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Gert Heilbrunn

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PSYCHODYNAMIC ASPECTS OF EPILEPSY

BY GERT HEILBRUNN, M.D. (SEATTLE)

Epilepsy for thousands of years has held a special place in the spiritual, artistic and scientific imagination of many peoples. The terrifying suddenness and the drama of the convulsive attack led observers to transcendental speculations of which the consequence was to treat this phenomenon with circumspection, lest it be sacrilegious to interfere with divine or demoniacal powers. It is perhaps in part this tradition of magic which has lured so many scientists into exploring this disorder ever since Hippocrates emphasized its biological nature; yet the natural sciences made no further gains. They called the patient afflicted with 'falling sickness' a degenerate and accumulated physiognomic proof of this theory. The same attitude permeated the 'exact' sciences. Isolated ganglion cells in the molecular layer of the cerebral cortex of some epileptics were regarded as evidence for the degenerative theory until their absence in most epileptic brains forced the pathologist to abandon their etiologic significance. The high percentage of convulsive disorders among imbeciles and idiots supported the belief that the convulsion was a manifestation of some primary cerebral degeneration.

This scientific pessimism was somewhat relieved when investigations found an increasing number of clinical and pathological conditions which were related to the etiology of convulsive seizures. The convulsion was interpreted to be a symptom of the underlying brain disease whether traumatic, inflammatory, neoplastic, metabolic, vascular or degenerative. This group could now be separated from those correctly classified as cryptogenic. Important for diagnosis and therapy, this step, moreover, proved a challenge to research which saw the problem clearly defined: to find the cause

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of that group of convulsive disorders which afflict about half a million people of all ages in this country, people who otherwise appear to be quite healthy. Neuro- and physiopathologic changes, initially hailed as pathogenic organic substrata, proved to be sequelæ. Only the discovery of preparoxysmal alkalosis continues to hold etiologic interest. A low *p*H, however, does not invariably prevent the occurrence of convulsions, nor will inversely a high *p*H always lead to seizure-discharges. The opinion prevails, therefore, that the selective susceptibility to seizures must be based on one or more other factors peculiar to the individual. Assuming that the electroencephalogram may reflect such a factor, one is still confronted with the fact that, according to Lennox *(1)*, cerebral dysrhythmia is present in ten percent of the entire population, whereas only one half percent are subject to seizures. EEG tracings show no correlation with the absence or presence of convulsive symptoms. It remains sheer speculation to ascribe the clinical symptoms to different qualitative or quantitative impulses. Organic research does not at this time furnish the missing link which leads from neuronal to convulsive discharge.

Psychiatric and, particularly, psychoanalytic work has contributed much to fill this gap. The convulsion has been explained as escape from an unbearable situation *(2)*, as forbidden sexual *(3)* or aggressive activity *(3, 4, 5)*; as suicide *(6, 7)*, and as rebirth *(7)*. The accuracy of these interpretations and the precision with which the clinical symptom fits the given emotional constellation are in each case supported by careful analytic study.

Mrs. R A, thirty-two years old, was a rather unattractive housewife. Her mother was a Polish immigrant who came to this country at the age of twenty-four, uneducated and without family. She had worked all her life at heavy manual work, mostly in factories and as a domestic. Both the patient and her brother, who was three years older, were illegitimate from different fathers unknown to them. The brother, always the favorite child, was obliged to go to work after he finished the

eighth grade. The family lived in poor surroundings, and there was never enough to eat. The patient graduated from high school when she was seventeen. Prior to this time she had worked at various jobs. She finally opened her own dressmaking shop, which she kept until one year after her marriage at twenty-five, after one month's courtship. Her husband, a machinist, was a tall, handsome, intelligent man of thirty-two, who, throughout the years, yielded to his wife's various moods and emotional demands. They had two daughters, three and four years old.

The patient described her mother as a severe, superstitious person, who left her with a good deal of responsibility for the housework. She often talked to the patient as she would to an adult but was 'never able to show any affection'. The patient was seldom allowed to go out with friends. She recalled vividly the many cruel beatings she received from her mother because of apparently trivial incidents. When the patient was nine and her brother twelve, the mother caught them in some sex play. She did not rebuke the brother, but for years tormented the patient with this incident. When she began to menstruate at thirteen, her mother accused her of having sexual relationship as the cause of the bleeding. When the patient was pregnant with her first child, the mother called her contemptuously, 'You pig!'.

At fourteen she began having petit mal attacks, which were always induced when she 'became scared'. At twenty-three she had a grand mal attack, and continued to have approximately five to eight major convulsions a year since then. Each seizure was usually preceded by an aura of hunger, lasting a few seconds. She might have diminished the frequency of the seizures had she taken the dosage of drugs prescribed for her.

At the age of twenty she slipped on the floor of the store in which she was working—under the eyes of the store manager, with whom she had been flirting—subsequent to which she developed arthritis in her hips. A year later she had sexual intercourse with him, her first sexual experience. Following

this she had relations with her dentist, a man many years her senior. She entertained a great many sexual fantasies about her family physician, whom she considered her 'father idol'. The arthritic symptoms persisted with particular intensity during the spring and the fall. At times the sternocostal joints, wrists and fingers were involved.

Over the years the patient had become increasingly concerned about her convulsive seizures. An EEG showed dysrhythmia commensurate with the clinical picture. Of late she had become a poor housekeeper, had neglected her children, was often depressed, and entertained strong suicidal ideas. Sometimes she resented that her husband was not forceful enough, allowing her to dominate him. Sexual intercourse was 'a beautiful experience' only when she was the aggressor or assumed a masculine position in the act. There were periods of frigidity.

From the beginning the patient sought to secure the analyst's sympathy by enumerating the many sufferings she had to endure in relation to her mother. In the first hour a dream betrayed her craving for oral gratification which she hoped unconsciously to find in the analysis. She professed love and admiration for the analyst, substituted him for her husband in fantasies during passionate sexual intercourse. Because her intense desire to touch the analyst's cheeks or hands could not be satisfied, she became depressed and had suicidal fantasies. The explanation that she felt guilty about her rage, born of frustration, enabled her to express hostility openly. The doctor was not a human being, simply a cold scientist to whom she was just an interesting mathematical problem; she had always been misunderstood by teachers; nobody loved her. The arthritic pains, practically absent since the beginning of treatment, reappeared with the hostile transference and hostile dreams about her brother. In them he was mother's preferred baby, who as an adult did not have any housework to do; a giant was threatening to kidnap him. Her mother was turning her back toward the patient and telling somebody that the brother had a pacifier which he did not want to give up. Her

penis envy was portrayed in a dream in which her body extended rigidly upward, reaching a height of nine feet. She dreamed of going into a butcher shop to buy meat; then she reported to her mother that she had failed; her mother was surprisingly gentle and gave her a wedding ring. This was followed by homosexual dreams.

Her dreams revealed her fantasy for gaining possession of a penis by oral incorporation, acted out by practicing fellatio with her husband toward whom she became unusually affectionate. There was hardly an hour in which she did not speak of her ardent love for the analyst, and fantasied having a child with him. Her guilt about her demands was expressed in feelings of intellectual and class inferiority to him. Her fear of being criticized prompted her to cancel her analysis after twenty hours of treatment. It required little persuasion to induce her to continue. After she had voiced her bitterness about the cold-bloodedness of the analysis, she sent the analyst a postal card telling him how well she felt, gave him a huge bunch of lilacs and ivy in a vase, and brought him a sentimental love letter she had written.

She continued to have sexual dreams and fantasies involving the analyst and felt reality as empty and frustrating. Periods of elation alternated with days of depression, during which she expressed bitterness and anger toward the analyst, and her wish to interrupt the analysis. Repeatedly she brought gifts of flowers and food to earn the analyst's love, and to assuage her guilt for the hostility deriving from the frustration of her insatiable demands. Her destructive aggression toward her husband, her children, and the analyst's children led to guilt and depression, and she renewed her efforts to appear as a good girl lest the analyst punish her by sending her away. This, however, hurt her pride. She reacted with fantasies of being a man, being a strong and resourceful pioneer woman, helping her brother, etc. She finally seized upon the occasion when the analyst had made an inconsequential mistake in a prescription for phenobarbital to go into a blind rage against men in general and the analyst in particular. She dreamed of

beating her brother with a stick. Fantasies of killing her children and herself culminated in a major convulsion and arthritic pains in her fingers and chest. Another seizure occurred approximately six weeks later, preceded by dreams of fellatio with castrative intent, followed by arthritic pains in the chest and hips. Abundant oral incorporative castrating dreams and fantasies were intermingled with the wish to have a baby boy by the analyst. Restitution dreams dealing with urine, feces and money occurred in proportionate frequency. In a dream in which she cut off her brother's penis, which looked like chicken skin, and threw it on a pile of refuse, she was afraid her mother would see her throw it away. She needed the penis to please her mother, acquired it at her brother's expense, and feared her mother's disapproval for having castrated the preferred child and hated rival. The erotized longing for her mother came to expression in a dream precipitated by a discussion of breast feeding: eager to have sexual intercourse with a buxom prostitute, she felt the woman's pubic region, buried her head in her breasts, and experienced full orgasm.

An interpretation linking her longing for her mother to the transference was ill-received: 'I do not want to believe that you are father and mother to me. I just want to continue loving you as you are.' She wished again to discontinue the analysis: she did not want to use the analyst as a crutch, wanted to be independent, did not want to be disillusioned. If only the analyst were a woman, she could be spared so much suffering. Dreams in which her oral demands were curtailed were devices to gain the analyst's love and approval.

The prevalent dynamic factor in this patient's emotional life was her nearly insatiable demand for love. She was reared a fatherless child by a mother who, in her embitterment toward life, smiled seldom and often punished the child cruelly. Economic conditions did not permit the mother to devote much time to her children even when they were very small. From the age of two she was left in the custody of her brother, three years older, while the mother was out working to earn money for food, which was not always plentiful. The brother, like

his mother, was bitter and hostile, and became an alcoholic. The girl's insecurity in relation to her mother was increased by the fact that the brother was always the preferred child. Reasonably, the girl longed for a father, the security of a mother's love, and release from an environment of poverty. Her adult strivings and achievements could not replace the unsatisfied needs of her infancy and childhood. Analysis promised unconsciously to her the hope of realization of all her desires. Deep disappointment and the rage of frustration were inevitable. By a process of testing reality she had to correct the aim: 'Mother kept father away from me; now I keep brother and father away from her!' It was a conflict between œdipal rivalry with the mother, and pregenital oral dependency on her, in which the latter enhanced the guilt about the former. The appearance of arthritic pains and convulsive seizures, particularly during phases of intensive transference, served a double purpose: the pains in the hips were defenses against hostile or erotic possession of the object; the inability to walk precluded the danger of the guilty sexual implications of 'slipping'. The painful condition, furthermore, kept her 'frozen' in her rage, the intensity of which determined the occurrence of convulsive seizures. The intensity of this defense proved to be a yardstick of the magnitude of the forbidden impulse.

That the pains were in the service of self-punishment for forbidden impulses found confirmatory evidence in the localization around the sternocostal joints. Her strong oral needs found gratification only in an exclusive claim to the mother's breasts, condemning her brother to starvation. There were several dreams in which she tried to find food for her starving brother.

The arthritic pains, the convulsions and the continued emotional suffering satisfied the patient's strong masochism which was the price she had to pay for her hatred of her mother, counterbalancing her oral aggression. Suffering was the medium, and submission the means through which she could be close to mother.

An anthropological research assistant, twenty-three years old, had been sent to an island to study, in preparation of his doctoral thesis, the sociopolitical aspects of the natives in relation to their religion and superstitions. For one year he had collected a wealth of material and on the eve of his departure from the island, while encountering difficulties with the customs officials, he had his first grand mal attack. In relating the incident he stated that he had had an increasing fear that his work would not meet the requirements of his sponsors. He felt excessively angered by the customs officials, when the seizures occurred without warning. He had been married three years. He had shown great promise and had enjoyed the personal interest of the leading men in his department in the university. He had found it increasingly difficult to concentrate on his work. Of several inviting opportunities, he had chosen for research an island in the West Indies in order to work 'independently'. After his return, he resumed his position in the department, idling about, unable to utilize the material he had collected for his dissertation. Three years later, still in good favor with the department because of his innate brilliancy, he and a co-worker were sent to a small town for a sociostructural survey. When he realized painfully at the end of the work that he had accomplished considerably less than his colleague, he suffered another grand mal attack. Afraid of the bad impression the impending report would unquestionably make on his superiors, he withdrew from the university and enlisted in the army as a 'face-saving device'. He received a commission, and initially he liked personnel and assignment work, always trying to avoid ranking officers, fearing authority. Eventually he grew tired of his job, which entailed too little responsibility and no opportunity for free reign, and he pursued with all vigor his transfer to a hospital unit in Normandy where he was to work with neurotic soldiers. When he arrived, promoted to a higher rank, the commanding officer told him that he was to be detailed to work in the post office. He suggested to the commanding officer that a mistake must have been made and, with an initial cry, had his third epi-

leptic seizure, biting his tongue. He was returned to the United States to be discharged. Wishing to visit his family, he applied for leave which was denied him after repeated requests. He went AWOL, and had his fourth convulsion on the train. A fifth seizure occurred after his discharge, when he received a friendly telephone call from the mentor in the department of anthropology who favored him the most. It was on this man's advice that the patient began analysis.

He had declined an offer to resume work in the university, he was not otherwise employed, and had abandoned the completion of his thesis. His conflict with authority, which so transparently motivated his convulsive seizures, caused him to appear for the first interview severely intoxicated. His wife telephoned to cancel the second appointment because the patient had had a convulsion just prior to it. The fear of the analyst, which soon assumed the guise of a passive homosexual transference, constituted the main theme of the analysis.

He was the second of four children. He remembered distinctly and with considerable bitterness that there had been no place for him in the car when the family took his mother and the newly born brother, who was three years younger, home from the hospital. He had had to stand, whereas the baby was securely nestled in his mother's lap. He continued enuretic until his fourteenth year. His dreams and associations were replete with wishes for the younger brother's death, and sadistic attacks upon the pregnant uterus. He neglected his two young daughters, jealously claiming for himself his wife who was equated with his mother in numerous slips of the tongue and in dreams. The father had been a towering, powerful man, prominent in his profession. Once, after particularly intensive analysis of the son-father relationship, the patient had a convulsion when, on his way home, he stopped in a book store and noted a book on a theme to which his father had devoted a good part of his career. Later, during a phase of acute conflict between rivalry with his father and brother and reactive passive submission to the analyst, the patient was invited to be co-author of a book on material which he had

helped to collect. His reaction was ambivalent: he felt inadequate to the task and sought arguments for withdrawing; yet he was flattered that he was chosen by the senior author whom he had always worshiped. When he learned that not he alone but several members of the department were to participate in the work, sudden nausea forced him to leave the meeting. He had hardly left the room when he had a seizure in front of the dean's office, bruising himself severely and biting his tongue deeply. The meeting had certainly touched the basic conflict between his ardent wish for and simultaneous fear of success which for him, in the final analysis, unconsciously meant incest with the implied threat of annihilation by father. Failure relieved him of that threat and allowed him continued dependency on mother. His repressed œdipus usurped nearly all of his available countercathexes, leaving an inadequate protective barrier of ego defenses. A heavy cigarette smoker, he had for years used alcohol not only to alleviate his anxiety and depression, but also as an oral, narcissistic gratification. He imbibed as well large quantities of fruit juices and water, which were considerably increased during times of relative or complete abstinence from alcohol.

A similar oral dependency was the main symptom of a forty-year-old epileptic patient, a divorced woman. Her grand mal seizures had been successfully controlled by daily medication; however, she still had numerous daily petit mal attacks, and bulimia every two or three weeks lasting about three days.

A girl of nineteen, in severe conflict with her mother, could not resist an urge to eat. Petit mal attacks and psychomotor seizures began when she served as a subject for hypnosis when a student in psychology. She could not rise from her chair, felt completely helpless, and screamed for about ten minutes. In sleep she was regularly plagued by terrorizing dreams full of persecution, disaster, and destruction. The patient's guilt about her hostility toward her mother had developed from the fear of not being loved by mother, a complex which had arisen from the mother's admitted ambivalent attitude toward the

daughter. During the first five years of her life, the child was left in the care of a nursemaid. Subsequently, whenever the mother cared for the child, tenderness, angry punishment and rueful solicitation were showered upon the child in quick succession. The girl's wish for love and protection was expressed in a touching dream: a girl wanted desperately to get into a house; the door was locked, and she cried bitterly.

The longing for his mother, dominating a patient's emotional life, is excellently portrayed in a patient who had his first convulsion the day he graduated from high school. Sixteen years old, he had taken great pride in his scholastic accomplishments. It was a matter of grievous disappointment to him that his mother did not attend his, but had attended a cousin's graduation. To his fourteenth year, the patient and his twelve-year-old brother shared a bed with their mother, which acutely fostered incestuous impulses and intense rivalry. The day following the first seizure, the patient felt the aura of another attack, ran toward his mother, and had an incomplete seizure as she fondled and consoled him. He had a third attack one year later while preparing a drawing with which he hoped to enter a contest. Unfortunately, he could not remember any pertinent feelings or facts which might have helped to understand the dynamics of that seizure. His fourth and, so far, last convulsion occurred seven years later when a girl, with particularly prominent breasts, quite unexpectedly put her arm around his neck while he was working in an office. The patient had always been fascinated by buxom women who resembled his mother. He sought analysis at thirty-four, afraid that he might have subsequent convulsions. He had not been successful, lacking education, initiative and drive. He had been employed in mediocre jobs and had spent two years idling, living with his parents, until the onset of World War II offered him the welcome opportunity to enlist. Under the protection of a military organization, he rose from a private to the rank of lieutenant colonel, scored fabulously in various tests, and performed excellently in military government. After

his discharge, he was confronted with his inner emotional insecurity. For a long time he avoided seeking work, gratifying his passivity in the analysis. After working through his submissive homosexual transference, the dependency on his mother was overcome. His selection of women was no longer determined by mother images, he became more energetic and self-confident, his church group accepted him as a leader, and he contributed valuable ideas to the firm which employed him.

SUMMARY AND CONCLUSIONS

Observations from the analysis of a group of five patients with idiopathic convulsive seizures lead to the conclusion that passive dependency on their mothers was the psychodynamic substratum from which secondary mechanisms emanated. The clinical psychopathological variations correspond with the patient's early and later experiences and serve as defenses against or as reactions to the original dependency. The epilepsy appeared as a sign of physiologic disintegration of one or several impulses at a critical moment, when rising emotional tensions overwhelmed the available countercathexes, or when the waning forces of the ego offered too little resistance to the pressure of the repressed. Oral, submissive and ingratiating traits of character signified a craving for the gratification of powerful narcissistic dependent needs and thus counteract the inherent weakness of the ego. It is conjectured that nocturnal grand mal seizures arise from a disequilibrium between forces of the id and the ego, physiologically prevalent during sleep, and, further, that the peak age for the development of such seizures during the first two years of life is determined by the relatively immature state of the ego at that period.

The patients studied could not tolerate any interference with their drives for dependent security and reacted with immediate motor discharge to any such threat, with complete disregard for reality. In the presence of the predisposing paroxysmal cerebral dysrhythmia, whenever the strength of the ego was exceeded by forces of characteristic dynamic pro-

portion, epileptic symptoms ensued. The reason for the varied symptomatologies of grand mal, petit mal or psychomotor equivalent is not clarified. The impressive intensity of the patients' emotions suggests the assumption of quantitative factors. The lack of precise measurements precludes the possibility of objective comparison. Whether the clinical variations are prompted by additional emotional factors which have so far escaped apprehension, or whether the varied responses can be expressed as quantitative ratios of the various components, must be reserved for future studies.

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Physiological Systems and Emotional Development

Leon J. Saul

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PHYSIOLOGICAL SYSTEMS AND EMOTIONAL DEVELOPMENT

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

A fundamental psychosomatic concept is emerging which is of psychodynamic importance but which has not yet received extensive recognition and study (*1*). It is well established that regression (or a tendency of the organism to revert to earlier childhood and infantile patterns) is a basic motivation for many psychosomatic symptoms as well as for all neurotic symptoms. Indeed, most psychosomatic symptoms are forms of neurotic symptoms, and are best understood and treated as such. They are disturbances of physiological functioning which are at a lower than cortical level—in other words, not in thought or behavior.

Thinking in terms of regression has been strongly influenced by Freud's libido theory and terminology. He called the period of approximately the first year of life the oral phase because of the central role of suckling, imbibition, and the sensuous enjoyment of these by the infant. Later toilet training becomes important with increased anal sensations. Freud called this 'the anal period'. He mentioned the increased muscular development and aggression at this time and hence applied the term 'anal-sadistic'. Later, because of the child's concern with the differences between the sexes, and with masculinity, he distinguished a 'phallic' period; then came the 'œdipal' period, so called because of sexual feelings and rivalries, especially in relation to the parents.

This is a very rough sketch of the original libido theory of the development of instincts which was later elaborated by Freud, Abraham (*2*), and others. Probably because of the initial concentration on libidinal feelings, the other physiological

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This paper should be read in conjunction with the one that follows, *The Punishment Fits the Source.*

From the Section of Preventive Psychiatry, Department of Psychiatry, University of Pennsylvania School of Medicine.

systems were neglected, particularly in relation to the mother or substitutes for her. Yet the psychobiology of these relationships is essential to an understanding of symptoms which are expressed in diseases of the skin, respiratory, muscular, etc. systems.

Before birth the child's relation to the mother is primarily through its skin and through respiration. At birth the skin is exposed to extrauterine environment and the child is forced to breathe for itself; also the circulation must adjust to these new conditions. Muscular coördination and locomotion become of great importance toward the end of the first year, spelling new powers and new independence from the mother, and speech commences to develop. These examples will suffice. There seems no doubt that what is known about oral needs and gastrointestinal symptoms (*3*) applies equally to the other physiological systems. The earlier dependent relation to the mother through skin and respiration, and the later relation in being carried (locomotor) are entirely analogous to the oral, suckling relationship. Thus we know that certain persons express their needs for love, care and help primarily in the form of eating or being fed, while other persons express their needs for love more via other physiological systems. In strongly oral personalities there is a persistence of, or return to, the infantile suckling and feeding relationship to the mother. In many of these persons this is expressed frankly in dreams of food, eating, drinking, being fed; and in life they are disposed to excessive eating or drinking, to reactions against this, or to other disturbances of this function. Their needs, with consequent frustrations and anger, tend to be expressed by and affect chiefly the upper gastrointestinal tract, which becomes for them the main field of battle. In other persons the main battle is fought over a different organ system.

This is quantitative matter. All major needs and reactions involve the entire organism which is a single, highly integrated unit. Varying from person to person, one organ system or combination of systems predominates over others as a pathway for satisfaction. Probably everyone uses all systems, the

organism being a unit, but there is a great quantitative variation in the proportional prominence and combinations. In terms of libido theory, all levels are represented in everyone, but in different proportions in each person (*4*). Everyone has suckled, hence everyone expresses needs and tensions to some extent in oral form—hence the universal popularity of social eating and drinking. But the intensity of the need is different in different persons, and in some the oral pathway is more, in others less important.

The needs for love and care may be expressed chiefly through the respiratory system, which, by the child's cry, is a vital link to the mother—the ego's cry for help, so to speak—rather than the libidinal gratification of suckling. If this relationship persists, and is suddenly mobilized by a threat of separation or estrangement from the mother, then the symptom is not oral or gastric, but respiratory. This is in part the psychology of asthma. The asthmatic has many dreams of being protected and sheltered, rather than of eating and drinking (*5*). So close is this correlation that when a patient presents dreams of going into closed places, such as a room, a closet, a cave, and perhaps under water, one must always look for a predisposition to allergy—although this tendency to intrauterine regression must be in a certain status to produce actual allergic symptoms. This may well relate to the original state of being in the womb, protected, and not having to breathe independently. Feelings of suffocation are common in persons who are very strongly attached to their mothers and often signify, in part, the regressive wish to give up struggling and return to the mother—most deeply, to intrauterine existence. Such a person is apt to seek his retreat not to breast or bottle but by crawling psychologically into a hole. The frustrations of his needs and the consequent anger all tend to be expressed by and to affect the respiratory tract.

However much or little erotism can be attached to the *respiratory* tract, through smoking, singing, talking, and the like, the *skin* is obviously a most important organ for sensuous and erotic sensations (*6*); and *muscular* activity, especially in

men, can also be erotized and is intimately involved in sexual desire. Although suckling may be the central libidinal satisfaction during the first year, these other physiological systems too are of importance for sensuous gratifications, as well as for self-preservation. This is readily seen in the infant's relations to the mother via these systems—in its attachments to her, its stimulation by her, and in the development of independence from her. Cuddling and bathing, for example, obviously are enjoyable largely because of the sensual stimulation of the skin. Meager evidence indicates that certain of these persons try to satisfy their needs for love (originally the mother's) especially by being admired and fondled. The pleasure of being carried and cared for may cause conflict later with the drives toward independence in walking and doing.

The physiological systems which predominate as pathways for gratifying needs dating from infancy form specifically vulnerable points. Under emotional stress one particular system is especially affected. It may be used for excessive gratification such as overeating (oral), or excessive smoking (oral-respiratory). It may go on partial sit-down strike, refusing adult functions and returning to some extent to early infantile or fetal ones, such as anorexia (gastrointestinal), breath-holding (respiratory), or refusal to walk (locomotor). The functioning of a physiological system may be disordered by emotional drives through a combination of 1, excessive stimulation; 2, inhibition; 3, frustration and consequent anger; and 4, rejection of the drive with reversal of function (as in some vomiting) (7). These disorders of function result in such pathology as peptic ulcer and asthma.

For other persons genital sexuality is the major pathway for satisfying needs—and also for symptoms, such as exaggerations or deficiencies in sexual functioning. In Freud's view the genital drive is so powerful because all other erotisms and tensions are drained to some extent in coitus.[1] Quantita-

[1] *Cf.* Ferenczi, Sandor: *Thalassa: A Theory of Genitality.* Chapter 2. New York: The Psychoanalytic Quarterly, Inc., 1938. (Ed.)

tively, some seek to satisfy their needs, suffer their frustrations, vent their anger, and otherwise live out their emotions and conflicts preferably by way of the genital system, more than do other persons. It is for them the dominant pathway.

Preliminary observations suggest that in skeletomuscular disturbances, such as arthritis, this system plays a special role emotionally and biologically which can be traced back to early stages of its development. In these persons muscular activity, rather than eating or being fondled, is apt to be of special importance as a pathway for satisfaction or for regression. In some of these cases the dreams are filled with fantasies of muscular activity at the expense of other organ systems. It is within the bounds of possibility that certain tachycardias may represent partial temporary regressions to the fetal heart rate. We may speak properly of preoral psychobiological development and relationships to the mother.

SUMMARY

There are biological attachments and relationships to the mother other than the oral which are important psychologically and for psychosomatic symptoms. Examples are the fetal relation to the mother via respiration, and the later relation through the cry for the mother; the relation through the skin, first intrauterine and then by cuddling, fondling, and bathing; and the locomotor relationship through being carried by the mother. The role of these relationships in the formation of symptoms in the respective physiological systems is analogous to the role of the oral suckling relation to the mother in gastrointestinal disorders. These organ systems are pathways for the satisfaction of needs and for expressing inhibitions, frustrations, and fight-flight reactions of aggression, and for regression in connection with them. Emotional conflicts may be expressed over these preoral paths just as over the oral.

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The Punishment Fits the Source

Leon J. Saul

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THE PUNISHMENT FITS THE SOURCE

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

Different persons express their emotional needs and the conflicts over them via different physiological systems, gastrointestinal, dermal, respiratory, skeletomuscular, cardiovascular, and so on. This seems to point to a general principle which includes superego reactions and other highly refined psychological processes.

By the law of the talion, the punishment fits the crime. There is no reference to the *motive* for the crime nor to the *source* of the motive. An eye for an eye, a tooth for a tooth—whether in retaliation against a man who unwillingly got into a fight in self-defense or against a ruthless sadist with no further motive than erotic pleasure.

Psychoanalytic material often shows clearly a further step, namely, the *source* of the motive. A girl, because of severe deprivation in childhood, developed heightened cravings for love. These appeared in her dreams in frankly oral form. She suffered from a peptic ulcer and showed the well-established dynamics of the ulcer patient: receptive desires for love, care, support, expressed in part in the behavior of her stomach and reflected in oral fantasies in her dreams. Frustration of these needs caused anger—and this anger apparently affected the gut *(1)*. When frustrated and angry she developed epigastric pains. On one occasion she set her heart, or rather her stomach, upon a certain relationship but suffered a serious rebuff. She reacted with a flare-up of her ulcer symptoms and with bleedings and hematemesis. Here the source, the craving, was expressed via the stomach, and the frustration and anger, both conscious and unconscious, also affected the stomach. The aggressive and regressive reactions affected the stomach. Here the punishment is not simply for the aggression but strikes at

From the Section of Preventive Psychiatry, Department of Psychiatry, University of Pennsylvania School of Medicine.

the motive for it and its source. The impulse is anger. Its motive is revenge for frustration. The source is the oral receptive need which is also expressed via the gut. The wish (source), the frustration (motive), the anger ('crime'), and the symptom (punishment) all affect the oral pathway.

Rather than marshaling the evidence to establish this conclusion on the basis of patients with peptic ulcers, it will be more interesting and profitable to test this principle with other, more purely psychological data.

The girl mentioned above is like very many women, and men too, who are seen in practice. A child is deprived for years, neglected, unwanted, unloved. It grows up therefore with excessive needs for love. The hypertrophy of these needs foredooms it to frustration—the adult cannot in reality get all the parental love that the little child craved. The frustration causes anger and hostility. This fits badly with the needs for love—one cannot hate a person and want and accept his love at the same time, without guilt. The greater the need for love, the more the hostility is repressed. The repressed hostility generates guilt and consequent self-punishment. And now the next step is the fateful one: *the self-punishment takes the form, as one sees again and again, of the patient depriving herself of the very love she craves.* That this is no sociological accident is demonstrated by repeated dreams which end in frustration of these needs (e.g., being rejected, being abandoned, getting miserable food or a shabby shack, etc., etc.).

Because of this mechanism many persons remain for life internally frustrated in their needs for love, by their own masochism, through the dynamics just described. *Regardless of the form taken by the hostility, the punishment strikes at the source*—the receptive needs for love.

This does not mean that other mechanisms are not also present. A common superego reaction is more direct: you want too much, you deserve nothing. The talion in its simplest form can also be expected. The mechanism of the punishment fitting the source is an additional one, and one which is often important in understanding patients. *It is one of the*

mechanisms by which a childhood pattern comes into dynamic equilibrium and persists for life. It can form one of the most common vicious circles or spirals seen in practice.

A few more examples may help consolidate this description. A man was rejected during childhood by both parents. He developed chronic anger with consequent guilt which led to provocative behavior. Through this behavior he repeatedly got himself rejected. He often dreamed that people were cold to him and many dreams ended in rejection. He thus punished himself by denying himself the love he craved, because this craving was the source of his frustration by rejection and thereby of his anger.

In other cases the source is quite different. A young man, the third child, but only son of wealthy, indulgent parents, grew up to be intensely narcissistic and found any kind of competition intolerable. At school, in athletics, and later in life, he seethed with rage against his inevitable competitors. This followed his œdipal competition with his father, whose attractiveness, prowess and success made matters no easier. In this young man, the punishment for the hostility was directed at its source—the cravings for prestige. In any new situation he would start out with his great drive for success, do brilliantly, and then rapidly ruin himself. Outstanding in personality and ability, burning with ambition, yet he was a repeated failure—the failure striking at the very success which he wanted more than anything else in the world. This case exemplifies predominance of narcissistic prestige needs over all others, including genital sexual needs. He had little interest in women.

The applications of the mechanism we have been discussing are manifold. It is not our purpose to trace them extensively. One more example will serve as an indication—paranoid jealousy. Freud described a number of mechanisms for this symptom *(2)* to which this one can, perhaps, be added. A patient's wife had a lover. The patient repeatedly dreams that the wife goes off with this lover or with other men. Sometimes

she dies or is killed. The wish is ego alien. He awakens with tears and terror. In reality he loves his wife and is devastated by her behavior. Why does he not dream therefore that she gives up the other men, returns to the patient, and they live happily ever after? The current dynamics quickly show that he is burdened with too much guilt to do this. He hates his wife for this and out of guilt punishes himself for this hatred by tormenting himself with the source of it, the jealousy. His wife is unfaithful—he hates her—he is guilty for doing so—he punishes himself—and the punishment strikes at the source: he hates her because of jealousy and therefore deserves to be made jealous. The hostility must be repressed. It is turned against himself. It takes this specific form.

The pattern was laid in childhood. This man's mother had had a lover because of whom the children were often neglected. The patient's hostility to her generated guilt and the superego reaction: because you hate your own mother, you deserve that kind of a wife. Here again, this was not the only mechanism in his choice of a wife—this is the one we are isolating for study. Crime—hostility to mother. Motive—jealousy. Source of motive—wishes for mother's exclusive love. Punishment fits the source—faithlessness.

This mechanism puts castration anxiety in a slightly different light. Where the emotional interplay involves predominantly the genital system, where genital desires are the source feelings, then whatever motives, frustrations, and fight-flight reactions result from these, since the punishment, i.e., the superego reaction, fits the source, would be expected to be castration anxiety. Freud touched on this in saying that the punishment was naturally directed to the organ which yielded the pleasure.

That the punishment fits the source appears to be a general principle. It is related to the broader question of choice of certain predominant pathways, physiological (e.g., gastrointestinal or other organ systems) or psychological (e.g., prestige needs) for expression of emotional interplay. Of course 'psy-

chological' is used here to mean the higher central nervous system levels. It is neurophysiological. It is of course also based in the instinctual drives of the organism. The distinction is a convenience in distinguishing examples of the general principle. These two principles bring the genital system, so outstanding because of its special features, into conceptual relationship with the other organ systems and psychological needs. For example, castration anxiety, whatever its unique features, appears as a special case of the punishment fitting the source where the genital system is the pathway—just as anxiety about eating is the special case where the upper gastrointestinal tract is the pathway, or about breathing where the respiratory tract is the pathway.

SUMMARY

According to the law of the talion, 'the punishment fits the crime'. In addition to this an unconscious mental mechanism is often seen in which 'the punishment fits the *motive* for the crime'. This can be carried further to cases in which 'the punishment fits the *source of the motive*'. A person whose hostility is revenge for oral frustration develops oral symptoms. One whose hostility is revenge for frustrated needs for love or for prestige punishes himself by frustrating these very needs. The main interplay of emotion, id impulse, and superego reaction takes place over this pathway. The central pathway may be an organ system, such as the gastrointestinal (e.g. as in certain oral cases) or the genital, or, on a higher or more sublimated psychological level, the pathway may be needs for prestige. Each person has, or tends to have, a particular pathway, or combination of pathways, for satisfying his needs—and over which his major emotional interplay is expressed—his frustrations, his fight-flight reactions, and the reactions of his superego. This is an important mechanism for understanding certain patients. It is of interest in relation to the behavior of the superego, and casts light upon various symptoms such as

paranoid jealousy and castration anxiety and upon the choice of symptoms.

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Mental Reactions in Patients with Neurological Disease

David Beres & Charles Brenner

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MENTAL REACTIONS IN PATIENTS WITH NEUROLOGICAL DISEASE

BY DAVID BERES, M.D. AND CHARLES BRENNER, M.D. (NEW YORK)

The interrelation between organic disease and psychopathology, a subject of growing interest, has been focused chiefly on the psychogenesis of physical illness. On the genesis of mental symptoms consequent to physical illness, the scanty literature gives two points of view. The first is that the psychological symptoms are the same or similar in all cases of the same disease, that is, they are dependent on the etiology of the disease. For example, Wilson (*1*) stated that the mental symptoms of multiple sclerosis were characteristic of the disease as a whole: '. . . the triad of eutonia, euphoria and increased emotional display is just as characteristic of the disease as Charcot's [triad]—in fact, more so, since it occurs oftener'. According to the second point of view the mental symptoms are determined by the psychological disturbances in mental equilibrium or libido economy resulting from the organic disability. This view was best expressed by Ferenczi (*2*) who did the pioneer work in this field, and who called such symptoms pathoneuroses. This study seeks evidence bearing on both points of view.

An organic illness presents a patient with two types of problems for which he must mobilize a variety of defenses and mechanisms of adaptation. First are problems, largely conscious, related to the realities of pain, inability to make a living, and hardships imposed upon the patient's family; second, are problems arising from the reactivation of hitherto repressed, unconscious conflicts. Special attention has been paid to the latter.

None of the patients included in this study had evidence of dementia (gross cortical destruction), either clinically or psychometrically. The symptomatic disturbances were essentially

From the Division of Neuropsychiatry, Montefiore Hospital, and the Department of Neurology, College of Physicians and Surgeons, Columbia University. The psychological tests were performed by Elaine Grossman, M.A.

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disabilities in motor control, loss of sphincteric control, pain, and other discomfort. To these must be added dependence on others for care and support, forced upon the patient in nearly every case by his serious physical disability.

CASE I

A twenty-three-year-old, single man with multiple sclerosis developed severe neurotic stammering. The neurological disease began suddenly when he was a boy of twelve and resulted in paralysis of the lower extremities, weakness of the upper extremities, incontinence of urine and feces, and loss of sensation below the fifth thoracic level. A gradual remission of symptoms over the years enabled him to get around with the aid of crutches. A second attack at twenty-two brought a return of paralysis not only to the lower extremities, but to the upper extremities, and an increase in the area of loss of sensation. Improvement from these symptoms has been moderate. The upper extremities are weakened but the patient is able to use them. There is total paralysis of the lower extremities. He has no bowel sensation, and cannot move his bowels spontaneously; but with regular enemata there is no fecal incontinence. His urinary function is controlled by carrying a bottle with him at all times, and voiding with the aid of manual pressure on his abdominal wall when he is aware of a feeling of discomfort, sometimes associated with an outbreak of perspiration.

The patient was a healthy infant, the oldest of four siblings, followed in order by two sisters and a brother. He was breast-fed until the age of six months and weaned without apparent difficulty. Toilet training was accomplished early; however, at the age of three years there were several episodes when the child came in from play crying because he had soiled himself. At that time he developed acute rheumatic fever which kept him in bed for many months. As he recovered he manifested a striking change in behavior. He became disobedient and stubborn and remained so until the age of nine. Following the sudden death of his father, he became a well-behaved, conscientious, and serious child. The mother kept the family

together by working. The patient assumed the role of the male head of the family with an awareness of his responsibility toward his younger sisters and brother. It is clear that there were important unconscious conflicts about his anal-sadistic drives, with considerable reaction-formation. The defenses appear to have been adequate to control the drives satisfactorily before the onset of his neurological illness.

The patient's only complaint to the psychiatrist was stammering. He believed he had not stammered before the age of fifteen, but his mother states that from the age of ten there was an occasional mild stammer. He stated that no other aspects of his illness presented any problem to him. He felt he understood the nature and prognosis of his disease, and that he could adapt to the limitations it imposed upon him. The stammer was first noticed in the hospital when the patient was fifteen years old, three years after the onset of his illness. It became progressively worse for several years and then improved as the neurological symptoms improved. With the second attack the stammer, which had almost disappeared, recurred in a severe form which persisted and was intensified in the presence of his mother, the psychiatrist, and others in position of authority.

The evidence that despite his conscious denial the patient was in considerable unconscious conflict about his sphincteric dysfunction was found in a narcoanalytic session under sodium amytal. As the sodium amytal took effect the stammer disappeared and in response to the suggestion that he talk about the onset of the stammer, there followed a flood of associations to his loss of bowel control and particularly his resentment against a nurse who at the time of the onset of the stammer refused to give him milk of magnesia which he required to regulate his bowel function. On only one other occasion, when he was off guard, did the patient confess his preoccupation with his loss of sphincteric control, and that was when he was asked, 'What bothers you most about your illness?' He replied promptly, 'That I cannot control my bowels and urine'; but he added in a moment, 'No, I don't mean that; what bothers me most is that I can't walk'.

Repeated dreams that followed the narcoanalytic session confirmed the unconscious preoccupation with and anxiety about his anal drives.

> I am in the Museum of Art with my brother. I have an urgent desire to move my bowels. I rush to the toilet. The doors are too low. I have to crawl under the door. It is too late. I move my bowels in my pants.

During this dream, as in many others of the sort, the patient did not actually soil or wet himself, although he allowed himself in the manifest dream the gratification of the lost sensation and of uncontrolled excretory activity.

The reaction-formations that before his illness had prevented the development of a neurosis, despite the occasional breakthrough of the repressed impulses, were not sufficient to protect him after he lost control of his sphincters. In the early part of his illness he was in a constant state of anxiety that he would be scolded for soiling himself, and he would lie awake at night to hear the rumblings of his intestines, the only means available to him of knowing in time that he might be having a bowel movement. In the course of the next three years, as his anxiety about soiling himself disappeared, the stammer appeared.

Although he was for some years a stubborn and rebellious child, the patient is now a friendly, generous, and amiable person. The only expressions of hostility toward members of his family are negative, for example, 'I don't blame my mother for sending me away to a hospital'. That this is a defensive attitude against his aggressive impulses is shown in the following dream.

> My cousin was over to see me and told me that her brother came home from Chicago with pneumonia, was taken to a hospital, and died. She then corrected herself and said that he wasn't dead, but in a hospital.

'I wouldn't like the idea of his dying', he commented, 'so probably that's why I had my cousin correct herself in the dream'. Behind this were his ambivalent feelings toward his own brother. The patient's conflicts about his ambivalence

were also apparent in a love relationship which was characterized by an uncompromising demand for the woman's attention as his 'right'. Once when she refused to share her mail with him, he became very angry and wanted to 'let loose', but his stammer became so severe that he could not articulate.

These observations are in accord with the conclusions of most investigations of stammering: it is the expression of a neurotic conflict with anal and oral instinctual drives. The loss of sphincteric control released in this patient a flood of repressed instinctual impulses and destroyed a painfully achieved equilibrium. Defenses previously adequate to protect the ego against these impulses now proved inadequate. Following a period of manifest gratification of these impulses, especially soiling—but accompanied with intense anxiety—new defenses (especially the oral displacement with the symptom of stammering) developed to protect the patient's ego against the dangers of uncontrolled anal and oral sexuality and aggression. The sexualization of speech afforded the patient some compensation for the loss of sphincteric control.

CASE II

A fifty-eight-year-old woman with a paraplegia entered the neurological service following an operation in another hospital for an osteoma of the eighth dorsal vertebra. Postoperatively she had lost all sensation and voluntary muscular control below the eighth thoracic level, as well as control of her anal and urethral sphincters. For several years her bladder had emptied reflexly, and by being put on the bedpan at two-hour intervals she was kept dry except during sleep. An enema every two or three days usually, but not always, sufficed to prevent fecal incontinence. During residence in the hospital she developed diabetes mellitus, controlled with diet and insulin. Before her illness she had been strong and well.

The patient came to this country at the age of twenty and worked in a factory for a few years before marriage. She bore three children who were well-educated despite the family's poverty. Her house was always immaculately clean, the brass

pipes in the kitchen were kept polished, even under the sink, and she told with pride that she insisted on living far enough from the center of the city so that the children had some open places to play in, even though it meant walking more than a mile to shop economically for food. Clearly she was the dominant personality in the family, and had waged a successful fight against the handicaps of poverty. During her hospitalization she continued to direct many of her husband's and youngest (unmarried) child's affairs. She was always a vigorous fighter against what she considered injustice.

'I don't mind dying, doctor', she said, 'but I don't want to be tortured. What for?' Her most bitter complaint during psychiatric interviews was about her fecal (to a less extent urinary) incontinence, which caused her great anguish. She was sure that the odor must be as disgusting to everyone as it was to her. She implied at first that were it not for incontinence she could live at home, though later, when this was discussed more explicitly, she realized that the degree of her motor disability was too great for her to dispense with nursing care. She had dreams about defecation and urination, but was usually unwilling to tell them. In those she related, she was usually well and active, vigorously fighting or arguing.

The outstanding characteristics of this patient's premorbid personality were reaction-formations against or sublimations of anal-sadistic drives. These defenses and adaptive mechanisms provided her with the means of making an apparently successful adaptation to the demands of reality. Her illness reduced her to a state of helplessness which she experienced masochistically as being tortured. It seems likely that her unconscious gratification in soiling accounted for her greatest conscious distress; nevertheless, her habitual defenses proved equal to the strain, and she developed no perceptible neurosis.

These two patients give evidence of considerable unconscious conflict about anal drives which had been adequately controlled premorbidly, but which was reactivated by the loss of sphincteric control. In the first case the premorbid defenses proved inadequate to hold in check the instinctual drives released from

repression, and the neurotic stammering developed. In the second case, the defenses proved more adequate and no serious neurosis ensued. These cases may be contrasted with that of another patient who also suffered loss of sphincteric control but with a different emotional reaction to his illness.

CASE III

A thirty-year-old man had had multiple sclerosis for three years. It began with motor weakness of the lower extremities which had progressed to an inability to walk, incontinence of urine and feces, accompanied by a coarse tremor of the upper extremities and nystagmus sufficiently severe to prevent him from reading. He was unable to move or to attend to any of his needs unassisted.

The younger of two sons, this patient lived with his mother, a devoted, oversolicitous woman. The father had died two years before of cerebral apoplexy after an illness of six months. The patient had nursed him through the nights while working by day as a clerk in civil service. Six years previously he had obtained a degree in law by attending college at night, but had never attempted to practice law; he defended this inhibition by the rationalization that he could not take the risk of giving up his job because he had to help support his parents. The father was described by the patient as an intelligent and idealistic man who was never successful.

At twenty-seven the patient became engaged. He had intercourse for the first time with his fiancée at her insistence. He described the experience as an 'anticlimax', finding he could 'take it or leave it'. He broke the engagement, giving the reason that he felt he had to continue to support his parents, although his brother got married about this time. He had masturbated almost daily when he was a boy. Except for some anxieties, especially about examinations, the patient did not recall any emotional disturbance before his physical illness began.

He reacted irreconcilably to his illness with a mixture of depression, despair, and hostility. He stated without apparent

emotion, 'I would kill myself if I could'. He could not become interested in people or events. He felt hopeless, defeated, admitting that he had no willingness to make any effort. He saw life in terms of 'fight and lose'. He constantly complained that he did not receive the nursing and medical care he needed. Other patients bored him and he disapproved of their interests and activities. He felt that he was the 'butt of the ward': no one liked him, and the patients made fun of him.

His chief preoccupation was his urinary incontinence. He called it a 'social disgrace', at the same moment confessing with embarrassment that the source of his disturbance was his small penis which kept slipping out of the bag. He began a series of attempts to control his incontinence by one device or another, culminating in the use of a clamp which he applied so tightly to his penis that it became cyanotic and swollen—an obviously self-castrative act. He bled from his irritated penis and said, 'I am like a woman who has a constant period'. He gained weight in the hospital and complained that his belly was growing 'like a pregnant woman's'.

Here is a person whose life is characterized by self-imposed suffering and inhibition of function in the spheres of both work and sexuality. The motivating force for this moral masochism appears to be a profound castration anxiety which helps to explain the patient's preoccupation with the size of his penis, his self-castrative act, and his fantasies of feminine identification. The illness supplied more than enough masochistic gratification, but took out of his power the control of the degree of the suffering. The conflict between his need to suffer (as a defense against his aggression) and the need to control this (as a defense against total castration) broke out in symptoms of depression, hostility, narcissistic regression, and paranoid tendencies. The predominance of castration anxiety emphasized his urinary incontinence in contrast to the two patients who, because of the anal orientation of their premorbid personalities, were preoccupied with disturbances of their bowel function.

The dependence imposed by the illness created a secondary conflict. He had previously maintained an appearance of

independence and had in part supported his parents, using this as a rationalization of his fear of marriage. He now found himself caught between a regression to infantile dependence and the demands of his ego to appear independent. He projected his hostility and rationalized his demands, but he could not resolve his conflict.

CASE IV

There were three patients in our series to whom the important aspect of their disability was their dependence on others. One of these, a thirty-nine-year-old unmarried woman, before her illness had been a nurse. For three years she had had multiple sclerosis in a severe and progressive form that was rendering her increasingly helpless. Her symptoms included loss of use of the lower extremities, sensory disturbances in the lower extremities with excruciatingly painful paresthesias, tremors of the upper extremities that limited her activities to simple knitting, marked nystagmus that made reading impossible, and disturbance of sphincteric control. Fecal incontinence was a rare occurrence, but urinary urgency with episodes of incontinence was more frequent.

Her mother had died when this patient was one week old. An only child, she had remained with her father in his mother's home until the age of sixteen, when the grandmother died. This grandmother was very strict but kind. Very closely attached to her father, she spent her vacations with him; he taught her sports. She sought no other attachments; her life was complete with her father. She complied with her father's every wish except in becoming a nurse, to which he had mild objections. This placid existence was thrown into sudden chaos by the death of her father when she was thirty-five years old. She continued to work although her mourning was one of prolonged weeping, brooding, and loss of interest in her usual activities. Eight months after her father's death she developed multiple sclerosis. Her only relatives were two distant cousins, and soon she became entirely dependent upon the community for her needs.

In the first interview she began by saying, 'This is a waste of time. I am licked. My condition is progressive. You ought to take me out and shoot me.' Nevertheless, she manifested pleasure and gratitude at each subsequent interview. She seemed to relish even the briefest contact with any physician or attendant. Her great dread, mounting at times to panic, was of becoming absolutely helpless. Her sphincteric disturbance affected her only in terms of what people would think of her. She avoided group activities because it would be embarrassing to have 'an accident'.

This patient suffered the major deprivation of the loss of her mother at the age of one week. The strict but kind grandmother was a less important substitute than the protecting, indulgent father. Her upbringing did little to prepare her for mature self-reliance. She remained with the need for constant evidence of love and support. The death of her father was followed so quickly by the onset of her illness that she had no opportunity to develop any defenses against her state of abandonment. The result was a state of depression. Her impoverished ego was in constant panic lest even the small evidences of love in the attention of nurses and attendants would be lost to her.

CASE V

An unmarried man of thirty-nine had progressive muscular dystrophy, first recognized when he was twelve but with retrospective evidence that the illness began perhaps at the age of six. The characteristic, progressive loss of strength and function of the muscles of the lower and upper extremities permitted him at the time of examination to sit in a wheel chair, but he was dependent on others for needs such as being dressed, eating, or being moved from place to place.

The oldest of three (there were two younger sisters) in a poverty-stricken family, he had to look after himself as long as he could remember. His mother died when he was eleven years old, and for one year he was totally neglected by his father. The sisters had been placed away from home immediately

after the mother's death. The patient himself asked to be placed in an orphanage where he was forced to walk up long flights of stairs many times a day. After months of silent suffering it became apparent that he was physically handicapped. Except for one short period he has since lived continuously as a patient in a hospital.

He recognized the progressive nature of his weakness and expected to be totally helpless within five years. He was an enthusiastic writer of song lyrics and he was sure that he would achieve success. In the face of repeated frustration he was never depressed, but smiled with the assurance that he was each time closer to his goal. His aim was to leave the hospital, engage an attendant, and provide a home suited to his disability. Behind this optimism there were grave misgivings. He said, 'I have to fight constantly to keep a spark alive, to keep my individuality. Patients are dead inside; they have lost the feeling of time and space.'

This patient had early in his life established the defense of denial. As a small child he faced poverty and the neglect of his parents with an appearance of self-reliance. He suffered without complaint, hiding the early symptoms of his disease for perhaps six years. After twenty-six years his attitude toward his illness was a continued effort to deny his helplessness by an unrealistic striving to achieve independence.

CASE VI

In still another case the emotional conflict was also around the problem of dependency, but it did not become symptomatic until the patient faced discharge from the hospital and the resumption of his normal activities. A fifty-year-old married male became suddenly ill with a myeloradiculitis with a cauda equina syndrome. His outstanding symptoms were inability to use his lower extremities and fecal incontinence. He improved progressively, and after two years the neurological signs disappeared. The patient continued to complain of weakness, and his disability was out of proportion to the physical findings. As his bowel sensation returned, he developed pain in the

rectum and a constant feeling of having to move his bowels. He insisted there must be a mass there, perhaps a cancer. This was his chief complaint at the time of the psychiatric examination.

Born in Austria, he had been closely attached to his mother who died sixteen years before. He described himself as a person who 'always avoided trouble'. In 1914 an older brother had sent for him to join him in the United States, but the patient refused because his mother did not want him to leave her. He subsequently was conscripted into the Austrian Army in which he served as an interpreter throughout World War I. He enjoyed his army career: 'I had a good time in the army. There was nothing to worry about. I was taken care of and I had plenty to eat.' His business relationships were similarly passive and submissive. Employed as a bookbinder, when his boss gave up the business the patient bought some of the machinery for which he overpaid with the full knowledge that he was doing so. His comment was, 'What else could I do?' In his marriage his wife was dominant and made all decisions; his job was to bring home the weekly pay check. He said, 'I have been a good husband'.

It was very difficult to persuade this patient to leave the hospital and resume his normal activities. He admitted he was 'waiting for something to happen; for an improvement to take place'. His rectal discomfort and apprehension that something had been left inside so corresponded to the sensations of a pregnant woman that the similarity was pointed out to him. He blushed and laughed. This patient had no conflict about his infantile dependence. He had always been taken care of by his mother, the Austrian Army, or his wife. During his illness his wife made it evident that she was dissatisfied with the marriage, and that she preferred to continue working and to live alone. Faced with the danger of losing his wife's ministrations, he sought to continue the gratification of his dependence in the hospital. In this case the illness served to reactivate the patient's passive-feminine (anal-receptive) wishes.

CASE VII

A fifty-year-old white widow entered the neurological service of a hospital complaining of headaches of four years' duration. Two and one half years before, a diagnosis of eosinophilic adenoma of the pituitary gland with acromegaly had been made in another hospital. The patient had received extensive x-ray treatment which arrested the growth of the adenoma, judged by the arrest of increase in size of the sella, arrest of the acromegalic changes, and persistently normal visual field examinations. The patient continued to have incapacitating headaches for which she was admitted four times to one hospital, and eventually referred to another. For three years she has spent all but nine months in the hospital. In addition to headache, she complained of transient blurring and loss of vision, pains in her gums, tongue and teeth, transient contractures of her arms and legs, and weakness of the extremities with or without pain. During this period she developed peritonitis from the perforation of a previously unsuspected peptic ulcer. She recovered promptly following an operation, and eight months later had a subtotal gastrectomy because of persistent abdominal symptoms and x-ray evidence of active ulcer. Since then there has been no x-ray evidence of ulceration, but symptoms of nausea, vomiting, pain and distention have been present at various times. In her premorbid medical history two events are of importance: at the age of twenty-one she struck her right eye on a door, developed a traumatic cataract, and has been blind in that eye ever since; in 1933 she had a hysterectomy for fibroids.

This patient was an energetic, hard-working woman. She was the third of seven children in a poor family. She was an unwanted child, resented by her mother. When she was three her mother became pregnant again and the patient was sent to live with an aunt for three years during which she recalls having been visited only by her father. At thirteen she left school to work. At twenty-three she became engaged to a man whom her mother approved, but broke the engagement to marry

another who was not approved. Her mother refused to attend the wedding. The patient was happily married for about five years when her husband suddenly died and she was left without money and with a three-year-old son (now twenty-two) to support. No one in the family helped her; she boarded with strangers. She returned to her former employment, at which she had always been proficient, and got along satisfactorily until her present illness began. In her relationship to her mother this patient was a paragon of filial devotion. She tried continuously to please and placate her, and during her mother's last years visited her often, helped with the housework, etc. It is especially noteworthy that her mother was blind from bilateral cataracts during the last ten years of her life. The patient often urged her mother to comply with the doctor's recommendation that the cataracts be removed, but her mother invariably refused and accused the patient of wanting to kill her. Toward the other members of her family as well as toward friends, the patient also felt the need to be helpful and 'giving'. The patient was frigid during marriage, her only sexual relationship. Several years after her husband's death when a male companion embraced her, she tore herself away and ran home, feeling disgusted and nauseated. On other occasions she ran from men before any sexual overtures were made.

For over five years—since it was found that she had a brain tumor—she has been unable to work. She has been dependent for care either on a sister with whom she lived or on a hospital. Her conscious wish has been to 'get well' so that she could go to work and support herself, yet illness invariably kept her dependent and suffering. During one of her hospital residences, for example, she was given psychotherapeutic treatment two to three hours weekly for several weeks. She improved rapidly, and her symptoms essentially disappeared, only to return in force as soon as plans were initiated for her to leave the hospital. Visual symptoms and headaches she linked associatively with her mother's blindness and headaches, and they seemed to be in part talionic retribution for her 'bad' (vengeful) thoughts about

her mother. The cramps and weakness of her legs were linked with the symptoms of an older brother who has been completely paraplegic for the past thirty-five years and who, though his mother's favorite, nevertheless turned against her after his illness, left the house, and never had anything more to do with her. The fact that the patient developed a peptic ulcer re-emphasizes the importance of unconscious conflicts about her dependent oral cravings. Of the same clinical significance is the fact that during the past year she has been sufficiently severely depressed to be given a brief course of electric shock therapy, without, however, producing any improvement.

This patient's psychic structure was profoundly influenced by early frustrations by her mother, with subsequent unconscious hostility against which the patient's ego defended itself by reaction-formation and denial. The appearance of a brain tumor with the grave threat of blindness was apparently accepted unconsciously as punishment for her hostile impulses against the mother. Her unconscious conflicts were reactivated, her old defenses proved inadequate and a severe neurosis developed.

There are finally two cases with the diagnosis of dystonia musculorum deformans. In both cases conflicts around hostile and aggressive drives were accentuated by the motor disturbances which characterize this disease.

CASE VIII

A married woman of thirty-five, shortly after her marriage seven years ago, developed a torticollis which cleared up spontaneously after one year. Following the birth of her only child five years later, there set in again a series of uncontrolled movements of the extremities, head, and trunk muscles that became increasingly severe.

She was the third of four siblings (two brothers and one sister); her father died when the patient was seven years old, her mother when she was eighteen. After the death of her mother she considered becoming a nun—following her best friend. Instead, she kept house for her brothers and worked

as a secretary until her marriage at twenty-seven, having worked in her last job eight years. She had a fussy, exacting, very indecisive, overconscientious personality.

Her present illness began about nine months postpartum. She was overconscientious and anxious about the care of her baby, a boy. In stating this she hastened to add, 'I don't blame the baby for my sickness'. She became clinically anxious and depressed. She related the anxiety to her unsuccessful efforts to control her involuntary movements. Her depression was manifested by repeated crying spells, self-blame and self-depreciation, loss of interest in everyone—including the baby—except herself. Before her admission to the hospital she was given electroshock therapy which resulted in marked improvement of the depression, and the dystonia nearly disappeared. In a few weeks the dystonia returned and with it the anxiety and depression.

The initial attack of torticollis was related by the patient to the following episode. About one year after their marriage, her husband did not come home until five a.m. She was worried and angry, until he explained that his car had broken down. Shortly thereafter the torticollis developed. The present illness is associated with her 'worry' about the baby, whom she hastens 'not to blame' for her symptoms.

The following is a reconstruction of the mental symptoms of this patient. To her unconscious, the hypermotility was the uncontrollable motor expression of her hostile and aggressive impulses. As she faced the breakdown of her lifelong defenses to keep these impulses in check, she developed severe anxiety, guilt, and depression.

CASE IX

A single woman,[1] thirty years old, had developed at the age of nine involuntary movements of her right upper extremity, diagnosed as chorea. By the age of eleven the movements had spread to include the axial musculature and the muscles of

[1] We are indebted to Dr. M. M. Stern for the psychiatric data on this patient.

the other extremities, and she was hospitalized first for observation, then transferred to a neurological service where she has since remained. She underwent an anterior cervical rhizotomy for relief of torticollis, and at present she has a static torticollis and tortipelvis with few abnormal movements.

The patient described her parental home as very strict and very clean. She was a tomboy, and in speaking of an older brother, with whom she had had a close relationship, she said, 'I was blamed for everything he did. . . . I always rescued him in fights.' She recalled three traumatic events from about the age of five years: one was of struggling against being given anesthesia for a tonsillectomy; another was of a burn which she suffered on her face and hands. The third was vaguely that her grandmother had given her a lollipop which may have stuck in her throat, but anyway was taken away from her by her parents.

The patient is one of the dominant figures on her ward. She adjudicates, for example, disputes between patients, and chooses the radio programs. Her attitude toward authority is rebellious, she has a keen sense of justice, and usually is on the side of the 'underdog'. Her dearest fantasy, which she feels should be realized, is of a community specially designed for disabled people like herself, so equipped with mechanical devices that they can care for themselves and need not be dependent on others. She frequently has the sensation of rectal urgency, and prefers to be always near a toilet.

The unconscious wish that apparently dominated this patient in childhood was the desire to be a boy. Her castration complex finds expression in her feeling that she was unjustly treated. The symptom of fecal urgency, and anxiety about anal functioning suggests that the control of her anal-sadistic drives is a major problem for her ego, and that this conflict constitutes a vulnerable point in her personality.

DISCUSSION

Ferenczi *(2)* emphasized as the initial psychological reaction to organic disease an increase of narcissistic libido, an observation

which Freud *(3)* had already elaborated to some extent. Ferenczi concluded that much or all of the increase of narcissistic libido was concentrated on the diseased organs or, in his later emendation *(4)*, on their psychic representations. Originally he stated that if the ego 'defends itself against this localized increase of libido by means of a repression' there would result hysteria, a narcissistic neurosis, or possibly 'a simple disease narcissism', and his discussion was principally about the conditions under which a narcissistic state or neurosis would arise *(2)*. He did not discuss the problem of the unconscious meaning of various symptoms or injuries beyond mentioning that castration was 'well adapted to induce (or revive) fantasies of femininity' and rectal operations, 'fantasies of having suffered a homosexual assault'. Neither did he discuss the relationship between the psychological symptoms produced by illness and the premorbid personality of the patient. In his later discussion of the symptoms of general paresis, to be sure, he observed that the paretic's choice of symptoms must be related to the way in which in each individual '. . . the ego and libido constitution is composed, and where the weak points, the "fixation points" of their development are situated . . .'. However, his consistent emphasis was on the point of view that physical illness acted as a psychic trauma which might precipitate a neurosis, even a severe narcissistic one, 'in spite of a normal sexual constitution'.

In the patients we studied, the aspect of their mental reactions to their illnesses that impressed us was precisely that which Ferenczi merely mentioned: the fact that in each patient it was the premorbid 'weak points' in his personality which seemed to determine which of his disabilities were traumatic and which were not, and that it was the psychological meaning of the disability that aroused an unconscious conflict.

Our observations suggest the following formulation. The symptoms of a serious physical disease and their inevitable sequelæ result in increased dependence and the loss of opportunities for customary gratifications and sublimations, as well as in the reappearance of previously forbidden infantile grati-

fications (soiling, etc.). These consequences of the illness greatly alter the customary task of the ego of regulating the instinctual drives in conformity with the demands of the environment and of the superego, and of altering the environment to permit the maximum gratification of the drives. In every individual there seem to be certain instinctual drives which the ego has had difficulty in mastering and which it can control only by some expenditure of the energy at its disposal (countercathexis). There thus results a persistent conflict between instinctual drive and ego defense which constitutes what Ferenczi *(4)* called a 'weak point' in the psychic structure. Any event which shifts the balance in this struggle against the ego we should expect to produce anxiety, the ego's signal of danger, as a result of which its defense is strengthened *(5)*. In the event that the ego is unable, even by thus strengthening its defenses, to keep the unwanted instinctual drives under full control, a neurotic symptom will result.

Such shifts in the balance between drive and defense are what we expect to find as the precipitating causes of ordinary adult neuroses *(6)*, and since each person's 'weak points' are specific, it is a commonplace that an alteration in the environment which is of no consequence to one person may in another precipitate a neurosis, or at any rate may occasion anxiety and an increase in the defensive efforts of the ego.

This seems to be the case in our patients with organic disease of the nervous system. In the first two cases there was evidence of extensive reaction-formation against and sublimation of anal-sadistic drives before the onset of the neurological disease, and the most traumatic aspect of their illnesses, psychologically, was the loss of control of the anal sphincters. In the two succeeding cases the loss of sphincteric control was of less psychological importance, and other aspects of the physical illness and its consequences were experienced as traumatic in each case precisely because they disturbed the balance between defense and instinct in a pre-existing unconscious conflict within the patient. In Case III the illness was unconsciously interpreted as a castration and intensified the patient's conflicts

about his masochistic and passive homosexual wishes, while in Case IV the unconscious meaning was that of desertion by her parents, which produced a serious depression. In Case VI it was actually improvement in the patient's physical symptoms and the prospect of discharge from the hospital that was psychologically traumatic. This patient was happy to be cared for, and developed mental symptoms only when he felt he would be forced to care for himself. Something of the same is true in Case VII, though here the situation was much more complicated since the illness also unconsciously represented a punishment, and the patient's profound ambivalence toward her mother made it impossible for her to accept without guilt the dependent status imposed by the illness.

Our observations therefore seem to show that the symptoms of physical disease may, like other events in a patient's life, act as psychological traumata and precipitate a neurosis. Whether they do so or not depends, again as in the case of other events, upon whether they touch on the 'weak points' of the patient's personality, i.e., whether their psychological significance is such as to shift against the ego the balance in one of the conflicts between the ego and an ego-alien instinctual drive. Our observations lend support to the view *(6)* that one can only speak of a psychological trauma in terms of the personality structure, and in particular of the unconscious conflicts, of an individual. An experience is traumatic precisely because such an unconscious conflict exists.

The series is too small and too miscellaneous to test adequately the hypothesis that the mental symptoms of patients with organic disease of the nervous system are dependent on the etiology of the disease process; nevertheless our observations of the three patients with multiple sclerosis offer no support to Wilson's statement that a characteristic mental triad exists in patients with this illness.

Our findings and conclusions neither confirm nor contradict Ferenczi's hypothesis *(2)* that the first consequence of physical illness is an increase of the patient's narcissistic libido, resulting from the withdrawal of object libido and the concentration of

narcissistic libido on the psychic representative of the diseased part. However, if such a shift in libido economy did in fact occur in our patients, it clearly did not result in an increased libidinization of the diseased organ itself, for example, the spinal cord, the pituitary gland, or the anterior roots of the spinal nerves. The site of overlibidinization could only have been the psychic representation of the organ whose *function* was disturbed, regardless of the anatomic localization of the pathological process.

SUMMARY

1. In studying the mental symptoms of a group of hospitalized patients with various diseases of the nervous system, it was found that the mental symptoms were related to the disability or suffering imposed on the patient by his illness and, moreover, that this relationship was a highly individual one since the same physical disability might produce very different reactions in different patients.

2. It was concluded that one can best understand why such a disability is or is not psychologically traumatic (pathogenic) to any one patient in terms of the personality structure and, in particular, the unconscious conflicts of the patient. The illness is traumatic precisely because of the existence of such an unconscious conflict, even though at the time of the onset of the illness it was symptomless, or, as one might say, in a state of equilibrium. When this previously stable balance is disturbed by the impact of the symptomatic disability incident to the illness, mental symptoms ensue.

3. Ferenczi's hypothesis concerning the shift in libido economy resulting from physical illness is reformulated to conform with these findings.

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Morris W. Brody

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THE MEANING OF LAUGHTER

BY MORRIS W. BRODY, M.D. (PHILADELPHIA)

Laughter is defined [1] as 'A movement (usually involuntary) of the muscles of the face, especially of the lips, usually with a peculiar expression of the eyes, indicating merriment, satisfaction or derision and attended by an interrupted expulsion of air from the lungs . . .'. Laughter expresses not only complicated conscious and unconscious psychological meanings, but the concomitant motor discharge adds a psychosomatic significance to this provocative subject. The voluminous literature on the subject attests less to our knowledge than to the elusiveness of the meaning of laughter. The aim of this paper is to add what little knowledge we have gleaned about laughter from the psychoanalyses of patients. There was no instance in our series of pathological laughing, such as is found in some forms of central nervous system disease.[2]

Laughter is not common during the analytic hour except as a reaction to occasional wit. The subject matter of analysis is usually serious; furthermore, since the analyst does not face the patient, a silent laugh may pass unobserved. As a rule it is the sickest types of personalities (the schizophrenic, the schizoid, or the compulsive) who laugh or smile frequently during the analytic session. Laughing in analysis is often mirthless and a sign of foreboding. Although the therapist may analyze every aspect of the life of the analysand, his mannerisms, walk, posture, speech, what he says or how he says it, his laughter does not lend itself readily to analysis. We may call to the patient's attention that he laughs at things that are not humorous, but once the analyst attempts to delve into the meaning of the laughter, the patient becomes uneasy, fearing he

The author is grateful to Dr. Joseph Robinson for his assistance in reviewing the literature.

[1] *Webster's New International Dictionary*. Second Edition.

[2] Davison, C. and Kelman, H.: *Pathologic Laughing and Crying*. Arch. of Neur. and Psychiatry, XLII, 1939, pp. 595–643.

is being laughed at or accused of having laughed at the analyst. Often the patient is not aware of having laughed and disclaims it as something apart from him. Laughter is a defense best left undisturbed, for the superficial cloud of mirth that cloaks it is all too easily dissipated, leaving a substance of sadness, despair, regret, anger or hatred that may overwhelm the patient. This we found true in nearly every instance where we persisted in attempting to analyze our patients' laughter. In most instances the meaning of the laughter arose from such deep sources of the unconscious and was so far removed from the patient's understanding that it was futile to continue its pursuit. The circumstances surrounding the laughter, however, allow empirical deductions.

Freud [3] says '. . . laughter arises when the sum of psychic energy, formerly used for the occupation of certain psychic channels, has become unutilizable so that it can experience free discharge'. Thus a sum of psychic energy hitherto employed in the cathexis (occupation) of some paths may experience free discharge. Since not all laughter (but surely the laughter of wit) is a sign of pleasure, we shall be inclined to refer this pleasure to the release of previously existing cathectic energy. Freud [4] quotes the French author Dugas who designates laughter as a *'detente'*, a manifestation of release of tension. Spencer [5] says laughter is a phenomenon of discharge of psychic irritation, and an evidence of the fact that the psychic utilization of this irritation has suddenly met with a hindrance. To describe the psychological situation which discharges itself in laughter, he continues: 'Laughter naturally results only when consciousness is unawares transferred from great things to small—only when there is what we call a descending incongruity'.

These investigators recognize laughter as a method for release

[3] Freud: *Wit and Its Relation to the Unconscious.* In: *The Basic Writings of Sigmund Freud.* New York: The Modern Library, 1938, p. 733.

[4] *Ibid.*

[5] Spencer, Herbert: *The Physiology of Laughter.* Macmillan's Magazine, March 1860. Quoted by Freud, *op. cit.*

of tension. Unendurable psychic conflict generates sufficient tension to result in motor discharge. In every instance the psychic conflict can be recognized to be related to fear, hate, aggression or frank hostility. Nietzsche said, 'Man alone suffers so excruciatingly in the world that he was compelled to invent laughter'. The laugher, unable to express his aggression directly, expresses it indirectly in the socially accepted manner of laughter. He has a desire to punish, but does it circuitously, causing it to appear as though the one being punished were not being hurt. The sadism having been turned from great things to small, a laugh results.

The laugh is capable of affording only a partial release of tension. Unable to express the sadistic drive more directly, the laugher turns part of the sadism against himself; or it may be the sadism of another person that the laugher turns against himself. Laughing, therefore, has a definite relationship to both masochistic and compulsive dynamisms. The depressed person, involved with his own hates, is unable to laugh because its meaning is too evident to him. The clinically recognized type of the fat, jolly person basically is an unhappy individual who denies his sorrow and in reaction-formation laughs at everything. It is as though he hastens to laugh at everything for fear of being obliged to weep.[6] The more normal person, who has learned to manage his hostilities and is unafraid of his aggressions, is capable of occasional laughter.

Freud,[7] explaining the muscular actions that characterize laughter, says, 'The grimaces and contortions of the corners of the mouth that characterize laughter appear first in the satisfied and satiated nursling when he drowsily quits the breasts. There it is a correct motion of expression since it bespeaks the determination to take no more nourishment, an "enough", so to speak, or rather a "more than enough". This primal sense of pleasurable satiation may have furnished the smilė, which ever

[6] Beaumarchais: In: *Popular Quotations for All Uses.* Copeland, Lewis, Editor. New York: Garden City Publishing Co., 1942.

[7] Freud: *Op. Cit.*, p. 733, fn.

remains the basic phenomenon of laughter, as the later connection with the pleasurable processes of discharge.' The studies of Spitz and Wolf [8] do not illuminate the origin of the smiling reaction. They abide by Gesell's formulation according to which expectancies of a highly varied nature are set up in the infant in connection with the stimulus of the smiling adult face. Petö [9] made careful observations of the evolution of the emotional expression of joy in the infant. He concludes that the laughing process consists of movements which aim at putting the joy-causing stimulus into the mouth, i.e., when the infant feels joy it tries to receive, to introject, the exciting stimulus. The tendency persists even when the stimulus exciting joy is not appropriate to the mouth, eye, or ear, as for instance when the infant is enjoying the play of its own muscles. Just as the organism tries to get rid of pain as if it were a foreign body by weeping (projection), conversely the organism makes efforts to get joy into the mouth by laughing (introjection). The mouth, the most archaic prehensile organ, tries to catch the stimulus, to cling to it. Darwin [10] refers to the behavior of primitive tribes whose expressions of joy support this view: Negroes of the upper Nile rub their bellies when they look at pearls; Australians suck their lips with joy; Greenlanders sip the air.

The suckling infant does not merely experience passive bliss at the mother's breast, and then relax with a smile of sufficiency. The conception of a smile in such circumstances could scarcely serve the utilitarian purpose which Darwin recognized to be true of all expressive behavior. To suck also means to drain, to rob, to achieve something actively. Observations of the laughter of adults leads to an empirical formulation that the

[8] Spitz, R. A. and Wolf, K. M.: *The Smiling Response. A Contribution to the Ontogenesis of Social Relations.* Gen. Psychol. Monographs, XXXIV, 1946, pp. 55–125.

[9] Petö, Endre: *Weeping and Laughing.* Int. J. Psa., XXVII, 1946, pp. 129–133.

[10] Darwin, Charles: *The Expression of the Emotions in Man and Animals.* London: J. Murray, 1872.

contortions at the corners of the mouth of the infant following feeding signify the satisfaction of its own activity, possibly of having devoured the breast or of having introjected the mother. The laugh is analogous to the 'licking of the chops', the baring of the teeth, the snarl of lower animals. In this sense, man is not the only creature endowed with the power of laughter. Due to the alliance of laughter with hostility, it is inevitable that the muscular system should participate in the motor discharge of superfluous sadistic psychic tensions with pleasurable relief.[11] A clinical example illustrates this point.

A brilliant young scientist, who had achieved remarkable success in his profession, sought psychotherapy for overt homosexuality. He was a timid man, almost too fearful to talk, yet at times he was remarkably aggressive. He was an only child, and his mother openly showed that she preferred him to his father. At meals he was served first, received the best portions of food, was given special favors, while the father received second best. In the face of overwhelming castration fears, the patient refused to relinquish the fantasy that he possessed his mother. After several months of analysis he became more self-assertive, functioned more efficiently, and began a love affair with a woman twelve years his senior. One day he relapsed into his frightened manner scarcely able to talk. Toward the end of the hour he said that on the previous evening, while in bed with his lady, he was suddenly struck by her resemblance to his mother. He laughed aloud, saying, 'It seemed weird'. Asked what he found humorous about it, his only reply was, 'Well, it seemed weird'. The laughter represented his desire to have the mother, destroy the father, fears of retaliation, relief that he had survived the ordeal and that he was still alive. Complicated psychic and somatic reactions coöperated to bring about relief of tension. Persistent attempts at this time to analyze the laughter would have tended to destroy the partially successful defenses and to release overwhelming anxiety and hostility with harmful results.

[11] Freud: *Psychopathology of Everyday Life.* In: *The Basic Writings of Sigmund Freud.* New York: The Modern Library, 1938.

This patient came to treatment one day full of smiles and laughter. He said he had had a dream about an attractive married woman who was making many friendly overtures toward him; he had first tried to avoid her but recently he thought they should become better acquainted. In his dream he saw a box resembling an oven which was pure white. Still laughing, he interpreted the dream as representing his interest in this woman and thoughts of having her as a sexual partner. He obviously was tickled that he could think in terms of heterosexuality, but incest fears lay heavy in the mirth.

That laughter, which is so much a part of the joy of living, has its origin in some form of hostility, or a sudden decrease in hostility, is a concept prevalent in the writings of Freud and other authors. In regard to wit, Freud states that where it is not harmless wit (wit for wit's sake), it is either hostile, serving as an aggression, satire, or defense, or it is obscene wit serving as a sexual exhibition. Tendency wit is in the service of hostile aggression. Our hostile feelings are subjected to restrictions, and wit affords us the means of surmounting restrictions and opening up otherwise inaccessible sources of pleasure. Even harmless wit is an ambitious impulse to display one's spirit or to show off. 'One gets the impression', says Freud, 'that the subjective determination of wit production is oftentimes not unrelated to persons suffering from neurotic disease'.

Grotjahn [12] noted that people rarely laugh in their sleep. He found in one instance a conversion of passive suffering into active aggression as though the dreamer were laughing in the face of death; in another, the laughter expressed murderous intentions converted into a practical joke. Bergson [13] says laughter intimidates by humiliating and succeeds because of the spark of spitefulness or mischief in all men. The laugher retires within himself more self-assertive and conceited than

[12] Grotjahn, Martin: *Laughter in Dreams.* This QUARTERLY, XIV, 1945, pp. 221–227.

[13] Bergson, Henri: *Laughter. An Essay on the Meaning of the Comic.* New York: The Macmillan Co., 1912.

ever, and is evidently disposed to look upon the object as a marionette of which he pulls the strings. Kris [14] speaks of laughter as a bodily process, a regression, the energy coming from energy which would otherwise be used to safeguard adult behavior. The telling of a joke affects the listener as an invitation to common aggression and common regression; thus the stronger the group spirit, the less effort required to create laughter.

Under the general heading of sadism, Fenichel [15] describes a form of laughter which is an obsessive symptom. It occurs not only after the death of a person against whom the patient has had unconscious death wishes, but may be a much more general expression of reassurance against anxiety: 'It is the other fellow who died, not I'. Elsewhere he describes a case of facial tic which turned out to be the representative of an intended, but forbidden, triumphant laughter directed against the patient's father, and later against his own superego.

A thirty-year-old single man sought treatment because of compulsive behavior. Feeling himself to have been rejected as a child, he violently resented his younger siblings. He was determined to force his mother to love him. He ignored his father and wished to get rid of his siblings. Prior to coming to his hour one day, he saw a dog run over by an automobile. Another car following crushed the dog. He did not like the sight but he burst into laughter as he related the incident. He next recalled that some years previously he saw someone strike a snake on the neck which caused its tongue to protrude. When, occasionally, he thinks of the incident, it holds a certain terror for him. Asked why he had laughed, as though frightened, he replied, 'I didn't mean anything by it'. The laughter was a reassurance against fear of castration which was the keynote of the entire analysis.

[14] Kris, Ernst: *Laughter As an Expressive Process. Contributions to the Psychoanalysis of Expressive Behavior.* Int. J. Psa., XXI, 1940, pp. 314–341.

[15] Fenichel, Otto: *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton & Co., Inc., 1945.

A twenty-two-year-old man sought psychiatric treatment because of his inability to concentrate on his studies. He was struggling to free himself from the yoke of dependence on a domineering mother. Describing his mother, he laughed as though amused and said, 'Mother always asks my opinions yet when I state my opinion she always says I am wrong'. It was a laugh of frustration, of futile, helpless anger toward his mother. It also represented helpless, despairing hostility toward his own superego which forbade open aggression against the mother.

A lady in her middle thirties sought psychiatric treatment for migraine. Basically insecure in her personal relationships, she sought compensation in her professional career, her masculine drives, her need to control and dominate. She was torn between her obligation to her family and her devotion to her career. One day she informed me her small son suffered frequent colds. She had sought advice from an internist who told her the boy had an allergy. At this point she laughed. When questioned regarding this inappropriate laughter, she replied that allergy implies emotional disturbance which would be a reflection on her as a mother. This made her afraid I would laugh at her. The laughter implied chagrin in her failure to be perfect—ultimately, the intolerable admission that she is a woman.

A severely obsessive-compulsive young man sought psychiatric treatment because of vertigo, a fear of death, and a morbid wish to throw himself out of a window. Initially overwhelmed by anxieties, he soon felt more comfortable. In his typical 'cocky' manner he denied that there was ever anything emotionally wrong with him. He rationalized by saying that he found analysis fascinating and that he wished to continue because of his interest in psychiatry. One day, with obvious feeling of guilt, he spoke of having deflowered a young lady the previous evening. He laughed uproariously. In explanation of the laughter, he said he had just begun to have a peculiar sensation of fibrillation in his muscles and pains in his testicles. Asked what was funny about that, he laughed louder and said finally

that it was amusing to be expected to talk of such trivial things. This effort to laugh off his anxieties characterized all of the patient's reactions.

A young physician sought treatment because he was a timid, inhibited person, too scared to meet people; yet he was very ambitious. After some months of analysis, he dreamed he was holding a culture medium that had red growths on it. Suddenly he heard his name called, and he awoke. The dream was so real he looked around to see if anyone really called him. Although it had the characteristics of a nightmare, the patient said it was a most pleasant dream. He burst into laughter saying he believed he understood its meaning. That day he had made the diagnosis of an obscure disease. One colleague at the clinic jokingly referred to him as Dr. Koch; another was critical, and the patient was aware of intense anger stirring in him. All day he had had fantasies of culturing the organisms of the rare disease and becoming famous. He said the dream meant that they were calling him Dr. Koch and he was tremendously pleased. Asked why he laughed since he did not appear very happy, he replied that he had recently injected a boy with a new vaccine for a harmless condition. Later he was called and told the boy had developed a temperature of 104 degrees. He was seized with acute fears that the boy would develop encephalitis and die. When he awoke from his dream his first thought was of being called and told the boy had died. His laughter, then, was not pleasure in the fantasy of becoming a famous person, but was a laugh of relief from the tragic despair of thinking himself responsible for the boy's death.

Endless examples could be cited to illustrate humorless laughter serving as a form of defensive hostility to protect the individual. The ostensible gaiety of laughter masks emotions such as sadness, despair, anger, fear, regret, or triumph. A patient who felt most rejected once said sadly, it seemed 'funny' to him that I gave other patients more than their allotted time while I always kept him waiting. He really meant to say that this state of affairs was for him tragic. The laugh is so

overdetermined that when we attempt to analyze it a torrent of emotion is released, or the patient becomes detached, and its content is repressed. It is the most psychopathological and the healthiest people who can laugh easily. It has been rightly said, 'The man that loves and laughs must sure do well'.

SUMMARY

Laughter expresses complicated conscious and unconscious psychological meanings. It does not lend itself readily to analysis, and when approached directly as a character defense an undue quantity of anxiety may be released. The ostensible gaiety of laughter masks emotions such as fear, hate, sadness, despair, regret, or triumph. Laughter results from a sudden reduction in sadistic psychic tensions; it has a definite relationship to both masochistic and compulsive dynamisms. The depressed person, involved with his own hates, is unable to laugh because its meaning is too evident to him. Study of the laughter of adults leads to an empirical formulation that the contortions at the corners of the mouth of the infant following feeding signify the satisfaction of its own activity, possibly of having devoured the breast or of having introjected the mother. A poignant conclusion is Bergson's dramatic concept of laughter as a remnant of foam on the sandy beach left by the receding waves. He continues, 'The child, who plays hard by, picks up a handful, and, the next moment, is astonished to find that nothing remains in his grasp but a few drops of water, water that is far more brackish, far more bitter, than that of the wave which brought it. Laughter comes into being in the selfsame fashion. It indicates a slight revolt on the surface of social life. It instantly adopts the changing forms of the disturbance. It, also, is a froth with a saline base. Like froth, it sparkles. It is gaiety itself. But the philosopher who gathers a handful to taste may find that the substance is scanty, and the aftertaste bitter.'

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Othello: The Tragedy of Iago

Martin Wangh

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OTHELLO: THE TRAGEDY OF IAGO

BY MARTIN WANGH, M.D. (NEW YORK)

In Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality, Freud [1] makes distinction between competitive or normal jealousy, projective jealousy and delusional jealousy. To illustrate projective jealousy, he quotes Desdemona's song from Shakespeare's Othello.

> I called my love false love; but what said he then?
> If I court moe women, you'll couch with moe men.
>
> Act IV. Sc. 3

Othello's mounting anguish under the impact of Iago's scheming is very moving, and the irrationality of the Moor's jealousy is obvious to every spectator. Many clues are given in the play as to why Othello is so easily afflicted by such a consuming passion. He says of himself, 'I am black . . . declined into the vale of years'; elsewhere he declares 'the young affects' are in him 'defunct'. The Moor's jealousy and conflict fill the foreground of the tragedy; nevertheless it is always clear that Othello is only a victim and the tool of Iago's machinations. It is Iago who starts the action of the play, sets its pace, and keeps it moving. It should, therefore, be rewarding to seek the motives of this villain who goads a man to murder his wife.

The hero of the drama is a noble Moor who has done great service for Venice as a general. Desdemona, daughter of the Senator Brabantio, falls in love with him and the pair elope. Othello's aide, Iago, angered by the fact that one Cassio has been given preferment over him, is overwhelmed with hatred for the two men, and thenceforth devotes his energies to destruction. First he plots to displace Cassio, then to stimulate Othello's jealousy and goad him until the maddened Moor strangles his beloved and loving bride.

[1] Coll. Papers, II.

Shakespearean criticism has always held the motivation for Iago's destructive hatred to be too slight. Critics of all lands have spoken of Iago's 'motiveless malignity'.[2] Some have called him 'monster';[3] others, the proponent of evil. To none has it seemed that the provocation was sufficient for the pitiless revenge.

One thing, however, has impressed all critics—the repeated shifting of Iago's ground. At first Iago is enraged by the slight he has suffered through Cassio's preferment. Soon the motive shifts to cuckoldry. Iago suspects that Othello and Cassio have slept with Emilia, Iago's wife, and this suspicion grows to a certainty.

Clearly, the two motives do not jibe. There is no direct relation between them; nor does either lead logically to the shocking murder of Desdemona. If the first motivation is the true one, then the play should end in the second act with the displacement of Cassio. If the second motivation is the true one, why is it not presented at once? Why does it not lead to revenge by cuckoldry rather than by murder? How explain Iago's hatred for Desdemona, when it is desire that should animate him? How, also, explain the hold this 'illogical' play has maintained upon the imagination of three and a half centuries of playgoers?[4]

We can conclude only that the apparent motivation is not the basic motivation. The magic of the play lies in its hidden content, which speaks directly to the unconscious of every spectator.

Jealousy grown to the proportion of paranoia is a clinical condition, sufficient to effect the murder of Desdemona. Although it is Othello whom Shakespeare depicts as the person afflicted, I should like to present the view that the prime sufferer is Iago. It is he who is jealous of Desdemona and hates her. Iago loves Othello. This is never expressed in so many

[2] Coleridge, S. T.: *Lectures and Notes on Shakespeare and Other English Poets.* London: Bohn's Standard Library, G. Bell & Son, 1884, p. 388.

[3] Strachey, Lytton: *Characters and Commentaries.* New York: Harcourt, Brace & Co., 1935, p. 295.

[4] Brooke, S. A.: *Ten More Plays of Shakespeare.* New York: Henry Holt & Co., 1913, p. 175: 'The improbability of the whole affair is shocking.'

words, but its opposite is repeatedly stressed. From the beginning it is clear that Iago has only disdain for women. He is 'nothing if not critical' of the entire sex. As he puts it to Desdemona and Emilia

> . . . you are pictures out of doors,
> Belles in your parlours, wildcats in your kitchens,
> Saints in your injuries, devils being offended,
> Players in your housewifery, and housewives in your beds.
>
> . . .
>
> Nay it is true, or else I am a Turk:
> You rise to play, and go to bed to work.
>
> Act II, Sc. 1

I should like to consider the tragedy first from the standpoint of the action and its timing, then to follow the emotional conflicts of the character, Iago; for, although the play is called Othello, it is Iago who is the absorbing personality, the evil genius of the play.

In listening to a patient's account of his illness, we are accustomed to pay special attention to the situation immediately preceding the onset of the symptoms. What then are the precipitating factors in Iago's psychopathology? Apparently, before the action of the play Iago has had no conflicts. He has been Othello's trusted aide, very much in the general's confidence, and seemingly deserving of it. Suddenly he is thrown into an explosive frenzy. The first scene finds Iago shouting, 'Thief, thief', under Brabantio's window. Iago thus spectacularly acquaints Desdemona's father with his daughter's elopement with the Moor.

It is night; the town is sleeping when Iago raises his outcry. The disturbance, moreover, occurs immediately after Othello's marriage. Iago has sped to Brabantio's house knowing that Othello and Desdemona have retired to the marriage chamber. We can assume that Iago, being Othello's trusted aide, knew about the plans for the wedding; yet he did not warn Brabantio beforehand. Only when the marriage is about to be consummated does Iago create an uproar.

We should be warranted in reserving judgment were this the only indication of a triangle. But the action is repeated—

not once but twice—and each time the uproar has the similar effect of disturbing the marital, sexual relationship. On the night of Othello's arrival in Cyprus, and again later, the couple are roused from bed by the tumult following Rodrigo's attacks on Cassio, both instigated by Iago. The conclusion is inescapable that in disturbing the marital relation Iago has achieved his immediate aim.

So far we can assume only that a triangle exists. On the face of it, Desdemona may be the object of Iago's affection. It may be simply an instance of competitive jealousy based upon the œdipus. Since Othello is a paternal authority, especially for Iago, the Moor's withdrawal to the marriage chamber reawakens the œdipal conflict in Iago. Three times there is a reproduction of the primal scene.

There is further evidence to support this interpretation. Othello is based on a tale called The Moor of Venice, a short story in the Hecatommithi [5] of Cinthio. This story also features the death of Desdemona, but not at the hands of the Moor. It is Iago who kills her, and the weapon is a stocking filled with sand. Significantly, Iago hides in a closet while Othello is in bed with Desdemona.

If Iago be motivated by projective jealousy, the object of that jealousy should be his own wife, Emilia; and the manner of revenge should be one of two: Iago should either cuckold Othello or kill him. Since neither of these happens, we are left with delusional jealousy as the final possibility.

Delusional jealousy, Freud says,[6] '. . . represents an acidulated homosexuality and rightly takes its position among the classical forms of paranoia. As an attempt at defense against an unduly strong homosexual impulse it may, in a man, be described in the formula: "Indeed I do not love him, *she* loves him".'

In his study of the Schreber case,[7] Freud states that the

[5] Cinthio, Giovanni Battista Giraldi: Hecatommithi Decca Terza, Novella VII. *Il Moro di Venezia.* Venice: G. B. Pulciani, 1608, p. 213.

[6] Freud: *Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality.* Coll. Papers, II, p. 234.

[7] Freud: *Psychoanalytic Notes Upon an Autobiographical Account of a Case of Paranoia.* Coll. Papers, III.

principal forms of paranoia can all be represented as contradictions of the single proposition: 'I (a man) love him (a man)'. The first contradiction is: 'I do not love him; I hate him'. A second contradiction may be: 'It is not I who love the man; she loves him'. In consonance with these contradictions the sufferer suspects the woman's relation to all the men he himself is tempted to love.

In the very opening lines of the play the first contradiction, 'I do not love him, I hate him', is spoken by Rodrigo, a disappointed suitor for Desdemona's hand. Quoting Iago, he says: 'Thou toldst me thou didst hold him in thy hate' (Act I, Sc. 1).

It is noteworthy that in Cinthio's story of the Moor of Venice there is no character Rodrigo. Iago is the unrequited lover, and the drive to murder is ascribed to hurt pride. Shakespeare splits Cinthio's Iago into two characters. Rodrigo represents normal competitive jealousy, expressive of the positive œdipal relationship between Iago and Desdemona; Iago is the pathological counterpart, present under the surface in Cinthio's version as well.

Iago's declaration of his hatred of Othello is stated repeatedly.

> Though I do hate him as I do hell-pains,
> Yet, for necessity of present life,
> I must show out a flag and sign of love,
> Which is indeed but sign.
>
> Act I, Sc. 1

> I have told thee often, and I retell thee again and again, I hate the Moor . . .
>
> Act I, Sc. 3

In an ensuing soliloquy a significant motivation for his hatred is first stated.

> I hate the Moor;
> And it is thought abroad that 'twixt my sheets
> He hath done my office: I know not if't be true,
> But I, for mere suspicion in that kind
> Will do as if for surety.
>
> Act I, Sc. 3

Before accepting these expressions of hate as paranoid, we must, of course, rule out the possibility that there is rational basis for Iago's hatred. But the fact that the protestations are so obsessively repeated would lead us to believe that we are dealing with what Fenichel calls a 'cramped emotion'.

What evidence is there that Iago denies his love by projecting the part onto a woman? What indication is there that he suspects the woman's relation to all the men he himself is tempted to love?

The evidence for the first is overwhelming. Iago's assertions that Desdemona loves the Moor are too numerous to quote. With respect to the second, it is out of the substitution of Emilia for Desdemona that the thought of Cassio as Desdemona's lover is born. The substitution of Emilia for Desdemona is easy, for their relationship is that of mistress and maid.

Iago reiterates his suspicions of being cuckolded. 'I do suspect', he says, 'the lusty Moor hath leap'd into my seat' (Act II, Sc. 1). From this suspicion Iago jumps to another equally unfounded: 'I fear Cassio with my night-cap too' (Act II, Sc. 1). This groundless conjecture is preceded by Iago's suspicion that Cassio loves Desdemona and that she returns his love.

> That Cassio loves her, I do well believe it;
> That she loves him, 'tis apt and of great credit.
>
> Act II, Sc. 1

Such rapid shifts are possible for Iago notwithstanding his previous assertion that Desdemona loves the Moor—possible because Iago is so tormented by Othello's love for Desdemona. Iago is driven to separate the pair and, the wish being father to the thought, he accomplishes it by asserting that Desdemona and Othello must tire of each other and that Desdemona must love Cassio. 'She must change for youth', he says, 'she must have change, she must'. It is an obsession with him.

This shift from Othello to Cassio certainly resembles a need to suspect the woman in relation to all the men Iago himself is tempted to love. The woman is Emilia who is interchange-

able with Desdemona. And so in consonance with the second paranoid contradiction we have a situation in which Iago suspects Desdemona's relation to the two men, Othello and Cassio, whom he is himself tempted to love.

Iago's various projections may be summarized: the Moor has lain with Emilia; therefore Cassio has lain with Emilia; Emilia equals Desdemona; therefore Cassio has lain with Desdemona. All of these serve the function of warding off anxiety and enable Iago to deny by projection his homosexual drive to lie with the Moor.

By the third act the drama has advanced to the point where Othello has been goaded into an intolerable state of jealousy and anxiety. He demands proof that Desdemona is unfaithful, and Iago offers him three. The second of these contains the evidence we need. With mock reluctance Iago pours the following invention into Othello's ready ear.

> I lay with Cassio lately
> And, being troubled with a raging tooth,
> I could not sleep.
>
> . . .
>
> In sleep I heard him say, 'Sweet Desdemona,
> Let us be wary, let us hide our loves!'
> And then, sir, would he gripe and wring my hand,
> Cry, 'O, sweet creature!' and then kiss me hard,
> As if he pluck'd up kisses by the roots
> That grew upon my lips; then laid his leg
> Over my thigh, and sigh'd, and kiss'd; and then
> Cried, 'Cursed fate, that gave thee to the Moor!'
>
> Act III, Sc. 3

Lies have a psychoanalytic interest similar to fantasies and dreams. A lie told about a dream combines two of these categories. In this instance it is accurate to consider the dream to be a lie and the lie a dream.

Clearly the first and unmistakable purpose of the fabrication is to goad Othello into further jealousy; but behind this there is another, an unconscious motive. Iago's fantasy is an invention to satisfy his own unconscious strivings. We can, then,

with confidence assume Iago's fiction to have quite another meaning. The lie can be interpreted as a product of the censorship of the dream, a censorship which contents itself with simple denial.

We feel justified in concluding that Cassio and Othello are equated in function on the accepted evidence that the person to whom a dream is told is himself involved in the dream. In telling the dream to Othello, Iago plainly says: 'I dreamt of you'. It has already been noted that Cassio and the Moor become interchangeable when Iago's jealousy is aroused. At first Iago suspected that the lusty Moor had leaped into his seat, and from this suspicion he immediately jumped to 'I fear Cassio with my night-cap too'. Iago's dream, then, means: 'I lay with you, Othello, and you made love to me, as you do to Desdemona'. The last line, 'Cursed fate that gave thee [Desdemona] to the Moor' should be reread, 'Cursed fate that gave thee [Desdemona, not me] to the Moor'.

Let us examine the details of Iago's dream and see how far they confirm this interpretation. Since the characters and the dream are the invention of a playwright, our analysis has to be on the basis of symbolism and analogy to the dreams of patients.

The dream begins with an imagined toothache which prevented Iago from sleeping. A tooth is one of the commoner universal symbols of the penis in dreams. 'A raging tooth' would then indicate sexual excitement. Iago's saying that he was 'troubled' with a raging tooth has two meanings: first, of censorship—resistance to his homosexual excitement; second, the wish for and the fear of castration. 'Kisses plucked up by the roots' can be similarly understood as a phrase heavy with castration symbolism, and the whole fantasy is replete with oral erotism. We can conclude that it is in part a fantasy of fellatio. 'He laid his leg over my thigh' is self-explanatory.

These considerations give ample confirmation to the thesis that Iago's dream is a homosexual wish fulfilment, and they are thus strong supporting evidence for the opinion that the basic motivation of the play is Iago's delusional jealousy.

Let us now trace the development of this paranoid condition and review the clinical course of Iago's illness as if the play were a case history.

The sudden onset of his disturbance is most comparable to a state of homosexual panic. In the course of the illness Iago tries to re-establish the countercathexis against the repressed homosexuality. He tries at first to rationalize his excitement. He insists that his jealousy is caused only by his failure to attain the post he desired and by its having been conferred on Cassio instead. However, the basic conflict is revealed in Iago's choice of words: 'Preferment goes by letter and affection, and not by the old gradation' (Act I, Sc. 1). The words preferment and affection point up the fact that Iago's hurt stems not only from a blow to professional pride, but from a rupture in his love relationship—another has been taken into favor in his stead.

The pathological conflict is hidden behind the verbalization of reasonable ambition. But at the next moment there is a return of the repressed, and Iago next attempts to curb his intolerable torment by denying the need for a love object; he tries to turn his love for Othello into love of himself. 'I never found a man', he says, 'that knew how to love himself. Ere I would say I would drown myself for the love of a guinea-hen, I would change my humanity with a baboon' (Act I, Sc. 3). But this is whistling in the dark. The regression into narcissism fails and Iago is found bolstering resolution by calling on intellect to control emotion. 'Our bodies', he says, 'are our gardens, to the which our wills are gardeners' (Act I, Sc. 3).

Now the need to destroy takes possession of Iago. 'Nothing can or shall content my soul till I am even with him wife for wife' (Act II, Sc. 1). Cuckolding, however, is not what he wants. Utterly frustrated, at last he makes Desdemona the object of his hate. Much more than Cassio, Desdemona is the rival to be destroyed. Iago will so work upon him that the Moor himself will destroy the hated rival, Desdemona: 'So

will I turn her virtue into pitch, and out of her own goodness make the net that shall enmesh them all' (Act II, Sc. 3). His intellectual and emotional awareness apart, he has succeeded in turning over the weight of his intolerable jealousy to Othello, and having projected it thus becomes free to declare his love for Othello. Now he can openly say to the Moor: 'My lord, you know I love you' (Act III, Sc.3). From now on he seizes every opportunity to pour out his hate for Desdemona. In a compelling crescendo he vilifies her, triumphs over each occasion when he has brought the Moor to express distaste for his rival. When finally the Moor says, 'Damn her, lewd minx' (Act III, Sc. 4), and in the next breath grants Iago the coveted lieutenancy, Iago lets go completely: 'I am your own forever' (Act III, Sc. 4).

The play moves relentlessly toward the murder of Iago's rival. Devoted, innocent, helpless, Desdemona, caught in the heavy web of Iago's intrigue, is unable to produce the handkerchief Othello gave her as a gift. In his frenzied state of jealousy this is evidence enough to convince Othello that his bride is faithless.

That Desdemona is the real adversary and that her murder is the objective toward which Iago works is still more clearly represented in the Cinthio version of the story in which Desdemona is murdered by Iago. Othello, to be sure, is an accomplice to the deed, but Iago himself beats her to death with a sand-filled stocking.

In Shakespeare's version the fatal stabbing of Emilia by Iago follows immediately on the murder of Desdemona. It is as though Shakespeare used this means to point up the fact that Iago is the real culprit and that Desdemona and Emilia in his mind are one. In Cinthio's story, a postscript states that Othello dies through an act of revenge by Desdemona's family, and Iago's death is due to injuries following torture by order of a court of justice. That the torture consists of stringing him up by the neck is a direct parallel to Desdemona's death by strangulation in Shakespeare's play.

At this point one might well ask: whence comes the driving power of Iago's devouring jealousy? Many writers[8] have given us the key. They have traced jealousy to its outgrowth from oral envy. In addition to the oral imagery of Iago's dream invention in Shakespeare's play, in Cinthio's[9] version of the tale it is not Emilia but Iago who steals the handkerchief from Desdemona and, significantly, he does this while Desdemona is holding his child in her lap. This is the classic situation of the envious older child. The handkerchief, on which the tragedy hinges, has long been identified as a fetish, the child's substitute for the breast.[10] In this instance, the symbolism is doubly clear. The handkerchief is embroidered with strawberries, easily recognizable symbols of the nipples.[11]

SUMMARY

Shakespeare's Othello is studied as a case history of the psychopathology of Iago. His struggle is against his feminine identification with Desdemona, Othello's wife. The power of the repressed homosexuality causes his jealousy, and drives him to contrive the death of Desdemona, his rival. Several mechanisms of defense are described in Iago's frantic attempts to maintain repression. The tragedy occurs for the very reason that Iago must hide the unacceptable truth from himself. Safety for Iago lies only in ignorance and denial; the affliction is too deep to be resolved. His last words are a final closing of the door.

> Demand me nothing: what you know, you know:
> From this time forth I never will speak word.
>
> Act V, Sc. 2

[8] Sterba, Richard: *Eifersüchtig auf.* Psa. Bewegung, II, 1930. Brunswick, Ruth Mack: *Die Analyse eines Eifersuchtswahnes.* Int. Ztschr. f. Psa., XIV, 1928. Riviere, Joan: *Jealousy as a Mechanism of Defense.* Int. J. Psa., XIII, 1932. Fenichel, Otto: *Beitrag zur Psychologie der Eifersucht.* Imago, XXI, 1935.

[9] Cinthio, Giovanni Battista Giraldi: *Op. cit.*

[10] Wulff, M.: *Fetishism and Object Choice in Early Childhood.* This QUARTERLY, XV, 1946.

[11] Arlow, Jacob: Personal communication.

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The Chorus in Sophocles' Oedipus Tyrannus

Joel Friedman & Sylvia Gassel

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THE CHORUS IN SOPHOCLES' OEDIPUS TYRANNUS

A PSYCHOANALYTIC APPROACH TO DRAMATIC CRITICISM I

BY JOEL FRIEDMAN AND SYLVIA GASSEL (NEW YORK)

The popular application of psychoanalysis to dramatic criticism has unfortunately found little favor; however, if we were to apply psychoanalytic findings to the internal mechanism of theater as an art form (as opposed to an analysis of the artist), we would find a much deeper understanding of that art as a communal expression and as a representation of group psychology. An example of this approach can be found in Œdipus where the Chorus and the hero bear a marked similarity to the primal horde situation described by Freud.[1] It is as if the Œdipus play (and the myth) were the dramatic formulation of that primal experience.

Briefly, Freud's hypothetical primal horde was headed by a violent, jealous father who claimed all the females and drove away the growing sons. At some time '. . . the expelled brothers joined forces, slew and ate the father, and thus put an end to the father horde'. Among the sons who killed the father, one possessing more courage than the others committed the murder and replaced the father.

In the drama the murder of the father, Laius, has already been committed. The dramatic action is involved with the discovery of the evildoer. Œdipus, the criminal, has committed 'the only two crimes which troubled primitive society': patricide and incest; for in addition to killing Laius, Œdipus

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The quotations in this paper from Sophocles' *Œdipus* are from the translation by R. C. Jebb, published in *The Complete Greek Drama,* edited by Whitney J. Oates and Eugene O'Neill, Jr. New York: Random House, 1938, Volume I.

1 Freud: *Totem and Taboo.* In: *The Basic Writings of Sigmund Freud.* New York: The Modern Library, 1938.

marries his own mother, Jocasta. Thus, having deposed him and assumed the rank and honors of the old Laius, Œdipus becomes the representative of the father for the Theban Chorus. In this role, he is the target for the ambivalent attitudes of love and reverence, hatred and envy. It must be remembered, however, that Œdipus is in the unique position of functioning in the drama both as the son and the father.

With these facts in mind, the Chorus of the Sophoclean tragedy gives us an excellent opportunity to study the reactions of a community toward a hero who has violated taboos, but has gained a position which makes him its protector. The negative attitudes are not manifested as open hostility to the hero; they are nevertheless as clearly expressed by the tendency of the Chorus to remain objective. The Chorus does not become actively involved in Œdipus's travails, nor does it exert itself to prevent him from going to his doom. By remaining detached, it absolves itself from responsibility. It makes moral evaluations which neither propel it into active support nor into denunciation.

This role of the moral evaluator has been recognized by many critics as belonging almost exclusively to the Chorus; nevertheless, the essential significance of the Chorus has been overlooked. We believe this is true only because the vibrant, unexpressed interrelation between Œdipus and the Chorus has remained, for the most part, unexplored. Actually, the Chorus maintains a driving demand upon the hero to fulfil what the community expects. This moral censure and demand subtly intensify the momentum of the play.

Early in the play we find the Chorus expressing great reverence and love to Œdipus, the father. These sentiments are expressed for the Suppliants by the Priest of Zeus but can be evaluated as being identical with the attitude of the Chorus, from which the function of the Suppliants is indistinguishable. When the Suppliants come to Œdipus to beseech him to alleviate the plague which has revisited them, he is addressed by the Priest of Zeus.

> . . . It is not as deeming thee ranked with gods that I and these children are suppliants at thy hearth, but as deeming thee first of men, both in life's common chances, and when mortals have to do with more than man. . . .

Œdipus had in the past performed such extraordinary acts for the community as, for example, answering the riddle of the Sphinx. The reverence and awe voiced by everyone throughout the opening of the play reveal the expectation that Œdipus must and will assume full responsibility. Œdipus accepts fully the responsibility which the community is so eager for him to assume.

> Oh my piteous children, known, well known, are the desires wherewith ye have come: well wot I that ye suffer all: yet, sufferers as ye are, there is not one of you whose suffering is as mine. Your pain comes on each one of you for himself alone, and for no other; but my soul mourns at once for the city, and for myself, and for thee.

Œdipus gives further assurance to Creon of his willingness to protect the community.

> . . . the sorrow which I bear is for these more than for mine own life.

It is interesting to note that the Chorus, in its very first entrance and strophe, expresses a personal, egocentric concern for itself in this dilemma. Creon has informed Œdipus that the oracle declares an evildoer to be present in the land who must be cast out. The Chorus, in the first person, bemoans the predicament of the community, and expresses its helplessness and fear.

> . . . I am on the rack, terror shakes my soul, O thou Delian healer to whom wild cries rise, in holy fear of thee, what thing thou wilt work for me, perchance unknown before, perchance renewed with the revolving years. . . .

This outcry, coming as it does almost immediately after the Suppliants have asked Œdipus to help them, creates a subtle tightening of the pressure around him to take action. The

Chorus is not unlike a helpless community which is in the habit of throwing responsibility to the leader (father). And like a father, Œdipus chides the Chorus for having failed in its earlier responsibility of tracking down Laius's murderer.

> . . . For even if the matter had not been urged upon us by a god, it was not meet that ye should leave the guilt thus unpurged, when one so noble, and he your king, had perished; rather were ye bound to search it out.

There is a particularly revealing moment in the relationship between the Chorus and Œdipus when he asks the Leader of the Chorus if he knows who the evildoer can be. While all men are unconsciously guilty of Œdipus' crimes, the Leader gives the following answer.

> As thou hast put me on my oath, on my oath, O king, I will speak. I am not the slayer, nor can I point to him who slew. As for the question, it was for Phoebus who sent it, to tell us this thing—who can have wrought the deed.

Here we can better understand the fragile balance of attitudes which exists between them. For the Leader to have so absolved himself of knowledge of the murderer is to indicate the presence of a self-exoneration which eliminates the Chorus from the possibility of committing such an evil deed; therefore it is not telling the psychological truth when Œdipus directs a psychologically truthful question at it. The denial of involvement at this point highlights the need of the Chorus to have somebody else consummate acts which it is incapable of performing.

The first outstanding example of the moral censure which the Chorus expresses toward Œdipus is revealed in an interpolation of the Leader of the Chorus during heated words exchanged between the seer, Teiresias, and Œdipus.

> To our thinking, both this man's words and thine, Œdipus, have been said in anger. Not for such words is our need, but to seek how we shall best discharge the mandates of the god.

It is the first sign that the Chorus, in spite of its reverence for

Œdipus, maintains a certain reserve toward him. He is not so omnipotent that it cannot afford to criticize his behavior. At the same time it implies that the main issue, its own deliverance, is the all-important problem. Again we see the Chorus, protected by its seeming objectivity, exerting a demand for the action of the play to unfold in a manner satisfactory to the community's needs. It is as if the Chorus feels a momentary concern that Œdipus may be diverted from his course should his anger at Teiresias become more important than his search. Yet when Teiresias hints strongly that Œdipus is the murderer, the Chorus automatically retreats into a protective confusion and helplessness, even though a moment before it has uttered a relatively bold criticism of Œdipus.

> Dreadly, in sooth, dreadly doth the wise augur move me, who approve not, nor am able to deny. How to speak, I know not; I am fluttered with forebodings; neither in the present have I clear vision, nor of the future. . . .

Practically in the same breath, however, the Chorus reveals the possibility that Œdipus as the evildoer is not altogether beyond its conception.

> . . . Yet, until I see the word made good, never will I assent when men blame Œdipus. Before all eyes, the winged maiden came against him of old and he was seen to be wise; he bore the test in welcome service to our State; never, therefore, by the verdict of my heart, shall he be adjudged guilty of crime.

The Chorus indeed nobly defends Œdipus, but it also qualifies its loyalty with 'until I see the word made good'. If we keep in mind that Œdipus functions to fulfil certain needs of the Chorus, it is inevitable that it will nurse its doubts.

It is at this point in the text that we come upon an interesting and not altogether clear aspect of the Chorus's 'personality'. It appears that the Chorus is given to telling lies, or at best, half-truths, for it was present during an argument between Œdipus and Teiresias when the former accused the seer of being Creon's accomplice in a conspiracy to dethrone him.

This was the only reason which Œdipus, in his anger, could think of for Teiresias' hint that he was the evildoer. Yet when Creon arrives and asks the Chorus whether it was true that Œdipus had accused him of such intrigue, the following exchange takes place.

Creon: And the saying was uttered, that *my* counsels won the seer to utter his falsehoods?
The Leader: Such things were said—I know not with what meaning.
Creon: And was this charge laid against me with steady eyes and steady mind?
The Leader: I know not; I see not what my masters do . . .

In the light of what has immediately preceded the entrance of Creon, it seems incredible that the Chorus can give such inadequate information. Perhaps we can interpret these replies as a result of its contradictory attitudes; for in its devotion to Œdipus, it cannot afford to reveal to Creon the irrational behavior which Œdipus displayed to Teiresias. But neither can it go so far to protect Œdipus fully because of the underlying resentment it has for him, which we shall see, develops into a wish for his destruction; therefore, it takes the safest position: it denies any involvement in the situation and passes the responsibility to its leader.

The Chorus's wish for Œdipus' destruction, although never overtly expressed, nevertheless is implicit in its behavior toward him. This is most noticeable in the ensuing conflict between Creon and Œdipus. The king accuses Creon outright of lese majeste and Creon swears under oath that he is innocent. Œdipus remains unmoved by his declaration and insists that Creon die. The Chorus and Jocasta intercede in his behalf and Œdipus turns to the Chorus for its opinion.

Œdipus: What grace, then, wouldst thou have me grant thee?
Chorus: Respect him who aforetime was not foolish, and who now is strong in his oath.
Œdipus: Now dost thou know what thou cravest?
Chorus: Yea.
Œdipus: Declare, then, what thou meanest.

Chorus: That thou shouldest never use an unproved rumour to cast a dishonouring charge on the friend who has bound himself with a curse.

Œdipus: Then be very sure that, when thou seekest this, for me thou art seeking destruction, or exile from this land.

Two meanings are involved in the destruction which Œdipus fears: one, he believes that Creon, alive, will seek to remove him from the throne; second, if Creon is adjudged guiltless, then the warning of Teiresias becomes valid. Thus we see that the first real decision of the Chorus automatically brings with it consequences which require the fall of Œdipus. But the moment that Œdipus brings this fact to its attention, it quickly renounces any such motive on its part.

> No, by him who stands in the front of all the heavenly host, no, by the Sun! Unblest, unfriended, may I die by the uttermost doom, if I had that thought! . . .

Nevertheless, it takes advantage of the occasion to remind Œdipus of his obligations to it.

> But my unhappy soul is worn by the withering of the land, and again by the thought that our old sorrows should be crowned by sorrows springing from you twain.

There now seems evident a repetitive pattern in the behavior of the Chorus. At each point that it is called upon to make an active decision, it retreats into a state of helplessness and suffering which serves to reinforce its demand upon Œdipus. This is apparent immediately after Œdipus grants its wish and releases Creon; but when he reproaches it for having forced this decision from him, saying

> Seest thou to what thou hast come, for all thy honest purpose, in seeking to slack and blunt my zeal?

the Chorus answers

> King, I have said it not once alone—be sure that I should have shown a madman, bankrupt in sane counsel, if I put thee away—thee, who gavest a true course to my beloved country

> when distraught by troubles—thee, who now also art like to prove our prospering guide.

This delicate balance and objectivity is not maintained consistently throughout the play. There is at least one occasion when the Chorus almost drops its mask and reveals its inner wish for the death of the father, Œdipus. This occurs immediately after it overhears a conversation between Jocasta and Œdipus in which the queen tries to quell Œdipus' suspicion of himself by informing him that the prophecy of old stated that only *her* child was destined to kill Laius. Since (to her knowledge) her child had been disposed of, and since the report of Laius's death was that he had been killed by robbers, she concludes that the mortal 'ministers' of the gods are fallible. She expresses contempt for these ministers and states that if the gods wish an event to come about, they do not need the assistance of 'messages of seer-craft', an attitude with which Œdipus has no quarrel.

The moment Jocasta and Œdipus leave the scene, the Chorus breaks into a strong reaffirmation of its belief in the gods.

> May destiny still find me winning the praise of reverent purity in all words and deeds sanctioned by those laws of range sublime, called into life throughout the high clear heaven whose father is Olympus alone; their parent was no race of mortal man, no, nor shall oblivion ever lay them to sleep: the god is mighty in them, and he grows not old.

At first glance, this outburst does not seem to be a logical sequence to the preceding scene. At no point in the conversation between the royal couple does the queen express any heresy toward the gods themselves. She has quarrel only with their human messengers; yet, the Chorus sings the gods' praises. Obviously, in this instance, the Chorus had distorted what took place. If its sympathies were truly with Jocasta and Œdipus, it would have found solace in the queen's logic. Instead, it seizes upon what it interprets to be Jocasta's profanity to expand its antagonistic sentiments.

> Insolence breeds the tyrant; Insolence, once vainly surfeited on wealth that is not meet nor good for it, when it hath scaled the topmost ramparts, is hurled to a dire doom, wherein no service of the feet can serve. But I pray that the god never quell such rivalry as benefits the State; the god will I ever hold for our protector.

This is the first indication of an outright accusation. It is a warning against superseding the bounds of convention. The statements are not addressed to Œdipus by name, but there can be no one else to whom it refers since he is the only man under suspicion. It would appear that the Chorus has found an outlet, through Jocasta's suspicion of the seers, to express its resentments against him. Up to this point, Œdipus has given the Chorus no cause to manifest its antagonistic feelings. For the first time, the Chorus is in a position to make strong statements without endangering its own security. In its defense of the gods against what appears to it to be heresy, it renders itself more moral than the king and queen. It might be said that the Chorus has been waiting for such an opportunity to such an extent that it distorts Jocasta's reasoning in order to create one. Its resentment seems to grow more intense with each thought it expresses.

> But if any man walks haughtily in deed or word, with no fear of Justice, no reverence for the images of gods, may an evil doom seize him for his ill-starred pride, if he will not win his vantage fairly, nor keep him from unholy deeds, but must lay profaning hands on sanctities.

It is interesting that the Chorus feels free to condemn a man to an 'evil doom' for profanity at the same time that Œdipus is under suspicion of being the evildoer, and especially since he is the only person who can be accused of irreligious sentiments. It is especially noteworthy that the Chorus demands, in return for its social obedience, that justice be dealt to those who defy the gods and their decrees.

> . . . Nay, if such deeds are in honor, wherefore should we join in the sacred dance? . . . No more will I go reverently

> to earth's central and inviolate shrine, no more to Abae's temple or Olympia, if these oracles fit not the issue, so that all men shall point at them with the finger. Nay, king,—if thou are rightly called,—Zeus all-ruling, may it not escape thee and thy ever-deathless power!

We see that under cover of its outraged feelings lies the demand that the oracle should not be proved false. Although this demand is revealed by its resentment against Œdipus' irreverence toward the prophecy of the oracle, we can say that the demand is synonymous with the wish to have Œdipus destroyed. It is almost as if the Chorus senses that unless the oracle is proved truthful, and unless the hero's actions proceed in the proper fashion, the very structure of society is threatened. Once more the Chorus warns of the danger, and links Œdipus inextricably with its threat.

> The old prophecies concerning Laius are fading; already men are setting them at naught, and nowhere is Apollo glorified with honors; the worship of the gods is perishing.

Not until the climax of the play has been reached is the full development of the Chorus's 'personality' discernible. Once Œdipus is revealed, beyond all doubt, to be the evildoer and disposed of accordingly, the Chorus's demands have been satisfied, its desires fulfilled. This gratification, however, does not suffice. It will be recalled that in the primal horde the brothers experienced remorse for the murder of the father which took the form of an attempt to undo the deed. The primitive hatred was transformed into constructive social organizations to restrict murderous and incestuous impulses. The Chorus makes a similar progression in development because of its remorse. Once the hero is put out of the way, the Chorus is in a position to evaluate its feelings; it can view life from a new perspective that moves to higher standards. This ability to utilize the experiences of the hero for its betterment and wisdom is directly connected with its psychological needs to have the hero removed.

> Alas, ye generations of men, how mere a shadow do I count your life! Where, where is the mortal who wins more of happiness than just the seeming and after the semblance, a falling away? Thine is a fate which warns me,—thine, thine, unhappy Œdipus—to call no earthly creature blest.

Through Œdipus, the Chorus has seen the tragedy of life and has understood it. It had created an Œdipus to venture into the world of truth, and he proved that no man, not even a hero, could survive. From the tragic point of view, it arrives at the only possible philosophy of life: no man can find true happiness, for happiness itself is merely an illusion.

As if to sharpen this discovery, the Chorus first commiserates with Œdipus, immediately to follow it by obloquy.

> But now whose story is more grievous in men's ears? Who is more wretched captive to fierce plagues and troubles, with all his life reversed?
>
> Alas, renowned Œdipus! The same bounteous place of rest sufficed thee as child and as sire also, that thou shouldst make thereon thy nuptial couch. Oh, how can the soil wherein thy father sowed, unhappy one, have suffered thee in silence so long?

It is important to remember that Œdipus has been created to express wishes which emanate from the community itself. The distaste for Œdipus' crime of incest is a self-chastisement. The reference to the long time which passed before the crime was revealed may be interpreted as its own inner knowledge that this crime lies dormant in us all, and that it is the cause of much of man's suffering. In this passage, the Chorus recognizes that Œdipus is both father and son. The 'bounteous place of rest' which sufficed Œdipus as 'child and as sire also' is a cause for envy—not overlooking the fact that Œdipus, as father and son, experienced years of grace before his discovery. In its revaluation, the Chorus does not completely renounce its basic incestuous desires; but it has learned from Œdipus' experience that such desires invoke disaster.

> Time the all-seeing hath found thee out in thy despite; he judgeth the monstrous marriage wherein begetter and begotten have long been one.

To destroy the father is not merely to gain the mother's love, but for the individual to maneuver himself into a position wherein he is neither father nor son, but ego, or self. This wilfulness to perpetuate ego is a contradiction, for ego exists as son begotten by father and, in turn, as father, a begetter of sons.

In light of this, it seems that the repetition of 'child and sire', and 'begetter and begotten' is an indication of such a conception of the Chorus. Œdipus' failure to perpetuate himself as ego demonstrates the impossibility of achieving such a state; therefore, this realization may be included in the process of enlightenment which the Chorus undergoes.

In spite of its newly acquired knowledge the Chorus never loses sight of the fact that the hero must not be permitted to survive his experiences. Its adjustment to this knowledge is indicated by its complete rejection of him.

> Alas, thou child of Laius, would, would that I had never seen thee! I wail as one who pours a dirge from his lips; sooth to speak, 'twas thou that gavest me new life and through thee darkness has fallen upon mine eyes.

Œdipus appears for the last time before the Chorus blinded and bleeding. The ensuing scene is the culmination of the tragedy. The hero has been maneuvered into a situation which the Chorus has been trying to create from the outset. Œdipus, the evildoer, has been caught; right and wrong are clearly defined. This is the foremost reason for the creation of the hero's tragedy. There can no longer be any question of conscious guilt on the part of the Chorus. There is only one direction in which the action can proceed. The hero must suffer the consequences of his acts and the Chorus must be purified and freed of the taint. Freely, it heaps its crimes and sins upon the hero and freely, he accepts them. The exchange between the Chorus and Œdipus is a complete communion, and

the religiosity of the scene is striking. Despite this process of purification, the Chorus is aware that still deeper questions have not been answered even by an Œdipus.

> . . . Nay, I cannot e'en look on thee, though there is much that I would fain ask, fain learn, much that draws my wistful gaze,—with such a shuddering dost thou fill me!

The ultimate conclusion the Chorus draws from the experiences of Œdipus is scarcely optimistic, but it demonstrates a certain maturity.

> Dwellers in our native Thebes, behold, this is Œdipus, who knew the famed riddle, and was a man most mighty; on whose fortunes what citizen did not gaze with envy? Behold into what a stormy sea of dread trouble he hath come!
>
> Therefore, while our eyes wait to see the destined final day, we must call no one happy who is of mortal race, until he hath crossed life's border, free from pain.

By rationalizing the community's attitudes into a superficial objectivity, the Chorus maintains a consistent, subtle pressure upon the hero. By taking no stand at all, a stand is immediately taken. The Chorus attempts to maintain itself above the conflict, but its contradictory attitudes are clearly revealed. The need which it has to expose the evildoer and the desire to dispose of the hero tips the delicate balance of its ambivalent feelings toward the destruction of Œdipus. In the unfolding of the action, this process increases the stress upon the hero. The Œdipus, then, is not simply the tragedy of one man, but of an individual against the group as well.

SUMMARY

It is our conclusion that the hero and the Chorus are projections of the audience's attitudes. When these two dramatic elements are analyzed, we understand the audience. We find that the hero is a collective ego, growing out of the psychology of the individual, and created to perform deeds which a community would like to perform but which are forbidden to it. Likewise, the Chorus is created to express attitudes which

reflect the moral censure and the restrictions which a community must impose upon the individual. Therefore, whatever holds true for the hero as an individual, for the Chorus as a community, and for the relationship which exists between them, holds true for the audience. The hero and the Chorus are dramatic representations of the audience.

The hero, because of his ambivalence toward his father, performs certain deeds. The Chorus expresses group ambivalence directed toward the hero because he dares to commit these deeds. The audience, as the root of these systems of attitudes, creates the hero in order to perform such deeds, and creates the Chorus in order to express communal moral censure, expose the evildoer, and drive him to his doom.

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A Commentary on Freud's an Outline of Psychoanalysis

Herman Nunberg

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A COMMENTARY ON FREUD'S AN OUTLINE OF PSYCHOANALYSIS

BY HERMAN NUNBERG, M.D. (NEW YORK)

When I undertook to review this book, I did not know how difficult a task it would be. A mere review can by no means do justice to this work; only a thorough commentary would be an adequate tribute to Freud's genius.

To get the full value of each single sentence, the reader should read this book over and over again. Then he will discover ever new thought-provoking formulations.

The Outline seems the last attempt of the Master to state the ideas of his lifework, an attempt, as it were, to convey to posterity the essence of his teachings. This, his last presentation, is not the only one in which he summarizes his doctrines. Such publications as The History of the Psychoanalytic Movement, the Autobiography, the New Lectures, etc., were the result of his vigilantly taking stock of his findings and constantly giving himself critical account of his doctrines. Revising them, he never hesitated to admit and correct errors. Yet, whenever he modified previous statements, he could always point out new problems, open new horizons. Analysis was never static in his hands; it was always alive and growing. Even in this final work he pointed out with admirable sincerity all the problems which analysis had been unable to solve.

The Outline is of all his summarizations the simplest, clearest and yet most comprehensive.

In none of his works did Freud ever try to force his ideas upon others. He expressed them and waited patiently. In the concluding sentence of his introductory words he says of this book: '. . . Its intention is naturally not to compel belief or to establish conviction'—just as, I should like to add, in analysis one should not try to force conviction upon the patient.

The author proceeds systematically. He tries at the beginning to examine the concept of 'psyche' or 'mental life'. He states: 'We know two things concerning what we call our psyche or

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mental life: firstly, its bodily organ and scene of action, the brain . . . and secondly, our acts of consciousness, which are immediate data and cannot be explained more fully by any kind of description'. Everything that takes place between the state of initial action of the brain and the emergence of consciousness is unknown to us.

On the basis of these facts and of innumerable observations of the development of the individual, he makes the far-reaching assumption that 'mental life is the function of an apparatus to which we ascribe the characteristics of being extended in space and being made up of several portions'.

Freud first offered this conception of the structure of the psychic apparatus in the theoretical part of The Interpretation of Dreams. The portions of this apparatus were then called the systems Unconscious (Ucs), Preconscious (Pcs), and Conscious (Cs). Although this conception was discarded as utterly fantastic by some of his followers of that time, especially those in Burghölzli, it remained the fundamental hypothesis of his doctrines. Subsequently, when the psychology of the ego began to take shape, these systems coincided to a certain degree with the division of the personality into mental provinces or agencies, the id, superego, and ego.

The id is the oldest part of these psychic provinces, containing everything that forms our constitution and is inherited, containing 'above all, therefore, the instincts which originate in the somatic organization and which find their first mental expression in the id in forms unknown to us'. In other words, the first mental expression of instincts is *absolutely* unconscious.

At the beginning of life, the id is not yet differentiated from the other psychic agencies; it is only surrounded by an external layer equipped 'with organs for receiving stimuli and with an apparatus for protection against excessive stimulation'. From this layer very soon another mental province arises, the ego. Its main task is self-preservation, mediation between the external and the internal world, the id. For the first time, Freud gives here a full enumeration of all the activities to be performed by the ego in the service of this task; then he stresses that they 'are governed by consideration of the tensions produced by stimuli present within it or introduced into it', that is, by the unpleasure-pleasure principle: the ego pursues pleasure and seeks to avoid unpleasure. Here he indicates that probably these feelings do not depend on

the absolute degree of the rising or falling of tensions as much as on the rhythm of these changes.

The third mental province or agency is called the superego. Its function is to reconcile the demands of the id, the ego and reality. It is the result not only of the child's prolonged dependence upon his parents and the social milieu, 'but also of the racial, national and family tradition'. In this connection he says: '. . . the id and the superego have one thing in common: they both represent the influences of the past (the id the influence of heredity, the superego essentially what is taken over from other people), whereas the ego is principally determined by the individual's own experience . . .'. It is thus very clear that Freud considers the id the carrier of the biological traits of man, and the superego the carrier of the tradition, i.e., of the experiences of past generations.

Here the author finds a connection between human psychology and the psychology of higher animals inasmuch as both have an ego and an id. He makes it very clear, however, that the superego, having as its precondition prolonged dependence in childhood, cannot be applied to higher animals.

After this brief discussion of the psychic apparatus, the author turns his attention to the theory of instincts. The instincts are those forces, he says, which 'we assume to exist behind the tensions caused by the needs of the id. . . . They represent the somatic demands upon mental life.' All instincts are distinguished by two characteristics: first, by the mechanism of displacement; i.e., by the two facts that they can change their aim and pass their energy from one to another, a mechanism which, according to the author, is still obscure; secondly, the instincts are by nature conservative, which means that 'the state, whatever it may be, which a living thing has reached, gives rise to a tendency to re-establish that state as soon as it has been abandoned'.

The underlying principle is the repetition-compulsion known to us since the publication of Beyond the Pleasure Principle, in which Freud first expounded his theory of instincts and assumed two basic instincts: the love instinct or *Eros* and the *destructive* or *death* instinct. The aim of Eros is 'to establish ever greater unities and to preserve them thus—in short, to bind together'; the aim of the destructive instinct 'is to undo connections and so to destroy

things. We may suppose', he continues, 'that the final aim of the destructive instinct is to reduce living things to an inorganic state. For this reason we also call it the *death instinct.*'

This theory of instincts has remained the most controversial part of Freud's teachings. Many of his pupils did not accept the existence of a death instinct.

The author stresses that the repetition-compulsion can be applied to the death instinct since living things arose from inanimate ones; not however to Eros, since that would imply 'that living substance had once been a unity but has subsequently been torn apart and was now tending toward reunion'. The deduction, in relation to Eros, is certainly correct, but, as the reviewer sees it, only in the genetic sense, not in the economic sense. For the tendency to reduce 'the tensions of the love instinct' and to return to the previous state of rest—of 'no-tension', of 'no-instinct'—seems to be governed by the same repetition principle, which, indeed is 'beyond the pleasure principle'. The pleasure-unpleasure principle is, to be sure, an economic one.

The two basic instincts almost never appear in a pure form. In their biological functions they either work against each other or combine with each other and form fusions. A disproportion in the mixture of these instincts results in psychic disorders. Both instincts display a certain amount of energy; the energy of Eros is called libido, while for the energy of the death instinct there is no analogous term. It is easy to observe the manifestations of the libido because they are 'clamorous'. It is, however, difficult to see the workings of the death instinct because they are 'silent'.

In the early stages of psychoanalysis we talked about 'sexual instincts' in contrast to 'ego instincts' (*Ichtriebe*). Freud considered the latter 'mute' as if he felt in advance what development psychoanalysis would take. At that time there was very little known about the ego. When Freud introduced the concept of narcissism, and ego love and self-preservation turned out to be of libidinal nature just as object love and the drive for the preservation of the species, there still remained a part of the ego that was 'silent'. The difficulty in understanding the 'silence' of the ego was removed by the assumption of a death instinct. As long as this instinct works within the boundaries of the ego, it is silent. Only when it is turned outward, toward external objects, does it

manifest itself as a *destructive* instinct. This instinct makes use of the skeletal musculature for its purposes, with action resulting in destruction or mastery of the external world, instead of self-destruction. When the superego, a product of civilization, begins to develop, it absorbs much of the aggression directed toward the external world and works thus within the ego.

As to Eros, there is hardly anything known about the behavior of its libido within the id or the superego: 'Everything that we know about it relates to the ego, in which the whole available amount of libido is at first stored up'. This state is called *primary narcissism*. The ego libido is changeable into object libido. It can, however, at any moment be withdrawn from object representations and be reconverted into *ego* or *narcissistic* libido. The ego 'remains the great reservoir' of libido.

Libido has two contrasting characteristics: mobility and fixation. (These characteristics obviously have a relation to libidinal types.) It has somatic sources and 'streams into the ego from various organs and parts of the body. This is most clearly seen in the case of the portion of the libido which, from its instinctual aim, is known as sexual excitation. The most prominent parts of the body from which this libido arises are described by the name of *erotogenic* zones, though strictly speaking the whole body is an erotogenic zone.'

The third chapter is devoted to the discussion of the development of the sexual function. In a few simple sentences the well-known basic ideas about sexuality are repeated:

'(a) Sexual life does not begin only at puberty, but starts with clear manifestations soon after birth.

'(b) It is necessary to distinguish sharply between the concepts of "sexual" and "genital". . . .

'(c) Sexual life comprises the function of obtaining pleasure from zones of the body—a function which is subsequently brought into the service of that of reproduction. . . .'

Reviewing succinctly sexual development, Freud stresses its *diphasic* onset: it starts at birth and continues until approximately the fifth year; a period of latency follows; this is succeeded by the second onset, the maturing sexuality of puberty. The diphasic onset of sexual life occurs only in man. *Infantile amnesia* is

probably connected with it. 'Our understanding of the neuroses and the technique of analytic therapy are derived from these views.'

The meaning of the concept of 'sexuality' is illuminated by the example of the sucking baby: 'The baby's obstinate persistence in sucking gives evidence at an early stage of a need for satisfaction which, although it originates from and is stimulated by the taking of nourishment, nevertheless seeks to obtain pleasure independently of nourishment and for that reason may and should be described as "sexual" '. 'Physiology should not be confused with psychology.'

The development of sexuality progresses through its four phases, each phase having a certain admixture of aggressive instincts. The first, the *oral* phase, during which sadistic impulses occur sporadically, is followed by the *anal-sadistic* phase. In this phase the aggression is increased to such an extent that the child exhibits pronounced *sadistic* tendencies. The author explains sadism by the assumption of a *fusion* of libidinal with destructive impulses and raises the important question, whether satisfaction of purely destructive impulses can be felt as pleasure. He answers this question in the negative.

In the third, the *phallic* phase, the fusion of destructive and libidinal impulses finds its expression in the *castration complex*. In this phase only the penis is known to both sexes (the girl's clitoris is analogous to the boy's penis). When infantile sexuality reaches its climax in the course of the phallic phase, the sexuality of boy and girl begins to develop in different directions. At this time the boy becomes subject to the *œdipus complex*: his libido is directed toward his mother and his aggression against his father; '. . . but at last, owing to the combined . . . threat of castration and the spectacle of women's lack of a penis, he experiences the greatest trauma of his life . . .'. He acquires the 'castration complex'.

Freud does not demonstrate the further relation of aggression to libido in both the castration and the œdipus complexes. Therefore I should like to add that the castration complex is ambivalent, positive and negative: it generally expresses castration fear, but in certain cases it contains a wish to be castrated; for the most part both forms are combined. The aggression which as a component part of the œdipus complex is usually directed against the

father, turns subsequently against the child's own ego and is felt as a castration threat. If another part of the same destructive instinct has remained in the ego, it is felt as a wish to be castrated, to be feminine, and results in passivity and submission to the father.

The development of the girl is somewhat different. With her, masturbation does not lead to the fear of castration as with the boy. 'The girl, after vainly attempting to do the same as the boy, comes to recognize her lack of a penis or rather the inferiority of her clitoris, with permanent effects on her character.' In fact, this means that the girl in normal development resigns herself, within certain limits, to suffering and masochism. Often, however, the girl becomes aggressive and turns away altogether from sexual life.

In the phallic phase the organization, i.e., the coördination of all component instincts (emanating from the erogenous zones) into one sexual aim, begins to evolve; but only in the fourth phase, in puberty, is this organization completed and only then do the genitalia become the central sex organ.

Frequently the development of the libido is disturbed, and inhibitions occur. Portions of the libido are fixated at earlier stages, while other portions progress to their normal aims. The genital organization may thus become unbalanced through the retardation of some sexual elements. The final result of such a sexual development is a weakening of the genital organization, whose degree depends on *quantitative* relations between the amount of libido that has remained fixated to pregenital objects and aims, and that which has progressed normally. 'Such weakening shows itself in a tendency . . . for the libido to return to its earlier pregenital cathexes (i.e., to *regress*).'

The author closes this chapter with the following words: 'During the study of the sexual functions it has been possible to gain a first, preliminary conviction, or rather suspicion, of two pieces of knowledge which will later be found to be important over the whole of our field. Firstly, the normal and abnormal phenomena that we observe . . . require to be described from the point of view of dynamics and economics. . . . And secondly, the etiology of the disturbances which we are studying is to be found in the developmental history of the individual, that is to say, in the early part of his life.'

After the discussion of the psychic apparatus, and the description of the energies active within it, the author turns to the fundamental problem of the actual nature of mental life of which this apparatus is the stage. Many scientists have been deluded, he says, by the unique phenomenon of consciousness to assume that consciousness alone constitutes mental life. But simple observation shows that there are physical or somatic processes accompanying mental ones which are not conscious and yet prove to have mental qualities. Thus somatic processes have mental qualities which can easily be identified as conscious, and other mental qualities which are not recognized and can be identified by the psychoanalytic technique as unconscious processes. Unconscious and conscious processes form together a complete series. The somatic processes are thus broader than conscious ones because, as the author stated at the very beginning, the brain is 'the bodily organ and scene of action of our mental life'. On the basis of these facts, Freud arrives at the far-reaching conclusion that psychic processes are somatic. He says: 'It thus seems natural to lay the stress in psychology upon these somatic processes, to see in *them* the true essence of what is mental . . .'. Although it may seem repetitious, the reviewer would like to stress that the hypothesis of mental processes being somatic includes the other assumption that not only conscious processes are mental but that all that is unconscious is also mental. Consciousness is only a transitory state of mental activity. This conception of the nature of mental life, Freud states, enables psychology 'to take its place as a natural science like any other. The processes with which it is concerned are in themselves just as unknowable as those dealt with by the other sciences. . . .'

I think that the conception of mental processes as somatic contributes much to a better understanding not only of human behavior but also of some organic sicknesses and of the somatic neuroses. It is, for example, very illuminating in relation to the problem of conversion hysteria. The somatic symptoms of the neuroses (and some organic illnesses) are thus *direct* manifestations of unconscious mental processes. The 'puzzling leap of mental states into physical ones'—as Freud expressed himself earlier—becomes less puzzling now than it seemed before.

The difficulties of psychoanalysis are very great as compared with those of the other sciences. While every other science is

'based on the observations and experiences arrived at through the medium of our psychic apparatus', psychoanalysis has 'as its subject this apparatus itself . . .'. Precisely with the perceptions of this apparatus we watch the events within it and even notice gaps in the series of conscious events; i.e., we notice some links to be missing, as a result of which we are confused and do not understand the mental process. Only by replacing these omissions with guesses, plausible inferences, and translating them into conscious language 'we construct, as it were, a series of conscious events complementary to the unconscious mental processes' which we now can understand.

Using this method one soon learns that it is necessary to distinguish between three mental states: conscious, preconscious and unconscious. The most surprising and yet prominent quality of the conscious state is its instability, its 'highly fugitive' condition. The preconscious state can become a conscious one at any moment. The unconscious mental processes cannot become conscious as such and are called the *unconscious proper*. As indicated before, they must be translated into conscious language.

Freud repeats here the warning given on many other occasions that mere interpretation and construction of the unconscious material presented to the patient is not sufficient to make this material conscious. He says: '. . . the material is present in his [the patient's] mind in two versions, first in the conscious reconstruction that he has just received and secondly in its original unconscious condition'. It seems as if by stressing this fact over and over again, the author intended to indicate that correct analysis does not consist of mere 'interpreting', and that the process of becoming conscious is a matter of emotional personal experience as well as of intellectual learning. It is, indeed, very difficult to transform unconscious material first into preconscious and then into conscious matter, but by persistent efforts we can succeed in causing both versions to coincide. (We estimate the resistance opposing this transformation by the amount of effort needed by the patient in order to overcome it.)

On the other hand, a spontaneous lowering of resistances to such an extent that unconscious material becomes preconscious and then conscious leads to psychotic states of mind. 'From this we may infer that the maintenance of certain internal resistances is a *sine qua non* of normality.' However, transformation of pre-

conscious material or processes into unconscious conditions brings about numerous psychic disorders.

The qualities of the mental apparatus, the conscious, preconscious and unconscious states of mind, naturally are related to the provinces of this apparatus. Consciousness is a function of the perceptual organ of the ego which perceives external and internal stimuli: events taking place in the surrounding world as well as feelings and sensations originating in the body. Feelings and sensations are usually projected into the outside world so that it seems as if all perceptions of the ego were located outside. But a complication arises through the fact that one's own speech and thoughts bring other internal material into consciousness, for example, traces of visual or auditory memories and intellectual processes normally not easily projected into the outside world. The perceptual organ of the ego is thus a meeting place for external events and internal feelings, sensations, thoughts and ideas, a place where they become conscious. It is, therefore, easy for the subject to confuse them as to the place of their origin, i.e., whether they are located inside or outside the ego. In fact, such a confusion exists in early childhood, in dreams, and in psychoses. However, very early, a new faculty develops which differentiates between external and internal events. This faculty is called *reality testing.* If it breaks down, perceptions of the internal world acquire the quality of *hallucinations.* In dreams the weakening of this reality-testing faculty and the forming of hallucinations is a normal phenomenon.

Contents within the ego that are in an unconscious state, as for instance intellective processes, can be perceived by the perceptive apparatus of the ego and thus be transformed into a conscious condition. These states of mind are unconscious in a *phenomenological* sense and are called preconscious. The ego is, therefore, preconscious. According to Freud, the preconscious state 'is characteristic of the ego and belongs to it alone . . . large portions of the ego, and in particular of the superego, which cannot be denied the characteristic of being preconscious, none the less remain for the most part unconscious in the phenomenological sense of the word.'

The mental qualities in the id are purely unconscious. 'Id and unconscious are as intimately united as ego and preconscious. . . .'

But developmentally the id consists of two kinds of unconscious material, the original part, its hardly accessible nucleus, and the repressed. The first, always present, is inherited; the second is acquired by repression of preconscious ideas and even conscious impressions.

Having established the fact that the ego is preconscious and the id unconscious, the author proceeds to investigate 'What is the true nature of the condition which is disclosed in the case of the id by the quality of being unconscious and in the case of the ego by that of being preconscious, and in what does the distinction between them consist?' Although he cannot answer this question, Freud speaks again in guarded terms of his cherished idea about the two forms of psychic energy, an idea which might at some future time give a positive answer as to the nature of what is called 'mental'. Nervous or psychic energy seems to exist in two forms, one freely mobile and the other bound. In the id or the unconscious this energy is freely mobile; in the ego it is bound. It forms cathexes and hypercathexes analogous to electrical charges. A hypercathexis 'brings about a sort of synthesis of different processes—a synthesis in the course of which free energy is transformed into bound energy'.

The study of mental qualities has led to the discovery of certain laws by which the unconscious conditions of the id are distinguished from the preconscious conditions of the ego. The events in the unconscious id are governed by the *primary* process while the events in the preconscious ego are governed by the *secondary* process. For the first time Freud points out that thus the concepts 'primary process' and 'secondary process' express in terms of psychology the same ideas as do the concepts 'freely mobile energy' and 'bound energy' in terms of physics.

Freud tries to explain these processes through the example of the dream. Although the dream looks like a product of insanity it is a normal phenomenon. This fact makes the dream particularly suitable for the investigation of the unconscious id in its relation to the ego. The dream consists, as is well known, of the *manifest* dream material and the *latent* dream thoughts. The transformation of the latent into the manifest dream is called *dream-work*. Its study 'affords us an excellent example of the way in which uncon-

scious material from the id . . . forces itself upon the ego, becomes preconscious and . . . undergoes the modifications which we call *dream-distortion'*.

The precondition of dreaming is sleep. In sleep the ego breaks off its relations with the external world and reverts temporarily to an earlier state in which it partially coincides with the id. 'We shall be justified in saying that there arises at birth an instinct to return to the intrauterine life that has been abandoned—an instinct to sleep.' The dream may be provoked by the ego or by the id: either a desire from the waking state is reinforced by an unconscious element, or an instinctual impulse finds its way into the dream; in the latter case an unconscious wish becomes so strong that it forces itself upon the ego during sleep.

As the ego is weakened in the dream, it is invaded by the unconscious id which helps to form the dream. The participation of the id in the dream formation manifests itself by many facts, among others by the following: the extensive memories in the dream, particularly those of early childhood (which are an indispensable help in the reconstruction of the patient's early childhood); linguistic symbols; and finally, material brought to the surface by the dream, which belongs to the *archaic heritage* of mankind. 'Thus dreams offer a source of human prehistory. . . .' As we have no direct access to the id and can recognize it only through the medium of the preconscious ego, the dream is, in a sense, the best 'experimental station' for observing how the unconscious id works. In the dream, preconscious thoughts in which the unconscious material expresses itself are treated by the ego as if they were parts of the id, and such preconscious thoughts which have attracted an unconscious instinctual impulse acquire likewise the characteristics of the unconscious id. 'Thus dream-work is in its essence a case of an unconscious working-over of preconscious thought processes.' As the ego organization is only weakened, not destroyed in the dream, it exercises also a certain influence upon the emerging unconscious material, which is modified by the ego, so that the dream finally represents a compromise between the demands of the ego and those of the unconscious id.

Thus the study of the dream-work permits us to recognize the laws governing the processes in the unconscious id. They are first the law of *condensation* which expresses a tendency of the unconscious id to form new units of incongruous elements and,

second, the law of *displacement* of mental energies from one element to another. On the basis of these two tendencies Freud assumes that in the unconscious id the energy is in a condition of free mobility. This condition defines the primary process as characteristic of the events in the id: that is to say, the tendencies in the id are in a chaotic state and their only aim is to discharge their quantities of excitation, no matter how and when.

The question arises: why does the ego make the effort to transform the unconscious material of the id into the manifest dream; why does it undertake the dream-work? The unconscious id 'makes a demand upon the ego for the satisfaction of an instinct', the solution of a conflict, etc. Since the aim of the individual, however, is to maintain sleep, it tries to ward off all disturbances. 'The ego achieves this by what appears to be an act of compliance: it meets the demand with what is in the circumstances the innocent fulfilment of a wish and thus disposes of the demand. This replacement of a demand by the fulfilment of a wish remains the essential function of dream-work.' To meet all doubts as to the validity of this formula, Freud enlarges upon it by explaining that all dreams are 'an *attempt* to put aside a disturbance of sleep by means of a wish fulfilment'.

The closing words of this chapter should be kept in mind: '. . . our study of the dream-work . . . helps us to understand the puzzling symptoms which attract our interest to neuroses and psychoses. A coincidence of such a kind cannot fail to excite high hopes in us.'

These hopes are stimulated by the fact that the dream exhibits all the characteristics of a psychosis and yet disappears spontaneously. Since this is the case, may we not hope to find a method for making a psychosis disappear? In the dream 'the ego is detached from the reality of the external world' and invaded and overwhelmed by the internal world, particularly by the instinctual demands of the id. The weak ego of the psychotic corresponds to a certain extent to the sleeping ego of the dreamer. Unable to resist the pressure of the id and the superego it changes its organization, gives up one of its main functions, the testing of reality, and forms hallucinations and delusions.

Psychoanalytic treatment is guided by this insight. The psychoanalyst offers the weak ego of the patient help against the

impact of the instinctual demands of the id and the moral demands of the superego. In exchange he exacts from the patient the promise of complete candor and confidence. Physician and patient form a pact with each other which constitutes the psychoanalytic situation. However, this pact can only be kept if at least a fragment of the ego is able to maintain some contact with reality—and the analyst. As the ego of the psychotic is unable to maintain such relations except for very brief periods, this pact will be ineffective with him 'until we have discovered some other plan better suited for that purpose'. (It seems to the reviewer that another such plan is now in the process of development.)

Since the ego of the neurotic is better able to maintain relations with reality than the psychotic, the neurotic can comply with the *fundamental rule* of free association and for a time be a coöperative patient. Soon, however, he will break this rule and complicate the psychoanalytic situation. This complication is caused by the phenomenon of *transference.* In transference the analyst becomes in the eyes of the patient a reincarnation of some important person or persons out of his past. The patient repeats his attitudes to them in his attitude to the analyst. The transference is *ambivalent,* positive and affectionate as well as negative and hostile. The positive transference is very helpful; at times it even stimulates a cure. The therapeutic success of the positive transference is probably due to the suggestive nature of this relation in the manner of hypnosis. This creates a great danger for the treatment since it might tempt the analyst to influence the patient according to his own ideals, 'to make men in his own image'. If he yields to this temptation he will repeat one of the mistakes of the parents, and will keep the patient in a state of dependence; 'the analyst must respect his [the patient's] individuality'.

Both the positive and the negative states of transference are repetitions of past relations to important persons. While positive transference brings about initial therapeutic success, negative transference undoes these successes. The danger of the states of transference lies in the fact that the patient mistakes them for realities and acts them out, instead of recognizing in them illusions reflecting the past.

Having established a positive transference, we try to obtain from the patient the unconscious material which 'helps us to make constructions in regard to what happened to him but has been

forgotten, as well as in regard to what is now happening in him without his understanding it'. It sounds again like a warning against unfounded assumptions and 'wild' interpretations when the author adds: 'But we never fail in all this to make a severe distinction between *our* knowledge and *his* knowledge'. The closer our constructions are to the forgotten real event and the nearer the patient himself has come to them through the preparatory work, the more easily will he accept them; '. . . *our* knowledge will then have become *his* knowledge as well'.

The most difficult task in treatment is the overcoming of resistances. The *transference resistance* which has just been discussed arises during the treatment. The resistance which the ego has built up against the resurgence of certain elements of the unconscious id is inherent in the neurosis and is called *repression resistance*. It counteracts the aims of the analyst. Consequently a struggle ensues between the patient's ego and the analyst for admission into consciousness of the unconscious material and thus for giving the ego control over it. Whether the outcome of this struggle is acceptance of a hitherto repudiated instinctual demand or its definitive rejection after re-examination is a matter of indifference: 'In either case a permanent danger has been disposed of, the compass of the ego has been extended and a wasteful expenditure of energy has been made unnecessary'. Aside from the resistance opposing the aims of the treatment on the part of the ego, there are other resistances whose sources lie in the other provinces of the psychic apparatus. Among them appear two resistances which demand the closest attention. 'They can both be included under the one description of "need to be ill" or "need to suffer". . . .' Their sources, however, are different. One source stems from the sense of guilt and can be dealt with only by making it conscious and weakening the hostile superego; the second source of this 'need to suffer' stems from the destructive instinct which becomes active and turns against the self when a defusion of instincts has taken place. This resistance is still very little understood.

After a masterly description of the neurotic's ego and of the changes brought about in it by psychoanalytic therapy, the author maintains that the final result of the treatment depends on *quantitative* relations, i.e., on the amount of energy which has to be mobilized in the ego in order to counteract the amount of energy

represented by the various resistances, as well as on the degree of the inertia of these energies, the ability to sublimate, etc.

It is noteworthy that the author mentions, among other therapeutic factors, 'order' which is established in the ego by psychoanalytic treatment. By order (and synthesis) is obviously meant the condition of bound energy which is active within the ego. In the neurotic, the free and mobile energy of the unconscious id has brought the processes within the ego down to the level of the primary process, as can be concluded from many signs. The ego behaves then in part as if it were the id. Treatment frees the ego from the primary process and transforms the freely mobile energy of the id into the bound energy of the ego, which corresponds psychologically to the *secondary process.* Order established in the ego means thus a solidified and unified ego, whose reactions do not occur at random any longer, but become intelligent, precise, clear and limited to a few but concentrated contents adapted to the exigencies of the actual situation.

Psychoanalysis began as a therapeutic technique, developed into a method of psychological investigation which opened new fields of research, and finally became a well-defined science dealing with the human mind.

The discoveries made with the help of this technique have shown that neurotics do not differ essentially from normal persons. Why, then, do they behave so differently and why do they suffer so much? In his preliminary answer to this question Freud says: 'It is *quantitative disharmonies* that must be held responsible for the inadequacies and sufferings of neurotics'. This explanation, however, is too general, since it 'applies to every case of mental suffering', not to neurotic suffering specifically.

Analytic experience has taught that there is one particular instinctual demand and one specific period of life that must be considered in connection with the origin of neurotic sufferings. All neuroses are acquired in early childhood, up to the age of about six years, although there may be a prolonged period when they are latent. Traumatic neuroses alone are not acquired in childhood; or at least, as the author adds, their relation to infantile situations is as yet unknown. The origin of neurosis at such an early age may easily be understood if one considers the fact that the very young ego is weak and incapable of mastering traumatic

events, i.e., certain external stimulations as well as internal excitations resulting from instinctual demands. Here again Freud calls our attention to the fact that 'No human individual is spared such traumatic experiences; none escapes the repressions to which they give rise'. These traumata and the various reactions to them, he further explains, are possibly necessary for the development of the primitive child into a civilized individual within a very short period. Although this development is made possible by hereditary disposition, it could not take place without additional parental influence, education which facilitates 'the setting-up of repressions'. Freud warns, 'We must not forget, therefore, to include the influence of civilization among the determinants of neuroses . . .'. This warning refutes again the assertion that Freud neglects the cultural factor in the etiology of neurosis. He adds, however, that the cultural factor ought not to be overrated and that the biological factor of which it is a reflection, the prolonged dependence in childhood upon the parents, should not be neglected.

The predisposition of the ego to neurosis is thus determined by the interaction of three factors: its weakness and immaturity, the prolonged dependence of childhood, and parental (in a broader sense environmental) influences.

As to the instinctual factor, Freud states that theoretically it is conceivable that any instinct may be pathogenic, but experience contradicts this theoretical expectation and proves that it is the sexual instincts that play a predominant part in the etiology of neurosis. 'The gap in our theory cannot at present be filled; and our decision is made more difficult by the fact that most of the impulses of sexual life are not of a purely erotic nature but arise from alloys of the erotic instinct with components of the destructive instinct.' Having indicated a few factors which may be responsible for the pre-eminent role of the sexual instincts, he states briefly: 'It is not psychology but biology that is responsible for the gap'. He concludes: '. . . the weak point in the organization of the ego lies in its behavior toward the sexual function, as though the biological opposition between self-preservation and the preservation of the species there found psychological expression'.

The specific nature of the sexual component-instincts of early childhood is reflected in certain reactions of the immature ego to sexual experiences. Such experiences, which are more or less common, as seduction by an older child, witnessing parental inter-

course, etc., force sexual impulses into certain channels. The ego becomes thereby oversensitized and represses those experiences immediately or as soon as they return as memories. The pressure of the repressed instinctual demands forms, then, the immediate precondition for a neurosis.

One or the other such experience may be accidental for the child, but not so the œdipus complex 'which follows inevitably from the factor of the length of his dependence in childhood and of his life with his parents'. This complex plays different roles in the boy and in the girl. Up to the period of the œdipus complex, there is almost no difference in the sexual behavior of boy and girl but 'We are faced here by the great enigma of the biological fact of the duality of the sexes: for our knowledge it is something ultimate, it resists every attempt to trace it back to something else'. However, each sex comprises some more or less distinguishable traits of the other sex which manifest themselves in psychological bisexuality. We do not know exactly what 'male' and 'female' are, but for the purpose of definition we consider everything that is 'active' as male, and everything that is 'passive' as female. Here again the reviewer believes it would be necessary to define what is understood by the terms 'active' and 'passive'. In the œdipus complex 'male' and 'female' sex instincts meet, and the bisexual character of the love instinct finds expression.

The 'prehistory' of the œdipus complex is very interesting. In the beginning of development there is no sharp differentiation between male and female; it evolves in stages. In the first phase, the oral, the mother suckles the child and takes care of its physical needs, thus becoming its first 'seducer'. 'In these . . . relations lies the root of a mother's importance, unique, without parallel, laid down unalterably for a whole lifetime, as the first and the strongest love object and as a prototype of all later love relations—for both sexes.' The author stresses here, as elsewhere, the fact that accidental experiences cannot change the phylogenetic foundations so 'that it makes no difference whether a child has really sucked at the breast or has been brought up at the bottle . . .'.

When the boy—at the age of two or three—enters the phallic phase he acquires the castration complex. The castration threatened by mother or nurse in connection with the boy's masturbatory activities acts as a trauma which is immediately effective if he has already seen a female genital. If not, the trauma is latent and

becomes effective when he first sees a female genital. In the acquisition of the castration complex the boy 'experiences the severest trauma of his youthful existence'. Never forgetting the influence of phylogenesis the author adds in a footnote: 'The possibility cannot be excluded that a phylogenetic memory-trace may contribute to the extraordinarily terrifying effect of the threat—a memory-trace from the prehistory of the human family . . .', castration performed by the primeval father.

As a result of the threat of castration, the boy gives up the practice of masturbation, but not the fantasies which have accompanied it. In these fantasies he identifies himself alternately with father and mother. 'Derivatives and modified products of these early masturbatory fantasies usually make their way into his later ego, and play a part in the formation of his character.' The castration complex also determines the formation of the manifold neurotic symptoms. The severity of the neurosis will, however, again depend upon *quantitative* relations.

The 'castration complex' of the girl is different. She has no fear of castration, of course, but has a 'penis envy' which influences her whole development. The formation of her character or a neurosis may be determined by her efforts at compensating herself for her 'defect'. She resents her lack of a penis and holds her mother responsible for it. In her resentment, she rejects her mother as a love object and, in normal development, identifies with her and loves the father. She enters the œdipus complex as the boy does.

The difference between the male and the female œdipus complex is thus clear: in the boy the threat of castration brings the œdipus complex to an end; in the girl it is the lack of a penis that drives her into the œdipus situation.

Freud closes this chapter with the significant remark: 'If we ask an analyst what his experience has shown to be the mental structure least accessible to influence in his patients, the answer will be: in a woman, her desire for a penis, and in a man, his feminine attitude toward his own sex, a precondition of which would necessarily be the loss of his penis'.

In the first two parts of his book, the author combines experiment with logical thinking. He states empirical facts and draws from them logical conclusions. In the last part, he makes a most condensed summary of his doctrines.

The discovery of the unconscious, and the hypothesis of the psychic apparatus extended in space, made possible the understanding of the workings of the human mind, and put psychology on a scientific basis. The author compares the method of psychoanalysis to the methods of the scientists which never reach the ultimate reality hidden behind the phenomena accessible to our perceptions. As the physicist, with the help of his instruments, draws conclusions about the nature of the unknown reality, so does the psychoanalyst: '. . . we deduce a number of processes which are in themselves "unknowable" and insert them among the processes of which we are conscious. And if, for instance, we say: "At this point an unconscious memory intervened", what this means is: "At this point something occurred of which we are totally unable to form a conception, but which, if it had entered consciousness, could only have been described in such and such a way".'

As to the psychic apparatus itself, he states he cannot give a complete picture of all its functions because not all of them have been thoroughly investigated. Recapitulating briefly the structure of this apparatus, he adds some details omitted before. Discussing the id and the organic instincts operating within it, he says that these 'are differentiated from one another by their relation to organs or systems of organs'. This seems to the reviewer to imply that the organs or system of organs produce specific instincts or that the instincts are determined in their way of expression and in their aim by the structure of the organ through which they seek to express themselves. Furthermore, the id has no anxiety 'or it would perhaps be more correct to say that, though it can produce the sensory elements of anxiety, it cannot make use of them'. Up to the publication of Inhibition, Symptom and Anxiety, Freud had expressed the belief that libido can be converted into anxiety. In that book he dropped this theory and declared that anxiety can only be produced by the ego as a signal of danger. In this Outline he seems to assume that single sensory elements of anxiety can arise in the id, but that only the ego can integrate or synthesize all those sensory perceptions in the affect of anxiety and make use of it for self-protection. Thus the inceptions of anxiety are unconscious. It is in accord with this conception of the beginning of anxiety that, as the author states, the id 'detects with extraordinary clarity certain changes in its interior, especially oscillations in the

tension of its instinctual needs, oscillations which become conscious as feelings in the pleasure-unpleasure series'. In fact, I have become convinced that the deeper the analysis penetrates, the more the analyst can see that the patient knows (perceives) more of the anatomy and physiology of his organs than we assume. Although it is not known by what means the perception of feelings—cœnesthetic feelings and feelings of pleasure-unpleasure—comes about in the id, one thing is certain, namely, that the id is governed by the pleasure principle. Not only the id but also the ego obeys this principle. The ego can modify, not nullify, it. Here the author raises the important question whether the pleasure principle can ever be overcome. Then he continues: 'The consideration that the pleasure principle requires a reduction, or perhaps ultimately the extinction, of the tension of the instinctual needs (that is, a state of *Nirvana*) leads to problems that are still unexamined in the relations between the pleasure principle and the two primal forces, Eros and the death instinct'.

The reviewer suggested (Cf. p. 230) that the application of the principle of repetition-compulsion to the sexual instincts as well as to the death instinct is possible from an economic although not from a genetic point of view. The satisfaction of the pleasure principle leads to reduction of tensions, which could also include the state of Nirvana (in Sanskrit literally 'blowing out', 'extinction'; in Buddhism Nirvana means extinction of all desires and passions).[1]

While the id is in no direct contact with the external world, the other agency of the psychic apparatus, the ego, is in direct contact with this world. However, it is not exclusively dependent on it, but it is also influenced by the id. The ego strives to free itself from this influence by 'raising the processes in the id to a higher dynamic level (perhaps by transforming freely mobile into bound energy, such as corresponds to the preconscious condition)'. This can only mean, the reviewer thinks, that the primary process of the unconscious id is changed into the secondary process of the preconscious ego when unconscious material becomes conscious, when the chaotic and unorganized id cedes some of its energies to the ego, thus contributing to its higher organization and order (Cf. p. 242). When this transformation of energy occurs in the

[1] *The Shorter Oxford English Dictionary*. Oxford: The Clarendon Press.

psychic apparatus, there develop several functions of the ego, such as the synthetic function of the ego, its selective function (perceiving and excluding certain stimuli), the reality testing (distinction between external and internal perception), the intellective activity, and anxiety as a signal of danger.

Danger threatens from the external as well as from the internal world. The defense against the dangers coming from the external world is a far easier task than that against the internal dangers. Danger is a relative conception dependent on quantitative relations between external stimuli or internal instinctual demands, on the one hand, and the strength of the ego, on the other. The ego of the little child is too weak to cope with the libidinal demands. It represses them but the repression proves to be inadequate in later life when the 'reanimation of sexual life brings a reinforcement to the repudiated instinctual demands. From the biological standpoint, then, it may be said that the ego comes to grief over the task of mastering the excitations of the first sexual period, at a time when its immaturity makes it incompetent to do so. We recognize the essential precondition of neuroses in this lagging of ego development behind libidinal development. . . .' Yet, these repressions in childhood seem indispensable for the cultural development because they enforce sublimations.

It is characteristic of Freud that he never loses sight of the implications of his findings: he sees the possibilities of both normal and pathological development from the same starting point.

When reality has become too painful to bear or the instincts have become excessively intensified, the ego withdraws from reality. This withdrawal results in a psychosis. The detachment from reality, however, is only partial. 'We may probably take it as being generally true that what occurs in all such cases is a *split* in the mind. Two mental attitudes have been formed instead of a single one—one, the normal one, which takes account of reality, and another which under the influence of the instincts detaches the ego from reality. The two exist alongside each other.'

Bleuler postulated a split in the ego for the Kraepelinian *dementia præcox* and therefore renamed it *schizophrenia*. Freud, however, maintained that a split in the ego is not characteristic of psychoses only, since it also occurs in neuroses and perversions. Having shown that there is no essential difference between what we call psychic 'normality' and 'neurosis', he now also lowered the

barrier between neurosis and psychosis, both having in common the split in the ego.

This fact proves to be the basis for any therapy. For, if the ego were *completely* detached from reality there would be no possibility of establishing any contact with the patient and of influencing him. In psychosis as well as in neurosis the rejection of reality is only a half measure. 'The rejection [of reality] is always supplemented by an acceptance; two contrary and independent attitudes always arise and this produces the fact of a split in the ego.' The treatment always takes advantage of that part of the ego which has remained untouched by the pathological process and accepts reality. With this intact part of the ego a contact can be established. The facility with which this can be done depends on quantitative relations. As the ego of the neurotic is less afflicted than the ego of the psychotic, it is easier to get in contact with the former than with the latter.

The split in the ego, naturally, is reflected in the behavior and the two attitudes of the patient: '. . . in that case, however, one of them belongs to the ego and the opposing one, which is repressed, belongs to the id. The difference between the two cases is essentially a topographical or structural one and it is not always easy to decide in the individual case with which of the two possibilities one is dealing.'

This last remark seems to the reviewer particularly important for practical reasons. It is true that first the resistances or defenses of the ego should be interpreted. But as it is not always possible to say what belongs to the preconscious ego and what to the unconscious id, we are often forced to interpret the material in the order in which it presents itself. By interpreting exclusively the preconscious defenses we run the risk of overlooking the unconscious id.

The relations within the structure of the psychic apparatus are more complicated than is apparent in the presentation up to this point. This complication is caused by the superego, which begins to develop at about the age of five years. Then the ego, in its function as a mediator between the external and the internal world, must also take into account the exigencies of the superego. Though the superego becomes an integral part of the ego, it represents in the latter a part at least of the external world, the parents.

The severity of the superego 'corresponds to the strength which is used in fending off the temptation of the œdipus complex. . . . During the whole of man's later life it represents the influence of his childhood.' In the superego are accumulated the experiences of the cultural past. Faithful to his conviction about inheritance of psychic attitudes, the author states: 'Some of the cultural acquisitions have undoubtedly left a deposit behind in the *id;* much of what is contributed by the superego will awaken an echo in the id; many of the child's new experiences will be intensified because they are repetitions of some primeval phylogenetic experience'. It seems as if Freud saw and felt in one man all mankind.

At the end of the book we find a striking comment: 'In the emergence of the superego we have before us, as it were, an example of the way in which the present is changed into the past . . .'. We cannot help but think here of the transference, in which the analyst is transformed into an object of the past.

The Outline was not completed; nobody knows how much more the author wished to say. But what he has said is enough to stimulate thinking for generations to come.

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Einführung in Die Technik Der Kinderanalyse (Introduction to the Technique of Child Analysis). By Anna Freud. Third Edition. London: Imago Publishing Co., Ltd., 1949. 105 pp.

Edith B. Jackson

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BOOK REVIEWS

EINFÜHRUNG IN DIE TECHNIK DER KINDERANALYSE (Introduction to the Technique of Child Analysis). By Anna Freud. Third Edition. London: Imago Publishing Co., Ltd., 1949. 105 pp.

The first edition of this small book appeared in 1927. It was translated into English under the supervision of L. Pierce Clark, M.D. and published in 1928 as No. 48 of the Nervous and Mental Disease Monograph Series, entitled Introduction to the Technic of Child Anaylsis. Dr. Clark wrote a highly appreciative preface, dated March 15, 1928, from The Psychoanalytic Institute, Stamford, Connecticut, and congratulated Anna Freud for her 'unique effort' in contributing this little monograph, a series of four lectures to psychoanalysts, 'the first of its kind in any language'.

A second edition appeared in 1929 which included, in addition to the four lectures presented before the Vienna Psychoanalytic Institute, a paper which Anna Freud read before the Tenth International Psychoanalytic Congress in Innsbruck (September 3, 1927), *Zur Theorie der Kinderanalyse.*

Just about twenty years after the publication of the second German edition a third edition in German (1949) has been brought out by the Imago Publishing Co., Ltd., London. The appearance of this third edition prompted the request for the present notations. The five lectures by Anna Freud which make up this book are classics in the child analytic literature and need no special review at this time. The present reviewer will limit herself to a reference to some of the previous reviews.

The 1927 German edition was reviewed in detail by Rado.[1] His careful and constructive review is supportive of almost all of the practical and theoretical points of difference between child analysis and adult analysis made by Anna Freud. It is very complimentary to the clarity of the author's presentation and to her accomplishment in clearing the way for the understanding and further development of child analysis.

The publication of the four lectures delivered by Anna Freud in 1926 before members of the Vienna Psychoanalytic Institute on the subjects of I, Introduction to Child Analysis; II, The Methods of

[1] Int. Ztschr. f. Psa., XIV, 1928, pp. 540–546.

Child Analysis; III, The Role of Transference in Child Analysis; and IV, The Relation of Child Analysis to Education, stimulated a Symposium of Child Analysis which was held before the British Psychoanalytic Society, May 4th to May 18th, 1927. The papers presented at this Symposium by Melanie Klein, Joan Riviere, M. N. Searle, Ella F. Sharpe, Edward Glover, and Ernest Jones were published in the International Journal of Psychoanalysis.[2] The symposium gave expression to marked differences in the theory and practice of child analysis between the English analysts and Anna Freud, and was subjected to an exhaustive critical review by Fenichel.[3] In his conclusion Fenichel states that the differences in points of view of child analysts are not slight; that they are partly reduced by the fact that Anna Freud was thinking principally of the latency period, and her critics of an earlier age period; that other differences could be explained away on the basis of misunderstanding; but there still remained a large number for which no way of agreement could be found.

In 1946 the Imago Publishing Company published a book in English by Anna Freud called The Psychoanalytic Treatment of Children. This book is made up of the English translation of the contents of the second German edition (four lectures on the technique of child analysis as differentiated from that of adult analysis and the Innsbruck Congress paper, On the Theory of Child Analysis), together with a much later paper which was published in 1945 in The Psychoanalytic Study of the Child, entitled Indications for Child Analysis. This book was reviewed by Judith S. Kestenberg[4] who noted the importance of the last paper which, although written on the subject of indications for child analysis, gives evidence of the progress which has been made in the field of child analysis in the last twenty-five years. As she states, the analysis of defense mechanisms has been largely substituted for the procedures described in her early lectures, particularly the introductory phase preceding the actual analysis of children and the educational measures which were undertaken hand in hand with the analysis of children.

The appearance of this third German edition, *Einführung in die*

[2] Volume VIII, 1927, pp. 339–391.

[3] Int. Ztschr. f. Psa., XIV, 1928, pp. 546–561.

[4] This QUARTERLY, XVI, 1947, pp. 553–556.

Technik der Kinderanalyse, is evidence of the permanent value of Anna Freud's original and vigorous presentation of the problems of child analysis. The 'classic' quality of this book is determined not only by the originality of psychoanalytic content but by the exemplary clarity of thought and style.

EDITH B. JACKSON (NEW HAVEN)

PSICOANÁLISIS DE LA MELANCOLÍA (Psychoanalysis of Depression). Edited by Angel Garma, M.D., and Luis Rascovsky, M.D. Buenos Aires: Asociación Psicoanalítica Argentina, 1948. 519 pp.

This work is a psychoanalytic symposium in Spanish on the subject of depression. Garma and Rascovsky have combed the literature and culled an excellent selection of articles on various aspects of the problem. The book opens with a resumé by Pichon-Rivière of the development of medical thinking about manic-depressive psychosis, from Hippocrates to Bleuler. This is followed by the papers on depression, which comprise the bulk of the book. There is a short section on mania and a final section devoted to Melanie Klein's ideas on manic-depressive states (1934).

The first dozen or more of the papers for the most part cover the development, in historical sequence, of analytic theories on the genetic structure of the manic-depressive psychosis. They include Abraham's paper on manic-depressive psychosis (1911), and on the oral phase of libido development (1916). From Freud's works the editors select a fragment of Totem and Taboo, dealing with the totem feast; short bits on narcissism and on the oral phase; an excerpt about identification from Group Psychology, and one on the superego from The Ego and the Id; a portion of Inhibition, Symptom and Anxiety; and of course the classical Mourning and Melancholia. This group includes also a more recent contribution to the problem of infantile sexuality, by Editha Sterba (1942), which contains an excellent discussion of the oral phase of libido development.

The remainder of the papers are relatively more recent works, with a more clinical orientation. There are papers on depression by Rado, Helene Deutsch, and Gerö; a lucid discussion of suicide published originally in German by Garma in 1937; two con-

tributions by Edith Jacobson on dynamics, and one by Lorand on neurotic depression.

The collection is introduced by a comment made by Freud in 1910, at a symposium on suicide at the Vienna Psychoanalytic Society, to the effect that (translated from the Spanish) '. . . we are completely ignorant of the affective processes of melancholia and of the fate undergone by the libido therein. . . . We must therefore defer our decision until experience has resolved these problems.' On the heels of this remark, the succeeding pages of the anthology become a dramatic unfolding of analytic knowledge about depression, so that at the end, when one reads Garma's brief summary of analytic investigations in the field, one cannot escape being impressed with the progress that has been made since 1910 in understanding the dynamic and genetic factors of this disease.

There are, by contrast, only three papers in the symposium on the problem of mania: an excerpt from Freud's Wit and Its Relation to the Unconscious, and two articles on hypomania, by Bertram D. Lewin and Helene Deutsch, respectively. This expresses the editors' feeling that the basic problem in circular insanity is the depression; and it probably expresses also the fact that less has been written about the manic side of the disease.

This book's only important defect, in the reviewer's opinion, is the lack of a unified bibliography. The bibliographic notes scattered through the various articles are not convenient for reference. Like its predecessor, *Patologia Psicosomática,* this publication of the Argentine group will aid the Spanish-speaking psychiatrist by making available to him in his own language an important body of analytic writing. The value of the present volume goes beyond that, however. It not only gathers between two covers the leading works on melancholia, but succeeds in presenting a coherent picture of the development of analytic thinking on the subject. To my knowledge we have nothing comparable in English, either on melancholia or any other disease. Anyone who has ever tried to review the analytic literature on any topic knows how difficult it can be. To the American student in analytic training, who is confronted by a literature widely diffused in time, space, and language, a library of symposia like this one, in English, would be a real blessing.

DAVID KAIRYS (NEW YORK)

MALE AND FEMALE. A Study of the Sexes in a Changing World. By Margaret Mead. New York: William Morrow & Co., 1949. 477 pp.

In the preface to the new edition of his great work, Élie Faure says, 'I have been reproached with having written not a "History of Art", but rather a sort of poem concerning the history of art'. This book of Margaret Mead's is a beautiful book, and it may be that she will be similarly reproached for having written a sort of poem about anthropology. She, too, understands how barren is the mere description of human experience and endeavor when stated in terms of action and conscious motivation alone. Human life is inextricably bound to values: desires, traditions, good and evil. She knows the need for the bare data to be reworked through the personality of the observer, to be interpreted in the light of special knowledge, special training and particular experience. Unfortunately there are but few social scientists who can thus produce the 'poetic transposition' that Faure hopes for, but Margaret Mead is one of these.

Mead employs new tools and has thought deeply since she published Sex and Temperament in 1935. Additional field work up to 1939 enabled her to apply these tools in simple homogeneous cultures and so gain deeper insight into much that she had observed during earlier work in the field. (Her field data, studied through new lenses, may be the foundation for another excellent study such as this.) It is sometimes said that one can not really and truly believe the findings of psychoanalysis until one has observed children intimately. Margaret Mead has observed many, many children, and very intimately. What she has learned of psychosexual development, of the meaning of body zones and their modes of functioning, of the flow of libido and its fixation, has been enriched by warm, sympathetic emotional participation. She is never 'too grown-up' to share the simple experiences of simple people and consequently understands easily the complications of complicated people. This book deals with the endless permutations of the relations between the sexes: 'What is it to be a man? What is it to be a woman?' And how is it these questions have come to be so difficult in this twentieth century?

The Ways of the Body (Part II) undertakes a basic approach

to sex learning and the relationships to the other sex. There is rich data here for the clinical or theoretical psychoanalyst, a wealth of observational detail, simple and clear, and integrated through theory and insight. For instance, speaking of the conditions that give a child the sense of its own sex membership: 'There is the structure of its own body, in which the girl finds that the reinterpretation of impregnation and conception and birth fits easily into her early experience with the intake of food, while the boy with the same initial experience can at most use it to interpret the female role, but will find himself heavily confused if he attempts to use it to interpret his own'.

Part III shifts the emphasis to the social forms, to the 'pattern of social life that comes to terms with the differences between the sexes'—the rhythm of work and play, religious ceremonials and copulation, the 'social invention' of fatherhood, potency and receptivity, sexual frustration and reproductivity. The author deprecates arguments as to what is 'natural' and what 'unnatural', saying, 'Our problem is to develop and elaborate this new method of evolution, this precious system of invention and learned social practice that man alone of all living things has begun'.

Part IV studies The Two Sexes in Contemporary America. Here the psychoanalyst is more at home, and delighted by the many cogent social generalizations which light up the background of his closely delimited studies of individual cases. Here is the cultural mirror image of the lives and problems, the hopes and fears, the struggles, failures and successes of individual Americans today. We are taken from Expected Childhood Experiences through Pre-courtship Behavior and Sex Demands on to the intricate problems resulting from the increasing separation of the generations in homes of their own (what effects upon the older generation, and thus upon the expectations of the younger?) and then on to the emancipations and penalties deriving from our social acceptance of divorce. The author has no quarrel with the moving hands of the clock but, rather, tries to demonstrate how the heterogeneity of our population has made divorce necessary and to show the need for development of a new pattern of behavior to fit the new conditions—'And there are signs that such a new pattern of behavior is developing'.

There are informative Notes to Chapters. Appendix I gives the author's background, and some bibliographical material on

the seven Pacific Island cultures which are described in the book and used to illustrate varieties of individual and social adjustment. Appendix II, The Ethics of Insight-giving, might well serve as a text for advanced psychoanalytic instruction. Here we find articulated a description of certain of the conventional ego defense mechanisms that underlie the more acceptable forms of social 'resistance', those elusive entities which most of us can communicate to our students only by a tone of voice, by the timing of a smile. Margaret Mead comprehends the dangers of leadership, the perils that accompany the process of enlightenment; and it is well that this is so, for the very resentments which she describes in this appendix have recently motivated a sterile review of this book in one of our widely-read, intellectual monthly magazines. Appendix III describes Sources and Experience in Our American Culture and includes a list of the author's publications on American culture. There is an index of personal names and an extensive index of subjects.

WILLIAM G. BARRETT (SAN FRANCISCO)

A PSYCHIATRIST LOOKS AT TUBERCULOSIS. By Eric Wittkower, M.D. London: National Association for the Prevention of Tuberculosis, 1949. 152 pp.

The nature of the ego, which has, above all else, the task of self-preservation, becomes a matter of more than psychiatric interest when chronic illness seriously endangers life or function. In order to establish the relationship between personality factors and pulmonary tuberculosis on the basis of modern clinical research, the National Association for the Prevention of Tuberculosis (England) engaged Dr. Eric Wittkower, a psychiatrist reputed for his psychosomatic contributions, to conduct a person-by-person study. The results of this scientific endeavor are published, with an introduction by Dr. John Rickman, in this readable little book which covers three years of painstaking psychiatric research on seven hundred eighty-five patients.

The book contains three chapters, deliberately phrased in colloquial style. The first is a documentation of patients' emotional reactions to the symptoms, the diagnosis, and the illness; the second explores various individual factors determining altered behavior; and the third assesses the relevance of emotional factors

in the etiology and course of tuberculous illness. A few clear statistical tables dispose of many prevalent, though contradictory impressions of the personality of the tuberculous patient as 'predominantly sensitive, neurotic, oversexed, euphoric, suggestible or of increased intellectual capacity'.

Although the Wittkower report conveys a valuable fund of information and depth of understanding, as a research document for the psychiatrist it has limitations. The lack of control studies on the incidence of comparable personality types in the general population and the absence of correlated psychological tests—particularly projective techniques—are the chief technical shortcomings. By virtue of being an extensive study, based on single interviews of one or two hours with each patient, it cannot provide analytic nuances of development and change.

What this preliminary volume lacks in range, however, it makes up in clarity, and medical practitioners can profit from the author's dynamic formulations which stand out as so many quotable psychiatric aphorisms. Brief case reports illuminate the impact of tuberculosis on the apparent defense mechanisms of various character types, and while these are essentially dynamically oriented psychiatric anamneses, they are, nevertheless, stimulating data which highlight salient factors determining the behavior of several tuberculous patients. The personality correlations in these studies lead to this conclusion: 'It may be safer to assess a patient's prognosis on the basis of his personality and emotional conflicts, than on the basis of the shadow on the film'.

Since similar or identical psychological factors are involved in any suffering from chronic organic disease, the Wittkower report should be valuable to all professions interested in psychosomatic medicine.

VICTOR W. EISENSTEIN (NEW YORK)

THE ABNORMAL PERSONALITY. By Robert W. White, Ph.D. New York: The Ronald Press Co., 1948. 613 pp.

This book is well written and well balanced. The information in it is valuable, and presented with a completeness consistent with a textbook in clinical psychology. While one could cavil at the title, since considerable portions of some of the chapters deal not at all with the abnormal personality, the title is well chosen and

the book begins and ends on a note consistent with it. Teaching psychology with this as a text should prove an informative and interesting task, and the reviewer will not be surprised if it is used as a text in many colleges and universities.

The substance of the book is for the most part objectively handled, and controversial questions discussed with a pleasing degree of fairness. One might question some minor matters in so far as they show a subjective rather than an objective approach on the part of the author. For example, he finds it difficult to accept the importance of sexuality in family relationships. This quaint touch of Victorianism seems quite out of place in a book which handles most of the areas of the abnormal personality with such clarity.

His discussions of fantasy, dreams and hypnotic behavior are interesting and instructive. One misses the discussion of a symptom which is becoming of increasing interest in the present day, namely that of depersonalization. Since this symptom has long been studied and discussed by psychoanalysts, it is surprising that more elaboration of it has not been undertaken by the author in connection with this chapter. His discussion of anxiety and defense is a good one and for the most part adequate. He speaks with a little more certainty than one feels inclined to accept, since the problem of anxiety is still one about which many authorities are uncertain and hesitant to make any didactic pronouncements.

The author's treatment of basic methods of psychotherapy seems to the reviewer somewhat poorly conceived, since he sees fit to include the so-called nondirective counseling with psychoanalysis and brief psychoanalysis. Since the reviewer has recently learned that the practitioners of nondirective counseling are now discovering the need for increasing length of time to accomplish a therapeutic result, one wonders if this minor departure from basic psychoanalytic theory and techniques is not going to find itself, in a few years, back on the same road from which it parted. It is always annoying, too, to find a failure to give credit to originators of a new technique that achieves considerable popular acclaim. Possibly the author is not aware of the fact that the nondirective technique was anticipated by several years in the associative anamnesis techniques of Dr. Felix Deutsch, as was the sound recording of psychotherapeutic interviews.

The proportion of the book devoted to psychoses seems entirely

appropriate in the light of the present day accent on preventive psychiatry and the treatment of emotional disorders early, before psychotic episodes develop. His discussion of the problem of the relations of the professions of psychiatry, clinical psychology, and psychiatric social work is a very fair statement, and indicates a detachment toward the problem that is not too widely prevalent in any of the professions. The recent decision of the Council of the American Psychological Association which opposes the practice of psychotherapy by clinical psychologists that does not meet the conditions of genuine collaboration with physicians most qualified to deal with the borderline problems which occur in this field is a heartening one, and represents a serious attempt to consider primarily the public good rather than the status needs and rivalries of any profession. The reviewer recommends this book unhesitatingly both as a text and as an informative source book for the college or graduate student.

HERBERT I. HARRIS (CAMBRIDGE, MASS.)

MAGNA MATER IM ALTEN TESTAMENT. Eine psychoanalytische Untersuchung (MAGNA MATER IN THE OLD TESTAMENT. A Psychoanalytic Study). By Ewald Roellenbleck, M.D. Darmstadt (Germany): Claassen & Roether, 1949. 187 pp.

This book applies psychoanalysis to the history of religion. The author bases his investigations on the Old Testament, canonical as well as noncanonical, apocryphal scriptures, the explorations of historians, anthropologists, students of comparative religion. The most outstanding psychoanalytic study of the Old Testament, Freud's book, Moses and Monotheism, was not at the author's disposal.

Roellenbleck sees in the religious productions of a tribe or nation a spiritual achivement representing specific solutions of conflicts between primary anxiety, primary guilt and primary trust. Different cultural groups have certain common universal symbolisms. The religiosity of the ancient Hebrews, however, differs markedly from the oriental mythologies that developed in geographical and historic proximity. The absence of a maternal deity in the Hebrew religion, the one-sidedly rational and ethical monotheism, centering on a male God, is fundamentally different from the polytheism of the Egyptians, Babylonians, Phoenicians, and ancient Greeks, for whom the ethical severity of paternal deities is balanced by the voluptuous indulgence or uncanny seductiveness of maternal deities.

Roellenbleck assumes that the cult of the mother goddess, the Magna Mater, has undergone a process of repression in the Hebrew religion. The descendents of Abraham carried the name of Hebrew or Ibri, which means immigrants or foreigners. They lived on the fringes of other cultures in old Palestine and later as immigrants in Egypt. They did not own the soil on which they worked and harvested. They could be expelled arbitrarily by the original settlers—certainly a sufficient reason to experience their existence as fundamentally a rejection by the mother goddess, earth. Even after they had reconquered their homeland, the relation to mother earth remained burdened with doubt and distrust. The documents of the Old Testament are abundantly misogynous.

The psychoanalyst expects that no repression is ever so complete that its product—more or less distorted—will not return from repression. The author finds vestiges of the maternal deity in the creation myth. The void chaotic darkness, *tohu-wa-bohu* is related to Ba'u, the feminine personification of the water dwelling of the good spirit of the earth in oldest Sumerian traditions. The Hebrew expression for depth, *tehôm,* is closely related to the Babylonic mother goddess Tiamat who was killed by the male god Marduk. He created the new world out of the dead body of Tiamat who is related to the snake, the dragon, and to Leviathan, the monster of the sea, or Behemoth the monster of the earth. In the Syrian Apocalypse of Baruch the author has found indications of a cultish meal. The survivors of a new era ate the defeated primordial monster, establishing therewith the mystic union with the mother goddess.

According to the author, not only is the chaotic material of world creation feminine, but the cosmogenic spirit hovering over the waters of the depth also carries vestiges of femininity. In *ruah elohim merahefet, ruah* is feminine, a hovering spirit, reminiscent of the hatching mother bird. According to Bachofen the egg is a universal symbol of life and resurrection (Easter egg). The mother bird with protecting wings returns later in the dove symbol of the holy spirit, the personification of heavenly wisdom, in which Ernest Jones has pointed out the maternal principle in the Christian Trinity. In the Catholic Church the cult of the maternal deity was permitted to reappear. According to Roellenbleck the fourth commandment was originally the order to venerate the mother goddess. It is the only one among the divine orders

which carries the promised reward of a long life and well-being in one's home country.

The author might have stressed more strongly the dichotomy of good mother, bad mother, with which we are so familiar in the psychoanalysis of individuals. The Magna Mater of all Oriental religions, Hathor, Isis, Istar, Astarte, Kali and Cybele, they are all either fascinating, orgiastically indulgent, abundant in fertility, with multiple breasts, or threatening to life and procreation, cruel, demanding the self-castration of their devotees or the sacrifice of newborn children. They are the chthonic goddesses of gloom and death.

The austere masculinity of Jahwe is mitigated by maternal features; the God to whom the Psalmist prays out of the depth of depression carries features of comforting tenderness and maternal protection. In the Song of Songs the deity appears in the garment of fascinating feminine beauty with all the attributes of magic charm. But the Proverbs of the Old Testament speak of the insatiability of four powers: the grave, the womb, the earth never satisfied with water, and fire. Ecclesiastes calls the woman with her alluring wiles more bitter than death.

In the creation myth the bad mother is represented by Eve, the snake, and the trees of knowledge and of life. They all symbolize seduction as well as doom. The tree is the symbol of life, protection, and fertility. In the form of Ashera, the idolatry of the holy tree intruded repeatedly into the spiritualistic Jahwe religion and was purged by eager prophets. Only in the symbolic form of the seven-armed candelabrum was the tree allowed in the sanctity of the Temple. Another maternal symbol, the Ark of God—an empty chest—acquired the acceptance of sanctity. David's dance before the Ark of God is reminiscent of the orgiastic frenzy characteristic of the ecstatic dancing rituals in the cults of the Magna Mater.

The ritual of spilling the blood of sacrificial animals on the soil indicates magic appeasement of the mother earth. Blood, the carrier of life, has to be given back to the soil. There was no belief in immortality in the ancient Hebrew religion. Jahwe, the jealous God, did not share this privilege with any mortal. Just and unjust alike were doomed to return to dust. The austerity of this concept betrays again the irreconcilable relation to the

Magna Mater, who in other Oriental religions comforted her devotees by the promise of eternal life.

The rite of circumcision, which serves to propitiate a cruel, persecuting deity, stems from the cults of Magna Mater where it was carried at times to the most drastic extremes of self-castration. A parallel to the male's circumcision is the temple prostitution of women in Oriental religions. The virginal woman was taboo, a representative of the mother goddess. Only defloration in a temple, by a stranger, made her accessible to the legitimate husband. Vestiges of this maternalistic cult can be found in the Old Testament in the lack of prejudice against prostitution (Jephtha's mother was glorified as courtesan) and the superstitious horror of the undeflorated woman.

To the degree to which the adoration of a maternal deity is repressed in the Hebrew religion, the woman remains excluded from cultic activities and from the sanctum of the Temple. Hebrew women who have attained historic or legendary significance are characterized frequently by rebellious heroism or impudence in the face of divine laws. The author mentions as examples among others: Sarah who laughed at God's prophecy; Rebecca who spitefully manipulated her husband to bestow the benediction for the first-born son on her younger favorite; the daughters of Lot who forced incest on the inebriated father; Miriam rebelling against her brother Moses; Isabel defying the prophet; Job's wife ridiculing her husband's steadfastness. Onan was taught by his mother the device of wasting his semen. Judith killed the national enemy and was glorified because of her fearless courage. The witch of Endor represents a gruesome authority, the power to conjure the spirit of the dead Samuel and to predict Saul's doom on the day before his suicide.

I have not mentioned in this review a biography or pathography of Mohammed, since the author has not quite succeeded in integrating it into the main theme of this book.

Roellenbleck comes to the conclusion that the high spirituality of the Jahwe religion is accomplished at a price, the repression of the mother goddess. Particularly, the protective, tender mother is eliminated to such a degree that the sexual as well as the emotional self-expression is largely curbed under rigid rules. The obsessional letter of the law has in periods throttled the spirit of

mercy. Primary anxiety and guilt have partially squelched a primary confidence in living and prevented a fuller integration of personality.

In the application of psychoanalysis to mythology and the comparative study of religions, the evaluation of maternal deities has been rather neglected. Dr. Roellenbleck's study therefore deserves serious attention in and beyond psychoanalytic circles.

EDITH WEIGERT (CHEVY CHASE, MD.)

PROGRESS IN NEUROLOGY AND PSYCHIATRY. Edited by E. A. Spiegel. Volume IV. New York: Grune & Stratton, Inc., 1949. 592 pp.

This, like the preceding volumes, is a review of important articles in the basic sciences, neurology, neurosurgery, psychosurgery and psychiatry that appeared in 1948. Only one third of the volume is devoted to psychiatry. The chapter on Psychoanalysis, edited by Dr. R. L. Frank and a number of associates, does not receive much space, covering thirteen out of a total of five hundred ninety-two pages. The authors abstracted the 1948 panel discussions of the American Psychoanalytic Association, reviews of books such as Fundamentals of Psychoanalysis by Alexander, Emotional Security by Sapirstein, Emotional Maturity by Saul, and a number of articles which were published in various psychoanalytic journals. Unfortunately, Nunberg's article on Circumcision and Problems of Bisexuality, one of the outstanding contributions, in the reviewer's opinion, was not discussed. Let us hope that in the future, this annual review will give more space to the subject of psychoanalysis.

CHARLES DAVISON (NEW YORK)

DEVELOPMENT OF FREUD'S CONCEPTION OF ANXIETY. By Dr. A. C. Oerlemans. Amsterdam: North-Holland Publishing Co., 1949. 124 pp.

The author takes the reader for a wild ride across the vast area of Freud's writings, his path strewn with uprooted quotations. The aim seems to be a critique of Freud's concept of anxiety in terms of a most naïve 'common-sense' psychology and terminology. The book is representative of much current thinking and writing here and abroad: devoid of clinical observations, formalistic and yet confused, without methodology but authoritarian in its dog-

matic conclusions, limited in the study of sources and utterly inadequate even in the intent to understand the subject matter under discussion.

MARTIN GROTJAHN (LOS ANGELES)

ŒDIPUS—MYTH AND COMPLEX. A Review of Psychoanalytic Theory. By Patrick Mullahy. Introduction by Erich Fromm. New York: Hermitage Press, 1948. 538 pp.

This is a commendably ambitious project, an attempt to satisfy a crying need. Its subtitle does more justice to the content which is much richer than the title leads one to expect. Here are structural outlines of the main theories of Freud (and of some of his students), of Adler, Jung, Rank, Horney, Fromm and Stack Sullivan. They are discussed with no more than proper emphasis on the œdipus. The inclusion in the volume of Sophocles' Œdipus Trilogy (Œdipus Rex, Antigone, and Œdipus at Colonus) adds an impressive note of solemnity to the scientific exploration of one of mankind's basic problems.

The book is simply organized. The genius of Freud is given its due not only quantitatively—more than one third of the book is devoted to him—but also qualitatively, inasmuch as the historical development of his work from primary concepts to late additions and modifications, including those of some of his followers, has been included. One may be inclined to object—particularly in the chapter on symbolism—that the choice of both problems and authors appears rather arbitrary; yet one cannot but admire the skilful condensation of the whole.

Possibly because of this very conciseness, the book makes for singularly frustrating and at times exasperating reading. The author's obvious striving for total and almost inhuman detachment and objectivity is frequently baffling, an effect intensified by his peculiar use of quotations alternating with careless vernacular which at places convey the impression—perhaps without any justification—that he is reporting with tongue in cheek. It is positively a relief to come across his outspokenly negative evaluation of Rank's ideas and to get a whiff of warm air, as it were, in the last part, entitled A Brief Criticism and Appreciation, in which he indicates his convictions. Freud's Collected Papers are quoted by volume and page numbers, but without the titles of the papers. Since the four

volumes are a more or less random collection, the omission constitutes a serious handicap. Apart from such blemishes, the book may serve as a work of reference for those interested in psychoanalysis, psychiatry, and in the social sciences.

GERTRUD M. KURTH (NEW YORK)

THE BATTLE OF THE CONSCIENCE. A Psychiatric Study of the Inner Working of the Conscience. By Edmund Bergler, M.D. Washington: Washington Institute of Medicine, 1948. 296 pp.

This extremely readable and in the reviewer's opinion highly rewarding book is dedicated (in general), as its title indicates, to the proposition that (to quote its author's words from another place) 'Every analysis is confronted with a loser in the "battle of the conscience". Were the patient capable of furnishing suitable defenses before his *forum internum,* we would never see the patient. To enter analysis means automatically that an unsatisfied portion of inner guilt remains, with which the patient cannot cope. This does not exclude that the patient fought desperately. He did and lost.' This battle fought unconsciously by the patient consists on the one hand of the unconscious ego's fight against the progress of the neurosis *per se,* and on the other of the unconscious ego's fight with and against the torturing inner conscience. Stated still more concisely: 'Unconscious neurotic feeling of guilt leading to self-punishment may invade every province of human action and reaction. . . . The feeling of guilt is always one participant in every neurosis. It does not cause the neurosis *per se,* but every neurotic symptom and sign is a compromise between repressed wishes and unconscious guilt' (p. 88). Thus, neurotic feeling of guilt is one of the cornerstones of neurosis: through a 'bribing' or appeasing of the neurotically 'corruptible' inner conscience, payment in unhappiness is made in exchange for the pleasure of living out (in modified form) the unconscious fantasy (p. 16).

Bergler's belief in the three-layer structure of every neurotic symptom (1, id wish; 2, defense resulting from superego protest; 3, defense against the defense, again as the result of superego protest. The second defense mechanism is the neurotic symptom.) was applied by him and Jekels some years ago to dream theory[1] in such wise that the original freudian formulation which made the

[1] Translated as *Instinct Dualism in Dreams.* This QUARTARLY, IX, 1940, p. 394.

dream analogous to the neurotic symptom still, *mutatis mutandis,* held good; for they, here again according the superego a rightfully increasing importance, concluded that every 'successful' dream not only fulfils in a hallucinatory way repressed libidinal and aggressive id wishes, but also refutes the reproaches stemming from the superego. A similar approach holds true for neurotic symptoms—among which the author first and *inter alia* cites the investigation of depersonalization carried out in collaboration with Eidelberg. 'Only with great reluctance', writes Bergler (p. 17), 'have I come to the conclusion that a neurotic symptom never "fulfils" the repressed wish, but fulfils only the defense against this wish. I have placed the stress more and more on the dominant part played by the powerful inner conscience.'

Chapter VI, entitled The 'Injustice Collector', devotes twenty-one pages to that 'mechanism of orality' or 'triad of orality' which the author has discussed in a number of other places, in particular, for example, in connection with the psychoanalysis of writers. The reviewer singles out this chapter for mention not alone because of an objection which seems to have arisen in this connection, such that the author found it desirable to discuss it specifically in a subsequent work,[2] the objection, that is, that the same mechanism cannot produce so many different clinical pictures. 'Obviously', writes Bergler in the latter place, 'in every orally regressed case the "mechanism of orality" is to be found—provided one doesn't want to overlook it. But to that *general* basis a *specific* feature, characteristic for that particular subdivision, must be added and distinguished. That *additional factor,* which I always stress specifically, is overlooked.' It seems to the reviewer not irrelevant to include here this correction of a misapprehension which has more than once been voiced; nor irrelevant to quote a passage from Freud (in reference to dreams) which could be said to express the *leitmotif* of much of this chapter: 'The other motive for counter-wish-dreams is so clear that there is a danger of overlooking it, *as happened in my own case for a long time* [italics mine]. In the sexual constitution of many persons there is a masochistic component which has arisen through the conversion of the aggressive, sadistic component into its opposite. Such people are called "ideal" masochists if they seek pleasure not in the bodily pain which may

[2] Bergler, Edmund: *The Basic Neurosis: Oral Regression and Psychic Masochism.* New York: Grune & Stratton, 1949, p. 10.

be inflicted upon them, but in humiliation and psychic chastisement.'[3] And finally, with reference to what in the reviewer's belief ranks rather high among the difficulties encountered by the analyst in daily practice, namely the masochistic misuse of reality, he would like to quote Bergler's succinct passage: 'In some cases, of course, the misfortunes are real enough, but the patient unconsciously perceives them, not as obstacles to be overcome or adapted to, but as maternal punishment which is to be answered with oral aggression, possible only in self-damaging conditions which alleviate the inner guilt feelings' (p. 101). In sum, it is the reviewer's considered opinion that, all in all, this chapter, together with its numerous references, is a veritable textbook of a quite considerable and important part of psychoanalytic practice.

Space forbids citation from the clinical wealth of the remainder of the sixteen chapters of this book. And I am forced also to end on a further note of regret—the absence of an index, an index particularly needed in a book which discusses so wide a variety of psychoanalytic topics, inclusive as these are of so many of the psychoanalytic minutiæ, so to speak, which the psychoanalyst encounters daily and which he finds so seldom if ever elsewhere discussed.

H.A.B.

CHILDHOOD AND AFTER. Essays and Clinical Studies. By Susan Isaacs, D.Sc. New York: International Universities Press, Inc., 1949. 245 pp.

This volume contains a selection of papers by Susan Isaacs which have been read or published between the years of 1928 and 1945. One group concerns itself with matters of education and child psychology, another with child analysis, and a third with analysis in general.

Susan Isaacs has for years been considered an authority on education. Her papers in this field are concise and illuminating, some of them, as The Educational Value of Nursery Schools, Fatherless Children, Children in Institutions, should be on the required reading list for all people engaged in education or child therapy. Children in Institutions is of greatest value to those who place

[3] Freud: *Interpretation of Dreams.* New York: The Macmillan Co. 1933. p. 163.

children outside the home. Recent Advances in the Psychology of Young Children, a survey of studies up to 1938, is of general interest.

Susan Isaacs' approach to child analysis is influenced by the theories of Melanie Klein. Due to her experience in education and to her continuous contacts with parents and children in everyday life, she puts a great deal of emphasis on the external life of the child, pointing out that 'the particular mode of dealing with internal problems is fixed by outside experiences' (p. 33). A particularly interesting example of Susan Isaacs' analytical procedure is An Acute Psychotic Anxiety Occurring in a Boy of Four Years. Two papers deal with psychoanalysis of adults: Modification of the Ego Through the Work of Analysis, and Criteria for Interpretation. Both are distinguished by the clarity of presentation, the emphasis on the necessity of analyzing both internal and external factors, and the importance given to the analysis of defense mechanisms. Although, as is well known, there are great differences between the Vienna and the English schools of analysis, it seems to this reviewer that Susan Isaacs' papers show that a common ground in practical work—and most likely also in theory—could be reached in time.

EDITH BUXBAUM (SEATTLE)

VARIETIES OF DELINQUENT YOUTH. An Introduction to Constitutional Psychiatry. By William H. Sheldon, Ph.D., M.D. New York: Harper & Bros., 1949. 899 pp.

After really reading this monumental work, necessarily becoming familiar with its many alphabetical and numerical symbols, it is hard to determine where one's main interest in it lies; whether in the technical aspects and conclusions of the ten-year research, in Dr. Sheldon's sharply enunciated ranging concepts and comments, in his challenges to psychiatry, psychoanalysis, religion, eugenics, or in the moot questions brought out by two hundred extraordinarily concise and vivid studies of cases selected from the youthful flotsam and jetsam that finds haven in the Good Will Inn of Boston. Each case is introduced with a fine photographic reproduction of carefully standardized back, front and side view for elucidation of the 'somatotype'.

Numerical values are assigned according to the 'endomorphic', 'mesomorphic', and 'ectomorphic' components perceivable—respectively the relative predominance of structure associated with diges-

tion and assimilation, with bone, muscle and connective tissue, and with the skin and its appendages embryologically associated with the nervous system. For such assessments of components we will agree that it takes training in expertness and perhaps a special gift, such as Sheldon admits possessing from boyhood days when judging fine points in exhibiting dogs or poultry.

Dysplasias and other physical data are recorded, and always something about the presence or absence of gynandromorphy, female structural characteristics. (Curious that when probable or possible epilepsy is mentioned no EEG findings are offered in evidence.) Then comes evaluation of temperament—viscerotonia, somatotonia, or cerebrotonia, followed by a 'psychiatric index', in a seven-point scale, indicating the proportionate amount of reaction type or combination of types—(a) 'Dionysian' (one of Sheldon's pet clichés), namely manic or cycloid, (b) paranoid, (c) schizoid or 'heboid'. Some cases may show one of these psychiatric components 'which are also psychological components' and carry it without much maladjustment, but in the 'psychopathic groups' there are marked instances of combinations. Such cases lead Sheldon to be highly critical of the 'nonoperational . . . Babel in psychiatry' which insists on a 'one or another' mental disease entity. For example, Case 93 (seen earlier in other clinics and termed schizophrenic, which is far from Sheldon's diagnosis) rates an index 4–3–1. Such a case serves to illustrate the 'crudity of Kraepelinian typology' similar to the futility of labeling physiques in the 'one or another' terms of Kretschmerian typology. 'It is not a question of *whether or not* the boy has a particular kind of psychosis. It is a question of *how much* of the various components of psychosis he may have.'

'Neither the Kraepelinian typology . . . nor the currently popular psychoanalytic slang brings order to the vagaries of human temperament. . . .' Sheldon flings his gauntlet viciously at the psychoanalysts. He finds that through psychiatrists and social workers freudian 'language' has seeped through at least to half of his youngsters—and he gives amusing illustrations. 'Priests of the freudian church are partly responsible, for they have commercialized and prostituted Freud's teachings as possibly no religious preachment was ever prostituted before.' Yes, at present psychiatry is in a strong position but 'the psychiatrist has been elected to power on the freudian ticket', and hence the future for the science is dubious unless it has an anchorage in physical anthropology.

Sheldon professes high regard for Freud himself and his work. On a second visit with him many hours were spent discussing Sheldon's thesis that without an orientation in morphology 'psychoanalysis was a house of cards *already* at the mercy of priestly and cultish exploitation'. Sheldon says that Freud agreed: 'Many who practice psychoanalysis in my name are either fools or scoundrels. But I study minds and I cannot quite believe that bodily structure and mind can be so connected that analysis of the one will lead to an understanding of the other.' So the interview, Sheldon frankly admits, ended in an impasse.

Space allows only this sketchy review of Sheldon's methodology, his fundamental thesis, and certain comments of particular interest to readers of this journal. Among other things neglected is his establishment of correlations between somatotypes and various forms of behavior. It is an important book, open to some criticism and bound to arouse indignant wrath in certain quarters. But it embodies a vast amount of research that leads Sheldon, for his part, to conclude with surety that civilization and the human race are in a bad mess because of the excessive continuous propagation of the somatically, and therefore the psychologically, unfit.

WILLIAM HEALY (BOSTON)

PROBLEMS OF EARLY INFANCY. Transactions of the Second Conference, March 1–2, 1948, New York, N. Y. Edited by Milton J. E. Senn, M.D. New York: Josiah Macy, Jr. Foundation, 1949. 120 pp.

The problems discussed concern for the most part the prenatal maternal-fetal relationship. Theoretical considerations, research, and the clinical experiences on the physiological and psychological interaction of the pregnant mother and the developing infant are presented by an impressive list of psychiatrists, psychoanalysts, gynecologists and obstetricians, pediatricians and psychologists.

The general thesis—that emotional-psychological dynamics of the mother affect conception (or sterility), pregnancy, labor and birth—is developed psychoanalytically in the keynote paper by Helene Deutsch. She shows how pre-existing tensions, which perhaps were apparent in menstrual disorders, incapacity for sexual gratification, etc., may intensify the conflict between the aims of the ego in the pregnant woman and her functioning in the service

of the species. The removal of an obstacle—such as sterility—by psychotherapy or other means does not remove the abnormal emotional factors which may find expression in other phases of the reproductive process or in the mother's attitudes toward the child later on. Good prognosis for motherhood depends not alone on successful pregnancy.

To this aspect of the child-mother unity, a paper summarizing Dr. Sontag's research at the Samuel L. Fels Research Institute brings physiological and biological documentation to show how the mother's emotional state may alter the functioning of the autonomic nervous system and thus of the infant's physiology and behavior, adversely affecting the ability of the fetus to cope later with extrauterine conditions.

Corroborating clinical experience of obstetricians shows the importance of psychological factors in unwanted, illegitimate births, in miscarriage, sterility, pseudocyesis, etc., though available to them only on the more superficial levels of conscious evidence. The discussion points out some confusion in the failure to differentiate between intrapsychic and external factors, since accepting or rejecting attitudes cannot be evaluated only by the conscious testimony of the mother nor by the favorable or unfavorable environment.

The papers about the use of relaxation techniques in obstetrics give interesting testimony on the extent to which relief from fear and anxiety about and during labor can be effected by education and by transference. Dr. Read's methods, with modifications introduced in this country, have had considerable success; generally the opinion is held that the traditional attitude toward pregnancy as a 'disease' accompanied by pain must now be changed.

Labor and childbirth as a natural process, not to be associated with pain, is an idea that caused some difference of opinion among a group of child analysts some years ago. This reviewer recalls a discussion centering upon whether the idea of pain should be included in explanations of childbirth given to children. Only a minority at the time had the opinion that explanations made to children should exclude the idea of pain in order to give the idea of birth as a fulfilling, natural process, and not a pathological, painful one. Fear in childbirth is perpetuated by the guilt aroused early in children by mothers who play on their emotions by recounting all the suffering they have caused. Though this point was not specifically made, it is of interest to note that psychiatrists

and obstetricians agree on the importance of cultivating the attitude that childbirth is a completing and fulfilling experience.

The separation of mothers from infants in our hospitals prevents the development of a healthful mother-child relationship, and suggestions are made for a hospital nursery plan of architecture to permit the mother's management of the infant from birth.

Appended to the main discussion are several papers by European specialists read in a supplementary conference in July. These deal all too briefly with postwar neurotic conditions among the children of Holland, France, Switzerland, Sweden, and among displaced persons. This subject seems too important to be appended as an afterthought.

MARIE H. BRIEHL (LOS ANGELES)

ORTHOPSYCHIATRY 1923–1948. RETROSPECT AND PROSPECT. Edited by Lawson G. Lowrey, M.D. and Victoria Sloane. New York: American Orthopsychiatric Association, Inc., 1948. 623 pp.

Many analysts are unfamiliar with the American Orthopsychiatric Association, notwithstanding the fact that two of its founders, four of its past presidents, and many of its members are psychoanalysts and that much of its basic orientation stems directly from psychoanalytic principles. This volume, which commemorates the twenty-fifth anniversary of the Association, presents a careful description of its history, development and achievements. It offers a scholarly group of well-documented articles on the integration of dynamic psychiatry, child guidance, delinquency, crime, clinical psychology, education, anthropology, pediatrics, family casework, industrial relations, psychiatric social work and psychotherapy. Much space is assigned to the evolution and aims of child guidance in America and the training needs of psychiatrists, clinical psychologists and caseworkers. The psychoanalyst who is unacquainted with orthopsychiatry will find this book an unusually good source for its past performances, principles, practices, and goals. For the orthopsychiatrist, it provides an excellent survey and summary digest of much valuable material.

What is orthopsychiatry? Literally, it means 'straightening of the mind'. One can hardly do better than quote the tenets preceding each of the three parts of the book: 'A fundamental task of orthopsychiatry is the study of behavior of the total personality and its integration in varied, perplexing and traumatic total life

situations. . . . Personal and social control are attained through the understanding of behavior and its multiple causation in the interactions of personality and environmental forces. To understand and influence behavior therapeutically requires a pooling of knowledge and techniques from the fields of medicine, psychiatry, psychology and the social sciences. . . . An essential principle of orthopsychiatry is that of collaboration amongst professional workers of varied training in related fields. Each contributes from his own experience and technical skill to the treatment of the individual who is involved in disturbed interpersonal relationships.'

Wherein does orthopsychiatry differ from other modern schools of psychiatry and what are its special emphases? First, it stresses the need of crossing out the boundary lines between many allied social professions to permit closer active coöperation. The American Orthopsychiatric Association is one organization which, though led by psychiatrists, includes pediatricians, psychologists, social workers, educators, sociologists, anthropologists and other related specialists of the humanities. Second, the therapeutic emphasis is not on psychiatric illness but rather on what the reviewer likes to call the pathology of health or personality. From this viewpoint, the concern is more 'with "deformity" than with "disease". Cure of disease is merely incidental. . . .' Treatment is aimed at the 'correction of deformities' (pp. 192 and 193). In this stress on personality, it is necessary to collaborate with specialists, like teachers, pediatricians, and others who work with more normal people. Prevention and treatment are directed not so much at signs and symptoms as at personality traits. In a sense, this movement is in the vanguard of a scientific attempt to influence character development prophylactically and therapeutically. This goal is close to the heart of every psychoanalyst and even if he does not take active part, he cannot help but have a deep interest in the project.

The book is a fine example of the bookmaker' s art, clearly printed on excellent paper, interestingly written and well edited. It is regrettable that the volume has not been indexed, especially since many subjects are discussed in separate articles from different viewpoints. Photographs of the twenty-three past presidents and biographical sketches of the twenty-nine contributors are included.

Every busy psychoanalyst would be wise to peruse this volume for a broader view of what is going on outside the esoteric field of

analysis and to learn how the basic discoveries of psychoanalysis are successfully spreading—modified, to be sure—into other related fields.

ABRAM BLAU (NEW YORK)

THE AMERICAN SOLDIER: COMBAT AND ITS AFTERMATH. By Samuel A. Stouffer, Edward A. Suchman, Leland C. DeVinney, Shirley A. Star and Robin M. Williams, Jr. Volume I. Princeton: Princeton University Press, 1949. 599 pp.

THE AMERICAN SOLDIER: COMBAT AND ITS AFTERMATH. By Samuel A. Stouffer, Arthur A. Lumsdaine, Marion H. Lumsdaine, Robin M. Williams, Jr., M. Brewster Smith, Irving L. Janis, Shirley A. Star and Leonard S. Cotrell, Jr. Volume II. Princeton: Princeton University Press, 1949. 675 pp.

These two books, which soon will be followed by the publication of two additional volumes, might be called a social-psychological study of attitudes. They contain the findings of the Research Branch of the War Department's Information and Education Division, and constitute one of the largest social science investigations ever made. Between Pearl Harbor and the end of the war, this branch administered over two hundred different questionnaires (many of which contained one hundred or more questions) to more than half a million American soldiers in all parts of the world.

These two volumes do not relate war history, nor are they concerned with various campaigns. They are clearly written, statistically well-documented, scientific reports which cover almost every phase of army life as lived and experienced by our soldiers.

At the beginning of the war the inducted civilians had to adjust to the army's authoritarian organization which demanded rigid obedience to its highly stratified social system, infractions of which were subject to penalties. The inductee had to become accustomed to the emphasis on traditional ways of doing things and to the discouragment of initiative. The first volume, therefore, deals in great detail with the adjustment processes which transformed the civilians into soldiers. Among the topics discussed are social mobility in the army, job assignment and job satisfaction, attitudes toward social leadership, social control, and the orientation of the soldier toward the war. The results of sociological-psychological

surveys greatly aided the army in the tremendous problems involved in the civilian-soldier adjustments and in the preparation for global war. Many of these changes turned out to be of permanent value, while others disappeared after certain objectives had been reached. It is impossible, within this limited space, to single out any one of these investigations. One might mention in passing that as a result of establishing a close liaison between the Research Branch and the Surgeon General's Office, psychiatric screening procedures at induction centers were greatly improved.

The last chapter in the first volume describes Negro soldiers and is, in the opinion of this reviewer, one of the best, clearest and least biased reports on this controversial topic ever published.

The second volume takes up very important aspects of warfare. Among the items studied and analyzed are attitudes and behavior before and during combat, general characteristics of ground combat and aerial warfare, combat motivations, attitudes of the combat troops towards rear echelons and the home front, and the specific problems of the combat replacement.

Other problems dealt with are the establishment of the point system for redeployment and discharge, which was one of the most useful and successful researches undertaken by the Research Branch, the aftermath of hostilities, and the transformation from soldier into veteran. A study of the postwar plans of soldiers provided the factual basis for the drawing-up of the G.I. Bill of Rights.

Since about twenty percent of our adult population consists of World War II veterans, a high percentage of whom have or will come to the attention of the psychiatrist and psychoanalyst, these two volumes contribute enormously to a better understanding of individual and group adjustments to military life and combat experiences, to the experiencing and handling (or failure in handling) of stresses, tensions and frustrations, whether the home front, the rear echelon or the battlefield provided the setting. This mass of data should help the therapist to evaluate and explain those factors which caught soldiers unaware and contributed toward postwar maladjustments.

Aside from their value as background for therapeutic considerations, these books are also recommended as a unique piece of sociological-psychological research which was based on clearly stated hypotheses and assumptions.

ADOLF G. WOLTMANN (NEW YORK)

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International Journal of Psychoanalysis. XXIX, 1948.

Clarence P. Oberndorf, Martin Wangh, Leon L. Altman, Charles Brenner, Marcel Heiman & Ruth S. Eissler

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ABSTRACTS

International Journal of Psychoanalysis. XXIX, 1948.

Symposium on the Evaluation of Therapeutic Results. Clarence P. Oberndorf, Phyllis Greenacre and Lawrence S. Kubie. Pp. 7–33.

Oberndorf proposed the theme of the Boston Round Table in 1948 which is reproduced in this paper. In his part he stresses: 1, the medical duty to cure; 2, diagnostic categorization; 3, scientific honesty toward results. He finds that results are in great part dependent upon the personality of the therapist. 'One wonders', he says, 'whether it is the personality and manner of application rather than the theory per se'. One cannot help but fear that such an argument might lead to psychoanalytic nihilism.

Greenacre earnestly underlines the need for clinical and statistical evaluation of the results of psychoanalytic therapy. Referring to a similar admonition by Freud, she warns that too narrow an approach to the screening of results might introduce a bias which would distort the truth.

Kubie enumerates factors which must be considered for a correct statistical evaluation. He mentions a dismaying number of them but with characteristic optimism believes the task can be done if given sufficient financial and mechanical help.

A considerable contribution is made by the discussants of these three papers. In particular the very fruitful idea is offered that the clinical conference presents the best opportunity for such research. This symposium, by proposing methods and clarifying principles, has opened the way for the actual evaluation of results.

MARTIN WANGH

On Genital Love. Michael Balint. Pp. 34–40.

Descriptions of genital love have been concerned heretofore more with what it is not than with what it is. Emphasis has been placed on the absence of ambivalence and pregenital object relationships rather than on the presence of certain positive qualities. Genital love, free from pregenital traits, may be examined for positive aspects, such as genital satisfaction or orgasm, idealization, tenderness and regard or consideration for the partner. Balint finds that genital satisfaction or orgasm may be completely narcissistic and exist without love. Idealization may be a hindrance to rather than a hallmark of a true love relationship. Tenderness is a quality associated with frustration, inhibited development, weakness and immaturity. Regard and consideration for the partner in love is an artifact of civilization and a perpetuation of archaic, infantile forms of love. Genital love has little to do with genital sexuality. It represents a fusion of contradictory claims, a reconciliation of pregenital and cultural needs. Fully mature genital love remains an abstraction.

LEON L. ALTMAN

Heredity and Psychoanalysis. H. G. Van Der Waals. Pp. 41–52.

Van Der Waals agrees with Freud that both heredity and environment are important in the psychic development of the individual. He emphasizes that investigations of each are in fact mutually dependent, rather than mutually exclusive, as seems so often to be assumed. The most fruitful field of investigation for genetic psychology in humans is the study of identical (monozygotic) twins; most of the paper consists of a clear and critical review of the literature on this subject. It is concluded that 'the supposition of an innate, basic character on a hereditary basis is strongly supported by the results of the investigations of twins'. However, 'there is still much to learn from a prolonged investigation of twins and families, especially when conducted by scientists who are conversant with analytical developmental psychology'. We still do not know the relationship between endowment ('basic character') and mental illness or maldevelopment.

CHARLES BRENNER

Analysis of a Cartoon in a Case of Hypochondriasis. Lois Munro. Pp. 53–57.

Munro's paper is based on a cartoon which her patient handed her three weeks after he started analysis. In the cartoon a bottle contains an Arab and a Jew, face to face, both crowded like a baby in utero, their teeth bared, knife and pistol drawn. The stopper of this bottle with the two hostile genii is a British soldier labeled 'British Mandate', showing unmistakable signs of the pressure underneath. The patient had hypochondriacal complaints from early childhood: colic and stabbing pains in his abdomen, gas perpetually escaping through mouth and anus, and a feeling of chokinglike constriction around his neck. Afraid of any social contacts because of the danger of exploding, the patient saw himself as the British soldier in the cartoon who had to maintain order 'in the Palestine of his inside'. An explosion of the warring forces inside would hurt him and his environment as well.

A childhood memory which the patient brought up in his second interview and the material connected with it, gathered over a period of seven months, are the basis for the conclusions reached in Munro's paper. The Jew in the cartoon was his mother, the Arab his father. His uncontrollable greed had caused him, in fantasy, to devour his mother (or her breast) and his father (or his penis). This had made both inadequate, unable to satisfy each other or to be satisfied by each other. Thus having unconsciously deprived them both, he assuaged his guilt by projecting the idea of deprivation onto them. Since his inside was the battleground on which both parents fought each other as well as him, he had to suffer the pain for his deed. The fantasy that a man is a castrated woman is seen in the fact that both parents are pictured as men in the cartoon.

It seems of particular importance that Munro states that this patient had what she calls 'addiction to analysis', i.e., periods of psychotherapy of several months' duration from different therapists. Munro states that this was an acting out of the idea that the therapist is breastless, impotent, and unable to help him. By picturing the therapist without breasts he denies the act of

having taken possession of the breast but at the same time makes it impossible for himself to be helped.

MARCEL HEIMAN

A Technical Problem in the Treatment of the Infant Patient. Betty Joseph. Pp. 58–59.

This brief paper deals with the problem of influencing the infant's or young child's disturbances by treatment of the mother. Joseph briefly discusses three cases. In one an eight-months-old baby suffered from a bus or tram phobia; in the second a boy of twenty-two months had difficulties in toilet training; in the third a nine-months-old boy had sleeping difficulties. In all three cases the clinician focused on the mother's own disturbances. Although therapy consisted only of superficial talks with the mothers, the disturbances of the children disappeared.

RUTH S. EISSLER

American Journal of Psychiatry. CV, 1949.

New Possibilities in Private Psychiatric Practice. Clarence P. Oberndorf. Pp. 589–593.

Oberndorf points out the tendency of private psychiatric and psychoanalytic practice to develop a self-centered and self-satisfied attitude. The therapist may select predominantly the type of case which proves most responsive to his particular treatment; his techniques and viewpoint are in consequent danger of becoming constricted.

To counteract these possibilities, Oberndorf recommends that the private psychiatrist spend part of his time in activities such as group practice which demand a greater range of skills and interests. Freud's advice as to periodic re-analysis offers another valuable corrective but the satisfactions and requirements of successful private practice make analysts reluctant to adopt this procedure.

MARK KANZER

Psychiatric Quarterly. XXII, 1948.

Further Studies on Beating Fantasies. Edmund Bergler. Pp. 480–486.

In analyzing beating fantasies in men, Bergler observed that after working through the more superficial feminine identification with the beaten child, a deeper oral layer usually becomes discernible, pointing to an early oral refusal. An original aggression is directed toward the mother's breast and secondarily turned toward the child's own buttocks which are identified with the breast in both boys and girls. In the girl this situation is complicated by the fact that she cannot find, as does the boy, a substitute for the missing breast in the penis. Therefore, a greater tendency toward masochism and compensatory malice is discernible in women. Some examples are given of how the beating fantasies have changed since their first description by Freud.

BERNHARD BERLINER

Father Time: An Analysis of Subjective Conceptions of Time. A. M. Meerloo. Pp. 587–608.

Time is a human concept with which man constantly struggles. Its subjective experience is an ego function. The unconscious has no conception of time. Time becomes associated with various aspects of the œdipal situation, hence Father Time, the symbol of creation and death. Pleasure shortens subjective time; fear increases it. Schizophrenics try to live in an autistic time world outside of reality.

The different time concepts are a steady development from a primary biological sense of time—the inner clock of the human organism—which is the ability to indicate a point in time on the world time line. Further development leads to a feeling of time, the ability to measure parts of the time line. Then comes the gnostic sense of time which marshals events along the time line into correct classifications. The highest development is that of dynamic temporalization, the experience of duration and continuity.

Meerloo discusses the pathology of these conceptions as well as their appearance in both organic and psychic dysfunction.

Fictions in Domestic Relationships. Wladimir G. Eliasberg. Pp. 638–640.

Eliasberg, referring to certain cited court cases, makes a plea for the disposal of the fiction that there is something mystical about the biological ties between parents and child. There are cultures in which this fiction is absent. The early emotional relationships between child and parents or parent surrogates are more important than the biological ties.

In artificial insemination with the consent of the husband, the child should be considered the offspring of the mother and her husband. Just as one cannot withdraw from the legal act of adoption so must neither mother nor father have the right to withdraw from an act of consent by which an artificial insemination is legalized. The legal profession is advised to act accordingly.

JOSEPH BIERNOFF

Psychology of Reputation in Neurotics. Edmund Bergler. Pp. 680–684.

A reputation seems to be made by the environment but it is a magnifying simplification, constructed by simpletons. Bergler shows that reputation is not something one acquires but is an act of unconscious misconception one imposes unconsciously on the environment to bolster one's own inner defenses. The purpose of this unconsciously determined technique is to produce a smoke-screen concealing one's inner self from one's self and others. Thus the outsider is misled into taking the unconscious defense structure of the subject for what the subject is, and by this coöperation from the environment the subject is helped to maintain his psychic balance.

BERNHARD BERLINER

On Various Uses of the Recorded Interview in Psychotherapy. Herbert Freed. Pp. 685–695.

This is an interesting application of the recorded interview in psychotherapy. The recording of the patient's voice is played back to him to demonstrate the unconscious character defenses in the tone of the voice. 'The tone of the voice revealed to the patients how babyish they were and how they irked people by their incessant complaints and bids for affection.' Freed also cites the use of the recorded interview in narcosynthesis and narcoanalysis. The patient is later faced with the material thus obtained. In postoperative lobotomies it was used to demonstrate postoperative progress and the loss of tension compared with the preoperative state.

Psychodynamic Factors in Narcolepsy and Cataplexy. Alfred Coodley. Pp. 696–717.

This case report and discussion is based on twenty psychotherapeutic sessions and includes a review of the confirmatory literature. The theoretical conjectures are supported by inadequate material. It is Coodley's contention that psychological factors played a major role in the causation of the symptoms.

The patient was severely traumatized in childhood by maternal rejection and a castrating father. He reacted with oral dependency and a partial homoerotic object choice. In an army situation he responded to a potential homosexual attack by a father surrogate with passive submission and cataplexy. Subsequent attacks resulted from verbal aggressions against men which provoked laughter. The symptom represented passivity and homosexual acquiescence as well as the defense against them. The narcoleptic attacks in this patient seemed to represent unconscious wishes during a somnolent state to return to a childhood fantasy of an incestuous relationship with an older sister who was accepted as a mother surrogate.

JOSEPH BIERNOFF

Bulletin of the Menninger Clinic. XIII, 1949.

Notes on Aggression. Anna Freud. Pp. 143–151.

This remarkably clear and lucid presentation is part of a symposium on Aggression in Relation to Emotional Development—Normal and Pathological, delivered at the International Congress of Mental Health in London, August 1948.

The first section briefly outlines the historical development of the instinctual theories in psychoanalysis. For thirty years the psychoanalytic study of instinctual life was directed almost exclusively toward the manifestations of sexuality. Aggressive behavior observed in children was first understood to be a component of pregenital sexuality. Later it was believed that frustration of instinctual wishes was the starting point of aggression. Freud's last formulations conceived of aggression as a manifestation of a basic instinct equal in status to the sexual instincts which led to his theory of the life and death

instincts, with sex as the expression of the life force and aggression of the destructive force. Clinically, neither of these forces can be studied in a pure form but they either combine with each other or act against each other. On each level of libidinal development the aggressive urges manifest themselves in different ways. If the destructive urges are not fused with the sexual urges but manifest themselves independently, they are then perceptible as criminal and dissocial tendencies.

This theory has given rise to many controversies among psychoanalysts. There are analysts who still maintain that the 'frustration theory' indicates the starting point of aggression. But even among those analysts who have adopted Freud's theories of the life and death instincts there is disagreement as to the significance of these two biological forces. Melanie Klein and her followers believe that the very existence of a life and death instinctual force is in itself sufficient to create a conflict. They further believe that this conflict is by its very nature a pathogenic one. Melanie Klein believes that every child goes through a stage of development in which it recognizes that a love object is in danger of being destroyed by virtue of being loved. When this love object becomes a whole human being instead of merely a part, the infant feels guilt. This produces a feeling of depression which is only lessened when reparative and restitutive ideas appear.

Other analysts, including Anna Freud, do not believe that the co-existence of the two opposing instinctual forces is sufficient to produce mental conflict. There are many clinical observations which point to a successful fusion between the destructive and erotic urges. Furthermore, these urges can appear in quick succession, seemingly unaffected by each other. It is only after a comparatively advanced stage of ego development is reached and there are attempts made to integrate all the instinctual strivings that conflicts do arise. Repression, reaction-formation, inhibitions, projections and displacement are typical mechanisms employed in dealing with aggression. One of the most fateful outcomes of attempts to master aggressive urges is their turning inward. This may lead to excessive superego severity, depressive states and suicidal tendencies. When aggressive urges are fused with erotic impulses they lose their destructive quality and may make a decisive constructive contribution to the life of the individual.

Anna Freud closes this survey by briefly stating some important practical considerations. Loss of love and other traumatic deprivations result in emotional retardation which then hinders the normal fusion between erotic and destructive urges. The parents' tolerance or intolerance can decisively influence the course of the child's spontaneous inner duality.

The Pathogenic Process in Schizophrenia. William L. Pious. Pp. 152–159.

From observations of patients with incipient schizophrenia, Pious attempts to describe what he believes to be the pathogenic process itself. Usually following an external deprivation, a phase occurs which is characterized as a 'sudden vacuum', 'sudden stillness', or a 'sinister and uncanny hush'. This phenomenon appears to be connected with death from organic illness. Pious reminds us that many schizophrenics die without demonstrable cause and that

chronic schizophrenics have remissions when they develop a serious physical illness.

With the occurrence of the sudden vacuum all evidence of ego functioning disappears, to return later, sometimes on the previous level but at other times on a more primitive, archaic level. The quantity of libido available for ego cathexis determines the height of organizational level to which the ego will be restored.

Pious believes that the structure of the superego determines the occurrence of this pathogenic process. The superego functions to contain and bind aggression. This makes postponement, judgment and action possible. If the superego is defective, mortido floods the organism and libido must then be withdrawn from its attachments in the ego organization to neutralize the mortido. When this happens we have the sudden vacuum. This defect in the superego is the result of a pathological relationship between the patient and his mother in the first months of life. The superego develops from several loci, the earliest of which is an introjection of the loving and protecting mother image. This primary mother image constitutes that elasticity of the superego necessary for the containment of aggression.

The Structure of the Grotesque-Comic Sublimation. Annie Reich. Pp. 160–171.

Annie Reich attempts to explain the conditions which result in the success or failure of grotesque-comic sublimation. The comic effect results from an economizing of psychic energy. A sudden breaking through of instincts under conditions which make them acceptable to the spectator's ego is necessary. Only the laughter or the applause of the audience makes the comic's performance successful, i.e., overcomes the guilt feelings. The function of the comic is to master what was terrifying in the past. Thus it often has a double-edged character. Some form of disguise is necessary in order to hide the real instinctual aim.

In the patient studied by Annie Reich, disfigured and deformed objects were portrayed by the comic. In this way exhibitionism, aggression and self-punishment in disguise were combined, making the performance ego-syntonic. What is intended for the hated object is demonstrated on the comic's own body. Disapproval from the audience means that the disguise has failed and the actor stands disfigured or guilt-laden.

It seems that people talented in caricature and grotesque-comic acting have a tendency to self-exposure and confession which drives them to exhibit. The difference between the comic and the melancholic is that the latter has unconsciously introjected the object and the comic consciously imitates the objects of his hostility. Comedians remain dependent upon the external world to a very high degree because the external world has taken over the role of their superego and they must repeat their performances in order to maintain the equilibrium between superego and ego. This form of artistic sublimation differs from all other forms because of its proximity to the original instincts and the concomitant anxiety. Incomplete desexualization leads only to a partial victory of the ego, making the personality of the grotesque-comic performer extremely labile.

RALPH R. GREENSON

Psychiatry. XII, 1949.

Countertransference and Attitudes of the Analyst in the Therapeutic Process. Leo Berman. Pp. 159–166.

'Countertransference' according to Berman means those reactions of the analyst to the patient which are based on the analyst's reactions to important figures in the analyst's past. By 'attitudes' Berman means the emotional reactions of the analyst as a person during the treatment hour, including the reasonable and appropriate emotional responses and his characteristic defenses. Berman describes the situation only as it develops with a competent analyst and he does not concern himself with instances of obviously faulty psychoanalytic practice. The analyst must be the cool, detached, surgeonlike operator and simultaneously the warm, human, friendly, helpful physician. The first point has been often emphasized; the second has been treated only sketchily in analytic literature.

The totality of the analyst's positive feelings is described as 'dedication' in the wide sense, dedication of the good leader and the good parent which apparently provides the optimal emotional climate for the specific work of the analysis. The qualitative emotional response in the analyst to his patient will tend to be about the same as that felt by most people, especially by 'good parents'. But the quantitative response will be less intensive and its duration shorter. The analyst is thus an active participant in the analytic situation. An important therapeutic factor is to be found in the patient's experience of the process through which the analyst under stress achieves realistic and well-integrated functioning.

Should the analyst manifest a tendency toward defensiveness and oversecretiveness, the patient may react either by behaving like the analyst (and important areas remain unanalyzed), or the patient may be driven to act out both inside and outside the analysis in order to provoke the analyst into expressing his emotional interest in him. Another difficulty arises when the analyst is impelled by his excessive feelings for the patient to manifest exaggerated responses, whether aggressive or oversolicitous. The patient perceives such responses as a failure on the part of the analyst to demonstrate the 'wisdom and strength which would lead him out of the maze in which he had been wandering unhappily since childhood'.

Many technical problems arise in relation to the manner, circumstances and dosage of the proofs of 'humanness' and dedication to the patient. Analysts try to arrive at them intuitively but it is not possible to be so keenly attuned to the patient that one can at all times achieve an accurate dosage. However, if this 'failing' does not become excessive, it too can contribute to the therapeutic result and the patient is afforded the experience of 'the reality of a person who dedicates himself to the task of helping him grow up and who comes through reasonably well, in spite of obvious difficulties'.

MARTIN GROTJAHN

Psychosomatic Medicine. XI, 1949.

The Use of Dream Analysis in Psychosomatic Research. Thomas M. French and Louis B. Shapiro. Pp. 110–112.

The study of dreams in patients suffering from psychosomatic disorders frequently shows a close relationship between the experiences represented in the dream and the somatic symptoms that follow such a dream. The authors' aim is to illustrate a method of relating the psychodynamics of such dreams to the psychodynamics of certain psychosomatic disorders, particularly arthritis. They are more interested in demonstrating this method than in their research findings concerning arthritis.

The case chosen for illustration is an arthritic whose symptoms increased after a dream containing the symbol of a strait jacket. Contrariwise, a dream of jumping up with agility after falling anticipated or reflected the subsidence of the patient's arthritic symptoms. The authors reconstruct the motives which activated the patient's behavior and dreams, taking note of the pattern of somatic functional activity implied by the observed, described, or dreamed behavior. By noting the relationships between this physiological pattern of behavior and the dreams, the authors get more and more detailed insight into the way in which the patient's psychosomatic disturbances are related to his habitual patterns of motivation.

MARTIN GROTJAHN

Role of the Hormones in Human Sexuality. William H. Perloff. Pp. 133–139.

Because the theory of the hormonal regulation of sexual activity in the human is still widely held, Perloff undertook to re-examine the thesis by a series of observations on patients with sexual and endocrine disorders. He arrived at the formulation that the sexual behavior pattern in the human species is the resultant of three influences: a genetic factor, which sets the basic pattern and determines the limits of operation of the other two elements; a hormonal factor, which stimulates the development of the sexual organs and increases their sensitivity to stimulation; and a psychological factor, which determines object choice and regulates the intensity of the sexual emotions. Aside from their role in increasing the size of the sex organs and augmenting their sensitivity to stimulation, Perloff found that steroid hormones have no effect upon sexuality. Such disturbances as homosexuality, 'sexual mannerisms', aggressive behavior, frigidity and impotence were found to be essentially psychological phenomena. No correlation could be found between those states and the levels of hormone excretion, nor could they be favorably influenced by the administration of exogenous hormones, except perhaps in instances where there was other evidence of endocrine disease. Perloff concludes that 'in the adult human, abnormalities of sexual behavior may usually be considered, in the light of our present information, to be due to psychologic deviations, with the hormones playing, at most, a secondary role'.

Treatment by Suggestion of Verrucæ Planæ of the Face. Maximilian E. Obermayer and Ralph R. Greenson. Pp. 163–164.

This is a case report of the successful treatment of warts by suggestion. The patient was a young woman who had an extensive involvement of the face with verrucæ planæ which for a period of two years resisted physical treatment. Suggestion given in three interviews under light hypnosis resulted in a prompt disappearance of the lesions, without recurrence at the end of six months. The authors recommend that an adequate trial be given this method of therapy to determine its suitability and limitations.

S. CABE

Archives of Neurology and Psychiatry. LXI, 1949.

Congenital Universal Indifference to Pain. David A. Boyd, Jr. and Louis W. Nie. Pp. 402–412.

A seven-year-old girl fractured her tibia and called her parent for help only because she could not extricate her broken leg from under the chair which had fallen on it. Manipulation and application of a cast without anesthesia brought no complaint. A huge area of necrosis which laid bare the muscles and tendons of the leg was only detected because of the odor. This girl had a history of many severe injuries starting before the age of one year, all without her giving any evidence of pain or distress. There was no sign that she enjoyed the injuries nor the attention given her because of them. There was also no evidence of a disturbance in consciousness nor of joy or ecstasy.

Psychometric examinations revealed no mental deficiency; she was alert and active. She would cry only when her feelings were hurt but never as a result of physical stimuli. There were no gross manifestations indicating that she was in any way emotionally disturbed. Thorough neurological examination revealed no pathological findings.

Several cases of this kind have been described in the literature, some apparently due to a lesion of the left supramarginal gyrus. One theory suggests the possibility of a congenital structural defect with incomplete neural connections in the postcentral area. Another theory suggests that this condition may resemble the congenital aphasias and is dependent on a lack of established cerebral dominance.

Psychosis with Hematoporphyrinuria: Clinical Report of a Case. Sol Levy and H. A. Perry. Pp. 699–704.

A patient was committed to a state hospital because of hyperactivity, combativeness, delusions, hallucinations, and ideas of persecution. Laboratory findings revealed a hematoporphyrinuria. Her psychotic episodes returned several times during her hospitalization and were not influenced by electric or metrazol convulsive shock therapy. However, whenever her urine changed from port wine color to amber her concurrent psychotic episode was terminated.

RALPH R. GREENSON

Journal of Nervous and Mental Disease. CX, 1949.

An Evaluation of Lobotomy and Its Potentialities for Future Research in Psychiatry and the Basic Sciences. Lawrence C. Kolb. Pp. 112–148.

Frontal Lobotomy and Impairment of Abstract Attitude. Kurt Goldstein. Pp. 93–111.

Journal of Neurology, Neurosurgery and Psychiatry. XII, 1949.

Clinical and Pathological Observations on Relapse After Successful Leucotomy. T. McLardy and D. L. Davies. Pp. 231–238.

Nowadays there are three ways of impairing the brain with therapeutic intent—deprive it of glucose, shock it with electricity and cut into its substance. Refinements of the latter vogue are considered in the above-listed papers.

Kolb reviews the literature of lobotomy with a bibliography of one hundred fifty-eight references. He divides the topic under the subtitles of Historical Perspective, Surgical Techniques, Neurophysiological Investigations, Psychological Investigations and Therapeutic Evaluation. For the psychotherapist the question of the therapeutic value of this operation is perhaps of most interest. 'The use of the technique on an experimental basis is justifiable but to conclude at this juncture, a decade after the initial operation, that it has indubitable merit as a therapeutic agent in a wide range of conditions is uncritical.' (Ethical objections to the experimentally justifiable procedure are dismissed as 'nonscientific moralizing'.) The author, pleading for more careful analyses, makes clear that the present statistics of therapeutic evaluation are a mess, with favorable results ranging from fifteen percent to eighty-eight percent. A remarkable figure emerges from five hundred ninety-nine cases of schizophrenia in the British Board of Control lobotomy series in which the discharge rate as recovered and improved was twenty-three percent. Bellak in his review of the literature on prognosis of schizophrenia without shock therapy reports of recovery rate between twenty-two percent and fifty-three percent and Rennie in a twenty-year follow-up of two hundred twenty-two cases of schizophrenia states twenty-seven percent recovered!

Another striking observation is that of the neurosurgeon Walker who reported that in obsessive-compulsive states, in which prefrontal lobotomy supposedly has its greatest value, the results for recovered and improved cases approximate those of psychoanalytic therapy. Kolb adds that while psychoanalysis is long and expensive, the patient at least has the chance of ending his treatment successfully with an intact nervous system. Lobotomy produces its best results in patients whose illness is of sudden onset and short duration and is accompanied by affective responsiveness. These are also the very clinical criteria which herald a favorable prognosis in all mental illnesses, treated or untreated. Kolb concludes, 'At the present time then, the evidence is quite inadequate to lead to the conclusion that lobotomy has significant therapeutic value in the treating of schizophrenic reactions though it may be effective in causing remissions of specific symptoms'.

Goldstein goes beyond this opinion to ask whether lobotomy actually has disadvantages which outweigh its advantages. That the usual I.Q. tests after lobotomy show no intellectual deficits only illustrates the inadequacies of

such tests. He feels that lobotomized patients suffer an impairment in their ability to abstract. In his experience this ability, once lost, can never be regained by training or learning. Hence the patient who made use of abstraction to an important extent in his premorbid life loses an essential of his personality through the operation. (In this connection the observation of Freeman and Watts is significant: after lobotomy, though relieved of symptoms, no physician, dentist, artist, musician or writer has been able to function successfully in his former occupation.)

The final paper is noteworthy in that it is the first report in the literature correlating relapse after recovery with the actual position and dimensions of the leucotomy lesions as established after death. Six patients are described whose preoperative psychosis recurred in full and who subsequently died—two of suicide, one of insulin shock, one during electronarcosis, one during an epileptic fit and one from chronic phthisis. Four of the cases had practically complete bilateral isolation of the prefrontal cortex. 'Bilateral isolation, therefore, of practically the whole prefrontal cortex does not prevent the remanifestation, after their relatively prolonged disappearance or striking amelioration, of many of the commonest psychotic symptoms.'

KENNETH MARK COLBY

Journal of Mental Science. XCV, 1949.

Some Reflections on the Nature of Affective Disorders from the Results of Prefrontal Leucotomy. Maurice Partridge. Pp. 795–825.

This paper surveys the development of views regarding the affective disorders and reports results of prefrontal leucotomy on eighty-two patients. Partridge's material and that available from the literature, both experimental and clinical, lead him to conclude that there are two types of affective disorders: 1, neurotic, functional or reactive in which the stimulus for the disease is some exogenous factor; 2, an endogenous type (manic-depressive) which has an 'enduring physical basis', and which is deduced to exist in the hypothalamus. Constitutional predisposition is posited. The frontal lobe cortex is understood as being primarily concerned with the conscious experience of emotion. Its stimuli arrive via the thalamus and hypothalamus. The argument for an 'enduring physical basis' in the endogenous type seems to be based on the assumption that the 'system', frontal cortex-thalamus-hypothalamus, is involved in all depressions. Leucotomy in the exogenous type permits the quickest recoveries while the endogenous type responds slowly with persistence of symptoms after the operation. The attitude of the patients who suffered from endogenous depression toward their illness was changed by the operation but the basic illness remained. In a single paragraph of this lengthy exposition, Partridge informs his readers about the psychoanalytic view concerning depression in which he demonstrates a fundamental misconception of psychoanalytic thinking as follows: 'The analytic school, also, would seem to regard all depressive states as reactive; and mainly to some form of loss, not merely in the material sense, but of something, whether a person, a cause or an idea, which had long been identified with the ego . . .'.

Investigation into Intellectual Changes Following Prefrontal Leucotomy. R. K. Freudenberg and J. P. S. Robertson. Pp. 826–841.

Two groups of patients were studied with a battery of tests. Both groups were matched as to sex, age, intelligence, and clinical status. One group was leucotomized and the other not. The leucotomized group showed a significant loss on Kohs' Blocks, the Bender Gestalt test and Paired Associates. The conclusions drawn were that the patients who are most improved clinically after leucotomy are those who are most impaired on the tests and that the changes on the test are dependent on conative changes in the patient, not on a reduction in capacity.

The Depersonalization Syndrome. Sidney Bockner. Pp. 968–971.

The depersonalization syndrome is described by using the patient's words to reflect the characteristic symptoms of depersonalization, derealization, emotional poverty, cephalic paresthesia, and thought disorder. The point is made that lack of projection of one's emotions produces an unreal world and that this underlies the syndrome of depersonalization which is a 'tentative withdrawal from reality'. Differential diagnostic criteria are discussed.

NORMAN REIDER

Mental Hygiene. XXXIV, 1950.

Normality and Psychosomatic Illness. James T. McLaughlin. Pp. 19–33.

McLaughlin refers to Ruesch's three levels at which feeling is expressed and tension discharged: 1, organ responses in infants; 2, action level responses, combined with regression as in such manifestations as alcoholism, overeating, and sexual promiscuity; 3, symbolic expression in verbal, gestural or artistic avenues whose scope and volume make up somewhat for lowered tension-draining ability. Individuals with psychosomatic illness react as does the infant, with organ responses, circulatory and tension changes, and other primitive 'fight or flight' reactions. Such patients are chronically prepared for action which they never take.

The Community and the Aggressive Child. George E. Gardner Pp. 44–63.

Gardner postulates a primary pleasure in aggression, as distinct from defensive counteraggressions. The latter are motivated by fear. A major problem in the latency period is the achievement of mastery over one's aggressions. The aggressive, destructive, sexual delinquent is one in whom pregenital impulses find overt expression because of a lack of such mastery and because of the 'priming' of the sexual urges during puberty. Gardner makes specific recommendations about some of the legal aspects of such problems.

JOSEPH LANDER

Journal of the American Medical Association. CXLII, 1950.

Life Situations, Emotions and Hyperinsulinism. Sidney Portis. Pp. 1281–1286.

Life situations and emotions may produce a symptom complex resulting in fatigue. The psychological condition can be described best as an asthenic

syndrome, with apathy, loss of zest, a general 'let-down' feeling, aimlessness and revulsion against the routine of everday life. Anxiety, rage attacks, and depressions are sometimes outspoken. There is experimental and clinical evidence to show that hyperinsulinism or relative hypoglycemia is a possible causal mechanism. These patients show a flattening of the sugar tolerance curve as in (relative) hypoglycemia. A combination of psychotherapy—worked out with Franz Alexander—and a diet—developed by Portis—have proven helpful.

MARTIN GROTJAHN

International Archives of Allergy and Applied Immunology. Separatum Volume I, 1949.

Allergy and Emotions. Milton L. Miller. Pp. 40–50.

The widely scattered psychosomatic and psychoanalytic literature dealing with the psychodynamics of asthma, hay fever, urticaria, and neurodermatitis is reviewed with great care and thoroughness. Miller comes to the conclusion that in allergic children unconscious maternal hostility, resulting either in marked rejection or overprotection, is the outstanding factor. In those asthma cases in which psychogenesis plays a prominent role, the attack seems to be one of acute anxiety and a demonstration of helplessness. In psychogenic urticaria, the attack seems to be more one of repressed weeping. In neurodermatitis there seem to be strong exhibitionistic and masochistic defenses against intense unconscious aggression toward a competitive figure of the same sex. The urge to be taken care of as a sick, helpless child, so noticeable in urticaria and asthma, seems equally typical of the neurodermatitis cases. In the latter the urge to exhibit failure is a typical defense against guilt and anxiety.

Some Paintings by Allergic Patients in Group Psychotherapy and Their Dynamic Implications in the Practice of Allergy. Hyman Miller and Dorothy W. Baruch. Pp. 60–71.

Twenty men and women, half of them allergic, were observed in group therapy. Some of these spontaneously brought in paintings of their fantasies and dreams. Upon associating to them, the allergic patients consistently manifested a characteristic emotional syndrome of hunger for affection, hostility to the parents, and inhibition of emotion. Several patients came to the realization that their allergic symptoms represented the expression of emotions which they could not otherwise bring out by word or deed.

MARTIN GROTJAHN

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Meeting of the New York Psychoanalytic Society

Joseph Lander

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NOTES

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

April 12, 1949. TERMINATION OF ANALYSIS. Philip R. Lehrman, M.D. and Annie Reich, M.D.

The point of termination does not appear suddenly in an analysis but has appeared many times previously, often as a resistance, Dr. Lehrman states. As the valid demands of reality gain ascendency and are contrasted to the infantile demands of the analysis, the testing-out period for termination sets in. Fantasies relating to termination appear and afford material for working through.

Dr. Reich selected for investigation the typical transference situation as it exists toward the end of treatment. Unlike Ferenczi, she does not believe that the transference can be completely dissolved; inevitably there remains a residue of infantile cravings toward the analyst. Even after the transference has been well analyzed and its important infantile sexual elements overcome, even after the neurotic symptoms have been given up, the relationship to the analyst is not a completely mature one. The analyst is still excessively important to the patient—the object of fantastic expectations. In nearly all cases a wish to be loved by the analyst, to build up a friendship, remains. Further analysis of these wishes proves them to be pregenital derivatives of a relationship with the parents. Attainment of an important object relation at this time can lead to a complete decathexis of the transference, but this may simply be an anticipatory response to the loss of the analyst. Such a situation may occur particularly in the analysis of adolescents. The termination of analysis is necessarily felt as a loss, particularly by patients whose reality situation is not happy. However, after thorough analyses, the wish to retain the analyst is slowly given up and the libidinal investment on the analyst shifted to other objects. Symptoms may recur toward the end of the analysis and tenaciously retained fantasies may be revealed. Therefore it is helpful to plan the termination a few months in advance without fixing an exact date.

In contrast to the beginning phase of analysis, Dr. Heinz Hartmann observed that no rules have been established for the terminal phase. Criteria for termination are primarily developmental, i.e., orgastic potency and adult object choice. Structural criteria will have to be added. The concept of health (in connection with criteria for termination) is complex: positive health values are compatible with negative values in other fields. The experience which analysts draw upon in terminating analyses has not yet been adequately formulated. Dr. Rudolph M. Loewenstein pointed out that one of the criteria for termination—control of instincts by the ego—has to be distinguished from compulsive control. The phenomenology of the termination phase can be subsumed largely under the heading of weaning. Dr. Fanny Hann-Kende made certain emendations of Dr. Reich's quotations of Ferenczi's views on termination of analysis.

October 30, 1949. THE CONSECRATION OF THE PROPHET. Jacob A. Arlow, M.D.

Arlow analyzes the character from the Old Testament—whom God designated prophet—as an individual functioning in the role of divine spokesman,

with the transformation of that individual's personality by virtue of his unique calling. The study is not of any particular prophet but rather of the psychological model—a type of individual who had the conviction that he was God's mouthpiece. Prophecy in the sense of prediction is not essential to the Biblical concept of the prophet. His function is closely allied to that of the poet and the artist. Utter submission to the will of God leads to a peculiar mixture of meekness and grandeur. Feeling is withdrawn from all other relationships and reinvested in the special relationship with God: the prophet's entire life centers around this pivotal point. The prophet's concept of God is linked to his relationship with his father, toward whom he shows profound ambivalence. Much of the material suggests sublimated passive homosexuality as a basis for the bond. 'At the time of consecration, the prophet temporarily breaks with reality and like the schizophrenic, gives up all emotional ties with his fellow man.' But unlike the schizophrenic, the prophet succeeds in reestablishing bonds with the real world. Because he represents an ego ideal, a deeply felt need of the people, he finds mass acceptance: the true prophet correctly divines and expresses the dreams and aspirations of his people.

Dr. Rudolph M. Loewenstein noted the prophet's great capacity for sublimation, a fundamental distinction from the psychotic whom he in some respects resembles. Dr. Ernst Kris stressed the parallels between the experiences of the prophet and the poet: something (idea) is projected, then introjected, with gratification of id impulses; behind the symbolic paternal penis as the source of inspiration lies the maternal breast. Dr. Gregory Zilboorg commented that religions originate with the death of a real king who then becomes reanimated as God: the prophet goes into mourning from which he emerges exalted by the act of having incorporated the spiritualized king who is now called God.

JOSEPH LANDER

November 29, 1949. OTHELLO: THE TRAGEDY OF IAGO.[1] Martin Wangh, M.D.

Contrary to the customary view, Wangh presents Iago as the central figure and prime moving force of the tragedy. The ostensible bases of Iago's violent hostility toward Othello and Desdemona are examined and rejected: neither resentment at having been slighted in the matter of promotion nor cuckolding can explain his relentless and ultimately successful plot to murder Desdemona. Instead Iago's hatred is examined in the light of psychoanalytic theories of jealousy. Iago creates an uproar on Othello's nuptial night and twice subsequently, under conditions indicating a desire to disturb the marital relationship—the primal scene is thrice repeated. In fact, in the original story on which the tragedy is based, Iago hides in a closet while Othello is in bed with his bride. The obsessive quality of Iago's hatred, replacing his former love for Othello, arouses suspicion. So also does Iago's accusation that Desdemona, his rival for Othello, also loves Cassio. In these fantasies Dr. Wangh finds a projection of Iago's unconscious homosexual wishes for Othello and Cassio. A dream concocted by Iago, intended to rouse Othello's suspicions of his wife, is an obvious homosexual wish fulfilment. The development of Iago's para-

[1] The complete paper is printed in this issue.

noid state, from the initial homosexual panic to the ultimate destruction of the hated rival, is traced clearly and convincingly.

Dr. Smiley Blanton discussed additional details regarding the probability of Othello's unconscious homosexual orientation. Dr. Ernst Kris commented on the portrayal of the œdipal conflict in the drama. Dr. Wangh amplified this in comments on the 'subsidiary sons' who portray different aspects of the œdipal theme: heterosexuality with ultimate maturity (Cassio), homosexuality and paranoia (Iago), and incest, punished by death (Roderigo).

JOSEPH LANDER