson writes: 'Johnson's observations, when collected together, constitute perhaps the best definition of biography as an art, which has yet been formulated'. Johnson often pointed out that the interest of the biographer stems from identification with the subject. He said once to Boswell, 'Nobody can write the life of a man but those who have eaten and drunk and lived in social intercourse with him'. Johnson's first published biography was of his friend Savage with whom he had passed the poorest years of his life, and whom he took to his heart in spite of his vices and weaknesses, all of which he described. Later he published his famous The Lives of the Poets. Bergen Evans in Dr. Johnson as Biographer notes Johnson's preëminence as a psychologist and biographer, who seized essential facts and presented them vividly. His narrative and dramatic talents placed him among the foremost of biographers.

It seems just to assume that the lion's share of the merit of Boswell's Life of Johnson belongs to the subject of the book, as author, teacher and innovator of a new kind of biography. If Boswell's originality is dubious, his merits as biographer are still less. Some interest that 'posterity dedicates to him with printer's ink' seems a luxury. But his character remains an instructive and rewarding study even if he is no longer 'one general paradox' (Fitzgerald).

A psychoanalytic interpretation of the character of Boswell, whom Krutch calls a 'neurotic drunkard and victim of satyriasis', is restricted by the lack of almost any report about his childhood and his pious mother. Boswell, once describing his feelings during one of his many depressions, said, 'All the dreary ideas of my youth recurred upon me. I thought myself a boy

and an unhappy discontented being . . . I lived at home in such bondage that I was not only afraid to stir from home without leave like a child, but scarcely opened my mouth in my father's presence' (letter to Temple). To Rousseau, Boswell complained: 'My education has in every way been such as to make me a slave of my father'. He often regretted his 'narrow upbringing'. 'His attitude towards his father was that of a frightened child, maintaining with some difficulty the proper level of respectful sentiment', said a biographer.

The father was a noted advocate and judge who on his elevation to the supreme court took the name Lord Auchinleck. He studied Anacreon and Horace, collected classic manuscripts and possessed a valuable library. He was conceited and sarcastic, as a young man very vain. James remembered mocking his father's 'red heels and stockings'. His attitude toward his sons may be characterized by the fact that even in later years he called them idiots. James bore the brunt of violent attacks from his inflexible and domineering father whose great contempt he felt keenly, all of which imbued the humiliated son with rebellion. In later years, the adult son still suffered from his father's unfeeling harshness toward him and his wife to such a degree that he was disturbed to find himself debating whether his father's death would not be 'a desirable event' (Private Papers). The evocation of such parricidal impulses is inevitably accompanied by intense feelings of guilt and a partial retreat into passive submission to the father-judge. In contrast to the exaggerated male character of his father, James showed feminine qualities. He admitted himself 'not to be of the iron race', but by temperament timid. He avoided dueling by apologizing. He felt 'a transfusion of mind from Johnson', about whose readiness to fight he stated: '. . . he goes with his sword through your body in an instant'. 'There is a complete surrender', Vulliamy says of Boswell, 'almost a womanly surrender'; and Macaulay, with consistent vituperative exaggeration puts it: 'Boswell was always laying himself at the feet of

some eminent man and begging to be spit upon or trampled upon'.

Psychoanalysis has shown that a man's conscience originates in an identification with the parents, chiefly the father, which is favored by a good relationship between father and son. Older men in positions of authority, whom the son meets in later years, may contribute to this development; but where a father merits only his son's hatred, the healthy development of the son's masculine character is impaired. Boswell sought to repair his damaged masculine self-ideal by attaching himself to substitute fathers. Chief among these was Johnson. There was a succession of other great personalities, as Hume, Rousseau, Voltaire and General Paoli, whom Boswell used as models, from whom he sought the acceptance of intimacy, acknowledgement, advice—also, of course, to boast of these acquaintances. More than he may have expected, he found in later years that Johnson 'had done him infinite service, assisted him to obtain peace of mind, to become a real Christian'. In contrast to the harsh, implacable father, Johnson had idealism moderated by humor and some cynicism and was a famous writer who accepted Boswell, in the company of distinguished contemporaries, as an equal. As part of a process of identification, Boswell basked in the reflected splendor of the great, and with tablets in hand visited the celebrities of his time.

Characteristic of Boswell's superego was his conscious awareness of its weakness for which he sought help. A memorandum to himself reads: 'Be like Johnson!'; another: 'Seek to attain a fixed and consistent character, to have dignity . . . deserve to be Johnson's friend'. Letters to his lifelong friend, the Reverend Temple, are full of good resolutions to attain a proper conduct of life, to make himself a man, to become steady and sensible. He wrote to Temple confessing his 'dissolute conduct', but begging indulgence. 'Admonish me, but forgive me!' But Boswell easily forgave himself. His conscience appeared to be more an adornment than an effective

force. He could not acknowledge that renunciation is the essence of morality.[2]

Boswell was extremely vain and narcissistic, tended to be exhibitionistic and to parade in showy costumes. One may assume the inner conflict behind such overstress to have its origin in feelings of inferiority which motivate compensatory corrections. He had to prove to himself and others that he was the equal or superior of any man. He never desisted from calling himself Esquire. The early humiliating injury to his self-esteem by his father's sarcasm accounts in part for the son's compulsive need to correct an unconscious conviction of his worthlessness by various excesses to a degree that achieved results opposite from those intended.

Boswell's sexual promiscuity may be similarly interpreted both as hedonistic overindulgence and the desire to prove that he was virile. Only during the first years of his relatively happy marriage to a poor cousin was this habit moderated. In his letters to Temple we find confessions (or boasts?) that, 'We drank a good deal until I was so intoxicated that instead of going home, I went in a low house . . . and like a brute as I was, I lay all night with her'. In the same year he wrote: 'I have got a [venereal] disease from which I suffer severely. It has been long of appearance and is a heavy one . . . I greatly fear that Mrs. X is infected; for I have been with her several times since by debauch.'

Boswell's correspondence with Erskine shows him in early years as an expert libertine, siring an illegitimate child, eloping with an actress, indulging whims of becoming a military officer and an actor, justifying his father's criticism that he was a frivolous spendthrift. Wine, women and gambling brought James into association with other young men of fortune, a company which he did not like to abandon. However, he had

[2] 'A moral man is one who reacts to temptation as soon as he feels it in his heart, without yielding to it. A man who alternately sins and then in his remorse erects high moral standards lays himself open to the reproach that he has made things too easy for himself. He has not achieved the essence of morality, renunciation, for the moral conduct of life is a practical human interest.' From Freud: *Dostoevsky and Parricide.* Int. J. Psa., XXVI, 1945, p. 1.

an idealistic love for his wife, and when he lost her he lost his guardian angel; also he never neglected his duties to his six children. Boswell had qualms about marrying, had to overcome much anxiety to do it, and did it with the significant reservation that he would 'not . . . be bound to live with her longer than he really inclined; and whenever he tired of her domestic society, he should be at liberty to give it up'.

It is well known that sexual promiscuity and whoring are often a defense against unconscious homosexual trends. Such a trend is inherent in a comment of Boswell about one of his mistresses: 'My lively imagination often represents her former lovers in actual enjoyment of her'. Boswell once gave a supper to friends in payment of a bet 'that he would not catch the venereal disorder for three years'. A gruesome note is recorded in the Private Papers: Boswell reads in Paris about his mother's death, rushes off to an Ambassador's dinner, and then 'as in a fever' to a bordelle! He had to prove repeatedly to himself and others that he was not inferior, not 'castrated'. Once he wrote to Temple, 'The death of Johnson will be like a limb amputated'.

The same Boswell who was so sociable, cheerful and humorous suffered often from depressions. Over a period of six years he wrote anonymous essays under the title, The Hypochondriac, in which he dealt extensively with problems of hypochondria, drinking, love, death. Here we find self-reproaches about the wretched inertia of hypochondriacs including himself, beside all the good intentions of a rational standard of conduct and of the consistency and dignity he never achieved. His depressions were severe. To Temple he wrote, 'I have at bottom a melancholy cast, which dissipation relieves by making me thoughtless and therefore, an easier, tho' a more contemptible animal . . . I am always apprehensive of it. I dread a return of this malady.' 'The mere gratification of the senses' was, says Boswell, 'during a depression the only pleasure of existence'. Inveterate drinking he used as an excuse for sexual debauches. Boswell's cyclothymia corresponded to different states of his conscience, which vacillated

between severity and indifference. Boswell in later years failed progressively in his legal, political and social ambitions, and his escape through drinking increased in proportion.

'It is a very remarkable experience to observe morality . . . functioning as a periodic phenomenon', says Freud. 'Our moral sense of guilt is the expression of the tension between the ego and the conscience. . . . The melancholic during periods of health can, like anyone else, be more or less severe towards himself; but when he has a melancholic attack, his superego becomes oversevere, abuses, humiliates and ill-treats his unfortunate ego.'

That a very gifted man with good intentions finally fails in his life and never achieves a lasting and genuine reputation, seems not easily understandable. There was in Boswell a compulsion to make a fool of himself, and by his buffooneries, which appeared at just the most unfavorable moment, to destroy himself the reputation deserved by his accomplishments. He had, for example, when a young man, placed himself at the head of an uproarious mob which broke his father's windows. Once from the audience of the Drury Lane Theater he took upon himself to imitate the lowing of a cow, so that the universal cry from the galleries was, 'Encore the cow!' His book, Account of Corsica, was a great success. But at a Shakespeare anniversary in Stratford, Boswell appeared dressed as an armed Corsican chief with a ribbon around his head imprinted 'Corsica Boswell'; moreover he publicized the fact in the London Magazine. Just when he had the chance of winning the esteem of the great Prime Minister Pitt, he made a fool of himself by composing a song about himself, six times repeated, exhibiting his insolence and wantonness.

> 'So not a bent sixpence cares he
> Whether with him, or at him you laugh.'

Was this behavior a demonstration against his father's overwhelming dignity? Was it a self-punishment for feelings of guilt? Did he need spitefully to conform to his father's low opinion of him?

After the deaths of his wife and of his mentor Johnson, the demoniac component of Boswell's personality became more and more visible in his downfall.

His ambivalence toward his father was occasionally betrayed in his behavior toward the father-image Johnson. Mrs. Thrale reproached him with 'inclination to treachery'. Macaulay expressed the opinion that Boswell published many anecdotes 'as never were published respecting persons whom one professed to love and revere'. Indeed, Boswell sometimes seemed to take peculiar delight in the absurdities of Johnson, who, it is true, could humiliate him like a school boy, especially when irritated by Boswell's obtrusive curiosity and provocative questions. But it is owing to just this ambivalence that Boswell's biography is so complete and amusing. Boswell's 'animosities' were called by Fitzgerald 'the motor forces' of his observation and writing. Some denudation belongs in every biography. Boswell said about himself: 'I impose nothing, I propose nothing, I expose'.

There is no doubt that Boswell had special abilities for writing vivid biography. His habit of writing down and preserving details of all events and impressions led him to instruct Temple 'to put his [Boswell's] letters in a book neatly'. The wealth of information in many diaries and private papers that are preserved regrettably includes nothing about his childhood. He well might not have liked to remember that unhappy time.

Boswell's boundless introspection and interest in his own character helped him to understand others: '. . . his knowledge of others began with himself'. Each new person he met excited his curiosity. 'I have ever delighted in that intellectual chymistry, which can separate good qualities from evil in the same person.' The striking variations of his mood—periods of conceited elation alternating with depression and disillusionment—make his efforts to become clear about himself by writing down impressions and confessions seem like attempts at self-therapy. He lived, it is said, 'a second life black on white'.

'One would have expected', Fitzgerald rightly said, 'that this gay young man would have followed someone of rank and

influence; but no—he preferred the excellent Johnson.' Johnson represented in many ways a contradiction, the opposite of the father who hated such types as Johnson and did not understand nor like Bohemians. Johnson was the reverse of the pedantic, implacable and parsimonious father. Boswell sought a father, not cold and dignified, but one who would show warmth and commendation, would be admonishing but forgiving too, be a great and wise man like Socrates who liked young men. Johnson, distinguished by intellectual and moral greatness, was above all humorous. He had an Olympian gift of often not taking the world's problems too seriously. He did not like to be alone with his compulsive thoughts, liked especially 'young dogs' and preferred wealthy young men who had not, like him, had to go through the ordeal of poverty.

Vulliamy came to the conclusion that only a mentally ill personality could have achieved and failed to achieve what Boswell did; that all that is unaccountable in his behavior, all the variations and facets of his life are understandable if we admit 'that the story of his life is the story of one who was doomed by a nameless, incurable and persistent malady of the mind'. We feel justified in declaring that Boswell was neither neurotic nor psychotic; that his abnormality is best specified as psychopathic personality. This type is not a sharp cut one, but characterized by intact intelligence, a defective superego not of criminal degree, by self-destructive tendencies, social maladaptation, unpredictable behavior, intense narcissism and a weak ego. These types are sometimes very gifted, even brilliant and creative. Boswell's inclination to manic-depressive changes of mood is not a regular symptom of the psychopath, but characterizes Boswell's dubious conscience especially and makes visible his defect in the superego.

We avoid here problems of heredity, constitution, general environment in his era and restrict ourselves to the influence on Boswell of his exceptional father. The psychoanalytic biographer 'can never have access to such first-hand information as is available to the physician who is working with a patient'

(Glover). The advantage over other biographers is based on the understanding of causal connections, unconscious psychological determinism and the effects of conflicts in family life.

Dr. Greenacre, a psychoanalyst, published a paper about the influence of a certain type of father on the development of psychopathies in the sons. Dr. Greenacre describes these fathers as usually respected and often prominent men, whose very work or profession puts them in positions of conspicuous public trust and authority, as clergymen, judges, heads of schools, civic leaders. Such a father is often stern, obsessional, remote, preoccupied and fear-inspiring in relation to his children. He is highly narcissistic in his more than ordinary dependence on the approval and admiration of his contemporaries. But his relationship to his children is poor, being to them fearsome, awe-inspiring and something of a frightening demigod, lacking substance and vital warmth, too exalted and aloof to permit the son to imagine himself as ever being able remotely to approximate his eminence. A son's masculine self-esteem is injured by such a father's harshness. A common defense for the son is to retain his infantile sense of narcissistic omnipotence; the development of healthy love impulses is diluted or stunted. A boy's need to identify himself with his father is in these instances not possible because of the hatred evoked in the son from being forced into suffering submission. It is an influence that often fosters the development of homosexuality.

The influence on Boswell's character and ego of this type of father was not simply traumatic: this wound had to be healed. Curiosity about people was one of the consequences. Boswell developed from early years not only this interest, but an urge to record his observations of the people he met. His introspective self-revelation belongs here too. Another fortunate consequence was Boswell's search for kinder, better, more famous substitute fathers, which landed him finally with Johnson with whom he attained, he said, 'peace of mind'. His identification with Johnson, who was fifty-four, had great in-

fluence on young Boswell, who was twenty-three when they met, even though in reality he never achieved a balance between idealism and cynicism. Boswell's extreme vanity and exhibitionistic behavior were compensations for the early lesion of his self-esteem; he had to attach himself to friends, inspire love and admiration to regain self-confidence. The ambition which 'raged in his veins like a fever' had a similar compensatory value.

Boswell represents an instructive example of defective moral development and infirmity of purpose stemming from the impossibility of developing a lasting ego-ideal by identification with his father. His ambivalence hindered him from making use of his father as a model. Something unknown in himself hindered him from doing what he knew he should. He talked and wrote much about morality but was often unable to do what theoretically he acknowledged. Moral weakness characterized him and his feelings of guilt caused depressions. That the attacks he called 'hypochondriacal' were manic-depressive seems evident.

This rebellious son vacillated many years in the choice of vocation, resisted naturally becoming a lawyer like the father, choosing first to become a military officer or an actor. But his literary gift prevailed and he left behind a masterpiece which with biographical genius makes better known to us than any other man in history the personality of a unique fatherly man, a many-sided spirit, an exceptional conversationalist and writer.

Deferred obedience to his father's wishes and practical considerations caused Boswell, in later years, to become a member of the Bar, but he failed as a lawyer entirely. He ended as a heavy drinker in forlorn condition, 'grievously aggravated by hypochondria'.

SUMMARY

The paradoxical and controversial personality of a historical figure is investigated and characterized as psychopathic. The reactions of his ego towards a father of a certain type are

described. They hindered the development of an equilibrated conscience, and influenced decisively his work and life.

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THE EFFECTS OF SHOCK TREATMENT ON THE EGO

BY JOHN FROSCH, M.D. AND DAVID IMPASTATO, M.D. (NEW YORK)

It has been the common experience of shock therapists to observe various reactions in patients before, during and after shock treatment. A recent publication (*1*) described a temporary psychotic picture which developed after shock treatment was discontinued. The symptoms differed in form and content from the clinical manifestations observed before shock treatment was instituted. Questions raised as to what had happened and why were cursorily considered. The number and frequency of treatment and basic personality structure were considered, but no satisfactory conclusion was reached. In this presentation we should like to review some of these questions but propose to broaden the scope of the inquiry to the general consideration of what happens to the patient in the course of shock treatment. Objection might be made to the use of an atypical and extreme type of reaction for this purpose, but just as the understanding of normal psychodynamics has been greatly advanced through the study of psychopathology, so a study of these special reactions may shed some light on what happens in general to patients treated by shock.

We do not presume to try to explain what it is that gets the patient well. As a matter of fact, this paper devotes more time to failures than successes. We hope, however, in our discussion to delineate one facet of the total problem which, combined with some of the others, might ultimately give us a more complete picture of what takes place in the course of shock treatment. It is the authors' opinion that shock treatment produces varying effects in different illnesses. This uniform experience, shock treatment, has a different meaning to each patient, what-

Read in part before the New York Psychoanalytic Society, February, 1947. From the Department of Psychiatry, New York University, College of Medicine, and Bellevue Hospital.

ever the clinical syndrome may be. There is, we believe, no one explanation to account for the reactions. Those who hold that the mechanism is solely organic and that a realignment of association pathways or alterations in the autonomic nervous system take place may be correct in certain cases. Those who believe that the treatment is only psychotherapeutically effective (either symbolically or by suggestion) are possibly right in certain other cases, especially those in which feelings of guilt and the need for punishment are conspicuous. The rôle of shock treatment in such cases as a punishment and death threat has been ably presented by many authors (*2, 3, 4*).

There is no doubt that organic changes—reversible or irreversible—of some sort take place. Anoxemia, convulsions, coma, memory changes are not psychological phenomena. The strictly organic explanations seek in these factors the rationale for the cure. The pure psychological approach sees in the convulsive experience or the state of unconsciousness a symbolic meaning which produces the results. One aspect, however, seems to have been ignored or somewhat neglected. The individual undergoing this organic experience must have some reaction to it; not only to the convulsion but to the totality of changes taking place in the individual—the confusion, the memory defects, the alterations in perception, etc., all of which are the usual post-shock reactions.

Every experience an individual goes through makes it necessary for the ego, in all its aspects, to make an adaptation or an attempt at adaptation. Every experience brings into play a series of events to maintain the physiological and emotional homeostasis. This is a process which goes on from the moment the child is born, and perhaps even before, and takes place on the deepest physiological as well as psychological levels. Bak (*5*) has pointed out that the birth process brings with it as one of its almost catastrophic results a complete change in environmental temperature, with a necessity for radical readjustment which takes place internally but also requiring external help. As the child develops there is a constant necessity for the grow-

ing ego to elaborate adaptive techniques to meet the environmental demands, as well as the inner libidinal drives. There is also a constant striving toward an integration of the ego and toward keeping it intact, to prevent disintegration. Disintegration of the ego is very anxiety-provoking as witnessed in the *Weltuntergang* fantasy of the schizophrenic (*6*).

Ferenczi and Hollos (*7*) discussed some of the psychological reactions accompanying organic disease of the brain which, especially when it is cortical, in addition to whatever symbolic meaning it might have, has a generally shattering effect upon the adaptive processes of the ego. This leaves the patient much more vulnerable to assault, both from without and within. Inner impulses and drives, be they libidinal or aggressive, around which the ego has established its defenses, threaten to overwhelm it, and require additional defense mechanisms. A reorientation is imperative or else the shattering of the ego defense structure may completely incapacitate the individual for any functioning at all, or for any contact with reality. The ego tries to combat this disruption with secondary techniques, which in turn represent psychopathological symptoms. Symptoms and signs are in the main defense mechanisms, attempts at cure and restitution, expressions of the synthetic function of the ego described by Nunberg (*6*). These may be on a more primitive level than those mechanisms in force at the time of the onset of organic brain disease. What we have just said about organic brain disease may be applied to the effects produced by shock treatment which in our opinion artificially produces an organic brain disease with accompanying alterations.

There are two main types of reactions to shock treatment, those reactions which are general, that is, those which by and large occur in most patients—namely, the confusion, the memory defects, etc., and those which are more specific. In the latter there are two sub-reactions: (a) slight variations in the general type of response (strength of convulsions, degree of restlessness, memory defects); (b) differences in quality of response whose

finer shadings may be specific for that particular patient. These more specific reactions are the ones of greatest interest to us.

One patient who begins to note her defective memory is rather amused. She laughingly recounts how embarrassed she is because she could not remember this or that person's name. Another becomes quite intolerant of the defect, anxiously questioning the examiner: 'How long will it last? What is happening to me?' Others become resentful, accusatory, even delusional about the treatment, maintaining that something is being done to them during the treatment to produce these effects, etc. We see a common experience, organic memory defects, which produces different reactions. Let us consider another feature, the reactions of the patient to the total treatment situation. Many patients lie down quietly and take the treatment without question. At the other extreme is the patient who has to be brought almost forcibly to the treatment. Some say: 'Couldn't we skip it today, I just don't feel right', or 'I have a little cold', or 'My arms hurt'. The patient may be quite coöperative at first, and as the treatments continue become progressively apprehensive to the point of panic. One such patient could not endure the prospect of going the next day for treatment. The very thought of it filled her with such dread that she broke into a sweat: 'When I even walk by the doctor's office my heart begins to beat and I run very quickly', she said.

Questioning of the patients as to what they are afraid of will usually elicit vague responses, occasionally more specific ones. In some instances they are fearful of electricity going through their brain. Some have jocularly referred to this as having their 'brains fried'. More frequently expressed is the fear of being unconscious and of not knowing what is happening. Sometimes this is a fear of remaining unconscious, of dying. Various studies by means of questionnaires leave a great deal to be desired in discovering the patient's unconscious attitudes toward treatment.

Proceeding to a more detailed examination of the subject, there are roughly seven or eight phases in the treatment during

which the patient's reactions are of interest to us. First, in the period before the treatment up to the point of application of the current, is his general attitude toward the treatment, his anxieties or his lack of overt anxiety—his reluctance or his willing acceptance of treatment. The second phase is the primary apnea and the convulsion which are impossible to study subjectively. A third phase immediately follows the convulsion, when the patient is completely comatose. The fourth, which lends itself more readily to evaluation of what is happening subjectively to the patient is the phase in which he is emerging from coma. Some lie quietly until it is time for them to leave. Others become very restless, thrash about and have to be restrained. Some moan and make all sorts of sounds. Still others pick at their clothes, sometimes exposing themselves. This gradually goes over into even more specific reactions during the fifth phase, during which we see a general state of confusion which all patients have, but some will talk and look around; some behave quite erotically, making advances toward the nurse or doctor; others try to get up and walk. Gradually some contact can be established with the patient in the sixth phase, where the patient looks around confusedly, sometimes asking questions, trying to orient himself. He questions, 'Who am I, who are you?' Sometimes he gives up, falls back on his pillow and closes his eyes. Later he might become apprehensive and begin the struggle anew. After having fallen asleep the patient may start up, look around in a bewildered, frightened fashion. We then come to the few hours directly following the shock treatment which constitute a seventh phase in which the patient is still somewhat confused and feels dizzy. The environment appears changed to him, and may appear somewhat unreal. Sensory perceptions are rather distorted. He may complain of dizziness and of numerous aches and pains or body sensations of various types. To all of these phenomena patients react differently. Some do not appear to be perturbed by them; others complain and refuse to lie down and rest. They walk around, questioning, asking for help. The eighth phase ensues when

the immediate effects of treatment wear off, leaving vague sensations of something not 'quite whole within me' as one patient expressed it. There are memory defects and before the patient can quite reorient himself completely he is again treated, and repeats the cycle described except that in some instances the individual reactions become more pronounced. Reorientation to his environment usually becomes more difficult after repeated shocks. He has to make more effort to concentrate and although at the beginning with some effort he is able to reorient himself, this later becomes more and more difficult. His whole relationship to the environment, both external and internal, becomes somewhat distorted. Something has happened to the patient, to alter his orientation in the environment, emotionally, psychologically and physiologically. The first question we must ask ourselves is, 'What has happened?'. We may then proceed to study the reactions of the individual to that which has happened to him. This may be clarified somewhat through an examination of case material.

An illustrative case is that of a thirty-three-year-old white female who for many years was troubled by obsessional thoughts, images and impulses, of an aggressive and hostile nature. These consisted of knives flashing into her mind and feelings of hostility toward her husband. Through the years she had elaborated a complex religious defense which reduced to a minimum her anxiety and guilt. Recently she had begun to drink, for relief from her obsessional ideas. One night she developed an alcoholic delirium during which she had anti-religious and hostile hallucinations. Following this she became depressed and suicidal and shock treatment was recommended. After the first one she felt better, but as the treatment continued, she became more and more restless and anxious: 'My head was in a constant whirl. All sorts of thoughts kept coming up in me. I couldn't stand it. I couldn't stop thinking. I became so frightened.' When treatment was discontinued after the eighth shock, she was agitated, restless and anxious. She was referred for analysis and it was interesting to note that both

in associations and dreams, material came up quite early which ordinarily does not appear until much later in treatment. At certain times her deeper hostilities against her mother and father, her incestuous wishes for her father, undisguised erotic impulses, a desire for her husband's death, welled up with such force and profusion that it threatened to throw her into a panic. We believe that the shock treatment weakened the integrative function of the ego, shattering the obsessive religious defenses the patient had erected. There followed a regression to archaic modes of defense, borderline hallucinatory experiences, in which ego-alien hostile obsessive thoughts were like a voice she would try to disown, with the feeling of estrangement and the mechanism of projection as a defense, described by Tausk. At such times she was objectively quite definitely psychotic. Repeatedly she appeared close to giving up her struggle to hold on to reality, and self-destruction or a disintegrative psychosis seemed to be the probable outcome but the patient ultimately worked through and is functioning adequately today.

We should like to describe another patient who developed a psychotic picture after shock treatment was discontinued. This patient's presenting symptoms were feelings of unreality and depersonalization, with fears that he was going to break down and that there were homosexual tendencies in him. The differential diagnosis was difficult, as it often is in cases of depersonalization. Some thought it was a neurosis, others a depression, and others a schizophrenia. Subsequently, he became very depressed, had suicidal tendencies, and stayed continuously in bed. He was given a series of shock treatments in the course of which he became quite confused, would walk around with a bewildered expression on his face, and after the fifth treatment said, 'I have the jitters today. Sometimes I feel that some parts of me are missing.' He spoke repeatedly of how the shock treatment was weakening him, complained a great deal of his defective memory and said, 'I don't know where I am or who I am'. At one point he felt that he was dead and would ask people to pinch him. After an extensive period of treatment, he improved and treatment was discontinued.

Just before he was to be permitted a trial at living at home he spoke at length with his psychiatrist about his mistress, with some anxiety about the status of his relations with her. He was not sure how and when to resume his relationship with her. That night he awoke quite suddenly and said, 'Something has happened to me. I have never been this way before.' Asked to explain, he rushed from the room, shouting loudly, hurled tables and benches, talked incessantly in a very obscene fashion, tore out one of his toe-nails and had to be restrained. Next day he was very confused, talked very disconnectedly, was actively hallucinating, but could occasionally be contacted. He kept referring to his girl friend, and when questioned he said he was afraid to have sex relations with her. He was afraid of the vagina: 'It was a big hole', he said, and his penis would get hurt and lost. 'I will never get well. I wish I were the other sex. I want to get well and marry but I will always be here and always be sick.' For the next few days the patient was exceedingly disturbed, had to be tube-fed, hallucinated actively, and it was only about ten days later that he became better integrated, saying 'I guess I must have gone off the beam', but could not remember what had happened. Soon after that he reverted to the previous picture of depersonalization and feelings of unreality, but did not show the psychotic manifestations described above.

Reconstruction of the psychodynamics of this patient's reaction justifies the assumption that as shock treatment progressed and its effects on the body image, ego-structure and adaptive defensive techniques began to make themselves manifest, he felt himself to be disintegrating. Aware of changes taking place within him which he could not explain, he would go around questioning what was happening, as part of his efforts to keep whatever he could of his ego intact.

One of the maneuvers consisted in a renewed attempt through depersonalization and estrangement to deny the changes going on within him, the emerging of libidinal impulses and wishes from repression. He reinforced his feelings of depersonalization to the point of considering himself dead and hoped thereby to

deny his libidinal stirrings. Then one night his makeshift adaptive defense collapsed and impulses and conflicts which he had hitherto been able to keep under control, even by pathological means, threatened to overwhelm him and panic ensued. A substitutive attempt at restitution was established, namely, projection. The disintegration of the ego brought with it a loosening of ego boundaries and with this diffusion of the ego boundaries a more archaic defensive mechanism was set into play, namely, projection. Before projection takes place there has to be a diminution of the sharp delineation between the ego and the outside world (*8*), permitting the extension of the ego boundaries which takes place in the process of projection. Shock treatment forces the ego defensively to regress to this narcissistic stage, mobilizing defense mechanisms more consistent with that stage of ego development. This is apparently not quite successful. All sorts of material from the id flood the ego; the patient's castration anxiety and wishes are seen quite clearly, but the ego struggles to hold on to reality: projections, hallucinations and the like dominate the clinical picture until gradually the ego is able to re-establish its previous pathological defenses. Perhaps it is possible because the distintegrating effects of shock treatment begin to wear off and the ego is able to re-establish its previous pathological adaptive defenses.

A Jewish boy of thirteen had numerous phobias and anxieties, especially about dirt, of several years duration. He resorted to numerous obsessive compulsive rituals to combat his phobias. After shock treatment was instituted, most of these rituals subsided somewhat, but they were replaced by other more intense symptoms. Although he had had the symptom of spitting before, he now began to spit all over the place. He complained of peculiar sensations in his body, felt weak and occasionally soiled and wet himself. Then he began to express ideas of reference, to feel that he was being watched and that he was being poisoned, that he was to be killed because he was guilty of his father's death, his father having died soon after the patient had quarreled with him. As the shock treatment

progressed he became more and more disturbed, threw himself about and tried to beat his head against the wall. Most of his productions revolved around the belief that people were talking about him, accusing him of his father's death, for which he was to be punished either by the electric chair—which he regarded the shock treatment to be—or by poisoning. He felt dizzy, and complained of having a heart attack. These and other sensations he ascribed to attempts to poison him. Subsequently, in view of the fact that he had not died from all these poisonings, he evolved the belief that Jesus Christ had intervened to save him and he crossed himself frequently, saying that he wanted to become a Christian. Gradually, he improved considerably, even to the loss of his obsessive compulsive defenses. Eventually these returned but apparently did not suffice, for over the next few months he regressed to his more archaic defenses, developing new ideas of reference and delusions of persecution.

This boy had protected himself from a pathological fear of dirt by elaborate obsessive-compulsive rituals which served to protect him from being overwhelmed by impulses and drives of an undesirable nature. By shock treatment, which produced certain organic changes in the brain, this precarious balance was shaken, threatening a collapse of the ego and loss of contact with reality. Breaking through repression into consciousness were parricidal impulses: 'I killed my father. I wanted him to die. I hated him.' Repression and simple denial not being successful, emergency measures have to be adopted and the ego-alien wish is projected: 'I didn't kill my father, but they said I did'. The superego demands condign retaliation, for, having killed his father, he should be killed: 'They want to kill me, to poison me. I'll get a heart attack.' 'Jesus Christ will save me', is the defensive regression of the ego to archaic infantile omnipotence. With threatening dissolution of the ego the individual tries to hold on to reality at different levels. At the most primitive level this is through cosmic identity, a megalomanic extension of the ego boundaries in an attempt at restitution. Gradually, through successful repression, the patient came to

appear quite well, but not for long; he soon reverted to his obsessive-compulsive syndrome. But something had happened, and it is not at all inconceivable that the effects of shock treatments made his former mechanisms of defense obsolete and ineffectual in the struggle to hold on to reality, and to keep the ego intact a more permanent regression to archaic defenses took place producing ultimately a clinical psychosis.

CONCLUSIONS

Shock treatment is a drastic physical assault, producing organic brain alterations plus general and specific psychological reactions to these organic changes. There are both immediate and remote reactions, the latter being the ones which concern us mainly in this study.

One of the major immediate effects is practically a complete dissolution of the ego. This immediate reaction is more or less overcome; however, with repeated assaults on the brain and repetition of this dissolution various changes take place. The subsequent effects on the ego, through the mounting organic impact on the brain, produce a milder chronic repetition of what takes place immediately after shock.

The drastic organic trauma to the brain brings with it a wave of ego and body cathexis with a regression to an archaic narcissistic ego as a defense. This ego in its attempt to hold on to reality strives to reachieve its previous level of development and usually this attempt at reintegration to some higher level is successful. At times this attempt is not quite successful and the ego remains either at an archaic narcissistic level or at some point on the road to higher integration.

The regression to a more primitive ego structure, with its accompanying disruption of the body image, ego boundaries and disturbances in relation to reality, brings with it a rising anxiety and feeling of disintegration. Bak (*9*) has pointed out that anxiety will develop when the ego is threatened with sinking back into a state of impersonality. Attempts at restitution

follow and there is a striving toward higher ego integration. Whether partially successful or unsuccessful, this attempt results in an alteration of the clinical picture since defense mechanisms are brought into operation which are in keeping with the stage of ego development. Freud (*10*) stated that in the process of regression there is a defusion of defense mechanisms to original forms.

The effects of shock treatment may produce a more primitive ego whose boundaries are more diffuse, resulting in that loss of definition between it and reality which paves the way for the development of projection as a defense, manifesting itself clinically in delusions which may disappear if the ego has time to reintegrate itself at a higher level. In some such cases we find a return to higher levels of defense and adaptation, sometimes even to better ones than during the illness. Accompanying these ego changes we see that as a result of the organic impact on the brain there is a disintegration of the ego-defenses. Here again we are talking not only of the immediate effects where this is seen more clearly, but of the remoter effects.

The disruption of the defensive apparatus leads to a welling up of hitherto more or less controlled or repressed impulses which may come to direct expression, followed by a series of regressive retreats to more primitive lines of defense established in an attempt at walling off. Ego reintegration may be achieved temporarily through successful repression, leading to seeming improvement (*11*). In other instances where repression fails, partial integration is attained at a more primitive level of defense. One may see here and there the appearance in the clinical picture of unconscious impulses and wishes, side by side with the defense mechanisms against them (return of the repressed). Through the establishment of regressive defenses, the ego is given, so to speak, a breathing spell, to build up its strength anew, to achieve later a higher level of integration, and to attack the conflicts with renewed vigor. This usually leads to a sharper delineation of the ego boundaries, the abandoning of the more

primitive defenses, and the establishment of defenses at a higher level, reproducing the previous clinical picture. In some instances this may carry even further to a still higher and a more successful level of defense, resulting in seeming improvement. There is a constant overlapping and interweaving between the results of the disintegration and regression of the ego and the disruption of the established ego defenses.

These formulations have been made with the full recognition that they represent but one of many facets in the exploration of unconscious reactions to shock treatment. As so often happens, we occasionally obtain some clearer understanding by a study of the failures rather than the successes, by a study of the pathological rather than the normal. We also realize that we have left many questions unanswered even within the scope of this paper. However, we have hoped to demonstrate that through a study of shock treatment and its effects, one might obtain corroboration of many hitherto known factors about the levels of ego development and their relationship to the hierarchy of the mechanisms of defense.

SUMMARY

An attempt has been made to understand what happens in the course of shock treatment. It is felt that shock treatment is an experience, producing alterations in the somato-psychic homeostasis leading to a disruption of the hitherto existing mechanisms which tend to maintain this homeostasis. In its attempts to re-establish the hitherto existing equilibrium, the ego may be successful, partially successful or unsuccessful, thus producing various clinical syndromes. The ego may defensively regress to more primitive narcissistic levels. This step brings with it more archaic defensive mechanisms in the attempt of the ego to hold on to some degree of reality. This may be only temporary and after a while it is possible that the ego may muster its forces and re-establish its previous or perhaps even a better adaptive defensive apparatus. All of these maneuvers produce varying kinds of clinical reactions some of which are described.

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THE DYNAMIC BASIS OF ANTI-SEMITIC ATTITUDES

BY NATHAN W. ACKERMAN, M.D. AND MARIE JAHODA, PH.D. (NEW YORK)

Anti-Semitism, currently a grave problem, is a sociopsychological phenomenon. It is a form of intergroup behavior, which increases in intensity at times of social crisis; it expresses itself in stereotyped accusations which seem to be part of a cultural tradition; it produces social consequences of a dangerously destructive nature. Cultural traditions, however, and social forces do not exist as mere abstractions; they have existence only in so far as they express themselves dynamically in the behavior of people. In the last analysis, a completely meaningful conception of social forces can be achieved only in terms of—or at least with close reference to—specific patterns of interpersonal behavior. But in the case of anti-Semitism especially, even those whose preferred frame of reference is primarily sociological might be disposed to turn to dynamic psychiatry for insight. It is not merely the irrational content of anti-Semitic accusations, but fully as much the self-defeating aspects of anti-Semitic behavior, which invites psychiatric clarification. Such behavior is rationalized as a means of self-preservation; yet, it ultimately brings harm both to the individual anti-Semite and to the society which nourishes such hostility. The analogy to neurotic self-destructive mechanisms is striking, and must attract attention to the relevance of a dynamic investigation of the phenomenon.

The psychiatric approach to the problem of anti-Semitism raises several fundamental questions. Why, under the same socioeconomic conditions, do some persons develop anti-

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Semitic attitudes while others do not? What is the rôle of the anti-Semitic hostility pattern in the current emotional life of an individual? What is its specific dynamic relation to unconscious needs? What genetic factors predispose a person toward anti-Semitic behavior?

We have explored the dynamic basis of anti-Semitic attitudes in a number of persons who are undergoing, or have already experienced, psychoanalytic therapy. The material was collected from twenty-five accredited psychoanalysts. We prepared a comprehensive schedule of all relevant aspects of a case history. After an analyst had presented a case study, the information was supplemented in intensive interviews, which generally followed the subject matter outlined in our research schedule. Some analysts contributed more than one case study. In the use of clinical material, every precaution was taken to preserve strict anonymity.

These patients had sought psychoanalysis for a variety of complaints and symptoms. Since the analyst was primarily oriented to the therapeutic problem, the characteristics of anti-Semitic behavior were observed only incidentally. The patients had varying degrees of awareness of their anti-Semitic feelings, but they did not regard those feelings as a 'symptom', and they were not aware that these particular feelings were scrutinized in any special way. So far as could be determined, the patient's consciousness was, therefore, not unduly aroused in this connection.

This preliminary paper is based on the data contained in twenty-seven case studies: sixteen men and eleven women. In age, the patients range from twenty-two to fifty-one years. Five cases of Jewish anti-Semitism are included; in addition, one was half-Jewish, and one had been converted to Protestantism during his teens; there were four Catholics, and the remainder were Protestants. So far as we could determine, the psychodynamic patterns underlying the anti-Semitic reactions were essentially similar in Jewish and non-Jewish anti-Semites. The majority of the patients had been brought up in middle or upper class

families; however, seven derived from a working class background. As to their social mobility, fourteen had maintained the parental level; nine had moved upward, and four downward. Fifteen patients were unmarried; of the eleven married patients, three were married a second, and one a third, time.

A fair sampling of the accusations heaped on 'the Jews' by these patients is the following. The Jews are dirty; they stink; they are vulgar, low class, debased, deformed, ugly, greedy, overaggressive, overbearing, noisy, and excitable. They exploit people and push them around. Yet, often, they are said to be intelligent, shrewd, ambitious, industrious, successful. They are social climbers. They are arrogant. They are superior, know too much, and are too ethical. They are either oversexed, or impotent. Socially, they are cohesive, powerful, wealthy, control Wall Street and the Government. They are also dirty Communists, internationally minded and unpatriotic.

We find evidence in our case studies for suggesting two distinct, though interacting, levels of dynamic correlation between anti-Semitic behavior and personality. First, there is the anti-Semite whose hostility to the Jews seems mainly the expression of social conformity to the attitude of the dominant group; this conformity, however, represents in part the patient's defense against anxiety. Second, there is the anti-Semite whose motivation for hostility to the Jews is patterned by some basic distortion in his own personality structure to which his anti-Semitism has a specific relation. Actually, all our cases represent a fusion, in varying proportion, of both levels of correlation. The first level illuminates the nature of the anti-Semitic reaction at the group psychological level of adaptation; the second, at the individual level of adaptation.

A comparison of the diagnoses of our patients leads to the first important insight gained through this study: anti-Semitism is *not* the concomitant of any single clinical category of personality. We find a considerable variety of clinical diagnoses. Because of the absence of a uniform terminology, the information in this respect is somewhat unsatisfactory. However, we

find a preponderance of character disorders, a smaller number of psychoneuroses, including four cases of obsessional neurosis, one case of paranoia, and a number of less precisely defined disturbances.

On the other hand, the evidence does suggest a negative correlation with one particular reaction, namely, depression. None of our patients suffered from a genuine, deep depression. While a few were described as having 'depressed' attitudes, the classical dynamics of oppressive guilt and self-blame were absent. In a few instances, the attack on the Jew seems to serve the dynamic purpose of offsetting a depressive tendency. The qualitative insight gained from the study of the cases leads us to believe that the absence of clinical depression in our material is more than an accident due to the limited number of cases. The existence of an anti-Semitic reaction presupposes a tendency to blame the outside world rather than one's self, and dynamically, such a tendency is in contradiction to the overtly self-destructive trend of a genuine depression. When the focus of hate is directed against the self, the basis for an externalization of aggression in anti-Semitism no longer exists.

While, in general, there is no correlation with the type of clinical diagnosis or specific symptom, there is a correlation between the quality of personality distortion and the quality of anti-Semitic behavior. The intensity and violence of anti-Semitic reactions will, of course, be in harmony with the degree of disturbance of a given personality. Thus, the crudest and most irrational forms of anti-Semitism have rightly been linked with psychopathic and paranoid personalities. Milder expressions of anti-Semitic attitudes occur in less sick personalities.

The common denominator underlying the anti-Semitic reaction in our cases is, thus, not a similarity of psychiatric symptoms, or total character structure, but rather the common presence of certain specific emotional dispositions. These trends are not in themselves specific for the production of anti-Semitism. They may as well be the dynamic basis for other

irrational group hostilities. Undoubtedly, they can exist without anti-Semitism. But in the culture in which our patients live, anti-Semitism does not develop without these character trends. They represent, therefore, an emotional predisposition, a necessary though not sufficient cause of anti-Semitism. In a different culture these character traits may be released in some other hostility reaction.

All the patients suffered from anxiety. The nature of the anxiety, to a great extent, was diffuse, pervasive, relatively unorganized; it was not adequately channelized through specific symptom formation. Generally, the anxiety was not experienced as a conscious dread, but manifested itself indirectly in varied forms of social discomfort and disability. The patients felt vaguely insecure, lonely, unhappy, confused, had difficulty in making friends and in establishing a satisfactory sex life, lacked a sense of direction, were vague and confused about life goals, were often unable to sustain a consistent interest in relationships and activities. Because of their inner weakness and negligible insight, the outer world seemed hostile, bad, menacing, inexplicably hard. They appeared unable to relate their difficulties in life to their personal deficiencies.

Such patients tend to live under continuous apprehension of injury to their integrity as individuals. They fear being overwhelmed by powers they are too weak to withstand. They have a wish to control, but lack the necessary strength. This wish is not realized in the normal channels of constructive social action, but instead seeks irrational outlets. Socially, economically, emotionally, and sexually, these patients are plagued by an exaggerated sense of vulnerability. They do not derive strength and emotional support from their identity as persons. They have a basically damaged self-esteem which, consciously, they endeavor to deny. At the unconscious level, they accept the damage to their personal identity as irreversible, and have little hope of repairing it. The general impression is one of weakness of personality organization, disordered self-image and, with this, an exaggerated sense of vulnerability to social injury.

Vital to the understanding of the anti-Semitic reaction is a knowledge of the concept which these patients have of themselves as individuals. The image of self is confused and unstable. There is concealed inner doubt and ambivalence. As one analyst put it, his patient just did not know how to regard herself. There is a submerged feeling of inferiority, weakness, dependence, and a tendency toward compulsive submission. The weakness, immaturity, doubt, and basic passivity of the self are rarely admitted to consciousness, however, although the patient continuously suffers from their manifestations. Hence the confusion of the self-image. The disadvantageous qualities of the self are denied, and an extreme effort is made to compensate for them.

One striking manifestation of the confusion of the self-image is the tendency toward homosexuality. While there are only two instances of overt homosexuality and one of bisexuality adaptation in our material, the fear of homosexual leanings plays a considerable rôle in many cases. Nevertheless, it would be erroneous to hypothesize a direct link between homosexuality and anti-Semitic attitudes. These are two separate products of one basic conflict, namely, the struggle against underlying passivity, which may or may not appear simultaneously. There are many other ways in which a confusion of the self-image is manifested by our patients. They react to the differences between their parents with insecurity and confusion. They react similarly to social groups which represent contrasting standards. They do not seem to know clearly who they are and where they belong. This basic uncertainty is dramatically reflected in the wavering, fickle quality of their group allegiances.

Some of the patients vacillate between feelings of superiority and inferiority; but the main trend is toward compensatory self-aggrandizement. They exploit their economic position and their pseudoidentification with dominant powerful groups for the reinforcement of such illusions. Nevertheless, even here there is an obvious contradiction between the conspicuousness

of their social anxiety and their alleged mastery of the environment. Often, the confusion of these patients is manifested in blatant inconsistencies between their actual rôle in life and their inner concept of self. An interesting sidelight on this confusion of the self-image is the finding that the confusion is greater among the professed liberals (ten cases) than among outright reactionaries.

The interpersonal relationships of these anti-Semitic personalities clearly reflect this deficiency. At the individual level, they have at best the capacity to achieve only a partial relationship which is continuously endangered by their overaggression against or overdependency on their partners. Repeated failures in social and personal contacts result in a subjective conviction of isolation. Often, they try desperately to overcome their loneliness by building simulacra of human ties.

At the group level, none of our patients achieve a strong identification. Overtly these patients wish to reap the rewards of social conformity, but unconsciously their fear of submission is too great and they struggle with intense feelings of destructive rebellion. It is the desire to appear like everybody else, rather than the achievement of genuine identification, which governs the striving of most of our patients. Frequently, we find them shifting from one group to another, overprotesting the strength of their temporary allegiance to this or that cause.

To persons beset by this conflict, people who are 'different' and, what is more, people who seem unwilling to wish to abandon their difference, are an eternal source of irritation. The Jews who appear to the anti-Semite as different from him in many ways, and yet alike among themselves, are uncanny because apparently they have the courage to be different and yet also succeed in being identified with a group. Thus, their very existence is a constant painful reminder of the emotional deficiencies in the anti-Semite.

The reality adaptation and the affective behavior of these patients show this same weakness. Their entire relation to

external objects seems impaired; their very perception of reality is vague, dull, and indefinitely formed. This drabness permeates the entire emotional life of the patients; the affective responses seem shallow, colorless, often quite constricted. The range of interests tends to be narrow. They have few significant and strong attachments to groups, persons, ideas, or even pastimes. They seem to lack definite conscious goals; more often, they seem vaguely concerned with impotent desires to restore some relationship to the world: there is no more concrete formulation of their aims than the wish 'to be happy'. In one sphere of their adaptation to reality, however, they seem to have the trappings of success; namely, in the pursuit of their economic activities. Only three out of our twenty-seven patients had actually suffered from serious inabilities in the work area. It is conceivable that the successful adaptation to reality in the work sphere is related to the outwardly directed orientation of their aggression.

Associated with this syndrome of pervasive anxiety, confused self-image, and partial failure at reality adaptation is another general trend: the disturbed function of conscience. In some cases, there is little evidence for the presence of genuine guilt feeling. Examples of this abound in our cases. There is the wealthy business man who cheats his newspaper dealer out of small change; the mother who neglects her child because she feels like going for a walk; the woman of forty who does not know whether to approve or disapprove of anything unless she first asks her mother, etc. The unmitigated hatred in adulthood of one or both parents is another such indication of deficient conscience.

In other cases, there is a definite guilt reaction which may be adequate in quantity, but is unreliable and fickle in quality. Some patients tend to equate the Jews with their own conscience, and oppose both. This was most clearly expressed in the case of one woman patient who had much personal contact both with Jews and with the Irish. 'The Irish', she said, 'want me to play and enjoy myself. The Jews want me to work, to be

serious and punctual.' Other patients equate the Jews with the uncontrolled release of primitive sexual and aggressive urges. They hate the Jews because they are loud, coarse, talk with their hands, and with undisguised animation. One patient, highly successful in a business career, hated the Jews for being shams and fakers who got into grand positions by unfair means. What she projected onto the Jews was exactly what her conscience blamed her for doing in her own career. She regarded herself as a fake in her extremely successful business life. The quality of fickleness of her conscience is demonstrated by the fact that she, nevertheless, continued to do what she thought one must not do. Another patient hated the Jews because they were untamed, overemotional, and ill-mannered. In such patients, an interesting question arises: is the quality of their conscience such that they must deny primitive sexual and aggressive urges per se, or do they have a secret, partial acceptance of such urges, but object violently only to an open display of them, because 'it isn't polite'. The evidence in many cases points to the latter conclusion. Such trends suggest an incompleted process of internalization of conscience. Psychoanalytic concepts indicate that in such persons the process of repression is defective. This is borne out by our evidence. The relative failure of repression necessitates the mobilization of other reinforcing defense reactions.

In this syndrome of anxiety, weakness, confusion, inner doubt, disordered self-image, and instability, anti-Semitism seems to play a functionally well-defined rôle. It is a defense against self-hate; it represents an effort to displace the self-destroying trends in the character structure outlined above. At the individual psychic level, the anti-Semitic hostility pattern can be viewed as an irrational effort to restore a crippled self, and at the group level as a device for achieving secondary emotional gain. The anti-Semite, unable to resolve or reconcile his conflicts, flees from the painful, insoluble dilemma into a preoccupation with external experience. He attempts to externalize his inner conflicts. He does this in the vain hope

of forestalling progressive destruction of precious parts of his ambiguous self. Such a defensive ego response inevitably entails significant shifts in the equilibrium of unconscious forces.

The central dynamisms around which the defense patterns cluster are the renunciation of parts of the patient's personal identity, the elimination of these unwanted parts through projection, and, parallel with this, the partial substitution of a borrowed identity through introjection. When, in the effort to assuage anxiety, certain aspects of the identity are disowned, there are immediate consequences. The more intense this effort, the greater is the inevitable damage to the integrity of the self. We have here a vicious cycle in which the effort to lessen anxiety in the end only creates more anxiety. Moreover, the ever-increasing tension leads to social situations which bring harm to the individual actually, not only in fantasy. Inevitably, the end result of this vicious cycle is increased damage to the self, and decreased capacity for coping with social reality.

Having submissively renounced parts of his own individuality, the anti-Semite feels deep resentment against anyone who does not do likewise. He demands that others conform in the same way. The demand for conformity is thus a further expression of the process of self-renunciation. Here lies the root of the previously mentioned excessive reaction to difference which characterizes our anti-Semitic patient. Every evidence of individuality in another person becomes a painful reminder of the sacrifice the prejudiced person has made in disowning parts of his self. The fear of the different is, hence, not in proportion to the extent of the objective, measurable differences; rather it grows in proportion to the implied ego threat. Thus, the difference comes to symbolize the fruitless suppression of self in the anti-Semite, the futile effort to achieve acceptance and security through compulsory obedience. It is understandable, therefore, that the prejudiced person should want to destroy the nonconformist. 'If only the Jews

behaved like everybody else'— this frequently heard remark, with its emphasis on conformity rather than on merits or demerits of behavior, clearly illuminates the resentment that is directed against the person who symbolizes difference.

In this connection, the fanatic fervor displayed by the anti-Semite in his effort to convert others to his own conviction becomes understandable as a compulsion to convert lest he himself be converted. He fears his own conversion as leading to passive submission to an authority figure with its symbolic threat of final destruction of self.

Closely allied with the process of renunciation of parts of the self is the mechanism of projection. Here, socially prohibited instinctive drives are displaced to external objects, thus forestalling unconscious guilt and fear of punishment from without. The content of the projection provides, therefore, a mirror of the unconscious conflicts with which the individual cannot adequately deal. Coincidentally, the patient attempts partial restitution for the disowned parts of self by way of building up a borrowed identity. The elements which are introjected and added to the partly fragmented identity are not so clearly discernible as those which have been projected. Self-renunciation and projection play a central part in molding the content of the final anti-Semitic reaction; in addition, their influence permeates the quality of all the other defenses.

At this point, we wish to discuss the operation of auxiliary defenses which, in general, are relatively crude and tend to operate in an all-or-none way. Since renunciation and projection operate as incomplete processes, these patients are forced to fall back upon conscious or preconscious denial of socially reprehensible and disadvantageous tendencies. Qualities of weakness, inferiority, passivity, are all denied. But denial, too, is inefficient. One patient tried all his life to deny emotions because they produced anxiety and increased his sense of vulnerability. He accused the Jews of being overemotional. Other patients try to deny to consciousness their fear of competition and fear of failure; they accuse the Jews of being too ambitious and too pushing.

In place of subjectively admitted anxiety, these patients substitute a pattern of social aggression. They persistently seek a dominant position from which they can intimidate others rather than allow awareness of their own fear. Thus they strive continuously to substitute an active rôle for a passive one in interpersonal relations. Since they cannot ever escape the inherent weakness of their character, they endeavor to preserve the efficacy of their defenses by avoiding situations in which they must be aware of anxiety. In one extreme case, a patient tended to reduce contact with current society to a minimum; he despised not only himself but the entire century, and retreated into an idealization of the eighteenth century. In another case, a highly successful broker had only one wish—to withdraw; he wished to retire as soon as possible; reduce contacts with people. Many patients shun personal contacts with Jews as far as possible. One patient gave vent to his violent anti-Semitic feelings only in analysis because he dreaded the vengeance of Jews.

The tendency to avoid is closely associated with the tendency to oppose. These people are not only against the Jew; they are against themselves and everyone else. They are notoriously 'against'. The reliance on attitudes of both avoidance and opposition subserves the primary defense pattern of substituting aggression for anxiety. Another mechanism frequently employed by these patients is the development of compensations for intrinsic deficiencies. In denying dependence, submissiveness, and inferiority, they assert a pseudo strength, pseudo self-sufficiency and maturity, and a false superiority. Frequent in our evidence are compensations in the direction of emphasis on external appearance and class snobbery. The patients give exaggerated attention to their clothes; the women long for glamour; they are concerned with belonging to the 'best society' etc. The obvious aim of these compensatory drives is to achieve power, money, privileges, and recognition.

An extension of these efforts lies in the patients' attempts to affiliate with dominant groups. Actually, some of the patients are social outcasts. All of them are lonely and isolated, even

when they have a number of surface contacts. The degree of their awareness of such isolation varies. Mostly, they try to deny it, and therefore make frantic efforts to achieve compensatory attachment to groups. The weaker their capacity for real human ties, the greater this effort to achieve compensatory identification with individuals or groups. More often than not, the pretense of belonging substitutes for true group membership. In this futile attempt to achieve acceptance, they are driven to slavish imitation of habits and ideas manifested by those who represent cohesive power. In many cases, this need to conform expresses itself in the imitation of anti-Semitic patterns in the community.

Another form of defense to which these patients resort is reaction-formation. In some social situations, they are overaggressive, gathering courage from the group to which they have temporarily attached themselves. In others, when it is to their advantage to curry favor, they show marked ingratiating and submissive attitudes. Their aggressive patterns are inconsistent. They may attack the Jew if they see him as weak and defenseless. On the other hand, when seeking social gain, they have no reluctance to ingratiate themselves with Jews who seem to hold positions of power or social superiority. Here they speak of doing business with a 'white Jew'. This in no way influences their usual urge to castigate Jews as a group.

Other reaction formations discernible in these patients are the substitution of conscious attitudes of righteousness and martyrdom for basic cruelty. The contrasting attitudes are also seen: overt cruelty takes the place of righteousness; often, an excessive identification with the underdog occurs as a reaction to sadistic tendencies. With this is associated exaggerated reactions of pity. In some patients, a false magnanimity is substituted for an inability to love, to give to anyone. Again, one sees the assumption of exaggerated attitudes of protectiveness to cover basic hostility; as, for example, in the case of the man who controlled his hostility to his parents and authority by becoming a prison worker.

The motivation toward secondary gain in these patients asserts itself most strongly. Superimposed on the basic defenses which these patients use in an effort to repair the damage and weakness of their personalities, there is a conspicuous exploitive drive for secondary emotional gain and social advantage. They seek attention, flattery, security in dependent situations; they dramatize their hurts in order to play the martyred rôle, to receive compensation or pity. They exhibit themselves, put a great stress on form rather than substance, and demand all the social advantages of adhering to conventional forms. And they are not above using their anti-Semitism to steal a rival's job.

The study of these mechanisms of self-defense in any individual takes its clue from the specific content of the anti-Semitic manifestation. In the content of the projection the link between an individual's attitude toward his conflicts and his accusation against the Jews becomes most visible. While these mechanisms are probably mobilized in all forms of irrational group hostilities, the relative specificity of the anti-Semitic pattern can be discerned in the elements of Jewish symbolism selected for projection. The mechanism of projection itself implies a previous deficiency of contact with reality and then a compensatory effort to restore contact. This mechanism seems to be necessary, in some degree, for the production of anti-Semitism.

The negative stereotype of the Jew that has been developed in the Christian era is particularly suitable as a projective screen because it is highly elaborated and highly inconsistent. Culturally, the Jew is described both as successful and as low class; as capitalist and as communist; as clannish and as intruder into other people's society; as the personification of high moral and spiritual standards and as given to low, primitive drives like greed and dirt; as oversexed and as impotent; as male and as female; as strong and as weak; as magically omnipotent and omniscient, possessing uncanny demoniacal powers or as being incredibly helpless, defenseless, and, therefore, readily destroyed.

The specific selection that an individual makes out of this wealth of contrasting attributes can be understood only if this selection is discussed simultaneously with the individual anti-Semite's attitude toward his own self. Invariably, we find in our cases that what is irrationally projected onto the Jew represents specific unwelcome components of the self or components envied in others. It is important to remember here that these partial rejections of the self are the result of ambivalence and conflict, in order to understand that in the deepest layers of the personality one often finds a lingering acceptance of just these attributes. Hence the frequent discovery that the conscious rejection of the Jew is often paralleled in the unconscious by a strong positive identification with him. The ambivalence of anti-Semites toward Jews is notorious. Thus, in one case a patient witnessed, as a child, the beating of a Jewish boy and felt in watching the scene that he was like that Jewish child. From that incident emerged his ultimate violent hostility towards Jews.

The deep-seated identification with the Jew's symbolic weakness, his crippled, castrated state and his subordinated, defenseless position, is denied because of its danger to the integrity of the individual's self and to his social position; in its place there is substituted an identification with the attacker, in order to avoid being victimized and also to draw strength from the identification. Thus, the Jew, at one and the same time, stands for the weakness or the strength of the self; for conscience, which reproaches the self for its deficiencies and badness, and also for those primitive, forbidden appetites and aggressions which must be denied as the price of social acceptance.

We have described in cross section those character trends which seem relevant to the production of the final anti-Semitic reaction. We shall attempt now to delineate the genetic patterns which underlie these character trends. One qualification is necessary, however. It is especially difficult, in psychoanalytic case histories, to correlate genetic development with

the social factors which may have contributed to anti-Semitic hostility. For this reason, we wish to be cautious in arriving at generalizations.

In scrutinizing the psychological atmosphere into which the potential anti-Semite is born, a striking similarity between cases prevails: we have not a single example of a permanently well-adjusted marital relationship between the parents. In about half the cases, the parental relationship, superficially viewed, is a respectable one. In its external aspects, the parental relationship conforms to conventional standards. Basically, however, there is no real warmth, affection, or sympathy between the parents. There is no essential closeness; the parents have detached attitudes. The sexual adaptation between the parents, where we have evidence, is poor.

A sharp contrast between the parents as individuals is the general rule. There are marked differences between mother and father in temperament, social values, sexual attitudes, and feelings toward the children. These differences are often emphasized by discrepancies in ethnic origin, social and religious background. Even where the parents maintain the surface appearance of a good relationship, the fundamental hostility between them is obvious. More often than not, this hostility is not expressed directly, but may be displaced against a child or is diverted into other channels. In the parental configuration, there is usually a contrast of aggressive patterns. One parent is dominant, overaggressive; the other is weak, submissive, masochistic.

The experience of rejection by one or both parents is common in our cases. Most frequently, the rejection is overt. In several cases, it is implicit in the narcissistic exploitation of the child. The effect on the child is clear: it feels unwanted, unloved, unworthy. Perhaps these effects are exaggerated because of the basically hostile relationship between the parents. In any event, there is deep damage to the self-esteem and confidence of the child. In this emotional context, there is a fixation of passive, dependent needs, and the related aggres-

sion. Both dependent wishes and aggression are repressed because of fear of the parents.

Usually, both parents are authoritarian: in most cases, discipline is severe and rigid, often enforced by brutal beatings. Indulgent attitudes toward the child are not common and certainly not consistent. Acceptance of the child is conditioned on conforming behavior. On this background, the rejected or exploited child learns early a pattern of pretense. The child assumes an overtly submissive attitude, beneath which rebellion and hostility continue to smolder. The pent-up aggression can only be released through displacement. In some cases, the aggression is clearly displaced from the parent into the sibling situation.

In several cases, the fixation of anal character traits can be traced back clearly to severe, early toilet training which was made a test of the parents' approval and affection. There are numerous other illustrations of parental coercion of the child—arbitrary imposition of certain forms of play, or forcing the child to become a musician in order to fulfil its parents' life dream. This compels the child to be as the parents demand, but does not permit the child to be itself. Thus, the first stone is laid toward the development of an identity conflict. It also reinforces a pattern of surface compliance, covering an underlying destructive rebellion; it stimulates chronic ambivalence and, with it, sado-masochistic and self-degrading tendencies. At this stage, the attitude toward toilet activities and dirt, as conditioned by the parent, colors the later sexual patterns.

Thus, the precœdipal experiences of our patients fixate a basic passivity, while the corresponding aggression is repressed. This passivity, and the associated ambivalence presents a strong hindrance to healthy œdipal development, reinforces castration anxiety, and provides the matrix for sexual confusion and homoerotic leaning.

The œdipal conflict into which the child enters is intense, characterized by confusion and fear, and is never fully resolved.

The process of identification with the parents is seriously distorted; the incorporation of parental images into the internal conscience often remains incomplete and variously deformed. The patient's self-image, particularly his sexual identity, is confused. Ambivalence, already strongly activated by pregenital conditioning, is reinforced by the œdipal conflict.

The process of identification with the parents is further complicated by the contradiction between the surface respectability of their relationship, and the basic hostility and mutual rejection between them. The child intuitively senses this hate, and attaches to it the frequent sharp differences between the parents. The child's fear of passive submission to either parent impedes the process of identification. Often the child begins by making a partial identification with the weaker parent, who represents, if not the kinder, at least the less menacing of the two. In many instances, this is the father, the mother being the dominant parent. The identification with the weaker parent, however, reinforces the child's exposure to the destructive hate of the stronger parent, more frequently the mother. Because of this danger, and because of the great need for the protection of a strong parent, the child tends, defensively, to renounce identification with the weaker parent and to strive for an exaggerated identification with the more aggressive parent (identification with the enemy). Under such circumstances, of course, there can be at best only a partial, ambivalent identification with the stronger parent. As a result, the patient withdraws; the identification remains incomplete and distorted with both parents. This produces a lifelong indecisiveness and confusion as to sexual identity; the patient gives his wholehearted allegiance neither to father nor mother, and, correspondingly, neither to male nor female attributes.

Such distortion of the processes of identification results in an incomplete conscience development. While guilt reactions quantitatively may be intense, the internalized standards of right and wrong remain vague and unstable in quality. More-

over, punishment is perceived largely as coming from without rather than from within. This is associated with a considerable tendency to project hated qualities of self in order to provide a basis for an extensive denial of guilt.

In many cases, one sees a clear, dynamic parallel between the patient's attitude to a parent and the specific meaning of the anti-Semitism. The hatred for 'the Jew' is often identical in content with the hatred for one of the parents, or identical with the hatred of one parent for the other. In the unconscious, Jewishness is sometimes equated with the image of an aggressive, domineering mother. In other cases, it may be symbolized in the father. In one instance, a young Nazi hated the Jews and his father for identical reasons: they and his father were 'more successful, more clever, more sexually potent' than he. This link between the unresolved œdipal conflict and the development and content of anti-Semitic attitudes is often striking. It becomes most visible, of course, in the cases of Jewish or half-Jewish parents. One is tempted, on the basis of these observations, to speculate that conflict between male and female, between mother and father, becomes later symbolized as conflict between Jew and Gentile. There is, of course, a common dynamic factor between prejudice against Jews and against women.

Castration anxiety is exaggerated in these patients. The accidental presence of a physical defect in several patients lends the illusion of reality to the castration threat. This often leads to either a strong pro-Semitic or a strong anti-Semitic attitude. Allegedly unattractive physical characteristics of Jews, especially circumcision, reinforce the ambivalence of the reaction. Thus, the Jews are seen as the underdog, as ugly and crippled people. The anti-Semite's unconscious identification with the Jew is such a profound threat that it must be emphatically denied and a defensive identification with the attacker results. So much for the intrapsychic development of our patients.

As indicated before, our information concerning external

factors conducive to anti-Semitism is far from complete. Nevertheless, some relevant questions can, at least, be raised and partially answered. The most obvious of these questions is whether any real life experiences have brought out into the open the anti-Semitic attitudes of the patients. Especially, one would like to know what rôle any real contact with Jews may have played in the development of such attitudes. This has obvious relevance in connection with the observed fact that some Jews masochistically invite attack.

Our material reveals that there is no clear or simple correlation between the development of anti-Semitism and actual contact with Jews. In some cases, there was apparently no contact at all until adulthood, and then the contacts were of a superficial nature (meeting Jews in stores, in business, in the subway, etc.) In other cases, the contact was of a decidedly positive nature. One patient, who was somewhat neglected by his parents in childhood, enjoyed the warm friendship of a Jewish family who gave him delicious food and all the warmth and affection for which he longed; another patient had a Jewish friend who helped him out of trouble when he was in a tough spot in his career. The quality of such contacts does influence the particular dynamic content of an individual's anti-Semitic attitudes. But it would be entirely unjustified to hypothesize a direct cause and effect link between anti-Semitism and pleasant or unpleasant contacts with Jews.

Our data showed also that there is no simple relation between the existence of anti-Semitic attitudes in the parents and in the children. In a number of cases, the patients' parents showed no sign of anti-Semitism; the parents of other patients even felt strongly pro-Semitic. Obviously, anti-Semitism is not merely passed from one generation to the next, as is sometimes assumed. The relationship between prejudiced parents and prejudiced children must be regarded as a function of the dynamic outcome of the œdipal development and the vicissitudes of identification. Thus the entire evidence we have presented in this paper leads us to believe that anti-Semitism,

like all other group hostilities, presents a reflection of a conflict in the prejudiced person, and not a rational reaction to the external world.

The pattern of character weaknesses, especially confusion in personal identity, which we have found in these anti-Semitic patients, tempts one to speculate about the mass success of anti-Semitic propaganda. It appears understandable, in the light of our study, that persons with such character weaknesses manifest a peculiar susceptibility to group pressures and propaganda. They accept them as crutches which fit their needs. Propaganda against prejudice has less effect upon them, because there is little gratification in it for those whose need is to hate.

The character weaknesses that we have outlined seem to get powerful support from certain established value trends in our society. These patients seem to have assimilated into their personality structure those social patterns which constitute the symptoms of the social pathology of our times.

In a broader social frame, anti-Semitism can profitably be viewed as the result of the mutual impact of two irrational patterns: the irrational conflict of the anti-Semite, which we have described, in his unsuccessful effort to find a definite and safe place in our society; and what we may justifiably assume to be the similar irrational conflict of the Jew who also tries, and also fails, in the same effort.

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Freud: His Life and His Mind. By Helen Walker Puner. New York: Howell, Soskin, Publishers, 1947. 360 pp.

Fritz Wittels

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BOOK REVIEWS

FREUD: HIS LIFE AND HIS MIND. By Helen Walker Puner. New York: Howell, Soskin, Publishers, 1947. 360 pp.

DOCTOR FREUD: By Emil Ludwig. New York: Hellman, Williams & Co., 1947. 317 pp.

Seldom has a life lent itself less to gossipy biography than Freud's. This was as true during his lifetime, when reporters had to leave his house without having secured hoped for interviews, as it is true now, almost ten years after his death.

Miss Puner's book is quite 'readable', she quotes Freud extensively, but whether writing his words or her own, she evidences an ambivalence which induces her to tear down a man she obviously admires. Even so, Miss Puner might not have failed were it not for her desperate search for 'news' in the events of Freud's life. Since there is almost none she exaggerates the bits she thinks she has found like the 'colorful' fact that a butcher had his shop just below Freud's office; then, since the greatness of her subject is beyond her, she proceeds to a superficial, often misleading, description of Freud's doctrine and, feeling that this could hardly be called biography, she adds her own opinion of the motives which are supposed to have guided Freud throughout his life.

We are told in the preface that 'it is apparent from the vantage point of nearly half a century that the weapons used by Freud in his courageous search for universal truth are almost as antiquated as the blunderbuss or the javelin'. Unfortunately, the author fails to validate her astonishing statement by any mention of just what has replaced psychoanalysis. Miss Puner's judgment that 'Freud was equipped with a faith in reason and an array of scientific ideas now largely outmoded' seems to be the result of interviews with superior spirits in New York and in Washington. One is reminded of Herodotus in Egypt, told tall tales by wily priests with deliberate intent to delude.

The best section of the book is about Freud's early years in his birthplace and in Vienna. The bulk of Miss Puner's description of Vienna is not particularly profound. It is a Hollywood's-eye-view with emphasis on Francis Joseph, *Schlagobers* and Johann Strauss. In this part she is at least on fairly safe ground, not yet

involved in her hopeless boxing match with a heavyweight. As she proceeds, her theories culminate in several astonishing conclusions. One of them is that Freud resented being a Jew and all his life harbored a fervent desire to be a gentile. For this she finds proof in Freud's dreams, in his repeated journeys to Rome, the papal city, and finally in his attempt to prove that Moses, generally considered the founder of Judaism, was not a Jew but an Egyptian. One need scarcely say in rebuttal, that we have more than one unequivocal declaration on this point from Freud himself.[1]

Another of Miss Puner's pet theories is that Freud, although living an exemplary family life with his wife and his six children whom he dearly loved, was in reality deeply dissatisfied with his wife because she was intellectually far beneath him. Mrs. Martha Freud is still alive, and I question the author's taste in so referring to the aged lady to whom the world owes so much. Anybody who had the privilege of knowing Freud's household was impressed by the loving care which made possible a tranquil life for this indefatigable intellectual laborer. Miss Puner's statement is made in the complete absence of any proof: about this, as about her other theories, there is not even any gossip. Anyone personally acquainted with Freud and his wife could have informed the author of the absurdity of her fantasy. One feels strongly that Miss Puner *needed* to have Freud an unhappy man, who failed in his private life just as he failed (according to this erudite biographer) in the world of science.

Many of the biographical data have been taken from writings which Freud published to illustrate his theories of dream and

[1] Freud's address to the Jewish Free Mason Lodge B'nai B'rith on the occasion of his seventieth birthday: 'My tie to Judaism—I have to admit it—was neither faith nor national pride. I was always an infidel, brought up without religion—although not without respect for the "ethical demands of civilization"; and I was always careful to suppress any tendency I might feel to exalt the Jews as a nation, for I considered the nations among whom we Jews were living as so many warning examples. Enough, however, was left in me to make the attraction of Judaism and the Jews irresistible; many obscure feelings which were all the more powerful for being inexpressible in words, clear intuitions of inner identity, the mystery of the same psychic frame.

'Moreover, I came to feel that I owed to my being a Jew the two characteristics which I found indispensable in my hard course through life: because I was a Jew, I felt free of many of the prejudices which limit some other persons in the use of their intellect, and being a Jew I was prepared to be in opposition, and to renounce agreement with the "compact majority".'

parapraxis. It is, of course, not known to laymen how little a dream idea, as a rule hidden behind the manifest dream, lends itself to valid conclusions about the dreamer's actual character, particularly if it is not set in the proper context and not completely interpreted. The dream is biased in favor of id or superego. That which is decisive about a man's nature, the ego, which understands and handles reality, is almost silenced in dreams. A man who dreams of killing his neighbor, of childish ambitions, of betraying his best friend, or of prostitutes cannot be denounced as a murderer, a fraud, or a philanderer. He may be far from an evildoer, and most probably is, because the dream acts as an outlet. Nor should we call him a saint when his dreams, in which he loves his enemies, sacrifices himself for his friends or for a cause, or dies for *l'amour unique,* are of the opposite character. A biographer who wishes to be taken seriously must be very wary—as Miss Puner has not been—in using dreams as factual sources, particularly dreams which are presented by a scientist exclusively for didactic reasons.

Finally the main weakness of the book is due to still other reasons. It is too early—and too late—to write Freud's biography. Freud wrote thousands of letters which are still scattered in many hands. Some will be published soon, others not for decades. Not only has Miss Puner neglected to collect a body of Freud's letters, she has not quoted a single one of them. As she was never in personal contact with Freud she knows nothing of two of his finest qualities: his unique sense of humor, and his elegance and princely dignity. Those who could tell her have apparently been unwilling to do so. Let us hope that some of them have made notes which they will leave behind them; for twenty or more years after the death of his contemporaries it may be possible to gain the proper perspective of this colossus.

If it can be said for Miss Puner's book that although objectionable it is the result of hard work and shows at least some attempt to understand, for Emil Ludwig's 'biography', published at about the same time, one can say nothing of the kind. Emil Ludwig, well known as the biographer of numerous men who were likely to bring a book-buying response from the reading public, has chosen to attack Freud, his doctrine, and his pupils. Ludwig's psychological understanding has never permitted him to progress beyond

the popular conception of the inferiority complex in his subjects. It was natural for him, for example, to explain the Kaiser's personality by reference to one of his arms which was injured at birth and later atrophied. Ludwig must have some good reason of his own for making this attack on Freud.[2]

[2] We quote, in part, a personal communication to Dr. Philip R. Lehrman written to him by Mr. Henry Himmell on this subject (Ed.).

'To say that Emil Ludwig has little, if any, "experiential" knowledge of psychoanalysis would not be reading my own opinion into his book, for Ludwig himself says: "But neither before nor after the one visit [with Freud] had I anything to do with him, nor personally with any of his disciples and opponents" (p. 271). This is probably not the perfect path for a friend of psychoanalysis to take, but . . . Ludwig is not a friend of Freud or psychoanalysis and is more content with writing a diatribe than an appreciation. However, when Ludwig continues . . . "None of them [Freud, disciples, opponents] ever *wrote* anything against me", I think he is mistaken. As a matter of fact . . . Freud himself [did] . . . on page 94 of New Introductory Lectures on Psychoanalysis (New York: W. W. Norton & Co., Inc., 1933) as follows: "Seeing that the inferiority complex has become so popular, I shall venture to treat you to a short digression. A historical personage of our own time, who is still living but who for the present has retired into the background, suffers from the maldevelopment of a limb caused by an injury at birth. A very well-known contemporary writer who has a predilection for writing the biographies of famous persons, has dealt with the life of the man to whom I am referring. Now if one is writing a biography, it is naturally very difficult to suppress the urge for psychological understanding. The author has therefore made an attempt to build up the whole development of his hero's character on the basis of a sense of inferiority, which was caused by his physical defect. While doing this he has overlooked a small but not unimportant fact. It is usual for mothers to whom fate has given a sickly or otherwise defective child to try to compensate for this unfair handicap with an extra amount of love. In the case we are speaking of, the proud mother behaved quite differently; she withdrew her love from the child on account of his disability. When the child grew up into a man of great power, he proved beyond all doubt by his behavior that he had never forgiven his mother. If you will bear in mind the importance of mother-love for the mental life of the child, you will be able to make the necessary correction in the inferiority-theory of the biographer."

'In my opinion the above quotation was written about Emil Ludwig and his biography of Kaiser Wilhelm II, and I also venture to predict that Ludwig knows it. What prompted so violent an attack on Freud I leave to you analysts. For myself it is difficult to conceive of Emil Ludwig as a real opponent of psychoanalysis, for if he were one, why would he try painstakingly to analyze Freud in the latter part of his book. I somehow cannot elude the impression that Ludwig considers himself a better scientist than Freud. That—I would rather leave to history.'

It is grotesquely late in the day to say that Freud 'based everything on sex' and further to lament about it in a hypocritical Victorian way. Freud is ruining the virgins of the West and Ludwig is the St. George who slays the dragon. He has already, he proclaims, 'debunked' Richard Wagner, and now he will unmask Freud.

Ludwig does not know that Freud's approach to Leonardo, Goethe, Dostoevski and Moses is purely psychoanalytic—which means that it is not aimed primarily at providing an understanding of the artistic achievement of these great creators. The psychoanalytic approach contributes no more than an insight into the mechanisms at work in the psychic apparatus; this insight may, secondarily, help provide a better understanding of the dynamics of artistic achievement. All analysts know this, but Ludwig fights the analytic approach as he would fight the fires of hell and instead of killing his own evil instincts by means of a personal analysis he tries to kill the method that might have saved him and made his work valuable. In a hodge-podge of some three hundred pages he tries to prove that Freud was 'confused'. Ludwig's book is boring and has justly been called 'disingenuous and vulgar'.

FRITZ WITTELS (NEW YORK)

SEXUAL BEHAVIOR IN THE HUMAN MALE. By Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin. Philadelphia and London: W. B. Saunders Co., 1948. 804 pp.

This is a profoundly important book and warrants the closest attention of all those directly concerned with the psychological and social well-being of man. The book is a compendium of raw data collected and classified under special conditions and from special points of view despite the authors' implication or perhaps conviction that this study consists of 'data about sex which would represent an accumulation of scientific fact completely divorced from questions of moral value and social custom'. The possibility of excluding these considerations in a systematic way in any interpersonal relationship (the operational method by which these data were obtained) is incredible on both logical and psychological grounds.

Furthermore, the closest attention will be essential if the data are to be incorporated into the moral values and social customs

from which they have been allegedly divorced. This caution is recommended to those for whom, according to the publishers, this book is primarily intended; 'workers in the field of medicine, biology, psychology, sociology, anthropology and allied sciences and for teachers, social workers, personnel officers, law enforcement groups, and others concerned with the direction of human behavior'. These individuals will, perforce, need to be equipped with a scientific knowledge of the interrelation and interdependence of sexuality with other and fundamentally limiting determinants of human behavior. It is this consideration that has been excluded generally from the study under review in a perhaps laudable effort to isolate the variable of sexual behavior for more precise observation. Unfortunately, biological and psychological dynamic processes often do not tolerate this arbitrary rupture, when the information thus obtained is intended to be used to influence the processes themselves; hence, a reiteration of caution to the groups toward whom the book is projected.

The privilege of reviewing a book for a journal devoted to psychoanalysis often poses special problems. When the subject is limited to an aspect of our special science and point of view, the commentator deals with the book from the narrow perspective in which he can speak authoritatively. However, as in the present case, the problem is not only to view the book as it relates to psychoanalysis in its narrower aspects (theory, therapy, and technique), but also in the broader sense (psychoanalysis applied to sociology, economics, political science), in fact, every aspect of summated social behavior. Moreover, attention must be paid to the way in which psychoanalytic principles have been dealt with.

This first report by Kinsey, Pomeroy and Martin is part of a monumental project 'of obtaining data about sex which would represent an accumulation of scientific fact'. The authors used a questionnaire-interview technique which developed both from the objectives of the research and as a result of experiences obtained in the course of the interviews. An effort was made to achieve a qualitative cross section of the male population using social, economic, occupational, religious, educational and other criteria for differentiation. As observed by others, the sampling method did not represent the quantitative distribution of males according to their proportions in our population. Whether this remains a

systematic error for which a kind of correction factor must be devised, is a matter for the statisticians. At any rate, at the present time it stands supreme as a statistical report on the genitosexual activity of the human male.

As with any pioneer and original research, revisions of the points of view and operational concepts will necessarily result from the critical analysis of the data and the conclusions drawn therefrom. For example, psychoanalytic psychology has demonstrated beyond question that the description of sexual behavior involves much more than the detailing of organic and manifest phenomena. It is precisely in this fact that there lies one of the gross defects of this book. The authors have not availed themselves of a systematization of the structure and functions of the psychic apparatus without which there would not have been any conception of 'sexual behavior'.

The concepts of drives, their aims and objects, their genetic development and transformations, their interaction with both internal and external environmental factors, and above all, their psychic representations (of which overt activity is only one aspect), provide the framework in which the data on the Sexual Behavior in the Human Male could have been systematically arranged. Instead, there is a discussion of 'normal' and 'abnormal' based on statistical majorities, as though the various subjects interviewed had cast votes for their sexual preferences. The concept of 'normal' is not a matter of majority preference or the result of the practices of the greater over the lesser. This is a static view in direct defiance of the fact that history, sociology, anthropology and biology have demonstrated qualitative changes in preferences and practices from the beginning of mankind. In fact, every current scientific formulation of developmental processes takes into account the dynamisms which bring about transformations and shifts in forms and functions, for example, Darwinism, thermodynamics and psychoanalysis. In other words, the analysis of behavior of any kind requires both a longitudinal as well as a cross-sectional approach. The work of Kinsey and his collaborators, is only an aspect of sexual behavior as it is at the present time. The integration of this cross section requires an hypothesis, a formulation, or else it becomes an additional dissociated body of observations. Perhaps these points could be well illustrated by examining the history of medicine. As long

as one hundred fifty years ago, any manifestation of physical disability, that is, every symptom, was designated as a disease. It was not until the concept of modern pathogenesis (based on the interaction of constitutional, developmental and adaptive mechanisms) that it was realized that apparently unrelated phenomena of disease could be associated in a simple way into systematic constellations. From these points of view, The Sexual Behavior in the Human Male is methodologically archaic, as far as the data on sexual behavior are concerned.

To return to what has been designated as the narrower point of view of psychoanalysis, it is apparent that this book must be evaluated in the light of the history, theory, technique and therapy. Just as psychoanalysis became possible as a result of the confluence of biology, psychology, physics, medicine and sociology, so too does the Sexual Behavior in the Human Male have certain preconditions. Outstanding amongst these, of course, is psychoanalysis, some of whose contributions have become so well known as to be included preconsciously or consciously in any study of human behavior. Most important is the fact that the psychoanalytic approach to the emotional life of man brought the subject of sexuality in its generic and specific implications into psychology.

It is gratifying that an independent approach using other technological devices, like statistics, confirms what has been phenomenologically known to psychoanalysis almost from its beginning. The problems frequently confronting investigators in fields subject to psychoanalytic examination are those of validation of psychoanalytic hypotheses and of formulating what constitutes evidence of such validation. In general, these problems are approached on two levels. One is phenomenological and is subject to statistical analysis and verification. The second is much more complicated and is based on an effort to show that the hypotheses of psychoanalysis which are based on empirical observations, are analogous to those of the physical sciences. The assumption, or more correctly, the prejudice often underlying this attempt, is that psychoanalysis necessarily stands or falls according to the degree with which its formulations conform to those of the disciplines which are being used for comparison. This is an especially subtle destructive device. No scientist working responsibly with dynamic methods would deny for a moment that a given body of data can bring

about changes in the systematization of data in the discipline which is being used as the framework for viewing the material under examination. Outstanding examples of this process, of course, are observable in the interaction of physics, chemistry and biology. In other words, psychoanalytic hypotheses which are not subject to validation by the methodologic approach just described should rationally compel the process to go in the other direction, i.e., a critical examination of the instrument which has failed to demonstrate the looked for correlation. This has already happened in medicine through the development of psychosomatic medicine.

Kinsey demonstrates this type of error. He reports statistics, admittedly confirming the *manifestations* of infantile sexuality, but rejects the concept of pregenital sexuality by stating there is no evidence for it—as if this evidence were accessible to the same interview technique that demonstrated the infantile sexuality. It is because the psychic representation of infantile sexuality was not considered that the information on pregenital sexuality failed to come to light in the investigation.

Much of the data, the points of view and conclusions expressed in the book are subject to critical psychoanalytic appraisal. However, because of limitations of space this review is confined to methodological considerations for the most part, and with some specific psychoanalytic issues of which only a few can be illustratively discussed.

Under the topical heading, Low Frequencies and Sublimation, the psychoanalytic concept *sublimation* is discussed and given a definition ascribed to psychoanalysis which 'implies that it is possible for an individual to divert his sexual energies to such higher levels of activity as art, literature, science, and other socially more acceptable channels'. The fact is that 'sexual energies' are not defined by Kinsey and therefore it is not known whether instinct-libido energy systems are meant. Moreover, no responsible psychoanalyst would so define 'sublimation' regardless of his objective opinion as to its validity. At any rate, it is apparent that Kinsey uses the term in the sense of substitution for, inhibition of—in fact, any damming up of what is referred to as 'sexual outlets'. He misses completely the meaning of desexualization, the broad implications of libido and instinct theory, the rôle of defense mechanisms, and above all a concept of the unconscious.

Of considerable importance are the remarks on the erogenous properties of female genitalia. The authors came to the conclusion that there is no difference between clitoral and vaginal orgasm, should there be such a phenomenon as the latter. In particular, they state this 'unfounded' opinion, that there is such a difference, is widespread among psychiatrists. This conception of female sexuality is, of course, due to the failure to acknowledge the psychobiological and genetic determinants of erogenous zones, a specific contribution of psychoanalysis to the understanding of the sexual behavior in the human female. In this connection, notable in the bibliography appended to the report, is the omission of the monograph on frigidity by Hitschmann and Bergler.

This report has had a general public distribution and sale. As a result many individuals who are in analysis have read it. Their reactions may throw some light on the nature of the impact of this book on the general public. To some extent, Kinsey and his collaborators have become authorities for the permissive part of the superego, thus removing restrictions on action, thought and speech with regard to some sexual practices previously prohibited. Others, on the other hand, found their reaction-formations reinforced by the book, and condemned it as a form of pornography, though at the same time regarding themselves as 'strong' enough to withstand practices which appear to have a mass indulgence and therefore are justified. For still others, Dr. Kinsey is a seductive teacher with parental authority. In particular, latent or overt exhibitionistic and voyeuristic fantasies were provoked which showed many polymorphous-perverse features. In other words, the book and its contents aroused the characteristic ego defenses against facilitation of unconscious impulses on the one hand, and against a threatening realignment of passive and aggressive forces in the superego on the other. All these conflicts were played out in a setting of considerable social anxiety. Moreover, the preoccupation with the book in social situations had very much the character of a repetition compulsion, i.e., an effort to master the anxieties aroused by reiterated discussion.

These observations lead to some speculations about the data and the methods by which these were procured. It is not improbable that the individuals interviewed displayed the same and probably other patterns of response to the interviewers as the patients in analysis. That is, facilitation of confession and exposure may

have been achieved in some, and reaction-formation and withdrawal in others. For example, it is well known to psychoanalysts that the clinical anamnesis obtained in the consulting interview often differs markedly from that evolved in the course of analysis, as repressions are lifted and the transference reactions achieve full play. As a result, the analyst is often compelled to interpret the patients' productions, in order to formulate the interrelation between the historical facts and the combined psychological and environmental circumstances that determined them. Moreover, even the clinical anamnesis is enormously influenced by both the fantasy life of the subject, and by the scientific insights and countertransference responses of the analyst. I agree wholeheartedly with those who feel that a valuable and instructive verification of a given subject's replies to the questionnaire would follow if he were subsequently analyzed.

However, these comments are in no way intended to minimize the extraordinary skill and sensitivity with which these interviews were apparently conducted. The profusion of the data is a tribute to both the personalities and the technique of the questioners. Here again, the psychoanalytic observation post, had it been occupied, would have yielded information on the science of interviewing. Instead, we see the incommunicable aspects of that art developed to the highest degree.

Attention is called to the correlation of sexual behavior with certain socioeconomic circumstances. Are the terms 'rural' and 'urban' used to designate economic status or a way of life besides? We all know that the rural and urban population is constantly shifting not only in absolute numbers but also in terms of the individuals and their backgrounds on whom this ratio is based. The fact that sexual behavior varies to some extent with social, economic, biological and cultural circumstances has been known to students of religion, history and anthropology.

It would seem that this statistical information misses certain fundamental problems. Cannot the socioeconomic and cultural settings in which sex finds expression also be evaluated as 'normal' or 'abnormal'? Cause and effect are obscured in the presentation of the data and in the conclusions drawn from them. The lack of a psychoanalytic approach constitutes a serious deficiency in this work, the more deplorable because of the value of the data and the

remarkable achievement its compilation represents. It is sincerely hoped that the authors and their advisors will be sufficiently challenged by the basic contributions of psychoanalysis, to utilize this tool in their subsequent reports.

SYDNEY G. MARGOLIN (NEW YORK)

THE PROCEEDINGS OF THE THIRD PSYCHOTHERAPY COUNCIL. Chicago: Institute for Psychoanalysis, 1947. 176 pp.

The Institute for Psychoanalysis of Chicago enjoys the distinction of being one of the few psychoanalytic organizations which as a group has consistently undertaken research projects in the field of psychoanalysis. The Proceedings of the Third Psychotherapy Council is a report of meetings held in Chicago on October 18th and 19th, 1946, and may be divided into two parts. The first consists of an introduction by Dr. Franz Alexander in which he outlines the departures from classical freudian psychoanalytic technique used in the treatment of many forms of neurotic illness at the Chicago Institute, followed by a description of the treatment of two cases illustrating the method. The second part is a symposium on the psychiatric outpatient clinic of the future.

The essence of Dr. Alexander's plea for greater flexibility in psychoanalytic procedure is that as physicians we should shift emphasis from scientific zeal in uncovering infantile memories and regressions to aiding the patient in the resolution of personal conflicts and problems by the utilization of the physician's psychoanalytic knowledge and experience. Whether this can be done effectively and perhaps permanently without investigation of the patient's reactions at precœdipal and œdipal levels has not been established, but the proof, as this reviewer has previously pointed out, that the very deepest and most prolonged analyses have resulted favorably in enduring personality changes and complete loss of symptoms, is also lacking in psychoanalytic literature.

Dr. Alexander's case of peptic ulcer with a personality disorder demonstrated great changes through the use of the modified method. The treatment consisted of thirty-seven interviews at irregular intervals, sometimes more than a week elapsing between them, with dream interpretation and discussion of the patient's problems in the light of past history, etc. The patient, a young man, had been afflicted with a peptic ulcer for five years and although

the symptoms were no longer acute he had continued on a strict diet and medication up to the time he came for treatment. His main disorder of personality consisted of difficulty in expressing emotion. The entire treatment was spread over a year but at the end of six months the patient was able to abandon his diet, and with other symptomatic improvement 'came proven changes in the dynamic structure of his personality'.

In the second presentation Dr. Adelaide Johnson reported a case of migraine existent since the the age of fifteen in a married female physician, aged twenty-nine. All in all the patient was seen about seventy-five times over a period of nineteen months. Dr. Johnson appears to have followed more closely the usual psychoanalytic technique and describes clearly how she penetrated the patient's defenses at the various levels of their development. The patient had definitely improved but the treatment was continuing, and Dr. Johnson promises to report the final results at the next meeting of the Council in 1949.

Each of the cases was discussed by a panel of physicians who had an opportunity to study the full reports in advance and the discussants' comments were thoughtful and vigorous, not only with regard to the method employed but the dynamics and interpretations offered. These discussions all have a rare but welcome quality: they are all strictly germane to the topic being discussed.

In the symposium on the outpatient psychiatric clinic of the future the discussions, all of which are carefully prepared, lack unity because of the special interests of the various physicians constituting the panel. Many of them deal with the problem of clinic organization and function, the needs for group diagnosis, community education, the training of psychiatrists and research and teaching.

The care and thought put into the preparation of the entire program was rewarded by the high quality of the contributions of the participants. The spirit of dignified informality with which the meeting (which this reviewer had the pleasure of attending) was conducted encouraged free expression of opinions on the part of the Chicago Institute members as well as the visitors, and made it not only extremely profitable scientifically but stimulating to those interested in psychoanalytic psychotherapy. In printed form the report loses none of these characteristics.

C. P. OBERNDORF (NEW YORK)

THE NATURE OF DETERIORATION IN SCHIZOPHRENIC CONDITIONS. By David Shakow, Ph.D. New York: Nervous and Mental Disease Monographs, 1946. 88 pp.

About 1930 the staff of Worcester State Hospital began a comprehensive study of schizophrenia. Psychiatrists, endocrinologists, physiologists, internists, statisticians and psychologists combined their research talents for the purpose of gaining a rounded picture of patients classified as schizophrenic. Some eighty patients were intensively studied over a period of seven months ('before directed treatment was begun'), with subsequent tests and observations throughout the succeeding ten years. The data from which this monograph was derived were 'integrated essentially as presented now' in 1941, but publication had to be deferred because of the war.

This book would more accurately have been called Prolegomena to a Study of the Psychological Aspects of Deterioration in Schizophrenia, being as much a preliminary survey of the field, and a critique of research methods, as it is a report of findings which, in any case, are most tentatively submitted with the fullest awareness of the magnitude of the task left undone. From the group of eighty patients, the psychological test findings of twenty-five were selected as offering data for the study of deterioration. These included the two top groups (out of five) from the point of view of coöperation in taking the battery of psychological tests. Ten tests were administered, falling into four groups: general intelligence, the Stanford-Binet and the Army Alpha; apperceptive, the Kent-Rosanoff and the Rorschach (in part); 'conative', accessibility to environmental stimulation and reaction to interruption of tasks; motor and learning, steadiness, tapping, prod learning and simple-auditory and discrimination-visual reaction time.

Deterioration is defined: functioning at a level below the subject's characteristic optimal performance due to an integral impairment of the organism rather than to such temporary or extrinsic factors as passing physical illness, fatigue, emotional disturbance, or poor external conditions for performance. This definition avoids such controversial questions as (1) permanence of impairment, including reversibility or irreversibility; (2) degree of impairment; (3) speed with which deterioration occurs; (4) how to differentiate qualitative and quantitative aspects of impairment;

(5) to what extent deterioration is limited to the psychoses. The author is aware that an adequate study of deterioration should embrace at least five approaches: (1) cross-sectional group studies; (2) cross-sectional individual studies; (3) cross-sectional type (and syndrome) studies; (4) longitudinal individual studies; (5) longitudinal type studies. He limits his present field to cross-sectional, and for the most part cross-sectional group, investigations 'by means of a battery of tests and experiments designed to determine certain characteristics of the schizophrenic personality'. Controls are found in a series of 'normals' matched with respect to age, education and socioeconomic status as well as in critical analysis of other studies of schizophrenics.

Significant findings, cautiously presented by the author, include: (1) schizophrenics are poorer as to mental age than are normals, but there is little difference on vocabulary scores; (2) schizophrenics are most affected on tests involving conceptual thinking and somewhat less on immediate memory; (3) the 'normal balance of apperception' is affected in schizophrenics, the Rorschach evoking very general whole responses and minutely specific details at the expense of more obvious details; (4) individual and 'unusual responses' are out of proportion to the 'most common' responses in the Kent-Rosanoff test; (5) schizophrenics consistently fail in experiments involving motor and learning functions, tending to be less persistent in self-initiated pursuits, and less likely to resume a task that has been interrupted. When the attempt is made to formulate a composite picture of the schizophrenic patient, it is found that 'the disturbance in psychological function, which is quite widespread, does not seem to be at the level of organization represented by the patellar tendon reflex or even that of sensory phenomena. It appears where perceptual organization and voluntary behavior play a rôle . . . especially in new situations where an adaptive difficulty is strikingly in evidence. . . . He is responsive to environmental stimulation in only a superficial way. The flow of energy into the environment is restricted unless in some way the environment is made "personal". Although the superficial intellectual disturbance is not great, the balance of function and the ability to conceptualize are apparently disturbed.' In summary: 'The dominant features of the picture we have drawn of the schizophrenic patient with respect to the problem of deteriora-

tion are those of a person disturbed by the psychosis in the formal aspects of the personality to varying degrees in different functions. This makes him a less efficient organism than he presumably had the potentiality of becoming.'

These are modest conclusions, and one is tempted to suggest that they are not especially illuminating. But the author has deliberately set out upon a limited operation; if he achieves limited objectives, no one is more aware of it than himself. His program comprises three additional studies: (1) the detailed study of the individual patient longitudinally in time, both with relation to personality changes in general and deterioration in particular; (2) the study of the dynamic motivational factors 'as well as the formal instrumental factors' within a patient; (3) 'a detailed qualitative analysis of the functions . . . for the purpose of detecting finer differentiations among disturbances'. Thus, ample opportunity remains for consideration of questions of motivation, of regression, and, in short, of the whole psychodynamics of schizophrenia as an adaptive phenomenon of disturbed interpersonal relationships, a point of view that seems totally neglected in the present study.

The reviewer remains in doubt, nevertheless, about certain aspects of the author's basic point of view and, therefore, of his methods. First, there appears to be an uncritical assumption that there is a disease called 'schizophrenia'. Actually, the term is currently so loosely and variably used as to have lost most of its value; at best it must be considered to embrace a whole group of psychopathological reactions, processes, modes of adjustment. Of the two most coöperative groups of patients selected for this study, one might ask whether a 'coöperative schizophrenic' is not often a contradiction in terms. There appears too to be an underlying assumption, at least in some of the words of the author, that a normal person is one who is eager to take a battery of psychological tests and that, in consequence, a schizophrenic who cannot do so, or appears unwilling to do so, shows an 'immediate adaptive difficulty', the disease preventing him from performing in a normal manner: 'he would perform if he could'. The schizophrenic's adaptive difficulties are judged, in part, by performance in tests of learning which are described as constituting 'nonaffective situations' in contrast to 'simple affective situations as those involving physical

pain'. Perhaps a question of definition is involved, but it would appear that, for many, learning is anything but a 'nonaffective situation'. So many young schizophrenics appear, at least in part, to have foundered in just this area: excessive competitiveness in schools, the sometimes implacable demands of parents that their children achieve a type of success that they themselves did not, or the hopeless attempt of a younger child to emulate the scholastic successes of an older sibling who is the pride of his parents, teachers and neighborhood. Certainly the meaning to the patient of the test, and of the person who invites him to undergo the tests, should not be ignored; and, although it is perhaps implied that such considerations will be taken into account in future (more dynamic) studies by the author, the question arises to what extent even the present studies suffer by their omission. Further doubts arise when one reads that patients included in this study were interviewed daily by a psychiatrist throughout 'the three months of active investigation', but that during the period of study 'no attempt at directed treatment was made'. This implies a relationship, but without therapeutic intent, for three months, after which the patient was 'dropped' by the psychiatrist. The psychologist got to the patient first, we are told. One wonders how this nontherapeutic intensive interviewing affected the subsequent course of the illness and the follow-up studies.

Can any study, however statistically and methodologically correct, have full value if dynamic psychological factors—the science of interpersonal relationships—are ignored? It is the reviewer's opinion that the author has failed to show that such factors can be profitably ignored or alternatively to indicate that they were not ignored in this study.

DOUGLASS W. ORR (SEATTLE)

THE PSYCHOANALYTICAL APPROACH TO JUVENILE DELINQUENCY. By Kate Friedlander, M.D. New York: International Universities Press, 1947. 296 pp.

Kate Friedlander's book is an important undertaking because it is the first systematic attempt to apply current psychoanalytic theory and practical knowledge to all the aspects of juvenile delinquency. The book appeared originally in England as one of a series of

sociological research monographs, edited by the late Karl Mannheim. Its aim, scope and purpose has been to bring to the postwar British public, to broad strata of society as well as to professional people in England, a greater awareness of the problems involved in juvenile delinquency. Even in this country, in which research in and treatment of juvenile delinquency in many instances is farther advanced, this book should be a welcome addition to essential reading on the subject.

Psychoanalytic research into criminal behavior is concentrated primarily on the fact that the same antisocial impulses, which are unconscious in the law-abiding citizen, lead to action in the criminal. A comprehensive, excellent recapitulation of the development toward social adaptation from the psychoanalytic point of view is given.

In discussing the factors responsible for the failure of social adaptation, Friedlander on the whole follows the conclusions of Aichhorn's concepts. One of her postulates is the biphasic nature of criminal development: (1) antisocial character formation, which may or may not develop into (2) manifest delinquent behavior. In the case of a seven-year-old boy, who had been analyzed by the author, the factors responsible for his antisocial character are discussed in detail.

> 'The antisocial character formation shows the structure of a mind where instinctive urges remain unmodified and therefore appear in great strength, where the ego, still under the dominance of the pleasure principle and not supported by an independent superego, is too weak to gain control over the onrush of demands arising in the id. This character formation is at the basis of the condition which Aichhorn calls the state of "latent delinquency" and it will depend on the various factors exerting their influences in the latency period and puberty, whether delinquent behavior becomes manifest or not.'

Very often a period of 'unruly behavior' precedes 'manifest delinquency'. Two typical representatives of manifestly antisocial personality pictures are (a) '. . . the common offender', who is identical with Aichhorn's 'aggressive youth', and (b) 'the wayward girl'.

A comparative study of neurotic versus delinquent symptom formation, a theoretical discussion intertwined with case material, follows. This reviewer feels that due to the arrangement of material in chapters IV and V of the second part of the book, the

lucidity which characterizes all the other parts of the monograph, suffers. We wonder whether it would not have been more helpful to the reader if Friedlander's impressive '. . . attempt at classification of juvenile delinquency. . .' had preceded the illustrative case material and theoretical discussion. We think many of her postulates, conclusions, and particularly the genetic and dynamic aspects of the clinical material would have appeared in clearer focus.

Friedlander's classification is rooted in the assumption that at the basis of delinquent behavior, whether complicated by neurosis or not, is either a functional or an organic disturbance of the ego. She distinguishes three main groups of juvenile delinquents: I, ego disturbance based upon antisocial character formation; II, organic disturbances by which the ego is put out of action; III, psychotic ego disturbance in which because of the psychotic ego's inability to distinguish between reality and fantasy, the ego is unable to control instinctive forces.

The psychoanalyst will be most interested in the first category of juvenile delinquents with 'antisocial character formation'. Friedlander subdivides this category into four groups. First are those cases in which antisocial character formation 'alone' persists and delinquent behavior is manifest from the latency period on. Representatives of this subgroup at puberty are Aichhorn's 'aggressive youth' and the 'wayward girl'. Second are those in whom to a lesser degree of antisocial character formation emotional stress or severe environmental frustration is added and causes unconscious mental conflict, leading to antisocial manifestations usually at puberty. The third subdivision consists of children and youths with a slight degree of antisocial character formation accompanied by neurotic conflicts, the presenting symptom being a delinquent rather than a neurotic one. Kleptomania, incendiarism, 'occasional crimes' and certain sexual offenses belong in this group. The fourth subdivision is a group in which an antisocial character with the neurotic disturbance of 'acting out' a fantasy in daily life characterizes the delinquent behavior. Reich's impulsive character, Alexander's neurotic character, Aichhorn's imposter type, Henderson's 'predominantly inadequate group of psychopathic personality' belong in this group.

The last part of the book covers a wide range of subjects including treatment, analysis of the public attitude toward delinquency,

transference, various methods of approach, indications and contra-indications for psychotherapy or environmental handling. The function of the probation officer and the importance of training field workers are discussed. A rational scheme for the prevention of crime is proposed.

This book deserves the full attention of psychoanalysts, and can be highly recommended to all workers interested in the problems of juvenile delinquency.

MARGARET S. MAHLER (NEW YORK)

PAINTING AND PERSONALITY. A Study of Young Children. By Rose H. Alschuler and La Berta Weiss Hattwick. Chicago: The University of Chicago Press, 1947. Two Volumes, 590 pp.

This study is based on a great number of painstaking observations in nursery schools. For an entire school year one hundred fifty children (twenty of them for a second year) were observed daily. Their use of paints, crayons, clay and blocks, and their general behavior were recorded in minute detail by special observers. Such a study should be valuable in heightening the sensitivity of teachers and child psychologists to the content and value of children's spontaneous paintings.

It was found that painting helped many of the children to talk about their personal problems. The apparently least realistic element in a child's painting is often the one about which it feels most deeply. The birth of a baby in the family, besides raising the issue of rivalry, is likely to renew old sexual conflicts. As paintings reflect primarily feelings and only secondarily the child's overt behavior, the mood of a child's painting may be in sharp contrast to its overt behavior. There are also oversimplifications, as for instance in the statement that 'each child in its paintings and drawings accentuates those parts of its body which it has experienced most keenly'.

The authors work with limited psychoanalytic concepts. They recognize that anal interests and anal conflicts are reflected in the choice of colors and painting techniques, yet they 'wonder whether decorative effects might be another sublimated form of the desire to smear and soil'.

The second volume of biographical summaries of the children is a disappointment. A number of the biographies does not even mention the child's father. The sibling constellation (sex, ordinal

position and age differential) is only partly given. Deaths, divorces, desertions, and adoptions are reported, but there is no history of infancy, of early child-parent separations, of operations, and other strains or traumata. The children came from widely differing economic and social environments, yet in most instances very little is revealed about the family's poverty or abundance, nor such essential data as whether a child shared its bed or room with parents or others.

The study aims to show how painting can substantiate or reveal that a child is in need of special consideration or help. Many children in these pages have neurotic and antisocial traits, yet we are not told how the child profited after its paintings had sounded the S O S; indeed the summaries are almost completely static. Even for the children who were observed daily for two years and subsequently studied intermittently, we are not given the developmental changes and trends. Two years are a large segment of a young child's life. There must have been significant changes in the expressions of instinctual needs and in the development of the ego.

Although this study employs the best known methods of investigation—trained observers who check and countercheck their findings (there were besides the teachers eleven full-time observers plus several part-time ones), collaborating psychologists, experts in nursery school education, specialists in primitive and children's art, a consulting psychoanalyst, Rorschach tests, play interviews, frequent staff and progress meetings, visits to homes, interviews with parents, even a full-time photographer—the statistical data elaborated in fifty-one tables do not justify this tremendous effort. The lack of a consistent psychology of human development curtails the value of this investigation. It would have been more valuable to have a concise booklet of significant findings, with tentative conclusions and a perspective of unresolved issues, including a clear statement of the authors' basic psychological working hypothesis (plus the valuable colored reproductions of the children's drawings).

For workers in the field of child development who have remained unaware of freudian concepts, this is a decade of fundamental reorientation. The danger of an eclectic use of psychoanalytic concepts is clearly visible in these volumes.

LILI E. PELLER (NEW YORK)

DE HAMLET A FAUSTO (From Hamlet to Faust). By Mario Carlisky. Buenos Aires: Editorial Ayacucho, 1947. 248 pp.

The author states that every literary character, when it is the fruit of real inspiration, reveals not only the basic problems of behavior but also the psychic mechanisms of a mental conflict. He makes a psychoanalytic inquiry into the problems of behavior through comparative analyses of the characters Hamlet, Œdipus, Sigismund and Faust. In all there is an acute problem of decision in the face of the many and different dramatic circumstances that surround each of them. This decision becomes so difficult because the same circumstances that would bring satisfaction of their conscious aims signify the consummation of unconscious strivings ladened with guilt. The author, a Professor in the School of Philosophy of Buenos Aires, develops his ideas in an easily readable and interesting book.

GUILLERMO FERRARI HARDOY (NEW YORK)

DYNAMISCHE REAKTIONSPATHOLOGIE (Dynamic Pathology of Reactions). By Kurt von Neergaard. Basel: Benno Schwabe & Co., 1946. 317 pp.

The phrase, Dynamic Pathology of Reactions, as used in this book means that pathologic organic conditions should not be looked upon as a product of a static process but rather as one which is the result of a continual active and reactive occurrence. The author considers this concept as a new one and unnecessary because of the revolutionary turn in modern physics, a science closely related to medicine. Plank's quantum theory has replaced the former mechanic and static concept of physics. The complete change of the meaning of the time factor in physics changed the concept of disease from one of being, to one of happening—a historical process.

The axiom of the 'substance', which was the basis of the mechanistic thinking in medicine, and which led to the long-lasting preponderance of the morphologic concept in biology and organ pathology, had to be given up. Classical physics had to readapt to the new discovery of space and time as an inseparable function; likewise, the viewpoint of functional organic processes. The demechanization of physics threw new light also upon the mind-body problem. In modern physics neither masses nor energies

but only 'effects' exist, thus abolishing the classical concept of 'substance'. The gap between mind and body, between material and immaterial, becomes narrowed. Since ultimately anything happening in the body is only a function, nothing is in the true sense organic; therefore, the difference between organic and inorganic becomes inconsequential. What is essential is the understanding of the dynamics of actions and reactions observable in the living organism. Since these processes are continually at work from the beginning of life, any given condition represents a developmental process with a history which has to be studied, if any bodily process is to be understood. The mechanistic thinking in medicine based on facts and curves becomes outmoded, and is replaced by the functional concept. The application of the quantum theory to functions leads to comprehension of a quantitative or quantum biology supplementing the physiochemical experimental biology.

Viewing bodily processes in historical terms, all processes are interlinked at all times, including pathological processes which can be understood only as a whole in terms of time. The author exemplifies this holistic conception in its influence on research, on teaching, on the relationship of patient and physician, and how it must lead, in his opinion, from individualistic to social medicine.

These are, in brief, the ideas which are elucidated in this book and which the author considers revolutionary. One is inclined to excuse the author for his lack of information about the literature in this field in the past ten years because the war presumably interrupted his scientific contact with the rest of the world. He is either not acquainted with the 'dynamic' and 'historical' concept of psychoanalysis or he has a purpose in ignoring it. Somewhere in the book the author makes the strange statement that he hopes these new concepts may restore to 'European' medicine its leadership over the highly mechanized medicine of 'other continents'.

FELIX DEUTSCH (BOSTON)

A TEXTBOOK OF CLINICAL NEUROLOGY. By Israel S. Wechsler. Sixth Edition. Philadelphia and London: W. B. Saunders Co., 1947. 830 pp.

It is twenty years since the first edition of this textbook of neurology was published. In this, as in the previous editions, it remains

the simplest, most compact, well-illustrated and clearly written textbook of neurology. It is most valuable and accessible for reading and reference, not only for neurologists but for all physicians.

The notable progress made in the last few years in neurology has been included in this revision. The chapter by Dr. David Wechsler on psychometric tests has been completely rewritten and changed to psychological diagnosis of personality disorders in organic brain syndromes. Descriptions of the diagnosis and treatment of many disease syndromes have been re-edited to accord with recently acquired knowledge. New syndromes and the chemotherapies (sulpha drugs and penicillin) have been included. The chapters on the neuroses and the history of neurology have been retained.

CHARLES DAVISON (NEW YORK)

THE PSYCHOLOGY OF EVERYDAY LIVING. By Ernest Dichter, Ph.D. New York: Barnes and Noble, 1947. 239 pp.

This book is a series of short articles on a variety of subjects, from the kind of soap people prefer, to why people worry. There is nothing in this book of interest to the psychoanalyst, the clinical psychiatrist, or the general practitioner. Though many of these articles have been printed in magazines with a wide reading public, it is incredible to the reviewer that anyone can have derived any benefit from them. It is replete with such pearls as . . . 'the cure for prejudice is not to be prejudiced'. People who worry are urged not to worry. Though the author does say that constipation is of psychological origin, he has among his suggestions for its relief '. . . relax your body if you feel too tense'. He never tells the poor reader how all this is to be accomplished.

SYLVAN KEISER (NEW YORK)

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The Mental and the Physical Origins of Behavior. E. D. Adrian. Int. J. Psa, XXVII, 1946, pp. 1–6.

H. W.

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ABSTRACTS

The Mental and the Physical Origins of Behavior. E. D. Adrian. Int. J. Psa., XXVII, 1946, pp. 1–6.

This is the first of the Ernest Jones memorial lectures. E. D. Adrian is a physiologist who has worked with the psychoanalytic movement since 1914. In this paper he puts forth a theoretical description of general cerebral activity in neurophysiological terms. He states that 'the essential difference between the nervous organization of the cerebrum and that of the simple reflex pathways seems to be expressed by [the] tendency to cell discharge [in the cerebrum] which maintains itself indefinitely in a vast mass of cell groups'. With the basic characteristic of this continuous and 'more or less stable pattern of electrical eddies' as a starting point, Adrian visualizes an afferent impulse stirring the somnolent 'ripples' into increased activity over ever greater cell groups until 'eventually it will attain the necessary intensity to be associated with the emergence into consciousness of the idea which corresponds to its particular configuration, or to some parts of it. The motor activity which follows will be determined by the nature of the pattern and all the conflicting claims to action which must also be satisfied . . . . as the achievement is approached the sensory signals to the brain will dissipate tension by providing a pattern which is in some way the inverse of the first. The two patterns will cancel and the field will be left clear for others to form.'

H. W.

An Address on the Occasion of Presenting His Portrait to Ernest Jones. Sylvia Payne. Int. J. Psa., XXVII, 1946, pp. 6.

A brief historical eulogy of Jones in which the point is made that he did psychoanalysis a great service in England in 1928 by serving on a committee appointed by the British Medical Association to investigate psychoanalysis, 'which ruled that only those trained by Freud's method by the Institute of Psychoanalysis had the right to be called psychoanalysts'.

H. W.

A Valedictory Address. Ernest Jones. Int. J. Psa., XXVII, 1946, pp. 7–12.

Jones asks what defenses have taken the place of the original reactions of panic and anger which have largely subsided against psychoanalytic concepts. He warns us that to propagandize psychoanalysis belligerently merely stimulates 'stronger opposition'. Freud and Darwin answered their opponents simply by producing more evidence. Yet this is no longer enough when we consider the critical danger in which society finds itself 'and how far those in need of our help are from taking seriously the very existence of such help'. The original vociferous resistances have simply hardened into silent social resistances against which we are almost helpless.

Early analysts were a close-knit group, in more or less constant contact with each other, marching evenly in line. With greater diffusion, separatist tendencies

reflecting differing social philosophies have appeared: Asia's preoccupation with religion, America's quest for quick returns in shorter analyses 'which look more like anamneses than analyses'. Aside from such differences, Jones believes 'that the greater part of the divergencies and discords proceed from more personal sources, however much they may be disguised in the garb of theoretical differences'. From his personal experience with many such 'painful situations', Jones believes that the problem can 'be attacked only on general lines'. He infers that 'complete inner harmony is more difficult to achieve by means of psychoanalysis than we think', that there 'may well be an innate factor akin to the General Intelligence G, the nature of which it still remains to elucidate, but which may be of cardinal importance in the final endeavor to master the deepest infantile anxieties, to tolerate painful ego-dystonic impulses or affects. . . .'. He thinks this factor may be a hereditary, physiological one. A knowledge along such lines 'should in time provide us with a more objective criterion for the selection of future practitioners of analysis than any we at present possess.'

Jones feels that while the original ideal of 'a veritable identity' of theoretical conclusions, technique and practice among psychoanalysts can no longer be hoped for, yet 'it is now being replaced by the more practicable, though difficult enough, endeavor to distinguish between what constitutes the essential characteristics of psychoanalysis and what are superimposed and more varying features'. Freud's dictum that the essential characteristics are simply those of studying unconscious processes by means of the technique of free association must not be dogmatized and anyone trained in psychoanalysis by standards similar to those evolved by medicine should be free 'to modify both the theory and practice of what he has learnt'.

He pleads for an ever closer integration of psychoanalysis with the main body of medical science. He maintains that 'if admission to the ranks of practising analysts was *equally* open to medical and nonmedical candidates, the result in time would be a flooding of the latter' and 'we should in time develop a separate and nonmedical profession, which in my opinion would prove most injurious to the interests of our work'. Only lay people who possess 'pre-eminent psychological gifts' should be trained. The experience of the British Society justifies this practice: 'Our Society is fundamentally a medical one, but we have enlisted from elsewhere a number of exceptionally valuable members'. The medical profession must further be made aware of the ubiquity of psychopathology and medical students should be introduced to it via a biological, then clinical and finally a psychological approach.

Finally, Jones feels that the fundamental inquiry of psychoanalysis is into the very nature of biological drives and instincts and 'to ascertain what exactly comprise the irreducible mental elements, particularly those of a dynamic nature'. He believes that the dichotomy of body and mind 'will be found to be based on an illusion'.

In anticipating those critics who think he advocates too great a 'tolerance towards diversities and even divergencies', Jones states that he derives his confidence from his 'conviction in the ultimate power of truth'.

H. W.

From *King Lear* to *The Tempest*. Ella Freeman Sharpe. Int. J. Psa., XXVII, 1946, pp. 19–30.

This is a reconstruction of Shakespeare's unconscious conflicts and their attempted resolution, through an analysis of two of his plays: King Lear (which ends with a storm) and The Tempest (which begins with a storm). The 'storm' in King Lear, Sharpe feels, 'represents the rage before the onset of a depression'. Seven years later, when he ushered in The Tempest with another storm, he expressed 'the re-emergence of [his] psyche after depression' and, in the rest of the play, his 'readjustment to reality'.

Although difficult to follow at certain points and incomplete at others, Sharpe's analysis is a penetrating and rich one.

H. W.

Teiresias and Other Seers. Géza Róheim. Psa. Rev., XXXIII, 1946, pp. 314–334.

The drama of Sophocles reveals that Teiresias and Œdipus are really two aspects of the same person: Œdipus in the dialogue represents repression and Teiresias the return of the repressed. The seer derives his ability from witnessing the primal scene and his blindness is the talio punishment for having seen it.

Analogies are found in European folklore as in folk tales of the language of snakes and birds. In classical antiquity the mantic art consists largely in observing the flight of birds, a coitus symbol. The seer and the primal scene in Hungary are represented by Alor and Yuma. The preœdipal roots of voyeurism —seeing and sucking—are observed in the natives of Normanby Island.

AUTHOR'S ABSTRACT

Telepathy in Analysis. Nandor Fodor. Psychiatric Quarterly, XXI, 1947, pp. 171–189.

Freud states that the feeling of uncanniness arises when our judgment, which has already rejected certain beliefs such as the omnipotence of thought or the animistic attitude of mind, is asked to reaccept them. It should therefore not be remarkable that there have been so few contributions on telepathic phenomena in the psychoanalytic literature in spite of Freud's interest and the several papers he has written. Nandor Fodor, erstwhile director of research for the International Institute for Psychical Research, London, from 1934 to 1938, is one of the few who has followed Freud in the investigation of thought transference. In this paper he discusses five dreams, four paired or occurring to two people and having common elements outside of probability or coincidence. These dreams occurred to two patients, man and wife, with whom the analyst was corresponding, to their secretary, known also to the analyst, and to the analyst himself. He interprets the dreams as telepathic. He expresses the view that telepathy is a mechanism operating wholly or predominantly on the

unconscious level, due possibly to a special cognitive faculty of the unconscious. He offers the suggestion that strong emotional ties may be a prerequisite for telepathic dreaming and that unrecognized telepathy may play an important rôle in analytic transference.

JOSEPH BIERNOFF

The Jew as Symbol. II. Anti-Semitism and Transference. Henry Loeblowitz-Lennard. Psychiatric Quarterly, XXI, 1947, pp. 253–260.

The attitude of the non-Jew toward the Jew is seen as a transference. Behind the frequently contradictory arguments there are pre-existent affects which are displaced upon the Jew. Why the Jew lends himself to such a displacement has not yet been sufficiently elucidated. The writer presents two case histories. In both patients the Jew represents that force which the anti-Semite feared most in his childhood, the omnipotent, threatening father. Displacement upon the Jew enabled the patients to avoid the resolution of their conflicts and to find a justification for refusing the demands of society (father). The expenditure of energy by the anti-Semite in hostile impulses against the Jews is made possible through the release of that psychic energy which normally cathects the ego in the control of instinctual drives. The problem does not lie in what the Jew is or does, but in what he symbolically represents or is thought to mean.

BERNHARD BERLINER

Problems of Identification. Henry Harper Hart. Psychiatric Quarterly, XXI, 1947, pp. 274–293.

Hart reviews the literature on identification and its relation to other problems of metapsychology. Some of the more important problems are: Is identification a bridge between narcissism and object love? Is it a method of mastering hate and ambivalence? Is it important in determining suicide or is loss of self esteem more so? Is it ambivalent only in its earlier phases of development and therefore dependent upon the libidinal development? What part does heredity play in the ability to form identifications? What part does the pleasure principal play in the two processes of introjection and projection inherent in the identification process? These questions are still to be answered by workers in the field.

JOSEPH BIERNOFF

Stereotypy in Schizophrenia. A Case Report. Henry F. Meyers. Psychiatric Quarterly, XXI, 1947, pp. 294–304.

Since Bleuler's early studies, the fact has become well established that stereotypy and mannerism in schizophrenia are not incoherent random gestures but have definite unconscious determinants and significance. This report deals with the elucidation of the meaning of a certain stereotyped behavior in discussions with a schizophrenic patient under amytal sedation and after electroshock treatment. Meyers feels that the stereotypy shows only the content and the precipitating factors of the psychotic process, but that the disease itself and the deep psychodynamics of the symptoms are not explained by it.

JOSEPH BIERNOFF

Differential Diagnosis between Spurious Homosexuality and Perversion Homosexuality. Edmund Bergler. Psychiatric Quarterly, XXI, 1947, pp. 399–409.

A precise distinction should be made between two forms of male homosexuality: perversion homosexuality and unconscious feminine identification. These types have nothing in common, transitions do not exist; they represent, genetically, completely different entities.

Peversion homosexuality represents a regression to the oral stage. Severe disappointments with the breast or breast substitutes make these persons discard the whole female sex and seek the 're-duplication of their own defense mechanism', the penis. The 'mechanism of orality', repeatedly described by Bergler, is accentuated in these individuals by the narcissistic structure which is a recompense for the defeat of weaning. A baby wanting to prove that mother is unjust, and a pathologic mother wanting to harm and refuse the baby's demands, form the basic conflict of every homosexual relation.

The passive feminine man need not be homosexual. Unconscious feminine identification is a hysteric condition which stems from fixation on the negative œdipus and is often hidden under compensatory 'he-man' attitudes.

BERNHARD BERLINER

The Psychoanalytical Approach to the Masculine and Feminine Principles in Music. Margaret Tilly. Amer. J. of Psychiatry, CIII, 1947, pp. 477–483.

This so-called psychoanalytic approach to music is based on the concepts of Jung. Certain elements in musical composition are arbitrarily selected as characteristic of masculine and feminine personality types and the composers are classified accordingly. Masculine qualities in music are supposed to be shown by drive, rhythmic power and 'superior thinking'; 'feminine qualities' by sentimentality, quickly shifting emotions, etc. The author is a music therapist.

MARK KANZER

Psychiatric Experience in the War, 1941-1946. William C. Menninger. Amer. J. of Psychiatry, CIII, 1947, pp. 577–586.

This authoritative review of the psychiatric problems in the army during the recent war manages in a brief space to cover the statistics and overall picture of military neuropsychiatry. The magnitude of the job emerges even from the barest description of the work done and receives further amplification from Menninger's clear and pointed observations. Although so many aspects of organizational and clinical experience are reviewed in these few pages, place is still found for some remarkably penetrating comments on psychopathology. 'We learned that maintenance of mental health was largely a function of leadership which included the extremely important element of motivating the man to want to do his job and remain loyal to his associates and his unit.' Environment rather than personality make-up or internal psychogenic stresses was of paramount importance in the breakdown of the individual and played a major rôle in treatment. Menninger emphasizes the need to organize psychiatry on a broad social scale, underlines the lessons to be drawn from the unprecedented mass

experiments of the war, and sets forth a detailed and far-reaching psychiatric program to meet the opportunities and demands of the future.

MARK KANZER

The Study of Psychiatry. Three Orienting Lectures. Harry Stack Sullivan. Psychiatry, X, 1947, pp. 355–371.

This series of three lectures, delivered at the opening of the 1947–1948 term of instruction at the Washington School of Psychiatry, was intended to orient the incoming group of psychiatric candidates. A schematic exposition of the field theory of interpersonal relations is presented and then illustrated by a hypothetical case of paranoid schizophrenia as it might be managed by three psychiatrists with different therapeutic approaches. Sullivan urges the field theory on the students, contrasting it with the best the hypothetical patient could derive from psychoanalysis, namely, the avoidance of an acute schizophrenic episode 'by "sublimating his homosexuality" or "resolving his œdipus hostility" or something of that sort which could be expressed more helpfully in terms of a field theory'. Among the practical hints for adjustment to the course of study, the suggestion is included that a dissident candidate, who persists in believing 'that Freud's original libido theory is an adequate basis for his current clinical thinking', may become a subject for administrative consideration.

S. GABE

Psychological Aspects of Obesity. Hilde Bruch. Psychiatry, X, 1947, pp. 373–381.

The problem of obesity is in the main a psychological one, except for the relatively infrequent instances due to endocrine malfunction. The behavior of the obese individual is characterized by overeating and underactivity. His attitude to his corpulence is an ambivalent one: while he bemoans its disfiguring and handicapping effects, he is seemingly unwilling or unable to carry through measures for its correction. That is so because the fat person is an immature, insecure individual and bodily bulk conveys to him a sense of strength and symbolizes a bulwark against an unfriendly and threatening world. It also provides a ready rationalization for withdrawal from social contacts which might provoke fear and anxiety. Furthermore, for the obese individual food has come to represent love, security and satisfaction, whereas muscular activity is associated with situations of danger. Such an emotional constellation is generated in a specific family setting. The family is usually small and the obese individual is either the youngest or an only child. The mother is a dominant personality and frequently tries to work out her own problems and frustrations through her child. She expresses her possessive affection by overprotection and overfeeding. This behavior of the mother at the same time represents a reaction formation against an underlying hostility, which leads her to devise far-reaching measures for the safety of the child. As a result, the child grows up with an inadequate sense of security and self-regard and food becomes his weapon against anxiety and the pre-eminent source of comfort in situations of frustration.

S. GABE

The Schizoid Maneuver. William V. Silverberg. Psychiatry, X, 1947, pp. 383–393.

The schizoid maneuver is a psychological mechanism for overcoming a feeling of helplessness by means of a fantasy which denies the feeling. It is resorted to whenever a judgment of impotence in the face of an intolerable reality situation is arrived at. The maneuver 'is an attempt to distort mentally an unpalatable reality, whether external or internal, into something more acceptable'. *Per se* the schizoid maneuver is not pathological; it may be used legitimately in situations of real helplessness. It becomes pathological only when the judgment that one is unconditionally helpless is erroneous. An individual who regularly resorts to the schizoid maneuver as a means of dealing with life situations and interpersonal relationships may be labeled a schizoid character. The schizoid maneuver stands in contrast to transference: in the former a premature judgment of helplessness is arrived at, whereas in the latter there is a refusal to admit the existence of a state of helplessness expressed in the fantasy of being able to manipulate the analyst and in the attempt to gain mastery over the feeling of helplessness by repetition compulsion.

S. GABE

Newer Genetic Investigations on Impotence and Frigidity. Edmund Bergler. Bulletin of the Menninger Clinic, XI, 1947, pp. 50–59.

Bergler discusses the most difficult problems in impotence and frigidity and presents his psychodynamic views in a very condensed paper. He contends that the greatest lack of clarity exists in cases where oral regression plays an important rôle. He believes that the basic wish in those cases is a masochistic desire to be refused. These patients provoke their environment to refuse them as they provoked their mother in the preœdipal period. Bergler believes that most analysts confuse the superficial aggressiveness of these patients with the original oral aggressive impulses, and neglect the masochistic elaboration. Impotence, premature ejaculation and aspermia are generally pseudoaggressive denials of this wish to be refused.

Bergler then turns to the problem of frigidity and strongly attacks the concept of a clitoral orgasm. He believes that the sole criterion for orgasm in women is the presence of involuntary contractions of the pelvic perineal muscles at the end of the sex act. In frigidity, too, the most difficult cases are the oral regressed ones, where pseudoaggressive behavior covers the dynamically decisive masochistic wish to be refused. Unfortunately, the genesis of this masochistic wish is not amply elucidated in the paper.

RALPH R. GREENSON

Alterations in the State of the Ego in Hypnosis. Margaret Brennan, Merton M. Gill and Frederick J. Hacker. Bulletin of the Menninger Clinic, XI, 1947, pp. 60–66.

The authors describe a series of observations in patients under hypnosis which occurred spontaneously and which seemed to be related to changes in the ego state. Bizarre skin sensations, strange equilibrium sensations and peculiar

changes in one's body-image are typical. The mode of thinking tends to symbolism and visual imagery. Sudden outbursts of intense emotion, relived in the present tense, occur frequently. Spontaneous loss of control of motility or impromptu acting out is another common occurrence.

RALPH R. GREENSON

Analysis of an Unusual Case of Fetishism. Paul Bergman. Bulletin of the Menninger Clinic, XI, 1947, pp. 67–75.

Bergman describes a boy whose sexual life was almost completely experienced in a fetishistic fascination for exhaust pipes of cars. These pipes had to be of perfect shape and had to emit softly blowing gases. During a long period in his childhood he enjoyed cruelly torturing animals. At puberty in attempting to combat masturbation he became an arsonist. It was during this period that his fetishism began.

The author agrees that his material confirms Freud's hypothesis that the fetish represents the mother's penis and is a defense against castration anxiety. He then discusses the genesis of this patient's strong pregenital sadistic strivings and has difficulty in correlating these findings with what he terms 'Freud's phallic theory'. Apparently Bergman was unable to find the connection between castration anxiety, the precipitating factor, and pregenitality, the consequence. It is characteristic for all the perversions that their symptoms are simultaneously a denial of castration anxiety and a gratification of some infantile partial instinct. These severe regressive features on all levels make the perverse patient extremely difficult to handle.

RALPH R. GREENSON

Preliminary Report on a Psychosomatic Study of Rheumatoid Arthritis. Adelaide Johnson, Louis B. Shapiro and Franz Alexander. Psychosomatic Med., IX, 1947, pp. 295–299.

Alexander and his co-workers report their findings in a study of thirty-three cases of rheumatoid arthritis. It was found that the women had a tendency toward bodily activity, an inclination toward outdoor sports and that they showed a strong control of all other emotional expression. Their dependence upon other persons was masked by service and activity, overtly masochistic in character. Towards their children they were demanding and exacting. They rejected the sexual feminine rôle, showed masculine protest reaction, competed with men, and could not submit. Their husbands were usually passive men, frequently with physical defects.

It was found that unconscious rebellion and resentment against men activated the disease. It also seems that in situations where self-sacrifice and service to others does not succeed in keeping guilt feelings satisfied, the disease breaks out anew. In a third situation a masculine protest reaction was intensified in order to serve as a defense against a fear of sexual attack.

In the deeper analytic material the masculine identification appears at times through the utilization of the neck or limbs, or of the whole body as phallic

symbols. This identification always has a hostile connotation and is often linked with castrative impulses both in the form of grabbing with the hands and of oral incorporation.

In their infantile background these patients usually have a strong, domineering, demanding mother, and a gentle, compliant father. The relationship with the mother is the source of their intense masochism; the female rôle becomes frightening to them at the œdipal period. In their oral aggressive attitude toward the cold and rejecting mothers lies the earliest basis of the later grasping, aggressive attitude toward men.

At one extreme are those patients in whom aggression and defense against attack are handled by discharge into somatic conversion with a symbolic expression of ideational content. In all gradations to the other extreme of the series are those in whom the ego-syntonic discharge of chronic inhibited hostility through muscle activity, hard work and sports has been interrupted, and there develops an increased general muscle tonus which may precipitate an arthritic attack. In other words, the patients learn to discharge aggression through muscle activity—in hard work, sports, gardening, etc. They live in a psychologic strait-jacket in which they hope to achieve an equilibrium between aggressive impulses and their control.

As stated in the title, this report is only a preliminary one but it points the way for further promising research.

MARTIN GROTJAHN

Some Aspects of the Dream in Psychosomatic Disease. Herbert I. Kupper. Psychosomatic Med., IX, 1947, pp. 310–319.

A case of angioneurotic edema and one of convulsive seizure are described. Both developed the symptoms of their sickness only during and after a dream state. The first patient, a man, suffered from severe episodes of abdominal cramps and edema of the extremities. While under hypnosis he relived witnessing, at the age of three, the butchering and castrating of hogs by his father. In another hypnotic trance he relived a period of intense rebellious excitement preceding the first attack of abdominal cramps, and he also remembered dreams which always occurred before the onset of each period of illness. While still under hypnosis he gave all the associative material needed to analyze his masochistic, homosexual, submissive and rebellious attitude towards his father and father figures. It seems that the symptoms appeared when the dream began to fail in its function of protecting sleep.

The second patient was a man with epileptic seizures. He, too, disclosed under hypnosis dreams which he had had the night before attacks, and also remembered his intense death wish against his father on an occasion during childhood when his father threatened to hurt the boy's mother physically.

This man was finally able to trace every convulsive seizure to an initiating dream. The day before the dream was filled with intense conflict characterized by aggressive feelings toward his father or an authority figure. The dream content was always that of an attack on him by a symbolic figure which association

always connected with his father. The feeling of muscular paralysis and the attempt to protect himself was contained in each dream. Several attacks were witnessed by the examiner.

The seizure represented a punishment for his aggressive and murderous thoughts, and also the release of his aggression as a defense against his homosexual desires. In this dependent, passive individual, the mother seemed to be the protective agent who helped to ward off the threatening parent. A fantasy of suicide by means of taking gas in the oven of a maternal aunt seemed to express the symbolization of an unconscious wish for an intrauterine type of care.

The case reports are extremely illustrative and demonstrate well Kupper's combination of psychoanalytic theory and modified use of analytic methods such as free association in connection with hypnosis and suggestive procedures. While the patients were under hypnosis, reliving and recollecting the traumatic situation, suggestions and interpretations were given. Theoretically and therapeutically, this highly modified psychoanalytic approach, in which Ernst Simmel did the pioneering work, seems to be a promising tool for further psychosomatic research.

MARTIN GROTJAHN

Treatment of a Case of Peptic Ulcer and Personality Disorder. Franz Alexander. Psychosomatic Med., IX, 1947, pp. 320–330.

Alexander treated—during thirty-six interviews extending over a period of ten months—a twenty-three-year-old university student who had suffered from a duodenal ulcer for five years, and manifested a deep-seated personality disorder. The patient's psychodynamic conflict consisted of repressed dependency needs, against which he defended himself by overcompensatory aggressive competitiveness and a sham independence. His sexual behavior aimed solely at conquest. Studied casualness and an inability to feel emotion served as a further defense against the dependency longings.

The treatment utilized the development of a transference neurosis of low intensity to effect a shift in the dynamic forces. The patient was consistently made conscious of his wish to be taken care of by the analyst. Through acceptance of his dependency needs in the transference relationship, the patient became more tolerant of a certain amount of dependence on others which, in turn, lessened the need for the character defenses. By a process of working through, he freed himself of his various defense mechanisms and allowed more mature attitudes to come to the fore. With the development of the transference and the beginning of alteration of the patient's character structure, the ulcer symptoms disappeared and had not recurred in the half year following termination of the treatment.

The technique employed in this case differed in some significant respects from customary analytic procedure. Interviews were conducted face to face. At the beginning, twice-weekly interviews were employed to facilitate establishment of the transference and more quickly alleviate symptoms; later, sessions were spaced at weekly intervals. The transference neurosis was not per-

mitted to develop beyond a certain intensity on the principle that the patient should not be allowed more regressive gratification in a dependent relationship than was strictly necessary. This was accomplished by making transference attitudes conscious from the beginning and by manipulating the frequency of interviews and introducing interruptions when indicated. According to Alexander, this procedure did not preclude the emergence of the same unconscious material usually obtained in psychoanalysis. A series of dreams of the problem-solving type were brought in, forgotten memories were recovered, some existing memories were filled with emotional content, repressed attitudes to primary figures were brought to consciousness and insight into character defenses acquired.

Alexander concludes: 'It is my conviction, based on extensive experience with similar cases, that the customary psychoanalytic procedure would certainly have delayed recovery and would possibly have resulted in the insoluble intensive transference neurosis of the so-called interminable cases. I am also convinced that there is a very large number of patients in which the type of treatment presented here is preferable, not only because it is more economical but also because in suitable cases it is more penetrating and avoids the danger of becoming an interminable psychoanalysis.'

It is regrettable that the stimulating discussion which followed the original presentation of the case, and in which K. Meninger, J. Ruesch, M. Gitelson, R. Grinker, B. Mittelmann, and T. French participated was not also published.

S. GABE

The Rôle of Hostility in the Pathogenesis of Peptic Ulcer: Theoretical Considerations with the Report of a Case. Thomas S. Szasz, Erwin Levin, Joseph B. Kirsner, Walter Lincoln Palmer. Psychosomatic Med., IX, 1947, pp. 331–336.

Anger may play an important etiological rôle in the pathogenesis of peptic ulcer. It operates through increasing secretory and motor gastric activity. The effect of anger on gastric secretion was observed in a patient with peptic ulcer, in whom gastric acidity had been completely inhibited by enterogastrone. Hostile emotions evoked during a psychiatric interview, but suppressed by the patient, overcame the inhibition and resulted in the secretion of a large volume of hydrochloric acid. This effect was abolished by bilateral section of the vagus.

The theoretical formulation is advanced that in the infant there exists a close association between anger and receiving food. This association may persist in some ulcer patients and in some 'normals' and may come to expression through a 'regressive innervation'.

S. GABE

Psychosurgery During 1936-1946. Walter Freeman and James W. Watts. Arch. of Neurology and Psychiatry, LVIII, 1947, pp. 417–425.

This paper is a survey of the results of ten years of psychosurgery. The most striking and consistent personality changes following prefrontal lobotomy are an increase of 'unself-consciousness' and a change in 'feeling tone'. These patients

emerge from the operation with an immature personality but seem to improve with time. There are defects in foresight and insight which remain permanent, but anxiety is diminished. It is denied that they become apathetic.

Freeman and Watts advocate caution in establishing indications for this procedure. Prefrontal lobotomy is an operation of last resort and should be performed only in patients who no longer have a reasonable hope of spontaneous recovery and only after conservative measures have failed. However, the authors apparently contradict themselves by stating that in their experience they have found that this operation is indicated while the patient is still fighting his disease. 'When emotion subsides and the patient accepts his dream world in lieu of reality, surrenders to his fantasies, then there is little that surgery can accomplish.' Prefrontal lobotomy performed on patients with dementia præcox within the first two years of illness resulted in eighty-five percent 'good results' compared with only thirty-one percent 'good results' when it was done later.

They claim to have achieved 'good results' with obsession-tension states, chronic anxiety syndromes, involutional depressions, and schizophrenic states. From the brief case reports in the appendix of this paper, it is difficult to ascertain what they consider 'good results'. The return to work and the cessation of agitation may indicate an improvement within the personality, but it may also indicate less of a personality. Since Freeman and Watts are not psychoanalytically oriented, they do not probe into the dynamics or structure of the personalities involved. It would be necessary to examine such patients psychoanalytically, both pre- and post-operatively, before one can properly evaluate the results of this drastic procedure.

Finally, the authors suggest prefrontal lobotomy for incurable organic illness where there is intractable pain. Here they have found that lobotomy brings relief and sometimes euphoria.

RALPH R. GREENSON

Outcome of the Tic Syndrome. Margaret S. Mahler and Jean A. Luke. J. Nerv. and Mental Disease, CIII, 1946, pp. 433–445.

A follow-up study of ten child *tiqueurs,* who had been patients at the New York Psychiatric Institute, revealed six who were making a fair to good adjustment years after discharge from the hospital. In some of these the tic syndrome had disappeared. The good results are attributed by the authors to excellent handling of the environment after hospitalization. Two patients in whom schizophrenic breakdown and poor social adjustment occurred, also showed improvement in the tic syndrome. Deep psychotherapy with undue emphasis on release of aggressive and erotic drives weakens the controlling powers of the ego and its continuation throughout adolescence is contraindicated. Psychotherapy of the type which will provide the child with some perspective concerning his instinctual impulses and the necessary strength to cope with them is indicated. It is essential to facilitate channelization of the increased amorphous motor urge into differentiated, highly organized locomotor and athletic outdoor occupation.

NORMAN REIDER

Motivation of Crime. David Abrahamsen. J. Nerv. and Ment. Disease, CIII, 1946, pp. 549–570.

This contribution deals with the unconscious motivations of criminal acts, the sources of motivation in the environment, the rôle of precipitating events, crime as a substitute for sexual devices, the need for punishment as a motive, and an attempt at classifying motives as 'symptomatic' or 'manifest'. In the discussion of the last point it is stressed that aggressive tendencies may be defenses against passivity.

NORMAN REIDER

Personality Reaction to Crime and Disease. David Abrahamsen. J. Nerv. and Ment. Disease, CIV, 1946, pp. 80–83.

A high incidence of psychosomatic symptoms exist in the members of a criminal offender's family, as compared with controls consisting of neurotic, psychotic and psychosomatic patients.

NORMAN REIDER

Electroshock and Personality Structure. Eric P. Mosse. J. Nerv. and Mental Disease, CIV, 1946, pp. 296–302.

The psychodynamics of successful shock treatment is understood as a punishment leading to relief of a sense of guilt. The temporary impairment of memory is seen as another therapeutic factor. Some clinical observations are made on the psychological reactions in the immediate aftershock period.

NORMAN REIDER

Mental Hygiene in the Atomic Age. Franz Alexander. Mental Hygiene, XXX, 1946, pp. 529–558.

Alexander observes that the widely publicized 'Atomic Age' cannot arrive until atomic energy is used for constructive purposes in medicine and industry. He expresses certain doubts as to whether we shall ever enter such an era, the essential prerequisite of which is a profound psychological change in man's attitude toward himself, toward his fellow man and toward his world. Hovering as we are on the brink of another war, there may be too little time in which to effect the drastic changes necessary for more rational behavior. Man's irrational motivations are essentially unchanged since the days when his behavior was more obviously determined by blind emotional forces, when his capacity to ignore reason led him to destroy his fellow man with bow and arrow instead of a chain reaction or biological warfare. Alexander eloquently reaffirms our 'cultural lag': the pathological 'preoccupation with the material prerequisites of civilization'. While the world as a whole is still in desperate need of material things, we have failed tragically to 'use the energies freed by technology for constructive purposes . . . to educate our youth not only for the production and distribution of goods but also for the higher expression of cultural life, for science, and art, and all those services that make for the art of living'. Alexander foresees an increasing disparity and incongruity between ideology and economy,

with consequent intensified personal insecurity and loss of self-esteem. Until society learns to employ constructively the energies liberated by machine civilization, the outlook for personal emotional health and for the survival of our civilization is dim.

JOSEPH LANDER

Group Psychotherapy with Veterans. Nathan W. Ackerman. Mental Hygiene, XXX, 1946, pp. 559–570.

In a clear, concise paper, Ackerman discusses in satisfying detail the technique, indications and contraindications for group treatment. He considers it 'a more real experience than individual therapy', and 'less bound to the irrationalities of the unconscious'. It should be viewed as an independent therapeutic technique and not as a substitute in competition with individual treatment. It is of little value for those with chronic rigid personality distortion with deep unconscious roots and is of particular value for those cases in which the conflict is between the individual and his environment. The emphasis in treatment is on the pathology of social behavior rather than on more purely intrapsychic sources of tension. The criteria for the selection of patients for group therapy are outlined in the paper, which is strongly recommended to those interested in the subject.

JOSEPH LANDER

Lessons from Military Psychiatry for Civilian Psychiatry. William C. Menninger. Mental Hygiene, XXX, 1946, pp. 571–589.

This is a thoughtful survey, of great interest to the clinical psychiatrist, the military planner, to those interested in public health and to those concerned with medical education. One is startled afresh to read that there were one million admissions to neuropsychiatric services in army hospitals between 1941 and 1946, and that three men received psychiatric help outside a hospital for every one who entered the hospital. Menninger considers group treatment, narcotherapy and elaborately organized hospital activities the three outstanding therapeutic contributions of army experience. He stresses the lack of dependable criteria for determining the soldier's threshold of tolerance of emotional trauma and indicates the forces which enabled men to function under conditions of great stress: effective leadership, indentification with the group, conviction of the importance of the job. Some of the lacks in military psychiatry are touched on briefly.

JOSEPH LANDER

High Lights on the Psychology of Infancy. C. Anderson Aldrich. Mental Hygiene, XXX, 1946, pp. 590–596.

This is a recapitulation of the successive stages of the infant's physical and emotional development. Aldrich stresses the overwhelming importance of parental flexibility in meeting the child's needs and demands. It cannot be repeated too often that the baby is itself a good judge of what it needs and when it should have it.

JOSEPH LANDER

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Notes

Ernest Jones

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NOTES

A MEMORIAL MEETING FOR DR. A. A. BRILL was held at the New York Psychoanalytic Institute, March 30, 1948. Among the tributes to Dr. Brill, was that of Dr. Adolph Stern, President of the Institute. The address of Dr. Sandor Lorand, President of the Society, will be published in the International Journal of Psychoanalysis. The meeting was largely attended by members and students of the Society and Institute.

DR. STERN:

Brill is a man who it is difficult to envision as having passed from our midst: he was so vibrant, full of interest and the joy of living. I recall my first meeting him in our last year at medical school in 1903. It was a refreshing experience, meeting and getting acquainted with him. We spent some time together, particularly preparing for our final examinations. He visited my conventional and orthodoxly religious home where he was a source of worry to my parents because of his unconventional and irreligious ways. They felt he might not be safe company for me. His positive, self-assertive, confident behavior, his knowledge of philosophy, literature, music, the different kinds of people with whom he associated and was on friendly terms, his sense of humor, his ability to tell of his experiences and good jokes, his gregariousness—these attributes made him an interesting individual. At the time we first met, Brill had been in this country some fourteen years. He was nonetheless characteristically cosmopolitan and remained so for the rest of his life.

The course in psychiatry at the College of Physicians and Surgeons, Columbia University, consisted of not many lectures in our last year. Our teacher was a man who talked of his patients in an interesting way, teaching us students to understand them as people who have symptoms which in some vague way were connected with their past history. Both Brill and I found these lectures of great interest. Some of us, Brill among them, were influenced by this teaching after we entered the New York State Psychiatric Service. Here an undynamic descriptive psychiatry prevailed, unsatisfactory to both of us. Brill at this time displayed an 'empathy' for the psychiatrically ill. His interest in psychiatry grew. On the occasional visits we made to each other, for we served in hospitals some twenty-five miles apart reached only by horse and buggy, we discussed our experiences. Brill's feeling for the patients and for psychiatry was something intuitive. He displayed an affective understanding of and a response to the patients. He was dissatisfied with psychiatric phenomenology then prevalent in the hospitals and in textbooks. No wonder then that later he was so inspired by psychoanalysis, with its promise for psychiatry.

Brill, by nature, was not inclined to be neutral. He was for or against as a rule, and as a rule unequivocally so. This characteristic was mobilized in the interests of psychoanalysis when Brill returned from Europe in 1907, following his first meeting with Freud and his followers. The infant years (1912–1930) of psychoanalysis in this country were strenuous ones. Brill rose to the occasion and was in the van. He took it upon himself not only to spread knowledge of psychoanalysis through his translations of Freud's works, his own publications, by lecturing and teaching, but he took it upon himself to reply

to attacks which were by no means always fair. Great courage was demanded of him. He never failed.

Among the membership of the American Psychoanalytic Association around the years 1918–1920—at that time it was a loosely knit, heterogeneous group—forces were set at work and kept going for some two years to wreck it and to form another organization, national in scope, but not called 'psychoanalytic'. Mainly through Brill's efforts this attempt failed and the American Psychoanalytic Association retained its identity.

Such in brief is my vivid recollection of Brill. His influence, unique of its kind, and our memories of him, will ever be with us.

Through the courtesy of Dr. Philip Lehrman, we print the copy of a letter received from DR. ERNEST JONES, written March 3, 1948, from Sussex, England.

DEAR DR. LEHRMAN,

I have just received the very sad news of Brill's death, and shall be grateful if you would convey to the New York Psychoanalytic Society my very special condolence at the loss of their great pioneer. I enjoyed a quite unbroken friendship with him for just forty years, and being in his intimate confidence was able to appreciate his very sterling qualities. He was a man of unimpeachable integrity and always maintained the highest standards, both professionally and personally. We were in the early hard fight to establish psychoanalysis in America together, and I always admired his unyielding spirit and constancy. His generosity and readiness to help wherever he could were unfailing and of the highest order. What he accomplished for psychoanalysis is well known to you all, and will no doubt be recorded in the proper place. He was certainly one of the most valuable personalities our special branch of science has produced, and his loss will be widely and deeply felt.

Yours very sincerely,

ERNEST JONES

DR. ROSE OWEN BRILL, wife of the late Dr. Abraham A. Brill, was elected to Honorary Membership in the New York Psychoanalytic Society. Dr. Rose Owen Brill is a psychiatrist, having served in the New York State Hospital Services at the time she was married to Dr. Abraham A. Brill. For forty years she has worked inconspicuously as a supporting partner to Dr. Brill in the advancement of psychoanalysis.

At the annual business meeting April 27, 1948, the NEW YORK PSYCHOANALYTIC INSTITUTE and the NEW YORK PSYCHOANALYTIC SOCIETY elected officers for the year 1948–1949.

INSTITUTE		SOCIETY
Dr. Phyllis Greenacre	President	Dr. Henry A. Bunker
Dr. Rudolph M. Loewenstein	Vice President	Dr. Dudley D. Shoenfeld
Dr. William Needles	Secretary	Dr. Herbert A. Wiggers
Dr. Harry I. Weinstock	Treasurer	Dr. Harry I. Weinstock

AMERICAN PSYCHOANALYTIC ASSOCIATION—Representative to the Executive Council—1948–1950: Dr. Philip R. Lehrman; Representatives to the Board of Professional Standards—1948–1950: Dr. Sara A. Bonnett and Dr. Sandor Lorand.

With the ratification of its Constitution by Mexico and Byelorussia, the WORLD HEALTH ORGANIZATION on April 7th passed from its status as an Interim Commission to become a Specialized Agency of the United Nations. The action of Mexico and the Byelorussian Soviet Socialist Republic made a total of twenty-seven UN members, one more than the required number, which have ratified the WHO Constitution. Accepted by the delegates of sixty-one nations at the International Health Conference in July 1946, the Constitution stipulated that it would 'come into force when twenty-six members of the United Nations have become parties to it' by depositing their ratification documents with the Secretary-General of the United Nations at Lake Success.

The first World Health Assembly will take place at Geneva in June 1948 with delegations from at least thirty-five nations, twenty-seven UN members and eight nonmembers. The WHO becomes the United Nations' ninth Specialized Agency—and the first in which the United States is not a member. France is the other major power which has not yet ratified the WHO Constitution. In the case of the United States, the bill for ratification had already passed the Senate last year and had been unanimously approved in the House Foreign Relations Committee; however, the House of Representatives Rules Committee—by a vote of five to two—tabled the bill, without explanation to the public.

The officers of the AMERICAN PSYCHIATRIC ASSOCIATION announce that Dr. Daniel Blain, Chief of the Neuropsychiatric Division of the Veterans Administration, became Medical Director of the Association February 16, 1948. He expects to devote his full time to the affairs of the Association about September 1, 1948. The position of Medical Director has been established for the purpose of making available to the members, the affiliated societies, the committees and sections of the Association and to public and private organizations interested in the field of psychiatry a full time psychiatric official of the Association. As Medical Director, Dr. Blain will activate policies approved by the Association, and stimulate the appropriate groups and committees of the Association to respond to the needs and demands of the Association and its membership. He will be available to members and to the affiliate societies as a source of information and advice. He will as well serve to effect liaison with the public and with interested groups on subjects relative to the work of the Association and to the general interests of society.