The Psychoanalytic Quarterly

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

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To cite this article: Bertram D. Lewin (1950) Paul Federn 1872-1950, The Psychoanalytic Quarterly, 19:3, 295-297, DOI: 10.1080/21674086.1950.11925804

To link to this article: https://doi.org/10.1080/21674086.1950.11925804

Published online: 07 Dec 2017.

PAUL FEDERN
1872–1950

We mourn our departed friend and colleague, Paul Federn. He came of a physician's family in which he learned high ideals of medical science and ethics. He received his medical degree from the University of Vienna in 1895 and, after postgraduate work at the University, he became first assistant in the medical department of the Allgemeinen Krankenhaus. After five years at this post, he entered general practice. It was natural for him to enter the psychoanalytic movement (in 1901) under the strong influence of his professional contact with Professor Freud, and he found no difficulty in throwing into his psychoanalytic life the vigorous idealism of his early upbringing. His rare gift for enthusiasm and earnestness made him immediately a leader and teacher. He assumed the post of acting chairman and director of the Viennese Psychoanalytic Society when Freud became ill in 1922.

Federn's life in analysis recapitulates the whole development of this science. The theory of sexuality was enhanced by his contributions to the psychology of sadism and masochism, and dream theory gained from his studies of pavor nocturnus and typical dreams. To him is credited the first interpretation of dreams of flying. This was in 1913, and a discussion of the feeling of being inhibited in dreams (in the same year) foreshadows his later interest in the role of the ego in dreams.

A journey to America where he made contacts with Adolf Meyer and August Hoch, which might have been richly fruitful for psychoanalysis in this country, was cut short by the first World War. In the twenties Federn became preoccupied with ego psychology in its analytic aspects, and in 1926 appeared his classical paper on variations in ego feeling, particularly the unusual variations that are to be found in the psychoses and sleep and half sleep. Following this came two other papers which carried on the same line of inquiry. In later years his interest in the role of the ego in psychopathology persisted, he

excelled in the consistent application of the dual theory of instincts, and he turned his vigorous attention to the understanding and treatment of the psychoses.

Although Federn had been preceded by Tausk in the discussion of ego boundaries, it is true that his own contributions on ego feeling and his distinctions between bodily ego feeling and mental ego feeling have been somewhat underestimated in wider psychiatric circles, which have received Federn's ideas through secondary sources. In analytic circles proper this has surely not been the case. We have never lacked in appreciation of Federn's fine perceptions and imaginative grasp. Along with Federn's great devotion to analysis went a vivid interest for large humanitarian ends. He recognized the importance of social work, he took a vital interest in such social problems as unemployment and the general role of the state in its influence on individual psychology.

Beyond Federn's scientific contributions, it is impossible for us not to recognize the effect of his greatness as a human being. A man of infinite courage, of outstanding charm, he was generous in every sense of the word. Federn was indomitable. His immigration to America late in life after the Hitler march on Austria, amidst all sorts of cares and anxieties, neither blurred his sense of reality, diminished his consideration for others, nor weakened one whit his magnificent spirit. He has left us an unwitting record of his attitude in those dark days in the form of a little essay called, A Dream Under General Anesthesia. Immediately after his coming to this country, Federn found it necessary to submit to a severe dental operation under general anesthesia. This operation symbolized for him the two facts that then most concerned him—external necessity and the individual's weakness. For, as he said, 'an exile can watch contemporary events and criticize what happens, but he cannot defend himself or his family or interests', and 'fettered in the chair' he felt intensely the strength of necessity and the indignity of submission. It is typical of Federn that he recorded his bodily feelings, his emotions, and the dream under anesthesia. Thus he turned this bad half hour, with all it signified for him,

into a valuable analytic document. He dreamed, 'I was the chief military commander and the chief statesman of great territories, and I put in order one province after another. In the dream, I knew which country, far in the east, it was; but remembering, I cannot decide whether it was China or Greece. These provinces had straight-lined frontiers like the states of the United States of America, but the country was not America. . . . I accomplished my task with continuous strain and tension. Everything was decided in a hurry and carried through quickly. I was very severe with myself but at the same time fully and continuously contented with the way I performed my duties. Never in my life have I felt such happiness or satisfaction with my personality or my work. . . . Life was a glorious and victorious fight without any conceit or show; I distinctly felt that I never failed to follow the motto: Do what you have to do.'

Federn modestly saw that in his dream he fortifies his weakness by identifying himself with a grandiose ego ideal, but the dream shows the *gesunder Narzissmus* of which Federn wrote so well. For us this dream image of his ego may well stand as an expression of the Federn we knew and loved and now mourn, a man whom we knew late in life but who must always seem a man in his full vigor, a man undaunted by the vilest adversities who strides through strange lands, mastering, setting in order, glorious and victorious, without conceit or show, one who never failed to do what must be done.

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The Psychoanalytic Quarterly

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

The Prepuberty Trauma in Girls

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To cite this article: Phyllis Greenacre (1950) The Prepuberty Trauma in Girls, The Psychoanalytic Quarterly, 19:3, 298-317, DOI: 10.1080/21674086.1950.11925805

To link to this article: https://doi.org/10.1080/21674086.1950.11925805

THE PREPUBERTY TRAUMA IN GIRLS

BY PHYLLIS GREENACRE, M.D. (NEW YORK)

This study supplements a paper about a special type of screen memory *(1)* of a sexual trauma occurring in the late latency period, the memory of the event being retained with gloomy clarity and singularly little apparent distortion. An extreme resistance to the analysis of this sort of memory, much more than in the case of screen memories from an earlier period of life, suggested that the memory and possibly the event itself served some special function to the individual. The earlier paper dealt largely with the relation of this type of screen memory to the earlier memories and with the general dynamics of memory. The present paper focuses on the economics of the event itself. It is based on the analyses of four women patients, the rather cursory observations of several patients seen in consultation in the course of clinic work, and the direct knowledge of one young girl in the prepuberty phase where the situation was observed as it arose and sequelæ observed through the early puberty phase, namely, the four years following the trauma.

In the chapter on prepuberty with which Dr. Helene Deutsch opens the first volume of her Psychology of Women *(2)*, she places the prepuberty period as roughly between the ages of ten and twelve. In the cases which I have studied, the traumatic experience occurred with rather surprising regularity either in the tenth or eleventh year. The trauma certainly belonged to the end of the latency period, but its instigation seemed motivated by unconscious attempts to prepare for puberty which was already being glimpsed by the little girl, especially in the development of older classmates or older sisters, although she herself had not yet undergone even the beginning pubertal changes in the sexual organs, and there was no indication of increased

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genital drives. The child precipitated the trauma out of curiosity rather than out of physiological pressure.

Dr. Deutsch defines prepuberty as 'that last stage of the latency period in which certain harbingers of future sexual drives may be discerned, but which in the main is the period of greatest freedom from infantile sexuality . . . sexual instincts are at their weakest and the development of the ego most intense' (p. 4). She further suggests that the increased passivity of early puberty is preceded by a thrust of activity, which is not really an increase in aggression but rather an intensive process of adaptation to reality; and that prepuberty is a period in which there is a tendency to renounce the infantile fantasy life and to launch an offensive against the environment, a turn toward reality (p. 7). It is a time in which there is great curiosity about sexuality, the telling of secrets among girls, singly or in groups, but very little actual interest in the opposite sex (p. 17). The interest is no longer in bodily or genital forms, but in body and genital function. This coincides rather closely with my clinical observations in the four cases analyzed.

It is a truism that in puberty there is a revival of the disturbances and unresolved conflicts from the period of infantile sexuality. What I found impressive, however, was the great specificity with which the prepuberty trauma repeated the main disturbances of the precœdipal phases of development, so that it seemed very clearly a condensed form of acting out in which the child herself became victimized by the trauma which she had precipitated, and the unhappy event was then used as a dramatic defense against entering into the struggles of puberty. In those cases which I have analyzed this has occurred in girls who had had especially severe disturbances of the pregenital phases of development, in addition to severe and unresolved œdipal struggles, followed by more than ordinary masculine identifications, sometimes of a sweeping nature but always involving a stubbornly intense effort to solve the castration problem through the persistence of the illusory penis. The last was the result of varying combinations of 1, particularly severe primal scene stimulation with resultant sadomasochistic fantasies reinforced by

disturbed anal functioning; 2, intense penis envy; 3, attempts to solve the œdipal struggle by identification with the father.

A woman of thirty sought treatment for severe inhibitions and emotional disturbances invading practically all phases of her life. Extremely shy, sensitive to the point of constant flight from others, she was unable to work for any length of time, and spent much time in idleness, becoming irritable whenever prodded by her family to do anything. In the second consultation interview she spoke hesitantly but emphatically of an experience at the age of about ten from which she dated her major difficulties. She believed that before this experience she had been predominantly a happy and innocent little girl, but that following it, due to the fright of the experience, she had turned from men and boys, been increasingly shy to the point of general incapacity. In adolescence she had drawn irritably away from her father to whom she had previously been conspicuously devoted. Among other symptoms she had then developed two rather strong and peculiar fears: one that she was being followed by a 'Black Presence' which sometimes nearly overtook her; the other that she 'did not want to grow up and wear white stockings'. These were not exactly phobias. They might be described rather as dreads that were so persistent that they had an almost delusional quality, though they were not quite true delusions. When under the influence of the fear of the Black Presence, everything light or white semed desirably pure; when under the spell of the white stockings, darkness seemed invitingly friendly.

This girl had had almost no relationship with men or boys after puberty. In her twenties there had been a brief engagement with a somewhat strange young man from whose physical overtures, slight as they were, she had fled and broken the engagement, later clinging to it in fantasy. She had subsequently a few mild attachments to women, mostly older, and two very shadowy friendships with older men, but even these relationships were too much for her. If they approached any degree of intensity of feeling, toward which she progressively drove

them, she retreated with outbursts of unexpected anger or suicidal fantasies and gestures, but continued to be preoccupied with daydreams of the friendships which she was having to sacrifice.

This case is obviously complex, and to organize the material, it is summarized under headings pertinent to the dynamic themes.

THE TRAUMA

At the age of about ten the girl was roller-skating in the cellar of her own home when a man entered to read the gas meter. She spoke to him and he offered to show her the meter, thereupon lifting her so that she could see the movement of the little hands upon the dials of the meter. In lifting her he put his hand under her dress and stimulated her genitals. She recalls having become extremely excited, ashamed and frightened; she squirmed free and the man quickly left. She could not recall exactly how the experience ended; she had the feeling that she lost consciousness or 'went blank', also that she might subsequently have gone into the next room of the cellar where the laundress was working. The whole incident had been very brief, she had not cried out, and the laundress could not have been aware of anything until the frightened child appeared. Admittedly an unpleasant experience, it did not in itself seem sufficient to be the turning point of a whole life, although it had obviously so served in the patient's estimation. The analysis was to prove that she was right: it had been a kind of condenser and, with one or two subsequent lesser traumata, became the barrier to a reasonably normal pubertal and adult development. In the period just prior to the incident in the cellar, the patient had been caught in a kind of tidal wave of sexual investigations among girls of her acquaintance. There had been repeated sessions of talking about sex with another child, always conducted in the dark, either at night or with drawn shades. There may have been some sexual play and mutual investigation, but the predominant activity was telling secrets about the sexual activities of adults. At a house party there was some actual

genital stimulation as her best friend told her about having discovered accidentally the peculiarly pleasant sensations aroused by lying in the bathtub and allowing a stream of water under pressure to play upon the genitals. My patient learned quickly. It seemed, indeed, that it was just the information she was waiting for, and it initiated a form of masturbation which was to continue intermittently up until the time of the analysis.

In the period after the trauma, she did not turn at once from boys; there was in fact a winter during which she resumed relationships with her cousin, a boy about a year younger than she, whom she had last known at five or six. She had had a rather warm companionship with him and two of his friends when they went skiing and hiking together. She enjoyed sports with boys in which she could compete reasonably well; in other games would allow herself to be tied up as mock torture—obviously a struggle between an aggressive masculine and a masochistic feminine identification. Her being so much with boys at this time when she had previously been with girls was partly at her own instigation but was certainly favored by the fact that the family had moved and that the only children she knew in the new community were her cousin and his friends. A second turning point in this unstable situation came with a new trauma when she expected her cousin to take her to a children's dance and she overheard him rebel because she had grown taller than he. She was intensely humiliated, and when the family moved to still another community just as she reached the age of puberty, the whole process of withdrawal from reality into fantasy became well launched. During this time the child was occasionally utilizing the technique she had learned of masturbation in the bathtub. That she was anxiously anticipating puberty was evident: she repeatedly observed the shadows of her own body, especially the contour of the breasts, on the wall as she bathed. Her aunt, whose namesake she was, was then pregnant. When the patient disingenuously commented on her aunt's fatness, the mother hushed her up. She reacted toward the baby boy as though he belonged to her, referred to him as her brother,

and when it soon developed that the boy was severely epileptic, she befriended him with a horrified fascination.

THE CURRENT SYMPTOMS

In analysis it became evident that she was concealing, for some time out of shame, underlying disturbances originating from her very peculiar sexual balance. One can only describe this by saying that she seemed to be in an unusual state of chronic tension, due to her efforts to control all of the elements of the polymorphous perverse drives which were constantly in danger of breaking through. She could maintain this precarious balance in a state of triggered tension for some periods of time, but in almost any situation involving appearance in public, any special pressure of accomplishments (examinations), or any special sadomasochistic stimulation (fights or accidents), she would 'go to pieces'. This meant that she had some sudden spontaneous bodily discharge: a vaginal orgasm, a burst of uncontrolled weeping, loss of control of the bladder, an unexpected diarrhea, or, during her menstrual period, an extreme degree of flooding which once caused severe anemia. In two instances of unusually well-organized acting out the patient, who enjoyed an occasional cocktail, drank two or three at cocktail parties where both men and women were present. This amount, which would ordinarily only cause her to be exhilarated, on these two occasions was followed by a sudden premonition of something about to happen. She made her way to a toilet where she lost consciousness. Her actions excited so much concern about her among the guests that she came to, to find others with her, and she requested that she be carried into the apartment of the caretaker of the school building in which the party had been held. She then rested in the room of the caretaker and his wife, went home after a few hours greatly chagrined, saying she would give up her work rather than face her colleagues.

At the beginning of the analysis, the patient practiced two types of masturbation: clitoral masturbation, often initiated by remembering at night in bed the trauma of the tenth to

eleventh year; and masturbation in the bathtub which seemed to include both clitoral and vaginal stimulation and usually resulted in a vaginal orgasm.

NATURE OF THE PREGENITAL AND GENITAL DRIVES

This patient was an only child of tense, rigid, overidealistic and unconsciously cruel parents. Until she was sent to school at the age of six she was constantly with the mother with whom she gave evidence of having been early in an almost mystical relation, as though appersonated by the mother. Both the patient and her mother stated that she had been an unusually sunny, docile, cheerful, nonneurotic child; however, the girl reported and the mother verified that, mostly before the age of three, the child had been much spanked with a hairbrush. Neither the patient nor her mother at first saw any contradiction between this fact and her supposedly sunny disposition. The patient obstinately clung to her bottle until she was about three. One of her earliest memories was of violently throwing the bottle down the stairs when her parents were having a party from which she was naturally excluded. She felt sure that she had been spanked for this, which may have been the cause of her giving up the bottle. She was 'successfully' toilet trained extremely early. Whether this was true or not I could not clearly determine. There was some indication of her having lost control of bladder or bowels on the first day of kindergarten. Certainly the patient lived in a state of fear of toilet accidents, always going to the toilet just before leaving the house and having to verify where the bathroom was in each new environment. (Later, in her twenties, she used this as a definite aggression against her mother; whenever they went out together she would keep the mother waiting while she stayed unnecessarily long in the toilet, involved with her bowel movements and with brooding sadomasochistic fantasies.) There was some positive evidence of early severe outbursts of temper which were ultimately controlled by whippings until the patient presented the obligatory sunniness which was then regarded as natural.

Perhaps increased by the maternal appersonation, certainly

by the too vigorous romping and tickling by her father, and the stimulation of early primal scenes, she developed an unusual kinesthetic erotism. There were memories of having been swung and tossed in the air by her father until she got into states of almost frantic exhilaration; and from reconstructed memories it appeared that these reached climactic states of genital stimulation but no true orgasm. She was able to reproduce something of this happy frenzy in her early play with her dog, a large collie. She would go racing through the house in a kind of competitive romping play of increasing tempo with her dog who often knocked her down and licked her face as child and dog rolled over and over on the floor. Sometimes such tempestuous play ended in accidents, a crescendo of breakage followed by punishment. Later in life under the pressure of time, as in rushing for a train, the patient would have other accidents, as the unexpected discharge of a watery stool or sudden flooding during a menstrual period (unconsciously equated); or she might have a spontaneous orgasm with a mucous discharge. It is my belief, however, that in the pregenital period there were few if any of these organ accidents which occurred only after there was a further amalgamation of bodily tensions under the stress of a peculiarly difficult œdipal period.

THE ŒDIPAL PERIOD

This was complicated by three major events: a special version of the primal scene at the age of five; a fantastic enema ritual practiced by the mother on the child a little later; sharing of toilet activities at the age of four with an old man. In this four to five year period she experienced curiosity and fantasies about primal scenes with many memories indicating her desire and efforts to keep the parents apart. When she was five her family moved to another part of the country, and soon after this her father fell ill. The patient first remembered that he had been sick for a whole year, that he had multiple arthritis, and that he had been practically encased in a plaster cast. During this time she was his devoted handmaiden, went each night to sing a good-

night song to him. Dreams revived and isolated a memory of going unexpectedly into his bedroom and finding her mother doing something to her father's genitals. The fantasy was that she was performing fellatio. Further analysis indicated that the mother was probably helping him with a urinal, bottle shaped and made of white enamel. This fused observation and fantasy gave a special turn to the primal scene fantasies, and verified the sex-urination and mouth-impregnation ideas of the child. On analytic investigation, checked later by the mother's own account, it developed that the memory of the father's illness was vastly exaggerated. He had had moderately severe arthritis, had been sick at the most four months, and the cast had encased only one leg and the pelvic girdle. This distortion of the primal scene led the little girl to reverse and confuse the sexual roles, as the mother was the aggressor, and the father helpless. The extension of the cast to include the father's whole body, and the extension of the time to include a whole year, were distortions of memory representing the child's defense against her intense œdipal wishes, and a projection onto him of the wall of restraint of bodily functions which was occurring in her. The idea of the white cast completely covering the father's body was also a displacement from the white urinal covering his penis.

From the observation of this and other cases, I have come to the opinion that in patients with a very faulty or incomplete separation of the self from the environment in the first stages of ego development, a 'wall' of some kind—the glass wall of the schizophrenic—becomes erected one way or another as a protection against the overly strong instinctive stimulation of the environment, but that it is given special form and structure by actual restraint in infancy. In other words, the child's pathological need for protective restraint is enormously increased by the poorly applied disciplinary restraints and converted into a confining wall rather than a helpfully protective barrier.

This patient's restraint was increased by enemas which intensified the reversal of sexual roles and the confusion of genital and pregenital functions. One can only suppose that the

mother was reacting with increasingly pathological behavior to the course of events. She was an exquisitely beautiful woman of finely chiseled features and, on the one occasion when I saw her, gave the impression of the hardness of fine steel combined with a dreamy preoccupation that gave one the feeling of seeing her through a mist. At any rate, when the child started in kindergarten she developed an obstipation, probably a reaction to her fear of not finding the toilet in time. The mother thereupon instituted enemas, given to the child in the bathtub where she was instructed to lie with her legs spread. This seemed clearly to prepare the girl for the later 'water masturbation' which was partly cleansing, and which she adopted so readily in the prepuberty era. As though the encasement of restraint were not sufficient, there was an additional event. The child contracted whooping cough, and since the illness was so protracted as to interfere with the summer vacation plans, the parents decided to go ahead anyway. The trip to the summer lodge was made by car with two overnight stops at wayside hotels. The child was warned that she must not embarrass the family by coughing or vomiting in hotels or they would be evicted. One suspects that she may have utilized the whooping cough aggressively, and that the parents sensed it; certainly they were parents who could tolerate very little aggression. On the journey she almost but not quite succeeded in complying with their demands and, although the family was not expelled, she felt ashamed, disgraced, a failure, and resented the parents' hypocrisy. It does not seem strange then that there was a restrospective distortion of memory of the father's cast 'up to his neck' when she herself was so encased by prohibitions. The father's cast and her restraint were reinforced by the memory of the white enameled urinal and the white enameled tub, in accordance with the body-phallus equation of this kinesthetically stimulated and appersonated child. On this visit, too, she had her first experience of clearly seeing the genitals of her little boy cousin.

It is possible to trace the recurrence of these patterns at puberty and in adolescence when she developed fears of the

Black Presence and of white stockings. The former seemed definitely the anally determined elements of the conscience, based on her own body tensions and apprehensions and the ever-threatening figure of the (phallic) enema-imposing mother. The plaster cast and the white legs of the primal scene reappeared in the complementary dread of the white stockings which signified growing up. The dirty masturbation at night was associated with sadistic fantasies, in contrast to the purifying, exciting masturbation in the bathtub (associated by the patient with Charles Kingsley's Water Babies).

Throughout adolescence the girl was encased in a 'cast' of defensive irritability and silence directed against her father. In her quite conscious fantasies, she was married to him. When she gave directions for the delivery of goods, clerks in stores seemed to hear her say Mrs. rather than Miss. She fantasied purchasing haberdashery for him and play-acted this for an imaginary audience as she window-shopped. In high school she avoided all associations with boys, but went through elaborate bits of play acting and pseudologia to make it appear that she was sought by older boys or men, superior to the high school boys. She was a little late in menstruating and this initiated an outbreak of new symptoms: an increase of muscular tension, a running, often fleeing gait, spontaneous orgasms, and uncertain control of her sphincters appeared at this time. A pressure of general physical activity and in sports was an effort to deny an approaching menstrual period; the development of intellectual interests, a reaffirmation of the illusory penis. In college, however, where she could not avoid competition with other girls, this fragile compensation broke down. Menstrual flooding took its place among the other climactic body discharges, she became periodically invalided, sought unnecessary operations and started a downward spiral of masochism, spoiling every possible success.

The latency period, up to about the age of ten, had been alleged to be a 'good' period of her development. After the difficulty in starting school, her intellectual development pro-

gressed quite well. There was the sexual talk and sexual investigation with other girls, usually in pairs. Her association with boys was freer then than at any other time in the girl's life, often characterized by competitive sport activities. Certainly the period from six to twelve did not approach absolute latency, but the sexual interest until ten was characterized by less intensity and pressure, and apparently less physiological tension than before five or after puberty. It was possible to trace a definite bisexual orientation throughout her development. She had confirmed the fact that she was a girl with the inspection of other girls. Nonetheless she allocated her illusory penis predominantly to the clitoris, the hair—both of the pubis and the scalp—and the stool. This was interestingly acted out in analysis. Whenever unconscious material having to do with the clitoris was produced but not accepted by the patient, she would reach up and pull first at her hair, then at the tissue on the pillow which she would twist into a small roll and, just as she left, drop it into the ashtray in a way suggestive of Abraham's patient who walked through the woods dropping paper behind her.

The greatest increase in anxiety and tension occurred, not with the prepuberty trauma, but with the intensification of the castration complex at the onset of the menstrual periods. The girl seemed actually to suffer from both male and female castration anxiety with shifts and attempts at denial, but with a cumulative burden from both. It was after puberty, too, that the compelling dreads, almost of a persecutory nature, appeared. There was a complete breakdown of the poorly integrated pregenital and genital drives, with the establishment of a kind of democracy rather than a hierarchy among them so that an anxious orgastic discharge might occur in any of the systems involved, with fewer determinants than is usually the case. The spontaneous orgastic relief, which involved so much secondary anxiety, appeared almost equal and interchangeable among the various body systems. This was chiefly characteristic of this patient, not occurring in any comparable degree in the other three of the series.

THE TRAUMA OF PREPUBERTY

The trauma has already been described. Largely through the analysis of dreams and disturbances of behavior, the meaning of this experience could be pretty well understood. The child had initiated the experience by asking the man to lift her up and show her the meter which was hung high on the wall. As she was ten years old and tall, this was especially seductive and it contained the unconscious wish to be tossed in the air as she used to be by her father. She was already in a state of kinesthetic exhilaration from roller-skating at the time of the incident.

Most strongly determined, however, was the choice of the man, who represented not only her father but 'the man downstairs'. That she twice succeeded in getting the caretaker of the building to carry her into his apartment after her exhilaration at the cocktail parties was in both instances an act of compulsive repetition. The factual 'man downstairs' lived on the first floor of a two-family house in which the patient's family lived when she was between four and five years old. This was a year which right up to the end of the analysis remained more hazy in her memory than the preceding year, when the man downstairs was revealed, first as the memory of a parrot (owned by the family below) with an enormous beak and bleary and wrinkled eyes. This screened the memory of an old man, a grandfather or old uncle, who was a member of this same family. Reconstructed, it appears that the four-year-old child going out to play often passed this darkened apartment where the old man stayed alone in the afternoons when the family was out. More than once she tiptoed into the apartment and found the old parrot (man) there. The stimulating event occurred one day when she ran in, urgently in need of finding a toilet. She asked him or he sensed her need, and helped her, lifting her onto the toilet seat, and afterward urinating into the toilet himself. This exciting experience occurred before her father's illness and her going into the father's room and finding her mother helping him. She seemed to have had a pleasant rather than a frightening affect to this experience of sharing the toilet; only under the influence of later events did it become charged with the

anxiety that caused it to be repressed; probably after seeing her young cousin's genital. The associations gave the conviction that the child defecated and the old man had urinated, and that there was in this comparison a confirmation of identification and contrast, which reinforced one factor in the polarities of black and white, earth and water, male and female—fantasies and symptoms crystallized in her dreads of the Black Presence and the white stockings.

The unconscious aim of the child's prepuberty seduction of the man was to see his genital. What he showed her (the gas meter on the wall), aided by his manipulation, since he inserted his finger into the vaginal introitus, only signified to her the realization of her own castration, a fact which she had certainly been verifying with girls, but which she seemed to wish either to confirm or deny in reinstating the former experiences shared with 'the man downstairs' when they had been so cozy in the toilet together. This series of events and the fact that the gas meter itself had the significance of the female genitals and of pregnancy was quite clear in a dream which she communicated at the beginning of an hour. This dream occurred under the influence of the menstrual period about two weeks after the second of the patient's cocktail-party-acting-out experiences into which she already had some insight. It was a time when the material of the prepuberty trauma was emerging into consciousness. She had glanced anxiously at me and remarked that I did not look well and feared that I might become sick again—a very unusual statement from her. As she lay on the couch she stated that the analysis seemed to have taken a new turn, almost like a new chapter, and related this dream.

> I was on a bus in New York City. I had to get off because I knew I was going to be sick. I crossed the street to a theater or movie and I seemed to have been there before. The place was dark. I pushed open a swinging door and entered the lobby of the theater and went toward the rest room. I seemed to know just where to go. Then I saw that the theater was full of groups of silent girls. They said I could come in. I did not want to because I did not want them to hear me being

> sick or having a bowel movement in the toilet. I finally did go in. Then there was another part to the dream. I had a little boy, a very small boy, and I was very proud of him. We were out some place. He put some money in a slot machine, and out came hundreds of packages of little cigarettes. I became frightened because the machine was emptying itself. The little boy suggested a bigger boy to my mind. I thought of my cousin. Then I realized he was really too old to have an interest in slot machines and to take so much pleasure in it. I also was concerned with what people would think of the little boy for being so abnormal.

She began her associations spontaneously, saying that on the day before she had seen on the street a very small woman, whom she could not place, who looked very familiar to her. (Note the familiar theater and the small boy of the dream.) She had tried all day to remember who she was. Perhaps something had happened to her mind that a memory should so completely pass out of it. This suggested having 'passed out' at the cocktail party and having been carried by the kindly caretaker into his apartment. Now she realized she wished to avoid understanding this part of her recent experience. She would almost rather have terminated both work and analysis than face her shame and understand its basis.

The theater recalled a memory from the age of five when she was with her parents on the street near a theater called the Alamo. She had begun to read, and spelled out the letters AL-AM-O, singing them crescendo and with increasing rhythm as she ran along. She had then started a game of hide-and-seek with her parents, running ahead of them to hide in the doorways of stores, and jumping out to surprise them as they passed. (This will be recognized as linked with the kinesthetic thrills of early childhood, and further analysis justified the interpretation that it was also an early anal-vaginal masturbation hidden from the parents.)

The swinging doors of the theater, which opened in the middle, suggested a hotel where the patient used to go with her mother to meet her father in the 'downtown section'. There

she would usually take advantage of a ladies' room which had an arched, padded, baroque door, painted black and bright red. At this point the patient became somewhat disturbed, and said that in the morning (following the dream) she had become unreasonably angry at a fellow worker; on getting up from her seat she was aware of some menstrual flooding which evoked the fear that there might be blood on the floor as there had once been when she had thought she saw a clot of blood on the floor (an illusion based on the fear of anal incontinence). She had hurried to the bathroom and arrived in time to prevent an accident.

The slot machine recalled at once the gas meter and the gas meter man. *She then first remembered clearly the man's finger* in her genitals, and that this had induced in her a state of great confusion. The little cigarettes signified bowel movements, and castration.

It seemed justifiable at this point to interpret the dream as representing her desire to see the genitals, and as a reliving of past conflicts in identification on the basis of genital comparisons, which were discussed with her. She had begun with anxious concern about my health and her own menstruation, expressed in the dream as having to vomit or to have a bowel movement. The theater primarily represented her concept of the female genitals, with a secondary combination of vagina and rectum: darkened rooms, silent girls, the red and black padded door. For this patient this was not merely a fusion of concept but an actual confusion of stimulation, due to early stimulation of the vagina through the rectum; symptomatically there was a practical interchangeability of vaginal and rectal discharge in excitement.

The little boy who was too big to play with the slot machine seemed clearly to refer to clitoral masturbation, deliberately undertaken, stimulating vaginal-rectal excitement; moreover, it represented the envy she felt of her cousin's penis, and her unsuccessful attempt to restore her own value by reclaiming the memory of the old man downstairs, through the experience with the gas meter man. The patient both confirmed and rejected

this interpretation: she shuddered slightly and said, 'I can hardly make myself think of the clitoris now. I am blocked about it. . . . I didn't like to see the movement of the little hands at the top of the meter. I think I must have got confused.' The following day she reported dreaming that Mr. D, the caretaker of the building, had seen her coming in and said, 'Hello, little girl, are you sick?', which referred directly to the Parrot Man.

A few days later the patient expressed the beginning of some spontaneous insight as to the significance of the trauma at the age of ten and her reaction to it. She had already recognized that she often seemed unable to anticipate pleasure; as longed-for situations approached she would precipitate events which would spoil her pleasure or make participation impossible. On this occasion she had been looking forward to attending a meeting in which there was to be a discussion of literature for adolescent children, a subject about which she felt she knew a good deal. She thought she really wanted to participate. The night before, however, she had a nightmare, awoke feeling distressed, and as soon as possible telephoned to report herself unable to attend on account of illness. The nightmare was as follows.

> I went to the meeting (on adolescence) because I should not run away from it. It was in a brightly lighted room upstairs (like our room for smaller children). I saw Mrs. S, a fellow worker, but she had an undressed appearance because she was not wearing her hat as usual. Her hair seemed flattened down and ordinarily she wears high crowned hats. I left them feeling I should not have come. I felt very sick. I was wearing a silver pin on the front of my blouse. I looked down and saw that the clasp of the pin was broken: two little prongs of the broken clasp were left. It could not be fixed, and really there is only one piece to the clasp. Mrs. M, another colleague, came in wearing fancy black suede shoes. She showed me that they did not fit properly and that she had cut them. I did not like that and I left the meeting.

The patient brought many associations confirming the obvious symbolism and giving specific content to the dream: the reactivated castration fear of puberty, for which the meeting on adolescence gave such a neatly convenient framework. This was the beginning of the patient's deeper and more or less organized insight, though it was repudiated and fought off for some time.

This patient had a much more severe disturbance of sexual functioning than any of the other patients, although all were markedly sadomasochistic. A strongly aggressive attitude sufficient for reasonable happiness was maintained in the latency period with the help of a bisexual orientation and the possession of an illusory penis. It seems that this is stronger throughout the greater part (especially the latter years) of the latency period in these patients than in the average girl child, although in only one of the four patients was there a sweeping masculine identification and a practical abdication then and later of the feminine position. In that patient, described in the paper on screen memories, a very severe sexual trauma had occurred in the immediate postœdipal period following which her abandonment of femininity became conspicuous. She also was the only one who became an overt homosexual adult.

In all of the patients the prepuberty trauma was induced by the child, generally quite clearly under the stimulus of observations of an adolescent or of an older woman, in one instance a sister, in another a mother. Although the traumatic situation was precipitated by the child under the influence of curiosity and seeming preparation for puberty, it represented in each instance a repetition and condensation of one or many preœdipal experiences which in a sense the child already knew to be disturbing. While this compulsive repetition may have contained an effort at reality testing, yet the highly defensive value of these traumata, their value as real evidences of the dangers of sexuality (even when, as in the instance cited, the actual danger was not great) was indicated by the regularity with which these children told their mothers or other adults about these expe-

riences and utilized them consistently as defenses against sexuality, especially after puberty. That prepuberty is especially favorable for the provocation of such traumata follows the heightened curiosity and the thrust of activity which is physiologically determined by growth processes preceding sexual maturation. It is interesting that according to studies of normal growth and development there is an acceleration of the rate of growth in girls between the tenth and thirteenth years when a deceleration of rate occurs, and the gain in weight follows a similar course *(3)*.

SUMMARY

While the prepuberty period is generally one of the more silent areas of analytic investigation, a particular group of cases is exceptional in the appearance in this period of fateful traumata which were part of the presenting picture of the neuroses when the patients came for treatment. These traumata were provoked by the victims, and were compulsive repetitions of pre-œdipal conflicts influencing the intensity of the œdipal phase and subsequent severity and deformation of the superego. These conclusions are drawn from the analyses of four patients.

The combination of the increased thrust of activity of the prepuberty years with increased sadomasochism derived from pregenital phases and a strong masculine identification during latency favors the occurrence of such traumata. There may, however, be a real element of fate as far as the child is concerned, which turns the significance of the experience one way or the other, depending upon the readiness to response of the person provoked or seduced to aggression. In all four cases the trauma involved experiences with adults: in three instances there were œdipal traumata, in one instance the re-enactment of a primal scene. The utilization of the trauma as a masochistic justification for a defense against sexuality was apparent and reinforced by its communication to others, and sometimes by its subsequent use for masochistic gratification. It is probable that the effect of the prepuberty trauma as a defense is dependent upon variable combinations of the degree of pre-

œdipal sadomasochistic development combining with the severity of the later trauma, which is not wholly dependent upon the child herself. Traumata of an œdipal pattern are also more utilizable for defense than those occurring with other children, since the guilt can be the more readily shifted to the adult, and the child's own instigation of the trauma, together with the earlier events which have produced the pressure of provocation, more readily concealed.

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The Psychoanalytic Quarterly

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

Mucous Colitis Associated with Phobias

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To cite this article: Melitta Sperling (1950) Mucous Colitis Associated with Phobias, The Psychoanalytic Quarterly, 19:3, 318-326, DOI: 10.1080/21674086.1950.11925806

To link to this article: https://doi.org/10.1080/21674086.1950.11925806

MUCOUS COLITIS ASSOCIATED WITH PHOBIAS

BY MELITTA SPERLING, M.D. (BROOKLYN, NEW YORK)

A twelve-year-old boy had been suffering two years from severe diarrhea of unknown origin. A series of tests and examinations established the diagnosis of mucous colitis. All treatment was ineffective, and his condition became progressively worse. He also had many phobias which, with the diarrhea, prevented him from attending school.

A very fearful and inhibited child, he came for analytic treatment accompanied by his mother. He was afraid of his father who, he felt, looked down on him. He stated he could not go anywhere without his mother. Whenever he attempted to leave the house without her, he got cramps and had to run to the bathroom. Before he had to stop attending, he had been doing poorly in school because of the diarrhea and because he worried so much: a little cut or scratch would throw him into a panic for fear that he would die of septicemia; the slightest cold threatened him with pneumonia. He could not concentrate on his studies, worried about his poor grades, and feared that he would be left behind. His belief that his classmates and the teacher were laughing at him caused him to withdraw from children altogether. He sat alone at home, listening to the radio or modeling airplanes which was his only hobby.

Whenever we discussed his relationship with his mother, he reacted with an immediate urge to move his bowels: 'It seems that I can't talk about my mother without having diarrhea', he remarked one day. This was then interpreted to him as indicating that he was very angry with her. 'Well', he said, 'she does prefer my brother'. He then complained that his mother held his brother, who was five years his senior, up to him continually as a model boy and superior student; also that his

From the Child Psychiatric Clinic of the Brooklyn Jewish Hospital.

mother gave a great deal of attention to his younger sister. He recalled that he had had a severe attack of diarrhea right after his sister was born (he was then about seven years old), and that he had been very unhappy because shortly before his sister was born, his grandmother, who lived with the family and who took care of him, had died; he had been very much attached to her. His sister had actually replaced him in the affection of the mother who had always wanted a girl and had made no secret about it; hence, the birth of his sister was a particularly severe trauma because he had then lost both his mothers: his grandmother through death, his real mother to his sister. The diarrhea and increased phobic dependence on his mother at that time were his reactions to this trauma. He also had lost his pet dog at that time. He had had attacks of diarrhea before that too, when he started school. He did not want to go to school and leave his mother. His father had brought him there by force and remained outside to make sure that the boy did not leave the classroom to run home. He remembered that when he was between three and four years old his brother showed him a picture of the world (a globe). He suddenly had a terrible fear of being separated from his mother and ran panic-stricken to look for her. He pleaded with her to promise him that if he should have to die, she would hold his hand and die with him, and if she should die, he wanted to hold her hand and die with her. When he was still younger, he had temper tantrums for which his mother hit him; so he gave them up.

He reported a nightmare which he had dreamed many times prior to the analysis.

> My mother was tied to a big bell and the bell drove her crazy and she became a monster that looked terrible. She came into my house and started to beat me up.

His mother constantly criticized and nagged him for being clumsy and slow; he had long since reacted by exaggerating this very behavior, and by calling himself 'a moron and crazy'. At the beginning and just prior to his analysis there

was a period when he was in a constant state of panic, unable to do anything for fear that he was going out of his mind. In this self-depreciation, he was actually depreciating his mother. In his dream the boy permits himself to say, 'Mother is crazy and a monster'. His mother often said to him, 'You're driving me crazy with your dawdling', but he never had admitted to himself that his mother was driving him crazy with her constant pushing and nagging. The sexual meaning of this dream was later analyzed when other dreams related to the œdipal situation made clear his sadomasochistic conception of intercourse. 'Crazy' meant his (sadistic) sexual impulses directed toward his mother and also his masochistic sexual identification with her. 'Crazy' also signified losing control and giving vent to his destructive impulses.

Although exaggerated and neurotically distorted, the boy's feelings toward his mother were a reflection of his mother's attitude toward him. The mother admitted that she had not wanted a child at the time her younger son was born. She had wanted still less another boy, and she had had some sort of 'nervous breakdown' as a reaction to his birth. She disliked the child intensely, was very impatient and punitive with him, thought him homely, was hurt narcissistically by his protruding ears. She had put great emphasis upon toilet training. During his first year, he was mostly in the care of his grandmother. When the mother took over his care he would soil occasionally. She beat him for this and he became 'clean' very soon. Between one and a half and two years of age, he had attacks of diarrhea alternating with severe temper tantrums and was generally a difficult child. He had many colds and, when he was about two and a half, he contracted pneumonia after which he changed and became a 'quiet' and 'good' boy. His mother was then annoyed with him because he would not go to sleep unless she lay with him on his bed, and because he clung to her all the time. In retrospect, she could see how her attitude had affected the boy and she felt guilty and greatly worried about him: looking through his books, as was her

habit, she found a paper on which he had scribbled, 'I'm afraid I'm going crazy'.

In proportion to the growth of his awareness of his repressed hostility and of his death wishes, directed primarily toward his mother, he was better able to tolerate frustration, and his general behavior and particularly the diarrhea improved. Psychoanalysis made him aware of the satisfaction he derived from the behavior which was so disturbing to his parents. He liked to scare his mother by telling her about an irresistible urge to kill his brother. He once sprained his brother's wrist in a fight, and in fights with boys he became very violent. Once he almost killed a boy who teased him. This murderous hostility gave vent to both his hatred of his mother and his implacable jealous rivalry with his brother.

Phobic clinging to his mother had the aim of protecting her from his unconscious impulse to destroy her. The common association of a phobia with somatic symptoms indicates failure of the phobic defense. The destructive impulses warded off by the phobia broke through and found somatic expression in diarrhea, in which, by devaluating his mother to and identifying her unconsciously with feces, he separated himself from her somatically. Since he felt very helpless and dependent on his mother in reality, he could give her up only symptomatically.

When he was ten years old, the paternal grandfather came to live with the family. Up to that time, the boy had shared a room with his older brother with whom he very much enjoyed roughhousing every night and morning. The patient first recalled that he was chosen to share a room with the grandfather, whereas his brother now slept in the parents' bedroom. The grandfather was a cardiac invalid. The boy was required to be quiet; he often remained awake to determine whether the old man was still breathing or already dead. Later this was found to be a retrospective falsification (confirmed by the mother) and that it was he, not his brother, who had first moved into the parental bedroom. He had had severe nightmares which kept him up most of the night and was for this

reason moved after several weeks into the room with his grandfather. These events were followed by acute emotional disturbances and recurrence of diarrhea.

During this phase of analysis he had frequent nightmares.

> I had a stomach-ache and thought I had to have my appendix taken out, but I found I didn't really. I tried to get out of the hospital, but I didn't.
>
> I was bitten by a mad dog on my arm and when I went to the hospital, it was so crowded that I couldn't see a doctor. There were little squares where the dog had bitten me and more and more came.

The father had often warned the boy that if he 'touched himself' he would become sick. He believed that, if after touching his genitals he should accidentally touch his eyes, his sight would be impaired. This worried him because it would thwart his wish to become an airplane pilot. He had started modeling airplanes when he was about eight, imitating his brother who then gave it up. He would walk daily several miles to an airport, and once he parachuted with an open umbrella from a tree, narrowly escaping serious injury.

A recurrent nightmare appeared in various versions. Of the two versions which follow, the first he had dreamed the previous night.

> I saw a mummy in a box in my closet and became very scared. I got up and awoke my mother. I went into my parents' bedroom. I went into my mother's bed and she went into mine. I saw my little sister. She was carrying a mummy like a toy and she was playing with it. She did not show any fear. I was very much afraid, especially when I saw that the box had a crack and I thought that I might see a mummy through this crack. My mother opened the box and I was looking on. Inside was a brown wallet. When I opened the wallet, it enlarged to about the size of two feet. While opening the box, I scratched my finger and I was afraid of it.
>
> My brother brought some mummy cases home and my mother put them into the cellar; then I found myself in the cellar and

was very frightened. I didn't know how to go out, being all surrounded by mummy cases.

He exhibited a scratch on his finger which he had noticed upon awakening, and which must have occurred in his sleep. He was very much disturbed about it and it revived his hypochondriacal fears about injuries and septicemia. He had once read about a curse on those who disturb mummies, and about a man who had died as a consequence. It appeared that he had been seduced by his little sister into sexual play. He had observed this sister masturbating without signs of fear, while he felt very guilty for having touched her genital.

In an almost hallucinatory way he visualized a scene in the house in which he lived when he was four years old. It was a warm summer day. He was in his room with a little girl, his cousin. They were masturbating each other when his mother suddenly entered the room. In reproducing this memory he re-experienced the severe shock he had felt at being caught. He remembered his mother's threat that he would become very sick. He knows that he stopped masturbating abruptly after this. It would seem that this threat, coming from his mother when he was at the height of the œdipal conflict, had profoundly influenced his psychosexual development to the exclusion of all genital activity. Part of the dream reproduces events of his third year when he could not fall asleep without his mother, and when almost every night he went frightened to his parents' bedroom to look for his mother and remain there the rest of the night. The father's later threats of punishment for masturbation only added weight to the mother's much more effective threat.[1] His terror of seeing a mummy through the 'crack' expressed his wish to see a penis where there was none (mother's, sister's genitals). Inability to resolve his fear of the castrating woman and failure to resolve the œdipus led to a partial unconscious acceptance of castration and the wish to take his mother's place.

[1] It is my observation that the boy reacts to the mother's threat of castration more severely than to the father's, perhaps because the mother is herself a castrated object who demonstrates the reality of such a threat.

Although an unwanted child, the first year of his life was comparatively unaffected because he was cared for by his grandmother. When he began to react to his mother's hostility by soiling and having temper tantrums, a struggle for control ensued.

Rejected and at the same time overstimulated by the mother (sleeping with her), her threat (castration) when she caught him playing with his little cousin put an abrupt end to this and seems to have precluded any sexual activity including masturbation. Very much afraid of his father who, he thought, always looked down upon him, he could neither compete nor identify himself with him. He also hated his brother as the rival for the mother's love, besides which, according to his mother's wishes, he should have been a girl. Utterly frustrated, he regressed to the anal level of libido development; therefore, the recurrence of diarrhea when he was about four years old (œdipal phase), at the start of school (separation from mother), at the birth of his sister (resentment toward mother), and at the age of ten when, overstimulated by sharing the parental bedroom, he found himself caught in a violent masturbatory conflict. All his thwarted aggressive and sexual impulses he released anally in the diarrhea.

During the first four months of treatment he was seen three times a week. He was able to resume his studies in school, and soon worked himself to the top of his class. He came and went without his mother, made friends and participated in school activities and outdoor play. The diarrhea had disappeared completely. For the first time in his life his mother went on a vacation with his little sister without him. He commented: 'I hope she will not interfere and make me depend on her again when she comes back'.

He was seen less frequently at greater intervals to help him achieve the emotional independence and detachment from his mother necessary for mature (sexual) functioning; also to resolve the transference. During the earlier part of this phase of the treatment, he became moderately depressed. He once had a prolonged cold which kept him away from the analysis

for several weeks. One day he called for a special appointment because he was very much disturbed about a dream he had had the previous night.

> I was with my best friend and suddenly someone plunged from a fifth floor window. My friend called out, 'It is your mother.' I ran over crying, 'Mother! Mother!' She got up and said, 'Nothing happened'.

That week he had felt very sad and whenever anyone talked to him, felt like crying. He recalled again with much emotion the episode with the globe which occurred when he was three or four years old. He understood that at present these feelings related to me. To him, to get well meant to lose the analyst, just as to grow up meant to lose mother through her death.

He began to show interest in girls. He was masturbating without any fear, but rather infrequently. The shift in his sexual interest was illustrated by a dream.

> It was dusk and I was up on the roof of my house. The Japs were coming. They wanted to do something sexually to my mother. I came down with a machine gun and they were all standing in a circle around her. One in the center, an officer, said, 'She's too old for me, anyhow'. I was turning my machine gun and shot them one after the other, so they fell down dead. Then I thought that if the Japs were at my house, they probably were also at Stella's house [his girl]; so I went to Stella's house to help her. When I arrived there, there were no Japs and she was all right.

He was defending his mother, as well as his girl against his own sadistic impulses.

The analysis ended when he was fourteen years old. He had just finished the first term of a high school for aeronautical training, where he had been awarded a scholarship, and worked during his summer vacations in an airport.

SUMMARY

The psychoanalysis of a boy of twelve is reported to demonstrate the interrelation between a somatic symptom (diarrhea)

and an anxiety hysteria (phobia). The phobia was a fear of being separated from his mother, protecting her against his unconscious death wishes, while in the diarrhea he was giving her up by identifying her unconsciously with feces. At the same time, however, the conflict whether to keep mother or to give her up continued in reality, expressing itself in these very symptoms—the phobic clinging and the diarrhea. The overdetermined psychodynamics of the diarrhea would seem to be as follows: 1, a retreat from the genital to the anal-sadistic level of libido organization which provided the possibility of discharging aggressive and sexual impulses (masturbatory substitute); 2, the direct release of sadistic impulses in an effort to protect himself from the overwhelming anxiety stemming from his own destructiveness (conversion on a pregenital level); 3, devaluation of the frustrating object (mother=feces) and getting rid of her; therefore, sadistic control over mother realized in the secondary gain derived from the illness (he could stay home with mother, take her away from the others, and have her accompany him wherever he went); 4, punishment through physical suffering and the restrictions imposed upon him by the diarrhea and his fears.

The Psychoanalytic Quarterly

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

Obsessive-Compulsive Symptoms in an Incipient Schizophrenic

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To cite this article: William L. Pious (1950) Obsessive-Compulsive Symptoms in an Incipient Schizophrenic, The Psychoanalytic Quarterly, 19:3, 327-351, DOI: 10.1080/21674086.1950.11925807

To link to this article: https://doi.org/10.1080/21674086.1950.11925807

Published online: 07 Dec 2017.

OBSESSIVE-COMPULSIVE SYMPTOMS IN AN INCIPIENT SCHIZOPHRENIC

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That in some cases psychoneurotic symptoms mask an underlying psychosis and may even serve somehow to prevent the outbreak of a psychosis has been repeatedly described in the psychoanalytic literature. In 1913 Freud *(7)* recommended that the first few weeks of psychoanalytic treatment be 'designed as an experiment'. 'Often enough', he said, 'when one sees a case of neurosis with hysterical or obsessional symptoms . . . a doubt which must not be overlooked arises whether the case may not be one of incipient dementia præcox . . .'.

Federn *(3)* gives repeated similar warnings. For example he reports an early experience with the psychoanalytic treatment of an apparently obsessional girl: 'Psychoanalysis proceeded with "too little" resistance. The girl lost most of her compulsions too quickly. I had to leave Vienna in 1914 for New York and left her able to continue her studies. When I came home four months later, she received me with pride and shyness in her eyes and confided to me that she was loved by a great actor and that Friedrich Nietzsche's voice had spoken to her.' He goes on to point out that early recognition of a latent psychosis is important as a guide to changing the therapeutic aims and methods. In discussing the early recognition of hidden schizophrenia, he refers to the relation of the neurotic symptoms to the underlying psychosis. He says that 'hidden schizophrenia is indicated during analysis by quick and even sudden disappearance of severe neurotic symptoms; yet, fortunately, as mentioned before, some schizophrenic cases resist dissolution of the superficial neurosis'. Such a relationship is further indicated when he points out that 'in the three cases with bad results, psychoanalysis of the neuroses was the leading goal'. He also refers to a communication from Freud (concerning a patient whom he had referred to Freud) which

again indicates that the neurosis seems to prevent the outbreak of a psychosis. Federn reports that 'there was no therapeutic success after two years. Freud told me that he suspected a paranoia to be the cause of the rigidity of the resistances, and that—although without success in regard to the neurosis—he may have protected him from the outbreak of his paranoia.'

Many case reports point by implication to the existence of a relation between neurotic symptoms and a latent psychosis. Of these by far the most outstanding are Freud's *(9)* report, From the History of an Infantile Neurosis, and Ruth Mack Brunswick's supplement *(1)*. It is noteworthy that much of the clinical material reported by Freud, Ferenczi *(5)*, and others to illustrate the relation of latent homosexuality to paranoia also reveals the existence of obsessional symptomatology. It would appear that in these earlier studies the interest of the various authors focused almost exclusively on the demonstration of the pathogenic effect of the latent homosexuality. In a discussion of recent articles and case reports by Staveren *(12)*, Tower *(15)* and Cohen *(2)*, Sullivan *(14)* points out that, among other features of schizophrenia, 'extraordinary use of obsessional substitutive processes is a feature of manifestly schizophrenic people'.

A particularly significant article by Stengel *(13)* reviews the extensive literature dealing with clinical aspects of the relation between obsessional psychoneuroses and psychotic reaction types. Fourteen illustrative cases are reported. One of his general conclusions is that the structure of the obsessional personality exerts a modifying influence on the schizophrenic process of such a nature as to prevent or delay deterioration and to influence favorably the clinical course of the psychosis. Stengel's discussion implies that the obsessional psychoneurosis and the psychosis in his patients are separate clinical entities, each of which modifies and influences the other.

Psychoneurotic symptoms in a patient with a latent psychosis have also been considered as evidence of a preceding psychoneurosis which has been undermined by the psychotic process. Such symptoms are referred to at times as 'defenses' against the

psychotic process, at other times as 'masking' the psychotic process or influencing it in some way. The inference that they act as defenses is derived partly from the fact that psychoanalysis of the neurotic symptoms in these patients often leads to the outbreak of a psychosis and partly, perhaps, from a subjectively determined preference. The dynamic interrelations of the neurotic symptoms to the latent psychosis are not dealt with in the literature which the author has thus far had opportunity to review.

The author had in treatment a patient who, on examination, was diagnosed an obsessional psychoneurotic. Early in the treatment it became evident that the obsessional symptoms were related to an incipient schizophrenia. The patient was able to describe the relation between his obsessional symptoms and the manifestations of his schizophrenia with unusual clarity. The material bearing on the relationship is summarized here, and some of the theoretical implications are drawn.

CLINICAL HISTORY AND EXAMINATION

The patient was a petty officer in the U. S. Navy, about twenty-five years old when he came to the Menninger Clinic as an outpatient. He complained of obsessional thinking which at times was so intense that he was afraid he would become insane. The decision to seek treatment, as well as the preliminary arrangements for examination, were made by him.

He was the second of three children and the only son of an unstable marriage which culminated in a divorce when he was in his early adolescence. The father, in his fifties, was a small man who, posing as a hail-fellow-well-met, was sensitive, subtly possessive of his son, and unable at times to conceal his jealousy of attachments which the boy formed. The father stated that he had tried to treat the patient as a 'pal', but he had, in fact, evolved ingenious schemes to try to 'sell' his ideas and plans to the patient. He rarely missed an opportunity to impress upon the patient and others his generosity, his big-heartedness, and his importance; yet in many ways he was niggardly. For example, he would send his discarded clothing for the patient to

have made over, although the patient is a considerably larger man.

The father remarried shortly after the divorce. The patient had no prior knowledge of his father's intention and said that he met his stepmother only once, very casually, some months before the marriage. He became quite jealous of her, felt that she did not treat his father well, and he quarreled with her a good deal.

The mother, several years older than the father, had recently remarried. Her second husband is ten or more years her junior. The patient and his father described her as a very tense, frustrated, neurotic woman, who attempted desperately to deny her age and shirked her responsibilities as a mother. She was frequently away from home on prolonged trips during which she accumulated debts. She was jealous of her daughters, severe and rigid with her son. She protracted his toilet training into his eighth year, with frequent use of enemata, mineral oil and laxative foods. She insisted on accompanying him to the toilet, and in public places required that he use the women's toilet. When he swore she washed his mouth with soap, and when he sought affection she pushed him away as being 'greedy'. Frequently she was absent from the home while the father was on a business trip, and the patient recalled that as a little boy he would sit up until three or four o'clock in the morning, watching for her return.

When the patient was ten years old, there began to be serious quarrels between the parents. Each parent would confide in the patient and try to turn him against the other. There were repeated and prolonged separations. The boy wept bitterly and told his mother that he wanted her and the father to love each other, feeling it was his responsibility to bring them together. Later he began to quarrel, especially with his mother, and then he became confused when he was repeatedly confronted with the choice of remaining with the one or the other. He remained with his father, adopted an indifferent attitude toward the situation, and did not permit either parent to speak about the other when alone with him.

About a year and a half after treatment was begun, the patient's mother wrote to us for the first time and at length. This letter and a subsequent questionnaire contributed significant historical data which are summarized here.

When the patient was born his older sister had whooping cough, as did the mother. The patient was isolated to protect him from contagion. He was reared 'scientifically'. She expressed regret that in 'following the book' she neglected to rock him and be affectionate with him. There was trouble between the parents and the mother was 'unhappy and worried because baby's father was showing undue attention to his stenographer'. Weaning and toilet training were completed at twelve months, the latter with the help of suppositories. When the patient was twenty-six months old his younger sister was born. The children were cared for by a neighbor during the mother's hospitalization. Punishments were administered by the mother who stated that the father was very inconsistent, but 'my disapproval was always apparent by my expression and he [the patient] knew it'.

She made the following curious statement: 'He [the patient] never had any curiosity about sex as he and his little sister had their bath together in the tub until he was seven. . . . While I was bathing him [at the age of eight] one day he asked about sex and I told him everything. He promptly forgot it.' He usually required no punishment other than scolding. As a child he was afraid of the dark and of dogs. The parents would leave the light on for him and they 'bought a dog for him to cure his fear of dogs, but he still never trusted strange dogs'. He showed preference for his older sister and 'heckled' the baby sister. The mother always defended the little girl because 'she was so gentle—she never defended herself'. In later childhood the patient was frequently awakened by nightmares.

Until he was in the third or fourth grade his eyesight was apparently normal; then he suddenly showed evidence of a severe myopia which puzzled his mother considerably until she

'discovered he had been reading in bed with a poor light for weeks'.

She described him as unusually affectionate with her, 'a precocious small boy, always at my heels, and at age three he asked more questions in a day than the others did in a month.

'At five he fell down six or seven steps. . . . I heard the thump, ran and picked him up. He wasn't breathing and was turning blue. I shook him frantically, then thrust my finger into his throat. His tongue was cutting off his breath. I held it down and he slowly became normal. He forgot the incident promptly.

'When he was five or six . . . he insisted on seeing the freaks at the World's Fair in Chicago. . . . In a few minutes he came outside with a very white face. He said he was sick, so lay down on the ground. After putting water on his face, he revived and said the man who pulled the skin away from his neck made him sick.

'When he was seven my mother died and we drove to her funeral. . . . A car hit us. . . . Our car overturned. The artery in my temple and lip were cut. He was on top of me, apparently not hurt, except he bit his tongue. The experience of having his mother pulled out of the car by two strange men with her face covered with blood and taken to the hospital was terrifying to him. . . . We were afraid to ride in a car for a while.'

After the divorce the mother visited the patient and found him alone. 'He seemed unfriendly. When I asked what was wrong, he said, "If you ever go to court to fight for anything more, I will testify against you". I was infuriated at my own son making such a statement to his own mother. I slapped him again and again. He did not move or attempt to hit back, but he had a strange expression on his face. I left the house crying and drove away, but I soon returned to ask his forgiveness for losing control of myself. He must have felt equally bad as his father called me and asked me not to come again to see him as he hadn't eaten for several days. He did not explain to his father.'

Other information from the mother indicated that preceding

the divorce the patient saw her go out with a man. In addition she '. . . gave vent to my anger against his dad . . . and his father was tearing me to pieces in his presence. So he was the helpless victim of two parents who were behaving like children—or more like fools. He begged me not to get a divorce, but my pride was too hurt.'

The mother had noticed, prior to the divorce, that the patient did not seem able to organize his work at school. She also remarked that for a time 'he talked very fast' and later began to stammer. Shortly after the divorce he began to stay out late at night and would be up at four o'clock in the morning to deliver newspapers. When she protested he told her 'he had trained himself to sit in a chair during the day and sleep at will'.

Following the divorce the patient observed a change in his relation with people: he became less spontaneous, concentrated more on his studies and was concerned with doing things to please people. He showed little interest in girls until his last year in high school and then very quickly began to 'go steady'. He selected a very neurotic girl who was jealous, possessive, and domineering. He had frequent upper respiratory infections during the third and fourth years in high school; nevertheless, he graduated with better than average grades, worked during his holidays, and was elected president of his high school fraternity.

He enrolled in a university known for its high standards. He was a successful student and was invited to join a scholastic fraternity. At this time he experienced his first 'attack' of obsessional thinking. These attacks recurred at intervals and on several occasions he sought psychiatric help. He states that he received only a 'pep talk'. One psychiatrist gave him two or three electroshock treatments; another recommended that he get married.

With the outbreak of hostilities, the patient enlisted in the navy. He was twice decorated for bravery. Following V-J Day he experienced his most acute outbreak of obsessional worrying.

This resulted in temporary hospitalization and his return to the States. He made plans directly to seek examination and treatment.

At examination he was an alert, affable young man who seemed warm and eager to coöperate. He complained of 'worrying about whom he should imitate', and about 'what the other person might expect'. He was afraid these thoughts would become so confusing as to affect his sense of values. He described numerous obsessions and protective rituals. A battery of psychological tests indicated a compulsive structure which was reasonably well integrated. The I.Q. was 131, in the very superior range, with minimal scatter. There were some schizoid trends and evidence of intense anxiety which apparently was not tolerated in consciousness. The diagnostic personality tests indicated '. . . the weak position the patient holds in the struggle against his passive needs and homoerotic trends'. There were signs of overalertness which in many instances was clearly suspicious and projective. Some of his perfectionistic attitudes showed an overcautious, rather than an overexacting quality. The tests, however, showed no indications which would suggest actual or imminent disorganization. The diagnosis at staff conference was obsessive-compulsive psychoneurosis. Psychoanalysis was recomended.

COURSE OF TREATMENT

In initial interviews the patient gave an impression of frankness, a sincere desire to overcome his difficulties, and good understanding of psychological relationships. He seemed eager to start and within a short time asked to use the couch. Very often, without assistance, he was able to reflect about and to gain insight into some of his attitudes. Within six weeks, however, he became increasingly tense, and an enigmatic aloofness became evident in his attitude. His trend was now self-depreciatory and his thinking stilted and superficial. He exploited whatever interpretations had been made, using them as substitutes for spontaneous self-expression. He became haggard, his expression lost some of its lability, and there were long

silences during which he seemed perplexed, blocked and withdrawn.

Shortly thereafter he was requested to discontinue the use of the couch. During some four months he sat on the floor, usually in the farthest corner of the room. He used his position in the room to indicate rapport with the analyst. When he felt 'in touch' he would sit much closer. At times he would make the gesture of drawing a line on the floor which he later explained as indicating that he was afraid to go any further with the subject under discussion. Gradually he began to appear warmer and less withdrawn. He made teasing approaches to the couch and then began to sit on it. He remained on the couch and after some six months spontaneously resumed the recumbent position. He then began to deal seriously and analytically with his relation to his parents, the impact on him of their divorce, and with related dreams, memories and fantasies.

FIRST PHASE

After the war was over he had recurrent obsessions that his testicles would be shot off. He said that most of the men were worried about this during the war, but that he did not begin to worry until the danger was over. He described obsessions that he might cut someone's throat, or that he might kill everyone around him. When he read about the atomic bomb, he became obsessed with the idea that the world would be shattered, followed by worry whether he was becoming insane. A newspaper reference to hogs led to obsessions about swine being castrated and justifications for such castration. He described that he could 'put certain parts of my life out of my life', due to the fact that remembering something painful was as bad as going through it again and that, therefore, he would either convince himself that it had not really happened, or that he was different from the way he had been at that time and that it no longer applied to him.

Early in treatment he developed obsessional fears that he would do something or say something to enrage the analyst.

He would frequently block and at such times would be preoccupied with thoughts that his analyst was a good fellow, that he need not fear him, etc. There were many obsessional worries about being homosexual, impulses to castrate himself, frightening thoughts about self-fellatio, and many similar recurrent 'worries'. During one interview he described a complicated process whereby he could separate what he said from what he felt so that he would be able to tell the truth and at the same time evade the issue.

During this phase of his treatment he became more and more preoccupied with dreams and fantasies. As he became increasingly perturbed, his fantasies dealt with ideas of oral and anal sucking, crawling into the analyst, becoming a woman, etc. Persistent fantasies were: 1, fear at night that someone escaped from a state hospital would come in to attack him, stab him or mutilate him; when this obsession became acute the patient was unable to sleep without locking all the doors and windows, pulling the shades, carefully searching the room, and leaving his light burning; 2, daydreams, associated with considerable tension, in which he would beat or kill some 'bad' person. Masturbating had originated in adolescence in an attempt to relieve the anxiety engendered by the first fantasy; later he stopped masturbating by using the same fantasy to frighten himself.

After some four months, the patient described episodes when his awareness of himself and of his surroundings underwent peculiar changes:[1] the feeling that the room was growing larger,

[1] Dr. Paul Federn, in a personal communication, suggested that the term 'estrangement' be applied to these phenomena. He wrote, '. . . all cases of latent schizophrenia describe *some* features of what is ordinarily called depersonalization. . . . I think it necessary to differentiate depersonalization from estrangement or alienation and to use them for what are topically different phenomena. . . . Estrangement is always due to a loss of the libidinous component of cathexis of a mental ego boundary. . . . In *depersonalization* no ego boundary has lost its libido cathexis, but the coherence of the ego cathexis itself is interrupted . . . intentions, although correctly carried out, are not felt to belong to the ego.'

The term 'estrangement' will be used throughout the text of this paper to designate the phenomena described, in terms of Federn's differential diagnostic

that he was receding, and that objects were losing their interrelations. Perception seemed intensified, yet detached and suspended as in a vacuum, as for example, the isolated ticking of a clock, a leaf on the tree, a shadow on the floor. He said such episodes had also occurred in his childhood. He now began to show evidences of confusion, incoherence, and of becoming paranoid. He reacted to encouragement with the fear that he was about to be discharged from treatment. He felt, with some conviction, that there might be a microphone under the couch, and once he had to open the door to make sure that no one was eavesdropping. Some of his associations became quite bizarre: to a question about a detail from one of his dreams—a map—the patient answered that he knew what the analyst was thinking, and that he was sure it was not Italy. The map of Italy, he explained, resembles a penis and, therefore, that was what the analyst must have thought.

SECOND PHASE

With these changes in the patient's attitude and trend, the use of the couch was discontinued. The patient felt almost immediate relief. He confessed that while lying on the couch he had been terrified by a mental image of the analyst as a gargoyle sitting high above him, and by obsessions that the analyst would suddenly become insane and that something horrible would happen. Shortly thereafter he associated his obsessional thinking with his feelings of estrangement. He would suddenly find himself out of contact with his surroundings and 'hear the ticking of the clock' (loss of relationship among objects and sounds). He would then become obsessed with worries that he might be castrated, that he might suck his own penis, or that he might make some impulsive homosexual advance. Afterward he would tell himself that he had to pull himself out of it, that he must force his attention back onto what was hap-

criteria. He wrote about estrangement that 'depending on the part of the ego boundary deprived of its libido cathexis, . . . objects, . . . sensory impressions, . . . memories, thoughts, fantasies, and even emotions, may be perceived as strange, although another part of awareness may still be normally felt'.

pening and stop this neurotic worrying; that one could only be really happy if one forgot about one's self and thought only of other people, of what they like and of what they do. On the basis of these facts the analyst could point out to the patient that his obsessions seemed to be a way of pinching himself in order to remain in contact with people.

For about a month he seemed to be testing the analyst's 'new attitude'. There were, however, frequent abrupt changes of mood. Talking animatedly, he would suddenly stop in the middle of a sentence and appear to be perplexed and withdrawn. He would then say he had been preoccupied with obsessive wondering whether he was saying something only to please the analyst, whether it was artificial or real, etc. He began soon to recognize that the following order of events preceded the blocking: first, a feeling of deprivation; then, anxiety, followed by a sudden experience of estrangement, succeeded, in turn, by obsessional ruminations which helped to bring him back into contact with the analyst.

Chief among other symptoms in this phase were hunger pains, head sensations of various sorts, and peculiar sensations in his legs which he related to the fact that the analyst wore special shoes. He described underlying intense 'sadness and loneliness'. On one occasion, in connection with this 'loneliness', he said he had been 'dodging back and forth from withdrawal to obsessional thinking'.

He had meanwhile developed a rather close attachment to an attractive girl. He experienced intense anxiety whenever he tried to discuss his feelings about her. He began to have the obsessional thought that the analyst looked like his father. He became sexually aroused with his girl, but could not accept a sexual relationship. After such excitement he was especially prone to attacks of estrangement, and he would then be unable to sleep the entire night because of self-tormenting obsessions.

After about three months the patient spontaneously adopted the interpretation of his obsessions as pinching himself. It had begun to dawn on him with unmistakable clarity that his painful obsessions invariably followed some feeling of unreality or

loss of contact. This recognition was followed by several sessions during which he would act as though he were about to sit on the couch, but would then place his coat there and sit on the floor. Then for several sessions he sat on the couch for a few minutes during the hour and soon thereafter he gave up sitting on the floor entirely.

THIRD PHASE

With the recognition that his tormenting obsessions seemed to protect him in some way from losing contact with reality, the patient entered the next phase of his treatment. The content of his production, as well as his attitude, gradually shifted from the predominantly schizophrenic material of the first and second phases to material rich in personal meaning and capable of analysis. With this change came a capacity to describe more clearly some of the experiences of the earlier phases of his treatment. At first he spoke of a 'deep chasm' which he could not bridge. He recognized that he obtained some relief from this by becoming obsessive. He spoke of a 'loose or missing connection' between what he said and what he felt, which he went into great detail in an effort to describe. He said that often the mere fact that the analyst was there, that there was one spot in the room where he could not be overlooked, was very irritating; this also occurred in connection with people who lived at his rooming home. He sometimes wished to be alone and to deny any intrusion, blissful states during which he did nothing, or at least of which he had no recollection afterward. These states alternated with others in which he was actively trying to grasp 'real things', as studying or social relationships. He believed that for many years there had been an alternation of the two; for example, reading fiction, followed by reading 'worth-while stuff'. He felt that each of these states was frightening, but particularly the blissful one in which he would suddenly feel that he was 'slipping', and 'begin to hear the clock tick'; then he had to make desperate efforts 'to pull himself back'. He believed that there was little separation between his awareness of reality and his tendency to 'project',

and he feared 'it might happen some day that I will begin to think people are after me and might hurt them or kill them'.

Later he stated a fear of his wish to get off by himself and not do anything. Asked why he should fear this, he became frightened, felt that the analyst did not understand, and described with some desperation how, if he permitted himself to indulge in the wish, he would lose touch with things and 'my vision would be limited as if all the background were excluded and just one or two concrete objects stood out'. In such circumstances he said obsessional thoughts would be a relief. A week or two later he described his loneliness as a dread that things would move away from him and that without help he would be lost, a condition also relieved by obsessional thinking: 'I focus on tiny details, and for the time it takes me to see things again, those little details become my whole life'. In the following hour he remembered the circumstances of his first 'attack'. He had suddenly found himself losing interest in the men at the fraternity and in his studies. This had made him feel very panicky and he began to brood about 'reasons' for things and about the existence of 'absolutes'. He then felt compelled to discuss these thoughts with the other men in the fraternity. At that time he clung desperately to his girl from fear that if he withdrew enough to lose her, he would be entirely gone: 'she represented a symbol of reality to me'.

A few days later the patient, after a moment of blocking, began to talk very rapidly and circumstantially. He moved after a little from the foot of the couch, where he was sitting, toward the middle. As he was talking he felt that the analyst was becoming smaller and farther away until he could not see him; the way he was talking constituted an effort to hold on. The following day, in trying to describe his loneliness, he suddenly developed obsessions about sucking his own penis. He had come close to experiencing the loneliness and he felt better with the obsession. In expanding the description of his loneliness in terms of his 'real feelings for people', he said that his 'feelings of affection seem to be always side by side with feelings of intense hatred'. He followed this with

a discussion of his inability to get interested in anything and his tendency to develop pseudo interests in things which someone else liked in the hope that they would then like him.

One day when he was particularly worried about his relation to his girl, he became lonely and frightened and took a long walk. He began to feel relieved and it was only on reflection that he recognized the type of thinking which had brought relief: he had 'forced' himself 'to think about woodwork and about each step in the process of making a cabinet'.

Some months later he compared his obsessions with praying. He felt that people pray to obtain a feeling of security or relief and that his obsessions somehow did this for him. He noted that he had two types of reaction: one, to which he was most accustomed, was of being preoccupied with obsessions and worries; the other, which 'seems to be always somewhere in the background', was a feeling of overwhelming 'sadness, littleness and fear'. He began to think of his obsessions as an impulse 'to divide things up', by which he meant that he obsessively took one little thing at a time instead of seeing the whole situation.

For nearly a year he had been most insistent that he had no interest in his mother, did not want to hear from her, and tore up her letters without reading them. Now he began to find evidence in his dreams and associations that there were other feelings for her. He began to take the recumbent position on the couch and, it seemed almost in spite of himself, he began to experience painful emotions. On several occasions he wept bitterly about his parents' divorce and his sense of loss. He began to ascribe his withdrawal and aloofness to denial of painful feelings.

In the next few weeks the patient gave a striking description of his relation to the analyst and to reality. 'When I started my analysis and during the first months it was like a panorama where most of the time it wasn't really real. I didn't have a sense of identity. I felt that things were happening and that they were important, but I couldn't really appreciate what they were and what their importance was. Then gradu-

ally things became different and I have a sense of identity now. I am able to think about myself in relationship to people and to things. However, when something happens, like your going away for a while, I seem to lose something; I don't know what. Anyway, I then find that ordinary problems and ordinary things lose their importance. I seem to withdraw and get preoccupied with fantasies and obsessions. There are a lot of things to tell you today, but I feel it would be meaningless because there is something like an empty space in the back of my head which has to be filled before I can feel real interest in the other things.'

He tried to describe how he felt when he felt better. It was a 'feeling of reality'. He could look out of the window and see things without effort and felt that he belonged and was in touch with them. This was a 'good feeling' which, however, could be easily shattered if his analyst or his girl had to leave unexpectedly. At such times he became threatened with estrangement and 'instead of seeing real things, I have to focus on them'. He added to this the relation between his 'feeling of reality' and his ability to retain a mental image of the analyst. He found that when he could picture the analyst as he is, he felt in touch with things, but when he could not recall a clear image, he was also disturbed and obsessional.

The patient returned repeatedly to efforts to describe more clearly his subjective state for which he used the word 'loneliness'. He found it most difficult to discover words which seemed adequate. He substituted such terms as 'emptiness', 'coldness' and 'littleness'. His earnest efforts to explain this subjective state emphasized its importance to him. For instance, while engaged in a friendly discussion in a mixed group, a girl, who had just come in, rushed toward him, called him 'honey' and extended her face to be kissed. The patient said, 'I did not sense any real feeling behind her gesture. That seemed to be horrible. Then suddenly I felt empty, helpless and very little. I had to focus to see the people who were

there. Later I was full of obsessions and fears and it wasn't till the next morning that I felt really as if things were all right and I didn't have to worry.' The girl's gesture, he added, reminded him of the way his mother looked when she demanded a kiss.

THERAPEUTIC RELATIONSHIP

Without discussing the therapeutic relationship in detail, there is one important consideration which became clear late in the treatment: that the patient spontaneously chose to use the couch at the beginning of the treatment subjected him to an isolation which was particularly traumatic for him. He might thus have denied the urgency of his need to maintain contact with people. Denial played some part, but a minor one. There is a considerable body of evidence to indicate that the patient actively brought about precisely those situations which he dreaded most. A dream revealed this clearly:

> I went into a drug store and met a lot of my good friends. Then I did something—I don't know exactly what—but it made them turn away from me and leave. I regretted what I had done.

At times, when the analyst failed to understand the patient and responded with flippancy, there would ensue several hours during which the patient was tense, aloof, and obsessional. His explanation would be, 'I don't know why, but I seem to be trying to create tension between us; a kind of separating action'. A skeptical response associated with sincere interest in understanding would result in diminution of tension, more warmth from the patient, and his explanation that the analyst had hurt his feelings and had left him to feel he was alone in his struggles. He was better able to accept genuine annoyance than its concealment in flippancy.

The interpretation that the patient converted a situation in which he felt passively abandoned into one which he actively left is again only a partial one. It certainly does not account for the disappearance of this device when the patient

felt in good contact generally and its reappearance in all of his behavior when something happened to cause him to be withdrawn.

What became clear was that this mechanism is really an archaic form of communication. He used the couch at first to show the analyst the major problem—withdrawal. When he was not understood he expressed the same idea by fantasies of incorporation. Later he complained about microphones and looked for the eavesdropper—subsequently explained as meaning 'nobody listens to me'. During the second phase of his treatment, the patient moved away from or closer to the analyst to represent his feeling that the analyst understood or failed to understand. This reaction is best understood in terms of an archaic language in which there is no difference between 'me' and 'you'.

FORMULATION

It is evident that what had appeared on examination to be an obsessional psychoneurosis was, in fact, an unrecognized incipient schizophrenia. During those phases of the treatment which have been reported, the obsessional symptomatology was not a consistent part of the picture; it tended rather to appear episodically. Toward the end of the third phase, when the schizophrenic manifestations were no longer prominent, the obsession could be demonstrated to be one of a series of mental states, ranging from schizophrenic manifestations to capacity for object relationship.

Each episode of disturbance with its progressive sequence was initiated by some current traumatic experience. The numerous traumatic experiences which were described and investigated during the course of the treatment had several features in common: deprivation, frustration, and most important, the patient's feeling that some significant person had withdrawn from him. Many of the patient's associations related these deprivations to quarrels between his parents and disruption of the home; others pointed to some terror in his childhood in relation to his mother. He frequently pictured

his mother with a crazed look in her eyes and complained that there was some coldness in her attitude toward him which she was unable to conceal.

The patient emphasized that when he was 'on the way up' after such a traumatic experience very minor deprivations would suffice to set the entire disturbance in motion again—an important point to bear in mind in the treatment of such patients. When, however, he had 'a feeling of reality' he could cope with relatively severe deprivations without any unusual disturbance.

The disturbances initiated by such traumatic experiences took the following course:

1. *Sudden 'emptying'.*[2] He had difficulty in defining this experience, using in succession such terms as 'withdrawal', 'loneliness', 'emptiness', and 'coldness'. He associated this phenomenon to the episodes of estrangement and to the related disturbances of hearing, vision and equilibration. In those episodes, his surroundings seemed to move away from him, all dimensions rapidly increased, objects lost their interrelationships, and he became limited to isolated perceptions.

The abruptness and magnitude of the change in the patient during such an 'attack' were extraordinary. Chatting animatedly, he would suddenly stop, all expression would drain out of his face, and his eyes would be dull and unfocused. There was no immediate or subsequent evidence of loss of consciousness. For that moment he resembled a catatonic schizophrenic. The blank, empty mien would gradually give way to a perplexed, frightened, groping expression. He would then say 'I was thinking over and over that you are a nice guy and that I need not be afraid'. (Compare this statement to his association of obsessional thinking with praying.)

The phenomenology described took place as rapidly as it

[2] The terms used for each of the three states are taken from the patient's descriptions. The word 'emptying' seemed most apt as a description of what could be observed—a draining of expressiveness and vitality. It undoubtedly corresponds to the detachment of the libido, but conveys a better picture of the observable phenomenology than would 'withdrawal' or 'detachment'.

was abrupt. Nevertheless, it could be observed that the sudden stopping preceded the draining of expression and might perhaps be described as a separate step in the sequence. The perplexity and the obsessive thinking are related to the next stages to be discussed.

2. *'Focusing'*. The patient's description of what he called 'focusing' is noteworthy for its clarity. He would have a horrifying awareness that he was 'slipping' and would then focus on an object, any object, and 'for the time it takes me to see things again, those little details become my whole life'. His descriptions leave no room for doubt that something catastrophic had happened and that the 'focusing' represented a desperate struggle. The patient described a variety of his mental states as characterized by more or less 'focusing'. These states were manifested in the treatment in a specific sequence.

a. *Schizophrenic manifestations.* Perplexity and blocking; bizarre and incoherent productions; preoccupation with fantasies of oral and anal incorporation; and the development of paranoid ideas.

b. *Preoccupation with self-tormenting fantasies and fears.* These preoccupations had a delusional cast on some occasions and at other times were more nearly obsessive in nature. Fears that he might become homosexual, castrate himself, kill someone, etc., were often accompanied by protective rituals. He had to watch the way he walked and had to review the events of the day or of his life to be convinced that the fears were 'neurotic'. To allay his fear that an escaped 'lunatic' would enter his room at night, attack, mutilate, or kill him, he had developed a rather detailed ritual. This particular fear had rich associations to early adolescent masturbation and to dreams in which the patient made love to a queen (who often had a phallus) and became frightened by the imminent approach of the king. It is of technical importance to bear in mind that the use of these fears in the process of 'focusing' was therapeutically more important than the analysis of their content.

c. *Obsessive thinking.* This stage of the process showed many

of the characteristics of the obsessional psychoneurotic. There was little evidence of the horror of the preceding stages. The patient would express doubts about his attitudes and motives and would, typically, seize on the choice of a word for further rumination. He was in relatively good contact at such times, but tended to be overingratiating and boyish. There was a certain tentativeness in his friendliness; if it was met with friendliness be became tense and withdrawn. If, however, it was met with friendly skepticism, he reacted with relief.

3. *'The feeling of reality'*. The patient's description of this state was that he could see things without 'focusing', and felt that he belonged and was in touch with them. Evidence of this capacity for object relationship appeared only in the third phase of the treatment. It was apparent, not only in the treatment situation, but in all his other relationships, and it depended on several factors for its maintenance: (a) uninterrupted contact with his analyst; (b) the ability to retain a clear 'mental image' of the analyst. Early in the treatment, only one session a day was a deprivation: the loneliness was augmented on week ends and on holidays. Later he could retain a clear 'image' of the analyst over the week end, but found that he would lose it when there was a holiday in conjunction with the week end. The clarity of this 'image' fluctuated with such traumatic deprivations as the analyst's failure to understand or a casual or joking response; unexplained cessation of letters from his girl or his father; and similar situations.

When such a disturbance of the 'image' occurred, the patient found that on trying to think of his analyst or of other people he could only think 'of the word or the name'. Apparently by 'focusing', he would link the 'word' with experiences, as hunger, cold, warmth, etc., to which he would add such concepts as eating, toilet functions and the capacity to feel distress and relief. In this way he was able to rebuild an 'image' which, however, remained 'peculiar, out of proportion, deformed' until he regained 'the feeling of reality'.

DISCUSSION

There are significant and fundamental differences between this patient's obsessions and those of an obsessional psychoneurotic who finds his obsessional thoughts to be persistent, alien, silly, and whose entire effort is to be rid of them. In this patient the obsessional thoughts appeared episodically and could be demonstrated to be one step in a process which he referred to as 'focusing'—a process striving toward contact with reality. Far from being symptoms or defenses, the obsessional state represented a partially successful restitution.

Freud *(8)* stated that 'in the clinical picture of the psychoses, manifestations of the pathogenic process are often overlaid by those resulting from an attempt at cure or at reconstruction'. Can one distinguish the pathogenic process from the efforts at reconstruction or restitution in this case? The unusual pertinence of this patient's descriptions allows the assumption that the pathogenic process occurs sometime between the traumatic experience and the sudden 'emptying'. The phenomenon in this case gives the impression that, in some almost impersonal way, traumatic deprivations created a sudden vacuum in his psychic apparatus that was followed by an abrupt withdrawal of the libido. The author cannot agree, on the basis of these observations, with the statement of Fenichel *(4)* and others that the essential process in schizophrenia is 'regression to narcissism'. The evidence in this case and other cases points not so much to regression as to a peculiar fluidity in both object and ego libido which is strikingly evident in the abrupt draining of this patient's interest, as well as in the less abrupt but equally striking capacity for re-establishing that interest.

In his discussion of the metapsychology of the schizophrenic process, Federn *(3)* takes a similar stand: 'Loss of reality is the consequence, not the cause of the basic psychotic deficiency . . . the primary schizophrenic process appears to be a functional deficiency or even exhaustion of ego cathexis. . . '. He adduces evidence to indicate the importance

of controlling sexual activity in these patients: 'They [psychotics] are adversely influenced when, by abundant sexual activities, the source of the libido cathexis becomes temporarily exhausted; it is then that . . . schizophrenic periods become graver and last longer'. On the other hand, Federn implies something more than a 'functional deficiency' when he says, referring to the existence of independently organized ego states in the psychotic, 'it is impossible to reunite them—before the psychotic process itself has ceased—by psychoanalysis of the causes of the change'. The material presented in this case points to the likelihood that the so-called 'functional deficiency of ego cathexis' is in itself a curative reaction to the pathogenic process. The nature of the process itself remains enigmatic.

The technique of psychoanalytic treatment of such patients has been variously described and discussed by Federn *(3)*, Fenichel *(4)*, Fromm-Reichmann *(10, 11)* and others according to each author's conception of the nature of the schizophrenic process. There is general agreement that one of the major aims of the therapist is to retain the positive feelings of the patient. To call this positive transference, as Federn *(3)* and Fenichel *(4)* do, seems to confuse the issue. From their statements, they refer to the friendship of the patient in the sense of a real relationship, rather than to the transference to the analyst of irrational, unconscious, unassimilated infantile attitudes.

The material from this case allows the following hypothesis: the psychotic process follows immediately on a traumatic experience and its nature is enigmatic; all observable manifestations in the patient are attempts at restitution. The amount of libido available to the patient for narcissistic purposes and for object relationships seems to vary in proportion to the intensity of the psychotic process at any given time. It would seem that with the diminution of object libido and of ego cathexis, more highly developed functions of the ego give way to more archaic ones. The psychoanalyst should make himself accessible to the patient in accordance with the

patient's capacity of the moment. Federn *(3)* expresses the same point of view in the following statements: 'Psychotic patients offer their positive transference to the analysts; the analysts must nourish it as something precious in order to preserve their influence, so that the patients regain control of their psychotic reactions through their own understanding. . . . Without it [positive transference] the psychotic scotomizes the analyst and what he says. . . . In all cases which I treated later with good results, I followed the rules dictated by the libidinous conditions of the psychosis and not those dictated by the claim for analytical thoroughness.'

As long as the psychotic process is active the major therapeutic device is to remain visible to the patient—'visible' in this instance because the patient literally lost sight of objects in proportion to the libidinal impoverishment of his ego. The quality of remaining 'visible' must be related to the patient's state of the moment and cannot be summarized under any technical generalizations. In this case the degree of success of any particular measure could be judged by the patient's subsequent description of the state of his 'mental image'.

SUMMARY

The literature concerning the relation of obsessional symptoms to schizophrenia is briefly reviewed. Material is reported from the psychoanalytic treatment of a patient which demonstrates the restitutional nature of such obsessional symptoms. A working hypothesis is offered about the psychotic process which permits some tentative formulations about psychotherapeutic procedure.

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The Psychoanalytic Quarterly

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

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To cite this article: Otto E. Sperling (1950) The Interpretation of the Trauma as a Command, The Psychoanalytic Quarterly, 19:3, 352-370, DOI: 10.1080/21674086.1950.11925808

To link to this article: https://doi.org/10.1080/21674086.1950.11925808

THE INTERPRETATION OF THE TRAUMA AS A COMMAND

BY OTTO E. SPERLING, M.D. (BROOKLYN, NEW YORK)

There are two approaches to the theoretical understanding of war neuroses. One group of theories is based on Freud's concept of the war neurosis *(18)* as a conflict between the civilian ego and superego, on the one hand, and the military superego on the other. This concept does not explain 1, why so many war neuroses continue after removal from the danger zone, and even into civilian life; 2, if based on the instinct of self-preservation, why there are suicides, depressions and unconsciously provoked accidents as a result of war neurosis; 3, the traumatic neuroses in civilian life. The last are so similar to war neuroses in their symptomatology, change of character and morale, and in their bitter fight for pensions, that a theory of war neurosis should include traumatic neuroses. A second approach to understanding war neurosis is the concept that it is a traumatic neurosis incurred during combat.

In the explanation of the pathogenic effect of psychological traumata, psychoanalysis has from the beginning borrowed from neurology. Freud *(20)* described the trauma 'as a stimulus breaking through the stimulus-barrier which is represented by a countercathexis'—basically a physiological theory. Freud did not account for the full course of the traumatic neurosis by the breaking through of the stimulus-barrier; but Kardiner *(26)* did, and was followed by a number of psychoanalysts, especially Fenichel *(13)* who described the trauma in the following neurological terms: 'Too high an influx of excitement within a given unit of time. . . . In order to master the intruding overwhelming excitation, ego functions are blocked—for instance, by fainting.' The emotional spells of the traumatic neurotic are explained as 'archaic emergency discharge', although it is

Read at the meeting of the American Psychoanalytic Association, December 1948.

well known that they do not achieve this result. Kardiner had stated, 'Because of fatigue and other physiological factors, the resources of the individual are reduced and his adaptive capacities fail. . . . The whole apparatus for concerted, coördinated, purposeful activity is smashed. The whole technique of adaptation has become permanently impaired.' The persistence of anxiety when there is no longer any danger baffles Kardiner, but he explains it by the assumption that ' . . . the traumatic neurotic considers his ability to negotiate the dangerous world as permanently impaired. The continuation of the affect is in conformity with the altered resources of the subject.' The sexual impotence of traumatic neurosis is likewise explained by Dreyfuss *(11)* as the mobilization of sexual energy for the purpose of mastering the intruded excitation.

Grinker and Spiegel *(24)* in their monograph on war neuroses go further in borrowing from neurological thinking. They see in id anxiety a group of diencephalic reflexes which can be inhibited more or less by the cortex. Ego anxiety, in their opinion, results from the stimulation of the cerebral cortex on the hypothalamus. In experimental animals, when the cortex has been removed, excessive and easily provoked sham rage develops. In the soldier, '. . . the cortex may be weakened by fatigue, physical stress or other physical factors. This may increase the stimuli from the cortex on the hypothalamus [increased ego anxiety], or it may lessen the inhibition of the hypothalamus [increased id anxiety].' The diencephalic mechanism may become excited to such an extent that the inhibitory action of the cortex becomes too feeble to control it: 'In either event, a break-down in the *phasic* relationship [between cortex and hypothalamus] results in *perpetual* action [of the hypothalamus]'.[1] Grinker and Spiegel find a substantiation of their theory in those experiments which have shown that '. . . the hypothalamus acts as a condenser, discharging repeated bursts of excitation which influence the cerebral cortex long after the cessation of the original stimulus'; furthermore, the results of pentothal therapy, which is known to act on the subcortical

[1] Italics added.

centers, seem to confirm their theory: 'It removes tremors, sweating, tachycardia, dyspnœa, restlessness, irritability, and inattention even before it affects sleep'. These neurological theories of traumatic neurosis are only a modern rebirth of Oppenheim's *(33)* theory of the traumatic neurosis as a 'molecular' damage to the brain. All these theories are, in my opinion, contradicted by the following facts.

1. Soldiers seriously wounded do not develop traumatic neuroses until their wounds have healed, and return to combat becomes imminent; or in circumstances in which they feel neglected and forgotten *(9)*. In civilian life, hospitalization with or without surgery may have a traumatic effect. Fessler *(16)* and Lehrman *(28)* have shown that operations are often unconsciously interpreted as a castration. One would expect that soldiers, having not only been subjected to the hardships of war, but to physical injuries and operations as well, would have a doubly severe war neurosis. If the adaptability of the uninjured, or slightly wounded traumatic neurotic is impaired, how much more should be the maladaptation of the soldier who is physically disabled? The opposite is true.

2. Studies of war prisoners in Siberia after the first World War *(12)*, of inmates of Nazi concentration camps *(3, 4)*, and of victims of internment by the Japanese *(25, 32)*, showed that these people had been exposed to more anxiety, more physical strain, avitaminosis, and exhaustion than many war neurotics. Initially, there were frequent depressions and states of anxiety, but despite seeing many of their friends tortured to death, and being themselves repeatedly tortured and humiliated, the number of traumatic neuroses remained extremely small.

It has been argued that those who acquired traumatic neuroses in concentration camps did not survive. From the reports of survivors I have analyzed, this is improbable. They observed nightmares and moderate depressions among those who shared their bunks, but not the typical symptoms of traumatic neuroses. Those survivors whom I analyzed had had, prior to their imprisonment, some form of psychoneurosis which seemed to disappear completely during incarceration. Those who regu-

larly fainted at the sight of blood failed to do so; the hypochondriacs who had feared heart failure from the slightest exertion endured intense emotional and physical strain with no thought of their hearts. Some who had suffered from gastric ulcers when they were carefully dieting had no ulcers with scanty and inferior food. Even chronic traumatic neuroses from the first World War disappeared. When these people came to the United States, and sometimes while they were still en route, their old symptoms recurred step by step. Although they were definitely predisposed to the development of psychoneurotic symptoms, none had acquired a traumatic neurosis in the concentration camp.

Hysterical syndromes among prisoners were basically different from those of war neurosis *(32)*. While the war neuroses made the soldier unfit and useless both as a soldier and a civilian, the hysterical symptoms of the prisoners of war consisted of anesthesias, deafness, reduction of vision, etc., symptoms which made it possible for them better to endure and to survive. Most prisoners of war preferred to work, while the war neurotics strove to be hospitalized. In stealing food, in other self-preservative inventiveness, and in the maintenance of apathy and superficial optimism, the prisoners of war showed an adaptability that was in striking contrast to the war neurotics *(23)*.

3. The influence of morale has never been more clearly demonstrated than in the second World War *(6, 2, 27)*. Kardiner acknowledges that the Japanese soldier 'continued to fight —no matter how low his resources had dwindled'. If morale or the threat of being shot if one retreats makes the difference which determines the incidence of war neurosis, then the dwindling resources or the overstimulation of the hypothalamus cannot be very important.

4. Whether returning home is '. . . too high an influx of excitement within a given unit of time' *(13)*, or whether '. . . it smashes the whole apparatus for concerted, coördinated, and purposeful activity', the neuroses of discharged soldiers bear, nevertheless, all the earmarks of war neurosis. It cannot be dismissed by the easy assumption that the individual would

have developed the same neurosis had he never left home. It poses, rather, one aspect of the problem of latency between the trauma and the outbreak of neurosis.

5. Another phenomenon of latency is the 'double-take' or delayed fright *(14, 35)*. After shrapnel explosions, unconsciousness did not always supervene immediately, but after intervals of seconds, minutes, or sometimes hours with no sign of intracranial bleeding. If the stimulus did not break the stimulus-barrier right away, why should it break hours later?

6. Most numerous were instances during war of soldiers who seemed to be cured of their war neurosis but who, when ordered to return to active duty, had a complete relapse of all their symptoms *(24)*. Grinker and Spiegel might say that the diencephalon in these cases was still so shaky that the fear of experiencing similar dangers again would throw the diencephalon into a state of massive anxiety. I have observed patients 'cured' of their war neuroses, who after three years of normal postwar civilian life relapsed into war neuroses from fear of being reinducted.

7. Most impressive were relapses into war neurosis occurring after ten and twelve years of latency *(10, 31)*. It can be argued that these were not war neuroses, but that the traumata of war had only established a pattern of reaction that years later, from different motivations, determined the form of the psychoneurosis. There are two reasons why this does not seem probable: the precipitating cause for this neurosis was especially a reaction to unemployment; it was characterized by bitterness against society as a whole. The victims felt that because they were war veterans the government was obligated to do something for them. They had proven their ability to compete in and adapt to civilian life for from ten to twelve years. They had worked, married, surmounted the grief of deaths in their families, endured insults from superiors, changes of jobs, marital infidelity, divorce and other dire misfortunes, without succumbing either to tremors or hysterical convulsions. But deprived of the opportunity of earning a living, their savings exhausted, these men became very bitter and relapsed into

neurosis so severe in some instances that some of the 'hystero-epileptic' type died in coma.

8. The change of morale and the transformation of the individual's whole set of values following the trauma cannot be accounted for by overstimulation of the hypothalamus. A Jewish soldier, with a traumatic neurosis, wept and clamored that Hitler had been right. 'Why', he asked, 'did we have to interfere?' Another patient, a veteran, had entered the war with an unshakable conviction about its import. Since the war he had become a fascist. What made him change his convictions? Released from active duty overseas because of a war neurosis, he had been assigned to all kinds of 'soft jobs' in each of which he had made himself useless through his psychoneurotic behavior, culminating in two serious attempts at suicide. After his discharge, he engaged successfully in one of the most exacting professions.

That the war neurosis and related conditions are not better understood may be explained partially by the fact that the exigencies of the times compelled the briefest symptomatic treatment of an overwhelming number of cases, rather than the psychoanalysis of a limited number.[2]

War neurosis is based on a conflict between love for and hatred of one's country. Trauma is one of several factors that mobilize the hatred. Among the patients studied, there was a scornful attitude toward patriotism which was held to be naïve and parochial. Sociologists, too, instead speak of 'loyalty to the primary group' *(7)* which is characterized by intimate personal association and coöperation.

In diaries, letters, questionnaires, and psychiatric interviews, soldiers have agreed 'that the idea to fight for the fatherland is a distant thought', and that loyalty to the companions in

[2] Between 1924 and 1929 the author studied approximately one hundred cases of chronic war neurosis, or relapses into war neurosis, four of whom were psychoanalyzed. From 1930 to 1938 he studied thirty-two cases of traumatic neurosis, and completed the analysis of five of them. Subsequent to 1938 twelve cases of former inmates of concentration camps were analyzed. Of thirty-nine cases of war neurosis treated during and following the second World War, thirteen were psychoanalyzed.

their outfits was their most important motivation *(39)*. The study of deserters revealed that the inability to feel a part of the group was the major cause for desertion. Rose *(38)* sees the main factor of morale in this country as the American habit of mind: 'to get a job done'. Clinically this has proved, in my experience, to be a rationalization. The American Army, too, is held together by love for a leader, in the sense of Freud, only this leader is an abstraction, namely, 'my country' or 'the people of the U. S. A.' Freud, of course, emphasized that the leader does not have to be a real person *(19)*, as, in the example he uses of the Catholic Church, the leader is the figure of Jesus: 'In other group formations, an idea can assume the place of the leader'. In the American Army, officers do not fulfil the role of leaders. Rose *(38)* concluded that the relationship of the soldier to the officers in the American Army lowered the morale of the group: fifty-three percent of the American soldiers in Italy in April 1945 complained about their officers, and felt that 'this is an officers' army'.

Especially since the beginning of the nineteenth century, citizens of civilized countries have felt that they are not so much subjects of a king or a leader as members of a nation. When American prisoners in Japan thought of liberation, they did not pin their hopes on General MacArthur or Admiral Halsey but on the United States *(25)*. When the Marines on Guadalcanal felt forsaken, their accusations were directed not only against the generals but against the country as a whole *(29)*, and if food or weapons were inferior, the people as a whole were held responsible. For their sacrifice and their heroism, the soldiers expected gratitude and rewards, not from General Eisenhower but from the representatives of the people in Congress. Some of the prisoners from Japanese concentration camps who returned to the States kissed not the officers, but the soil of America *(25)*.

In psychoanalyzing veterans it was surprising to discover the extent to which there existed hatred against one's country. This corresponds to the wish for the death of the leader. The attitude toward one's country reflects the relationship one had with one

or both parents. Patients from broken homes or with unloving parents have little love for their country. Even the character of the love for the parents is transferred to the country: some expect to be loved and supported by it; some are willing to give love and to be self-sacrificing; some are boastful, others ashamed of it; some are curious and want to see all of it. Most are ambivalent, some are openly rebellious, others pseudo-obedient. Seldom is the hatred of one's country fully conscious, the duty to love one's country being incorporated in the super-ego.

Shakespeare revealed his deep understanding of human nature in Coriolanus who is the prototype of the neurotic veteran. He fights for his country; then he hates it and fights against it. Persuaded by his mother's entreaties, he fights again for his country and is killed. That the soldier with war neurosis is motivated not by hatred alone finds confirmation in statistics that a group of cases of combat fatigue was awarded as many decorations for valor as the average group *(31)*. Two cases observed first felt impelled to acts of special bravery after the onset of the neurosis.

The onset of psychoneurosis in soldiers during training was often correctly regarded as a measure of their predisposition to psychoneurosis requiring only separation from home and regimentation in a strange environment to precipitate it. In some instances the expectation of registration for the draft alone precipitated a psychoneurosis.

Freud's definition of the trauma as a stimulus that breaks through the stimulus-barrier leaves undetermined of what the stimulus-barrier consists. Probably the most effective stimulus-barrier is knowledge and awareness of the stimulus. Children, for instance, who are given complete and honest explanations of what to expect are better equipped to undergo surgical operations without traumatic effect *(13)*. In instances of psychic trauma the individual has failed to understand the stimulus rationally, and an intellectual and emotional regression takes place which Federn has described as a withdrawal of the libido

from its boundaries. In my experience, the regression goes to the level of animism on which the stimulus is interpreted as a command to do or to refrain from doing something. This command is ascribed to God, to Fate, to Spirits, or to the Enemy. The emotional structure of the personality and previous experiences, especially those of childhood, play a part in this distortion of reality *(37)*.

Ferenczi *(15)* observed that sexual seduction in childhood leads either to overdevelopment of the stimulated partial sexual drive, or to a reaction-formation against it. I analyzed twins who had been seduced in church at the age of five by a man who played with their genitals. One twin, who was submissive, began a period of very active masturbation, especially in church, with no conscious feeling of guilt. The dominant twin reacted with an intense hatred of homosexuals and of religion. The first had interpreted the experience as a command to masturbate; the other rebelled against this command as he had against many others of his parents, including the command not to masturbate.

In the analysis of patients who had been injured in sports, the accident was interpreted by some patients as a command to refrain from the sport, associated with a threat of castration for masturbation. Those who reacted to the accident as a challenge defiantly pursued the sport even more daringly.

In the transference, everything the psychoanalyst does or fails to do is interpreted—and more often than not falsely—by the analysand. It is well known that primitive man interprets every happening as a message from the spirits whom he tries to placate by obedience or bribery. In psychoanalysis of soldiers the traumata of war were sometimes similarly found to be unconsciously felt as commands from the enemy which something within them was ready to obey. In a fist fight between two boys, each knows that his opponent, by inflicting sufficient pain and threatening destruction, is trying to force him to 'give up', admit defeat. The primitive reaction is to throw away one's arms and flee. Modern psychological warfare has made the broadest use of this technique *(30)*. Much propaganda was, in fact, designed to induce hypochondriasis and neurosis. Such enemy propaganda

had begun long before the war: 'Your way of living is effete; it has led to your weakness and confusion. Our strong leadership is invincible; it is the wave of the future. Only the best race has the right to survive.' In ancient times rumors spread by traders had a similar effect on morale *(5)*. Studies with the sampling method of prisoners of war captured by the American armies showed that American psychological warfare had relatively little effect on them *(39)*. This may be ascribed to the shortcomings of their methods. Psychoanalysis showed, however, that American soldiers were deeply influenced by enemy propaganda.

In many families the moral code is hammered into the child's brain by the mother's spanking. In the same way messages of psychological warfare are hammered into the brain of the soldier by bullets and grenades. Rado *(36)* has shown that the hypnotist's suggestions establish in the mind of the medium a foreign body of commands and standards which operates as a 'parasitic superego'. Enemy propaganda, or the soldier's interpretation of what the enemy wants him to do, can become in some instances established as a kind of parasitic superego. This is comparable to the effect of hypnosis induced by fright *(17)*. In hypnosis, too, the medium often does not limit himself to specific commands but adopts certain attitudes to please the hypnotist, and often guesses wrong.

Students are more ready to believe and to accept teaching from those whom they love, but history teaches that conversion is possible by fire and swords too. Most of the Mohammedans accepted their religion by yielding to brute force, as did the Saxons in Germany. The most striking contemporary example is the great number of prisoners in concentration camps who espoused the doctrines of their torturers *(3, 21)*.

To the credulous acceptance of propaganda is added the problem of misinterpretation. Pfister *(35)* studied the stream of thought of people who survived falling from great heights. He found that, in the few seconds of falling, a momentary realistic appraisal was followed by an irrational and regressive flight of fantasy. The soldier's 'interpretation' that the shelling and

bombing of the enemy is to frighten him and to demand that he give up the fight is still rational. That the enemy wants to drive the soldier 'crazy' is a misinterpretation based on individual experiences in childhood. The ultimate threat is of castration, in these cases displaced from the penis to the intellect.

The commonest unconscious fantasies of enemy commands that emerged in analysis were: the command to die, to hate one's country, to make oneself useless for the war effort, to yield to one's anxiety, to adopt the enemy and his ideologies. These repressed ideas were in conflict with the civilian and, even more, the military superego. Many factors weakened the countercathexis to such enemy commands: for instance, disappointment with officers, rejection by the group, injustices attributable to the government, suffering incident to bureaucratic regimentation, narrow escapes from danger and traumata inflicted by the enemy which demonstrated one's helplessness and hurt one's narcissism—these and others gradually enabled the parasitic superego based on identification with the enemy to win power over the soldier. A woman in her early thirties who acquired cancer of the breast had been a very religious Jewess. When she realized that she had cancer, she was dramatically converted to Catholicism. The religious attitudes of soldiers often changed. According to Crespi and Shapleigh *(8)*, of veterans with combat experience, twenty-four percent were less religious than before the war, twelve percent more, and nineteen percent unchanged.

In the defense against his parasitic superego, the individual, according to the structure of his personality, reacts as he did to parental authority, i.e., by obedience, defiance, repression, passive homosexual compliance, neurotic compromise, etc. The course of the chronic traumatic neurosis is determined by vicissitudes in the fight against the command inherent in the trauma. Of the symptoms of traumatic neurosis, only nightmares can be regarded as the direct result of the breaking through of the stimulus-barrier. Nightmares have been observed in concentration and prisoner-of-war camps when other effects of the traumata had been warded off. Freud interpreted the state of uncon-

sciousness as an unconscious feeling of being abandoned and passive surrender. To this may be added his willingness to die in obedience to the enemy's command, which is revived whenever the veteran feels himself abandoned, betrayed, or frustrated by his country or its representatives.

Anxiety is a symptom of demoralization, of yielding to the enemy's commands and, at the same time, an appeal to the mother country and its representatives to take heed of one's suffering and do something about it. Outbreaks of rage are hatred against one's country. The cruelty of the enemy neutralizes the inhibition against one's own sadism. The impulse to return to the scene of battle is a belated defiance of the enemy's command to surrender, plus a feeling of guilt about having given up the fight so soon.

Mutism, deafness, blindness, paralysis, anesthesias, impotence are symptomatic compromises with the command to die. Falling flat as reaction to sudden noises, tics and ceremonials have been identified as a belated and exaggerated obedience *(24, 29)*.

As a brief clinical illustration, Edgar had observed the primal scene repeatedly from the age of two. He had interpreted it as his father's victory in a wrestling match with his mother, and he imitated the father's role in play with other children. When, at the age of five, he tried to mount his mother she forbade him the privilege of getting into her bed, and when she caught him masturbating she threatened to tell his father who would cut off his penis. He reacted by ceasing to adore his mother, and treated her as a servant. He also relinquished his ambition to be a hero, and ceased defending himself in quarrels with other boys; he had the idea of letting them hit him three times, usually without striking back. He wished he had been born an orphan. He hated authority and became an atheist (his parents were religious). He attached himself to his father and later worked for him with occasional outbursts of rebellion about small matters until he went into the army. Sexually he showed a typical split between adoration of the madonna type and sadistic sexual intercourse with prostitutes.

In the army he was an 'idealist' and looked with disdain on those who were afraid. He disliked officers, volunteered for dangerous missions, had several narrow escapes but felt happy. One day, artillery shells exploded among some trucks, and Edgar was among those ordered to retrieve them. He 'refused to be frightened', was making his fourth trip when he was struck in the face, losing several teeth.

When he became conscious in a hospital, a colonel told him that he should thank God because other men of his outfit had had their arms and legs torn off. This frightened him more than it comforted him. Everything seemed strange, including himself. It seemed to him ridiculous that he had been so aloof and indifferent to danger. He reproached himself for having been an idealist, cried without shame, and wanted to commit suicide. He was discharged with the diagnosis anxiety neurosis after psychotherapy failed. Later he sought psychoanalysis because of depression, irritability, nausea and headaches, and a right-sided claw hand.

The traumatic threat of castration at the age of five had changed this man's whole set of values. He re-experienced this threat in the army. 'Idealistically' he had transferred to his country the love he had felt for his mother up to the age of five. As his mother had threatened to deliver him to castration by his father, his country had delivered him to castration by the enemy. So he had changed all his values again, accepting from the new father—the enemy—a parasitic superego with the command to die, to run away, to make himself useless, to be afraid, to hate Jews, Negroes, etc.

He submitted to the command to run away by falsifying a document, doubling up with fear at the remotest sound of shelling, and yielded to the command to die by depression and thoughts of suicide. He made himself useless by a hysterical contracture of his right hand. Formerly a New Dealer in his political outlook, he espoused the Nazi philosophy. From having believed he should love his neighbor, he now wished the war would continue until fourteen million Americans were dead; then there

would be less competition. Especially he hoped that 'Washington would get a few bombs so that the "brass hats" would know what war is like'. In the same way that he had degraded his mother to the position of a servant, he now expected that his country would take care of him.

Analysis soon relieved most of his symptoms, and he enrolled in a course of studies. One of his teachers became his mother substitute from whom he expected love and affection transcending the teacher-student relationship, provoking her criticism, playing the bad boy to get attention. Toward a male teacher, a father substitute, he set himself to oppose whatever he was told.

Suddenly, he had an attack of pseudo angina pectoris. He asked a policeman to get him an ambulance and started to pray. He was again depressed, suicidal, and he stopped his studies. In his dreams a Nazi laughed at him for being an idealist. Typical nightmares of war neurosis recurred. For months he fluctuated between being an American hero and an obedient Nazi. The anxiety was characteristic of resistance stemming from the parasitic superego.

If the neurosis of the veteran is not a reactivation of a previous neurosis, it is based on an ambivalence conflict about his country. There is always the demand that the country give him a living. The prisoner of war has no neurosis because he hates the enemy, not his country, and expects no courtesy from his host. When he is released, he has the same reaction as the returned soldier. The wounded soldier has no neurosis as long as he has no conflict with his country; but when he is expected to return to active service, or when he feels forgotten and neglected, the conflict and the neurosis develop.

It is not necessary in every war neurosis to assume that there is an identification with the enemy. Ambivalence about one's country suffices to explain most neurotic reactions to training and to rejection by officers, and the traumatic neuroses which are resolved shortly after the cessation of combat. Only in the

chronic cases, and especially those exhibiting the specific resistance described, is the assumption of a continued conflict stemming from the introjection of the enemy necessary.

Identification with the aggressor, as described by Anna Freud *(17)*, is a transitory defense. The identification in war neurosis, on the contrary, is deeply implanted in the personality and remains a foreign body and an inexhaustible source of conflict. The strictness of this parasitic superego is analogous to the strictness of a superego based on identification with a sadistic father.

Severe chronic cases, similar to the ones described by Kardiner *(26)*, in my experience interpreted enemy action as castration with a displacement of the penis to the brain—a personal interpretation of the trauma, not an invariable sequel. They had resigned themselves to having lost their perception, judgment and interest in the external world. The unlimited variety of symptomatic combinations corresponds to the variety of personal interpretations of the trauma. During the first World War, the incidence of encephalitis with Parkinsonism was responsible for an epidemic of symptomatic trembling; the interest of many doctors in 'effort syndrome' created it. In the recent war, on Kiska Island in the Aleutians, 'frozen feet' frequently represented a war neurosis *(26)*. Hysteria was prevalent in the first World War; claustrophobia and gastric ulcer in the second. It is clear that the great variety of symptoms could neither be explained by the breaking through of the stimulus nor by the stress of the conflict. Cases in which emergence from initial states of unconsciousness were accompanied by a full-fledged neurosis are rare. In one instance, later analyzed, I learned that the neurosis had been latent, and the trauma the precipitating cause.

In instances of delayed reaction to traumatic stimuli some patients in the interval had retrospective fears enhanced by the suggestions of friends or physicians about what could have happened to them, shaping their symptoms according to these suggestions *(40)*. In the interval following the trauma, the healthy ego summons its reserves to surmount the traumatic stimulus. If the injury can be blamed on somebody else and there is a

promise of reward, as in compensation cases and war neuroses (with the promise of veterans' benefits), these reserves of the ego are apparently not mobilized.[3] The question whether these reserves are mobilized or not does not depend on the severity of the stimulus but rather on the intensity of the ambivalence. A strong superego in the case of war neurosis, a feeling of guilt in the case of sports accidents, and the fear of annihilation in the case of prisoner-of-war and concentration camps, help in the mobilization of ego reserves.

Erben and others, in the first World War, treated war neurosis with painful faradic currents with excellent success. Apparently the ego mobilized its resources to overcome the war neurosis to avoid the painful treatment; but these veterans, upon their return from the war, became the most violent revolutionaries. Panse *(34)* in Germany recommended complete abolition of pensions for chronic war neurotics. He examined them after five years and found almost no instances of psychoneurosis, but in a footnote he reports that twenty-three percent were in jail. This could not be a coincidence: if the hostility is not assuaged by pensions, it finds expression in criminality or revolution.

Judging from reports of patients, electric shock treatment is not so different in its effects from Erben's treatment by painful faradic current. The patients develop so much fear of the treatment that the strength of the ego is mobilized to dispel the symptoms. Independently of their organic and cathartic effects, narcosynthesis and hypnosis neutralize the influence of the enemy by the countersuggestion of the therapist to the soldier that his country still loves him and is more powerful than the enemy (for instance, by making him talk and reveal his secrets).

The traumatic experiences of prisoners of war and of survivors from concentration camps were reacted to in two general ways. 1. Those who obeyed 'the command to die' had only to transgress a little to be killed by their torturers; or they exchanged their minimum food rations for cigarettes. Subse-

[3] *Cf.* Huddleson, James H.: *Accidents, Neuroses and Compensation* (Review). This QUARTERLY, II, 1933, pp. 164–166.

quent patients were those who had defied this command successfully as long as they were in the concentration camp. The aggression aroused in them, even if not expressed, remained at least directed against the enemy. When they came to this country and had nobody to hate, they turned the aggression against themselves and fell into depressions with a tendency toward suicide. 2. Another interpretation of these traumata was the command to be reckless, selfish, cruel and suspicious like the enemy; to throw off all decency, love and confidence in human nature, trust in friends, etc. Coming to this country, they still suspected every action of their benefactors, saw in them enemies, and tried to hate them. When they were convinced that they were not being punished, they behaved like the wayward youths in Aichhorn's *(1)* reformatory; what the cruelty of their torturers had not succeeded in doing was achieved by the kindness of their benefactors, and they developed psychoneuroses. Similar observations have been made by Friedman *(21, 22)* in Israel among children who survived the German concentration camps.

Grinker assumes that the adjustments which many war neurotics have made will fail under the stress of difficult circumstances. I would emphasize again that a specific breaking-point for rehabilitated neurotic veterans will be unemployment during a period of depression. Were the pension boards to deny the connection with military service of these relapses, it would only increase the resentment of the veterans against society, and they would still have to be taken care of by civilian welfare institutions; besides, this group of disheartened and resentful Americans would become fertile soil for any radical political movement.

SUMMARY

Present theoretical approaches to the psychoanalytic understanding of war neurosis are insufficient to explain its various manifestations and related conditions after civilian accidents and in extreme situations. War neuroses and civilian traumatic neuroses are based on the conflict between love and hatred—transferred from the œdipus complex to society (the country)

as a whole. A trauma is a stimulus which is interpreted on a regressive animistic level as a command. In some cases of war neurosis which offer great difficulties in treatment, the traumata have led to the establishment of a parasitic superego which represents the enemy's commands.

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The Psychoanalytic Quarterly

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

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To cite this article: Talcott Parsons (1950) Psychoanalysis and the Social Structure, The Psychoanalytic Quarterly, 19:3, 371-384, DOI: 10.1080/21674086.1950.11925809

To link to this article: https://doi.org/10.1080/21674086.1950.11925809

Published online: 07 Dec 2017.

PSYCHOANALYSIS AND THE SOCIAL STRUCTURE

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THE BASIC COMMON FRAME OF REFERENCE

Both psychoanalytic theory and the type of sociological theory which is in process of developing a new type of analysis of social structure and its dynamics go back to the same basic conceptual scheme or frame of reference which it is convenient to call the theory of action. This theory conceives the behaving individual or actor as operating in a situation which is given independently of his goals and wishes, but, within the limits of that situation and using those potentialities which are subject to his control, actively oriented to the attainment of a system of goals and wishes. Studying the processes of action, the scheme takes the point of view of the meaning of the various elements of the system to the actor. Meaning may be of several different types, of which, perhaps, the most important are the cognitive and the affective or emotional. Finally, the mutual orientation of human beings to each other, both as objects of meaning and as means to each other's goals, is a fundamental aspect of the scheme. Though it is logically possible to treat a single individual in isolation from others, there is every reason to believe that this case is not of important empirical significance. All concrete action is in this sense social, including psychopathological behavior.

There are two main foci of theoretical organization of systems within the broad framework of this conceptual scheme. One is the individual personality as a system, and the other is the social system. The first is, according to this point of view, the primary focus of the subject matter of the science of psychology; the second that of social science in the specific sense. The same

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The substance of this paper was presented at the meeting of the American Psychoanalytic Association, Washington, D. C., May 1948.

fundamental conceptual components are involved in the treatment of both, and on a broader level whatever theories exist in both are part of the same fundamental theoretical system. Nevertheless, it is extremely important to differentiate the various levels and ways in which these conceptual components are involved or combined. It is dangerous to shift from the one level to the other without taking adequate account of the systematic differences that are involved.

THE SOCIAL SYSTEM AS A STRUCTURAL-FUNCTIONAL SYSTEM OF ACTION

It is essential from the point of view of social science to treat the social system as a distinct and independent entity which must be studied and analyzed on its own level, not as a composite resultant of the actions of the component individuals alone. There is no reason to attribute any fundamental logical or ontological priority to either the social system or the personality. In treating the social system as a system, structural categories have proved to be essential in the same sense as in the biological sciences, and presumably also in psychology.[1] In the present state of knowledge of social systems, it is not possible to treat a total social system directly as a dynamic equilibrium of motivational forces. It is necessary to treat motivational problems in the context of their relation to structure, and to raise dynamic problems in terms of the balance of forces operating to maintain or alter a given structure. At this point, however, psychological categories in social science play a fundamental role which is in some respects analogous to biochemistry in biological science. In this context what is meant by social structure is a system of patterned expectations of the behavior of individuals who occupy particular statuses in the social system. Such a system of patterned legitimate expectations is called by sociologists a system of roles. In so far as a cluster of such roles is of strategic significance to the social system, the complex of patterns which

[1] *Cf.* Cannon, Walter B. and Higginson, George: *The Wisdom of the Body*. Second Edition. New York: W. W. Norton & Co., 1939; Freud: *The Ego and the Id*. London: Hogarth Press, 1927; Parsons, Talcott: *Essays in Sociological Theory*. Glencoe, Illinois: The Free Press, 1949, esp. Chaps. I & II.

define expected behavior in them may be referred to as an institution. For example, in so far as the behavior of spouses in their mutual relationships is governed by socially sanctioned legitimate expectations in such a sense that departure from these patterns will call forth reactions of moral disapproval or overt sanctions, we speak of the institution of marriage. Institutional structures in this sense are the fundamental element of the structure of the social system. They constitute relatively stable crystallizations of behavioral forces in such a way that action can be sufficiently regularized so as to be compatible with the functional requirements of a society.

From the psychological point of view, institutionalized roles seem to have two primary functions. The first is the structuring of the reality situation for the action of the individual. They define the expectations of behavior which are generalized in the attitude patterns of other individuals with whom he may come in contact. They tell him what the probable consequences of various alternative forms of action are likely to be. Second, they structure the 'superego content' for the individual. It is fundamentally the patterns institutionalized in role structure which constitute the moral standards which are introjected in the process of socialization and become an important part of the personality structure of the individual himself, whether he conforms to them or not. It may be stated as a fundamental theorem of social science that one measure of the integration of a social system is the coincidence of the patterns which are introjected in the average superego of those occupying the relevant social statuses with the functional needs of the social system which has that particular structure.

THE DISCREPANCY BETWEEN PERSONALITY STRUCTURE AND INSTITUTIONAL MOTIVATION

One of the most important reasons why it is dangerous to infer too directly from the psychological to the social structure level and vice versa is the extremely important fact that there is not a simple correspondence between personality structure and institutional structure. On the level of clinical diagnosis, the

persons occupying the same well-defined status in the social system will be found to cover a wide range of personality types. It is true that seen in sufficiently broad perspective there will be modal types which differ from one society to another, but this is a statistical correspondence and not one of the social pattern to the personality pattern of each individual. This means that there must be mechanisms by which the behavior of individuals is motivated to conform with institutional expectations, even though personality structure as such does not give an adequately effective background for it.

It is convenient to refer to the fundamental mechanism involved here as the 'structural generalization of goals'; thus there is a level of the structuring of motivational forces which is essentially a function of the institutional situations in which people are put, rather than of their particular personality structures. It may be said to operate within the range of flexibility which personality structures permit, and, of course, to involve a greater or less amount of strain to carry out that conformity. This, however, is one area of the analysis of motivation where the relation of psychology to social structure is particularly important. To cite just one example, most attempts at a direct psychological attack on the problem of so-called economic motivation, or the profit motive, have proved to be singularly unfruitful. The essential reason for this is that the uniformities of social behavior do not directly correspond to uniformities on the psychological level independent of the institutional context. Anything like the profit motive of modern Western society is not a psychological universal, and the corresponding behavior would not be found in many, for instance, nonliterate and other societies.[2]

THE PROBLEM OF THE USE OF MOTIVATIONAL CATEGORIES IN DYNAMIC EXPLANATIONS ON THE SOCIOLOGICAL LEVEL

The most notable direct contributions of psychoanalytic theory to the empirical understanding of behavior would seem to fall

[2] *Cf.* Parsons, Talcott: The Motivation of Economic Activities. *Op. cit.*, Chap. IX.

in the dynamic theory of motivation of the individual in the context of the structure of personality. The most important problem of the relation of psychoanalysis to social structure from the point of view of the sociologist is how these categories can be used for explanatory purposes on the level of the analysis of social structure and its changes as such. This is a field in which it is particularly dangerous to attempt too direct an explanation. The lack of correspondence between personality structure and social structure should make this clear.

The sociologist is, in the first instance, concerned with behavior and attitudes which are of strategic significance to the social system. In the terms stated, this means tendencies which either support the structure of an existing social system or tend to alter it in specific ways.[3] The judgments of significance on which the statements of sociological problems of motivation are based must therefore be couched in terms of the frame of reference of the social system, not of personality, though of course they must be compatible with established knowledge of personality.

Such problems must in turn be approached in terms of constructs of typical motivation, typical of the persons occupying given statuses in the social structure. The most obvious of the ingredients of such constructs will of course be derived from the situation in which a given incumbent of such a status is placed—a situation principally compounded of the behavior and attitudes of others. But psychoanalytic theory shows that these alone are not sufficient; certain typical elements of structure of the particular personality, such as superego content and ways in which the instinctual components are organized, are also involved. It is furthermore often necessary to link these elements in a developmental sequence so that the motivational structures resulting from an earlier situation in the life cycle become elements in shaping the situations of a later stage.

There is involved throughout this procedure a peculiar process of abstraction from the frame of reference of personality

[3] This excludes behavior which varies at random, relative to structural patterns, from being treated as sociologically significant.

as a functioning system. Psychologists and psychoanalysts tend to take this frame of reference for granted and thus find it difficult to accept the sociologist's mode of abstraction. They feel it is psychologically inadequate, as indeed it is. But adequacy is not an absolute; it is relative to the problems which facts and conceptual schemes can help to solve. The typical problems of the psychologist and the sociologist are different and therefore they need to use the same concepts at different levels of abstraction and in different combinations.

In general it may be said that psychological analysis is oriented to the explanation of the concrete acts, attitudes, or ideas of individuals. Both motivational elements and the social structure come into this, the latter as describing the situation in which the individual must act or to which he has been exposed. Adequacy is judged in terms of the completeness of accounting for one given act, attitude, or idea as compared to another. The frame of reference is, as has been said, the personality of the relevant individual treated as a system.

The sociologist's problems are different. They concern the balance of motivational forces involved in the maintenance of, and alteration in, the structure of a social system. This balance is a peculiar sort of resultant of very complex interaction processes. It can only be successfully analyzed by abstracting from the idiosyncratic variability of individual behaviors and motivations in terms of strategic relevance to the social system. Conversely the psychologist abstracts from what are to him the equally idiosyncratic variations of social situations in reaching psychological generalizations about such matters as the relations of love and security.

If we had a completely adequate dynamic theory of human motivation it is probable that this difference of levels of abstraction would disappear. Then the use of structural categories, on the levels of either personality or the social system, would be unnecessary, for such categories are only empirical generalizations introduced to fill the gaps left by the inadequacy of our dynamic knowledge. In the meantime, however, we must put up with the complications involved in the diversity of levels.

It follows from these considerations, if they are accepted, that the motivational constructs needed for the solution of any sociological problem will generally turn out to be inadequate to explain the action of any particular individual involved in the very concrete events being studied. They will be concerned with certain elements in this motivation, but the combinations of these elements with others, and hence what will be the order of their strategic significance to the psychological problem, cannot be inferred from the sociological analysis.

Conversely, psychologists, whether they are aware of it or not, categorize the social structure. But by the same token, the conceptualizations they find adequate for their purposes will generally turn out to be inadequate to the explanation of a single process of change in a social structure in which the same concrete persons and action-sequences were involved.

It is, in my opinion, neglect of the indispensability of distinguishing these levels of abstraction which, more than errors or differences of opinion about facts, has accounted for the difficulties. These dfficulties, from the sociologist's point of view, have been prominent in much of what may be called psychologically (psychoanalytically) oriented sociology which attempts to generalize about societies from Totem and Taboo to Geoffrey Gorer's American People. In the absence of very careful discrimination of these levels it was almost inevitable that the analyst would 'extrapolate' directly from what he found in the personalities he had studied in the clinical situation. He would then necessarily categorize social structures *ad hoc* in the light of these references without systematic reference to the social system as a conceptual scheme and the criteria of relevance inherent in such a reference.[4] Certain sociologists likewise indulge in *ad hoc* psychological constructions without reference to technical psychological considerations.[5]

[4] In extreme instances, the history of social change has tended to be interpreted as the simple consequence of the collective 'acting out' of the emotional tensions observed in personalities.

[5] In essence this is what Max Weber did on a high level in his construction of ideal types of motivation. *Cf.* Parsons, Talcott: Introduction to: *The Theory of Social and Economic Organization* (Sec. 2) by Max Weber. New York: Oxford University Press, 1947.

AN EXAMPLE OF THE USE OF MOTIVATIONAL CATEGORIES FOR SOCIOLOGICAL PURPOSES: AMERICAN YOUTH

To give concrete content to the abstract analysis presented above, a brief account of one example of what may be considered the most fruitful level of use of psychoanalytic categories in sociological interpretation is given. The essential facts are matters of common observation.

Starting at about high school age young Americans, especially in the urban middle classes, embark on patterns of behavior and attitudes which do not constitute a stage in a continuous transition from childhood to adulthood but deviate from such a line of continuity. Instead of gradually assuming increasing responsibilities there is a tendency to such irresponsible acts as reckless driving. A major aspect of increasing maturity would seem to be progressively greater freedom from needs to conform with rigidly detailed patterns of the group. On the contrary, there is in youth a rather extreme pressure to conformity in details of dress and behavior. Finally, maturity seems to involve increasing capacity for realistic orientation to emotionally significant objects, but in youth there is a resurgence of romanticism—a resurgence of unrealistic idealization not only in relation to age-peers of the opposite sex, but also in the form of hero worship; moreover, such figures as athletic stars whose functions are of quite secondary importance in the adult world tend to be idealized far more than eminent statesmen, executives or scientists.

This pattern of attitudes and behavior is sufficiently general and pronounced to be singled out as a distinctively structured complex conveniently called the youth culture. Its principal characteristics may be summarized.

1. Compulsive independence of and antagonism to adult expectations and authority. This involves recalcitrance to adult standards of responsibility and, in extreme instances, treating the conformist—who, for instance, takes school work seriously—as a 'sissy' who should be excluded from peer-group participation.

2. Compulsive conformity within the peer group of age mates. It is intolerable to be 'different'; not, for example, to use lipstick as soon as the other girls do. Related to this is an intense fear of being excluded, a corresponding competitiveness for acceptance by the 'right' groups, and a ruthless rejection of those who 'don't make the grade'.

3. Romanticism: an unrealistic idealization of emotionally significant objects. There is a general tendency to see the world in sharply black and white terms; identifications with one's gang, or team, or school tend to be very intense and involve highly immature disparagements of other groups.

There is thus a well-defined sociological problem. In the socialization of the younger generation in the American social system, there is a specifically structured deviation (a mass phenomenon) from the path of asymptotic approach to 'maturity'. What is this all about? Comparative evidence adequately disposes of the popular view that it is a consequence of physiological maturation because there is no reason to believe that Samoans or Chinese 'adolesce' differently from Americans in a physiological sense.[6] It is therefore plausible to suggest that the American social structure through its impact on the human material may provide a field of interpretation.

The essential structural facts are very simple but must be considered at two age levels. American middle class children, unlike many others, are reared in small conjugal families normally separated in place of residence and other respects from other close kin. There is a very small circle of emotionally significant persons on whom the child's object cathexes must be focused: father, mother, and one, two or three siblings. Of these the mother occupies a particularly central place for both sexes because no other women have a remotely similar role, and because the father works away from home and is thus absent a great deal of the time; moreover, there is a very sharp distinction between relations inside the home and those outside. In

[6] *Cf.* Mead, Margaret: *Coming of Age in Samoa.* New York: William Morrow & Co., 1928, and Levy, M. J., Jr.: *The Family Revolution in Modern China.* Cambridge: Harvard University Press, 1949.

the neighborhood play group and later in school, the child must 'find its own level' in competition with others with whose parents his parents have no clearly ordered status relationship, who are just neighbors.

Approaching adulthood the American youth faces a situation very different from the youth of many other societies. Both sexes look forward to the 'independence' of leaving the parental home and setting up a home of their own. The choice of a partner in marriage is their personal responsibility, without major parental participation in the decision. Boys must make their own way, achieving status and income in a competitive occupational system. Most girls can look forward to support by a husband, but they must choose the husband on their own responsibility, and their own status and welfare and that of their children depends most crucially on the wisdom of the choice.

What is the impact of these two successive situations on the human material exposed to them, taking due account of differentiation according to sex? Insights into motivation which stem from psychoanalysis more than any other source provide the principal clues.

In the first place, the sharp limitation of the circle of objects of cathexis tends to intensify emotional involvements. This is particularly true of the common significance of the relation to the mother since she is unique and the father tends to be remote. This intensity is reinforced by early exposure to a competitive process outside the family in which it seems reasonable to assume that the insecurity generated tends to be compensated by greater dependence on familial cathexes. Thus more than other family systems the American makes the child highly dependent emotionally on its parents, particularly the mother.

The child is then placed in a situation, as it approaches adulthood, where it must, if it is to live adequately up to expectations, break away from these ties far more drastically than is necessary in most societies. If a male, he must choose his own occupation and make his own way in it. He must make the complicated emotional adjustment to a sexual partner and spouse on his own initiative and responsibility. A girl must 'catch' an acceptable

man by exercise of her own feminine attraction in sharp competition with other girls and without adult support.

For boys the situation is greatly complicated by the tendency to feminine identification inherent in the especially intense relation to the mother and the remoteness of the father. This seems to account for a reaction-formation of 'compulsive masculinity' which appears in the latency period and is carried, in a socially structured way, over into adolescence and beyond. With it goes a deep ambivalence toward moral values (since these tend to be felt as feminine) and toward the acceptability of sexuality. For girls there seems to be greater stability in childhood through identification with the mother which probably accounts for much of their precocity. When, however, they face the 'man-catching' situation, to be too much of a motherly figure is, in the face of masculine ambivalence, by no means an unambiguous asset. The conflict between 'glamor' and the domestic pattern seems to have its roots in this situation.

Thus the compulsive independence of the youth culture may, according to well-established psychological principles, be interpreted as involving a reaction-formation against dependency needs, which is for understandable reasons particularly prominent among boys. The compulsive conformity, in turn, would seem to serve as an outlet for these dependency needs, but displaced from parental figures onto the peer group so that it does not interfere with the independence. The element of romanticism finally seems to express the ambivalence and insecurity which are inherent in the emotional patterning of both sexes when faced with highly crucial decisions. It is a tonic stimulus to confidence and action in the face of potentially paralyzing conflicts.

The above is a highly schematic and simplified interpretation of the psychological dynamics of American youth culture. Any experienced analyst can add many more nuances of motivation, as a sociologist would on the details of the social structure. The analysis is carried only far enough to illustrate concretely an application of psychoanalytic concepts to sociological usage. This is not 'psychoanalytic sociology' in the sense of generalizing

from clinical insights in terms of their 'implications' for society. It involves the use of technical sociological theory in the statement of problems and the analysis of social structure; nevertheless, the contributions of psychoanalysis are crucial. Without them a far cruder level of dynamic interpretation would have to be accepted. By further refinement of both components of the scheme, far more refined and subtle interpretations are likely to be attainable.

CONCLUSION

Psychoanalytic theory can make a crucially important contribution to the problems of the sociologist, though not, of course, to the exclusion of other traditions of psychological theory. This contribution is, however, likely to be much more fruitful if it is made in the form of the adaptation of psychoanalytic concepts and analyses of motivation to the technical needs of sociological theory in terms of problems stated in sociological terms.

This way of using psychoanalytic theory, it has been pointed out, involves putting it into a frame of reference, the social system, which is not usually familiar to the clinical analyst and which is not reducible to terms of his own clinical experience and standards of expectation, couched as these are, implicitly or explicitly, in terms of the frame of reference of personality. To make the transition requires such a shift in perspective and problems that it must be held that the analyst, no matter how well trained, is not per se competent to apply psychoanalytic theory to sociological problems. To do this he must be a trained sociologist, he must learn to think in terms of social systems, and he does not automatically learn this from clinical experience as an analyst but only from studying sociology as such.

But if the sociologist is to utilize the potential contributions of psychoanalysis to his problems, he can only do so competently by going to the authentic sources, by learning psychoanalysis himself, as far as possible by the regular training procedures. To some important degree the same people must have real competence in both fields. Only from such a solid base is the

diffusion of psychoanalytic knowledge into such a neighboring field possible without distortion.

If the general position here taken is sound, there is a further implication which may be briefly noted in conclusion. If psychoanalytic theory is as important to sociology as it certainly seems to be, the converse relationship should also be important. This is indeed strongly indicated by the fact that analytic theory has laid so much emphasis on the psychological importance of social relationships—of the child to parents, of the adult to love objects, etc.

Concretely, these relationships are aspects of social systems; the family, for example, is a small-scale social system. The sociological aspects of the family as a social system have, understandably, not been explicitly considered by psychoanalysts because they have concentrated on the particular relations of each patient to each of the members of his family in turn. There has been little occasion to consider the total family as a social system, though this might well yield insights not derivable from the 'atomistic' treatment of each relationship in turn.

Unfortunately the sociologists as yet have not provided as much help as they might. The science is in general very immature (but then, psychoanalysis is not yet very old) and the principal preoccupation of sociologists has so far been with 'macroscopic' social systems. But the evidence is strong that the same fundamental conceptual scheme, the social system, is applicable all the way from the largest-scale societies (like the United States) to groups of such small size as the family.[7] But the sociological study of small groups is in its barest beginnings and, paradoxically, only suggestions of the technical analysis of the family as a social system exist.

But in relation to the family the problem for the psychoanalyst is the obverse of that outlined above for the sociologist. Supposing that in the near future we attain something which could respectably be called a sociology of the family; this would

[7] This is also true of the classical mechanics, e.g., celestial mechanics, terrestrial mechanics, and the kinetic theory of gases.

no more as such solve the analyst's problems about family structure than a psychoanalytic theory of personality solves the sociologist's problems of motivation. But such a theory would contain the essential conceptual bases on which the analyst could construct a theory of family structure adapted to his needs.

The sociologist must face the problems of human motivation whether he wants to or not. If he does not acquire a genuinely competent theory, he will implicitly adopt a series of *ad hoc* ideas which are no less crucial because they are exempted from critical analysis. Turning to psychoanalysis with the proper adaptations can provide him with a way out of the dilemma. Perhaps the situation is not altogether incomparable in reverse. The analyst is in fact dealing with social systems. His ideas about them have tended to be *ad hoc* and common sense. Such ideas may be adequate for many empirical purposes but tend to break down as subtler levels of generalization are attempted. There is the possibility that this gap can be filled by the products of genuinely technical analysis. Originating as they do in another frame of reference, to be useful to the analyst these would have to be adapted to his problems and needs. But can he in the long run do without them any more than the sociologist can do without the insights of psychoanalysis?

The Psychoanalytic Quarterly

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

The Application of Psychoanalytic Concepts to Social Science

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To cite this article: Heinz Hartmann (1950) The Application of Psychoanalytic Concepts to Social Science, The Psychoanalytic Quarterly, 19:3, 385-392, DOI: 10.1080/21674086.1950.11925810

To link to this article: https://doi.org/10.1080/21674086.1950.11925810

Published online: 07 Dec 2017.

THE APPLICATION OF PSYCHOANALYTIC CONCEPTS TO SOCIAL SCIENCE

BY HEINZ HARTMANN, M.D. (NEW YORK)

Many theories and findings of sociology appear ambiguous if viewed from the angle of psychoanalytic interpretation, and similarly some aspects of psychoanalytic findings and theories, important as they may be in the study of the individual, seem irrelevant to the sociologist. For mutual understanding it would be desirable to create a common conceptual language, or to define sociological problems in terms of their psychological meaning and, as Parsons [1] has stated, formulate psychological problems in direct relation to the social structure.

Certainly when what appears to be the same 'subject' is approached by both sciences, the relevant factors may not be the same, the centers of fruitful interest do not necessarily coincide. The psychoanalyst, for his purposes, may put certain features that interest sociologists into parentheses; sociologists in some fields of social studies may make valid predictions with no consideration of the total personalities of individuals. Such predictions will most likely be correct where social action is predominantly determined by the conscious or preconscious ego,[2] as in rational action, or in action involving such ego interests as we plausibly may assume are present in the average member of a group. An obvious example is economic theory.

But there are other social actions and functions where one cannot rely on such simple psychological models if one wishes to make valid predictions. These models will prove a source of failure for the sociologist in matters where functions of the per-

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Read at the panel on The Study of Social Issues, American Psychoanalytic Association, Washington, D. C., May 1948.

[1] Parsons, Talcott: *Psychoanalysis and the Social Structure.* This QUARTERLY, XIX, 1950, pp. 371–384.

[2] Waelder, Robert: *Bedeutung des Werkes Sigmund Freuds für die Sozial-und Rechtwissenschaften.* Revue internationale de la théorie du droit, X, 1936.

sonality other than rational or ego interests come into play in a way which is dynamically relevant and likely to differ from individual to individual. However, when we apply this rather general formulation to concrete sociological problems, we should obviously feel on safer ground if we could take into account the psychological meaning of the sociological data in a systematic way. We should, for instance, wish to know the significance of the sociological data not only for the egos of the persons in question, but for all three of the psychic systems of the personality: ego, superego, and id. And it would be most helpful if also the sociological meaning of the psychological data were known. Such systematic knowledge would assist us in determining the direction and degree and the specific problems in which those abstractions from the 'total motivation of the concrete personality' have to be made, or are likely to be fruitful, whose importance for analysis on the level of psychic structure has been stressed by Parsons.

A mutual reinterpretation of analytic data by sociology, and sociological data by psychoanalysis, presupposes some previous agreement between the two on a definite theory of social action that would make correlation possible. At the beginning of his clear and comprehensive outline, Parsons states that both sociological and analytic theory have a common ground in the frame of reference presented by the theory of social action; yet there is a disproportion or lack of symmetry: social action may be the most basic concept of sociology but it is not the most basic in psychoanalysis, nor is action in general. In psychoanalysis, structurally and genetically, action is derived from more fundamental human properties. No completely systematic analytic theory of action has been achieved or presented up to now, although analytic contributions to the theory of action are important enough to suggest that the sociological theory of action will need and include many aspects of analytic theory, even beyond those that Parsons has recognized as common to both fields. Though often in science it proves useful to handle different problems on different levels of conceptualization, to reduce problems to their most general level is not

necessarily the optimal approach; nevertheless, if we are to have a general theory of action, there is no alternative to basing it on the most fundamental psychological concepts.

Action, in analysis, is primarily defined by its position in the structure of the personality and the contributions made to its various aspects by the psychic systems. But action is also viewed genetically, and described in relation to the energy factor involved, its motivation, the motor (or other) means of attaining its goal, and with respect to reality. To refer to this vast field of research, without pretending to systematic presentation, what analysis has discovered about the various types of action—its structural, dynamic and reality aspects, overdetermination, and conflicts in the structure of goals—will enrich theories of action used by social scientists, who until now have oversimplified the motivations of action and their relation to other aspects of behavior.[3] Actions in various forms (rational and irrational, utilitarian, moral, reality-syntonic and reality-dystonic) can all be studied by analysis in their interrelations and assigned their proper places in the structure of the personality. And the question of the mutual relevance of psychological and sociological data can be solved only by the use of a pluridimensional theory and structural concepts.

A point worth emphasizing is that most of what we know in analysis about action has been gained from a study of social action. Analysis studies human conduct in relation to an environment. In contrast to some other schools of psychology, psychoanalysis includes within its scope of interest the structure of reality. Since human beings are by far the most important of real objects, the structure of reality most interesting to analysts is the structure of society. Society is not a projection of unconscious fantasies, though it offers many possibilities for such projection and their study reveals to us the influence of unconscious factors on men's attitudes to society. We must accept social reality as a factor in its own right; certainly most analysts

[3] *Cf.* Hartmann, Heinz: On Rational and Irrational Action. In: *Psychoanalysis and the Social Sciences.* Edited by Géza Róheim. New York: International Universities Press, 1947.

do not attempt to interpret human behavior exclusively in terms of unconscious drives and fantasies. This 'reality aspect' is an intricate topic and has manifold connotations; we are quite aware that the same institution can be used to canalize a great variety of tendencies.

From these considerations, it appears that the intimate analytic study of an individual's interaction with his social environment can be included among the methods of sociology. Analysis has taught us as much about the various family structures as it has about biological human needs. Analysts' attention has been perforce directed to the object relationships of childhood, for these are infinitely more important to the development of personality than those of later life; the general and legitimate prevalence of the genetic point of view among analysts has reinforced this attitude. This is a second point, besides the general theory of action, where psychoanalytic data and hypotheses are indispensable to sociology but in which there has been a divergence of interest between the two fields. This statement in no way denies, indeed is far from denying, that our patients' current social environment constantly enters the analytic picture. It simply explains why this aspect has been less energetically studied, and why our knowledge about the current milieu appears less clearly in our largely genetic psychological concepts. I agree with Parsons as to the possibility of being more explicit in this regard in our description of analytic work. If a concerted attempt in this direction were systematically made it would probably yield to us a more complete insight into the psychological meaning of specific social structures than could be obtained through any other method.

The term 'meaning', used here rather vaguely, refers to the fact that a given social structure selects and makes effective specific psychological tendencies and their expression, and certain developmental trends. This relation might, by analogy to Freud's term 'somatic compliance', be called 'social compliance'; or rather, this relation is one part of something that might receive such designation—one side of social compliance. The other part refers to the relation between an individual's psychological characteristics and the potentiality of social function,

status, etc., with which a concrete social structure provides him.[4]

To heed Parsons' warning, we repeat that between personality type and institutional structure there is no simple correspondence. I refer to his statement concerning the 'structural generalization of goals'. The structuralization of motive forces as a 'function of the institutional situations . . . rather than of . . . particular personality structure' is familiar to analysts, though they use different words. To approach this problem at the level of the individual, we must go beyond what we are accustomed to call 'personality types'. In analysis we have found that most psychological typologies, especially the merely descriptive ones not based on genetic principles, though perhaps useful for certain purposes, do not account fully for the manifold dynamic interrelationships of an individual's characteristics. Thus they often fail us when we try to determine whether such characteristics are modifiable or capable of being superseded or replaced by others in keeping with internal or external situations; and just such points are the ones most relevant to the issue under discussion.

Modifiability, replaceability, and similar qualities explain why the external behavior and part of the motivation of an individual (who belongs to one or the other personality types according to one of the usual typologies) will more frequently be equal in regard to a given institutional structure than we might expect on the basis of such a typological diagnosis only—granted that the relation to reality is unimpaired. These qualities tell us more of such possible behavior and motivation than could be learned from a purely typological diagnosis. Obviously the variation in such qualities also depends on the institutional structure with which the individual is confronted. Nor does this run counter to the previous remarks concerning social compliance; the factors just mentioned must be given equal consideration. The main point is that a study of the individual's plasticity in relation to concrete reality, its degree and its conditions, must be included in the psychological

[4] *Cf.* Hartmann, Heinz: Psychoanalysis and Sociology. In: *Psychoanalysis Today*. Edited by Sandor Lorand. New York: International Universities Press, 1944.

approach. Psychoanalytic typologies, precisely because they are less descriptive and more genetic than others, take this element into consideration and define expectations of behavior in regard to internal and external situations. In clinical work, too, the analyst is constantly aware of this problem, with all its implications as to reality-syntonic behavior in its structural and genetic aspects and also as to the possible participation of superego functions.

Thus far, I have referred only to such contributions to sociology as may be gathered from the analyst's couch. What the analyst garners from the analytic situation in regard to conscious and unconscious motivation, psychological mechanisms, and attitudes to social reality, he may try, as many analysts have tried, to apply elsewhere in dealing with social phenomena. This 'application' of analysis, as it was once called, to the interpretation of myths or other anthropological data, for example, at first served to demonstrate the presence of certain contents of the id, discovered in analysis proper, in many different ages and forms of civilization. To this same sphere was extended our gradually growing knowledge of the ego's mechanisms of defense. Reconstructions of the past of mankind dealt with prehistoric rather than with historic times (Freud: Totem and Taboo, and others). It is not necessary to trace the development of this branch of psychoanalysis; it suffices to say that in his second decisive contribution to this field, the description and explanation of group psychology in terms of structural psychology, Freud again chose for his subject a type of behavior not limited to a definite historical epoch or social organization.[5]

From this we may see that to deal with specific social structures in specific historical situations our approach cannot only be through an understanding of the unconscious contents and mechanisms; it must be supplemented by a study of their interrelation with the reality aspects of behavior and with the institutional setup. An interpretation, for instance, of group formation in a totalitarian society of our day would not be limited

[5] Freud: *Group Psychology and the Analysis of the Ego.* London: Hogarth Press, 1940.

to the categories used by Freud. This is not to imply that an analytic approach to such fields is doomed to failure, but the approach must be modified in the direction of that mutual interpretation of psychological and sociological problems previously discussed.

Parsons has sounded a warning also against attempting too 'direct' an explanation of sociological phenomena by the use of psychological categories, and I partly agree. Undoubtedly the work in many of these fields needs a sounder methodological foundation. In approaching problems outside clinical psychoanalysis, many appear to forget what an analyst would hardly forget in his clinical work: we cannot understand human beings independently of the reality in which they live. Institutions that characterize a social system have often been interpreted solely as the direct expressions of the unconscious and conscious desires of people living in that system, as if reality were no more than a wish fulfilment. This approach avoids the problem raised by my statement that social structures are, in the first place, imposed upon the growing individual as an external reality. It overlooks the interesting role that tradition plays in the actual setup, and the different contributions that different social strata make toward the formation of institutions. It sometimes neglects entirely the variability of individual attitudes toward them, the ways in which individuals are affected by institutions, and the ways in which they manage—or do not manage—to conform. The avoidance of these issues is not a simple, wise, and operationally legitimate limitation to what is often called 'the psychological side' of the problem. It leads inevitably to a misinterpretation of this 'psychological side'.

Another difficulty is exemplified, for example, in much of the voluminous anthropological literature currently devoted to the investigation of 'national character'. In tackling the infinitely complex phenomena of Western civilizations, into which we have incomparably more detailed extra-anthropological insight than into any primitive culture, the application of the usual methods of anthropology often resembles somewhat a wilful turning of a scientific economy of plenty into one of

scarcity. From our point of view, the data actually used remain ambiguous so long as they cannot be analyzed with regard to motivational structure, dynamics, orientation to reality, to social reality itself, and to their history. Obviously a concept of 'national character', as of character in general, should include much more than statements concerning actual behavior; it should, we have a right to expect, tell us about the potentialities of behavior in relevant intrapsychic and outer situations. As previously stated, descriptive typologies do not sufficiently reveal such potentialities, for which we should need such dynamic and genetic typologies as are employed in analysis. Though not genetic in our sense, the studies of 'national character' that are based on the investigation of typical childhood situations and emphasize such matters as differences in child rearing represent considerable progress. While not covering all aspects of the problem, Kardiner's concept of basic personality types appears to be useful in some respects.[6]

Psychoanalysis can be helpful in the study of 'national character' mainly by indicating fruitful points of approach, eliminating certain shortcomings, and insisting on a more complex view. Potentially, it could make an even more incisive contribution by using its own method in its original setup, at least in cultures where analysts and analysands are available. A comparative study based on analyses of representatives of different cultures has never been made in a systematic way, but it seems eminently possible. The method of analysis is well suited to deal with the intricate aspects of the problem.

To 'apply' psychoanalytic findings and theories to sociological phenomena is not sufficient. We must, rather, aim at a mutual penetration of sociological and analytic theory, the posing of new questions, and the discovery of new ways of checking against the data in both fields. This will mean that one must set up patterns which are as specific as possible at the same time as to their psychological and sociological aspects.[7]

[6] Kardiner, Abram: *The Psychological Frontiers of Society.* New York: Columbia University Press, 1945.

[7] Hartmann, Heinz: Psychoanalysis and Sociology. *Op. cit.*

The Psychoanalytic Quarterly

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

Unsatisfactory Results of Psychoanalytic Therapy

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To cite this article: C. P. Oberndorf (1950) Unsatisfactory Results of Psychoanalytic Therapy, The Psychoanalytic Quarterly, 19:3, 393-407, DOI: 10.1080/21674086.1950.11925811

To link to this article: https://doi.org/10.1080/21674086.1950.11925811

UNSATISFACTORY RESULTS OF PSYCHOANALYTIC THERAPY

BY C. P. OBERNDORF (NEW YORK)

A review of the diversified psychotherapies which have been devised to bring about a change in the patient's psychological attitude to enable him to convert pathological symptoms into a healthy state establishes that psychoanalysis most nearly approximates a scientific approach. The theory of its therapeutic operation is well established. The technique by which the theoretical principles can be applied to achieve beneficial results is being taught in numerous psychoanalytic institutes—notably in the United States.

The application of psychoanalytic ideology to social problems and the practice of psychoanalytic therapy have gained a wider recognition in this country than elsewhere. This is due, I believe, largely to the fact that from the time of its introduction in America more than forty years ago psychoanalysis has been advanced as a medical discipline, and its active proponents attempted to coöperate closely with the other medical specialties—and especially with psychiatry of which it is essentially a part and to which it has contributed so abundantly. The great increase in the demand for psychoanalytic therapy has attracted a proportionately larger number of physicians to the field, some of whom possibly have less intrinsic interest in and characterological adaptability for this specialty than those who chose it thirty to forty years ago when it was less popular.

The members of the Psychoanalytic Association are physicians who offer their services to relieve persons afflicted with bodily and psychical dysfunctions resulting from mental conflict, conscious as well as unconscious. For their therapeutic ministrations they are remunerated—sometimes in a not too niggardly way, it is rumored. However, a review of two outstanding

Read at the meeting of the American Psychoanalytic Association, New York, December 1948.

psychoanalytic journals over the past ten years (The International Journal of Psychoanalysis and The Psychoanalytic Quarterly) reveals that practically no articles have been devoted to the results of psychoanalytic treatment, and very few deal with therapy directly. One of the most recent books on technique also fails to mention results, except in fragmentary cases, and the question of unsatisfactory results is not considered.

The term psychoanalysis, of course, is limited to the psychological theory of unconscious motivation of mental processes and a form of therapy, both of which were discovered and developed by Freud. Although Freud modified and extended his theory in many ways during his scientific productivity which lasted over fifty years, it is only fair to restrict the term psychoanalysis to Freud's general conceptions. Here we may give Freud's own definition quoted by Ernest Jones *(4)*, after more than forty years of leadership in psychoanalytic therapy as well as in contributions to collateral applications of psychoanalysis: ' . . . we cannot do better than follow Freud's own definition. Psychoanalysis is simply the study of mental processes of which we are unaware, of what for the sake of brevity we call the unconscious . . . by the free association technique of analyzing the observable phenomena of transference and resistance.' I might add also those subtle, unobservable and indefinable phenomena which occur in the relationship between physician and patient.

Possibly some psychoanalysts may be unwilling today to assent to this liberal definition of psychoanalysis. However, I think that most analysts would agree that psychoanalysis demands the patient be seen at least three to five times a week in sessions lasting approximately an hour each. As late as 1922, when Freud was analyzing nine students, he regarded it as an exceptional and regrettable concession to the ideal method that he could give them each only five instead of six hours of analysis a week. Most psychoanalysts also agree that at least two hundred hours and often more are necessary to attain a perceptible change and permanent alteration in the personality structures of those patients whom they accept for treatment.

The criteria of satisfactory or unsatisfactory results are often

indefinite in many forms of medical and surgical therapy, as the arrest of the process in tuberculosis, a disease to which many authorities are unwilling to apply the term 'cured'. The same criterion obtains in estimating the results in such surgical conditions as cholecystectomy where the healing of the wound is often followed by distressing disturbances.

Psychoanalysis differs from other forms of psychotherapy in that it attempts a reconstruction of the personality rather than the limited goal of symptomatic relief. The therapeutic results with this method, however, have never been entirely satisfactory in many apparently appropriate cases, and this is the topic of papers by Ferenczi *(1)*, Freud *(3)*, and others *(5, 7)*.

The efficacy of the treatment of mental conditions is more difficult to estimate because we are confronted with a great number of imponderables both in the patient and in changing external conditions which may profoundly affect the outcome. In psychoanalytic treatment the general aim is to relieve the patient of the distressing symptom or symptoms of which he complains through a radical change in the structure of his personality. This would reflect an understanding of the unconscious factors originally responsible for symptom formation and an adaptation to normal psychic and physical heterosexuality which is rarely present.

While the attainment of all of these objectives might be partially satisfactory to both the patient and the physician, at times the opinions of each as to the degree to which they have been achieved vary greatly. Likewise the results may be entirely unacceptable to relatives and associates close to the patient. Results in which all concerned (the patient, his environment, and the physician) are content with the outcome are frequent. On the other hand, there are many instances when none of these participants in an analysis is satisfied, and these are the cases with which this presentation deals.

From 1910 to 1925 many of the leaders in psychoanalysis believed that the deeper into the unconscious and the further into the past one penetrated the better the therapeutic results. The British school of psychoanalysis with its emphasis on infan-

tile aggressions and introjections is representative of the theory that the recovery of the very earliest infantile impressions and activities is desirable if not therapeutically essential.

It is my impression that the proportion of unsatisfactory results may have increased with the extension of the psychoanalytic method to include cases with marked schizoid personalities or schizophrenia, as well as those with extremely weak or uncertain superegos ('psychopathic personalities'), and with the use of the method by physicians whose natural talents are unsure or training is incomplete.

Excluding errors in diagnosis, and cases where unrecognized physical disease existed in conjunction with psychogenic illness or some intercurrent physical disease interrupted treatment, instances where the psychoanalytic method has yielded unsatisfactory results fall roughly under the following headings.

1. Cases in which the symptoms and the patient's intelligence and personality justify the application of more or less classical psychoanalysis. The unsatisfactory results may here be due
   (a) to difficulties in the technical application of the method due to disturbances in the contact between the analyst and the patient. These in turn may be influenced by the social attitudes and philosophy of the analyst as well as the general technical approach on the part of the analyst in regard to passivity, activity, flexibility and counseling;
   (b) to untoward and impedimental external conditions.
2. Cases whose apparently mild symptomatic front masks more serious and intractible psychiatric conditions for which the psychoanalytic method was not originally intended but is now frequently used.

In the first category, in which the physician would be entitled to expect satisfactory psychoanalytic treatment, failure offers a challenging field for investigation. In many of these the neurosis may be almost monosymptomatic—such as a compulsive need to touch or a fear of insanity; nevertheless, after two to three or more years of analysis the patient may still retain his

presenting symptom. Psychoanalytic treatment of the more complicated schizoid, paranoid depressive, or extremely narcissistic personalities may have continued three to five or even more years by the same or successive analysts. The unsatisfactory results in this group are discouraging and arouse doubts in the mind of the analyst as to whether the inadequacy lies in limitations of the method or in his own skill in applying it.

These cases particularly suggest research to determine more accurately the efficacy and scope of psychoanalytic therapy; also to judge earlier the type of personality likely to respond favorably, the suitability of the analyst to the patient, and to assess promptly the patient's difficulties. The latter fall into the realm of transference, empathy, their derivatives and corollaries, which are of paramount importance. This is always true whether the therapy aims to make the deeply repressed unconscious conscious, adapt the individual to cold, cruel reality, integrate the id with the ego and the superego, or also, I presume, in the procedure seeking the goal of 'orgastic release'.

For this reason the attention of most investigators dissatisfied with their own results has centered about the question of technique with the hope that improvements in technique, especially the analysis of the transference, would bring about better results. Fortunately the analyst as well as the patient is human and fallible, for were either an automaton it is unlikely that the tremendous force of the transference could be mobilized and utilized in the interest of therapy; and it is within the human limitations and frailties of all therapists, psychoanalytic or other, that we must estimate the results of psychotherapy. Regression to very early periods of life with profound affect may occur during the course of psychoanalysis, but the repeated reliving of these events does not necessarily produce an assuaging abreaction. Even when such regressions are combined with apparently adequate appreciation of the unconscious factors entering into the causes for the symptoms, the combination does not produce alleviation but may replace the original neurosis with a neurotic search for or compulsive rehearsal of analytic interpretations.

As an example of such a discouraging reaction, the instance is recorded briefly of a patient who first sought psychiatric treatment at the age of forty-three for relief from a compulsion of twenty-five years duration. This consisted of a need to terminate all sorts of actions on the number seven, such as ending his steps each block on the seventh step. This number in turn represented an assurance that the seven words of the sentence, 'No, I don't hope that it happens', represented his true feeling. Neither the meaning nor the double negation of the sentence was apparent to the patient. His entire life had been burdened with unhappiness punctuated by periodic depressions, conflicts about homosexuality and masturbation, fear of women, and the feeling that he was a failure.

He was first depressed at the age of twenty-eight for six months. A recurrence a year later continued about a year. Contemplating marriage at the age of thirty-six, he became depressed and, advised by his family physician that marriage might relieve his neurosis and depression, he married. He proved to be sexually inadequate, and he remained sick two years at the end of which he resumed work with what he considered his previous efficiency.

Initially the varied neurotic symptoms made me think that the depressions resulted from his long-standing sexual conflicts. I saw him three times a week, later twice a week over a period of ten months, when he had improved so greatly that he decided to discontinue; he was told, however, that he had not attained the structural integration of personality possible for him although the compulsive symptoms had disappeared. Two years later he sought further treatment but because of a full schedule I referred him to a colleague. A negative transference to his new analyst led him to return to me three months later. With an hour or two of treatment a week, he became quite well and by mutual agreement he discontinued six months later. In the next nine months he functioned socially and in his work at a level he had never previously attained or hoped to attain. Following disappointments in business and a mild streptococcic

throat infection, he had a recurrence of depression and anxiety, and he resumed treatment.

Recently he stated: 'I am now more concerned with why I got sick than I am in getting well. In times gone by when I did not know why I got sick I got well. Now I have the feeling I must discover all the reasons for getting sick.' He summarized, as he had often done before, the interpretation of his depression at which we had arrived analytically: 'I did not achieve what I wanted. I always said that I wanted to be a big success but unconsciously I wanted to be a failure like my father. I loved my father. As a child I wanted to help him when my mother treated him badly. Maybe in loving my father and not loving my mother I was saying to myself, "God, make me suffer like my father" [another seven-word sentence]. I felt the same when I broke off with Mary [a young woman whom, when he was twenty-four, he decided not to marry] and she had a nervous breakdown. I felt the same way I thought she felt. . . . Yet I want to be no good like my father. But I don't care so long as mother does not find it out. That was my problem as a child. . . . My brothers, Abe and Hyman, were in an orphan asylum. We could not take care of them at home. Abe was in the band and I went to see them at the Hippodrome.' He began crying like a baby, and when he had stopped, he recalled: 'I started to cry like that at the Hippodrome. Father said, "Why do you cry? He has it better than you." No, I don't hope that it happens. When I grew up I was afraid to get married. I would not make enough money and would not be a success. Unconsciously I had to be a failure. If mother found out that I did not love her, she would hate me. So I grew up chasing after money. That's funny: if I made a lot of money people wouldn't know that I can't make a living.'

The patient related this as though he were withdrawn from reality but with deep affect. He appeared to have regressed to about the age of three, crying and lapsing into Yiddish baby-talk in which he said in a pleading tone, 'Mother, love your little

boy'; then he cried in agony, 'For that is what we live for, Doc, to have our children be a success'.

Similar, deeply emotional experiences of cathartic abreaction have not relieved his depression, feelings of inadequacy and incompetency, nor his inability to concentrate and work. The patient states that as compared with his previous attacks, he formerly felt in depressions that he had the power to do his work; now he wants to work but the power is not there.

Of prime psychiatric interest is his spontaneous recovery from the first three depressions and the extent to which psychoanalytic interpretations influenced his rehabilitation after his fourth and fifth depression. It is apparent that whatever grasp the patient had acquired of the unconscious hostility embraced by his obsession, 'No, I don't hope that it happens' (the death and frustration of his mother), this comprehension did not change the pattern of his reaction when confronted by realistic disappointments. His ruminations about the psychoanalytic interpretations of his symptoms had become a neurotic preoccupation which more analysis might remove; however, it seemed advisable to avoid any interpretations whatsoever and merely reassure him, instead of aiming at the recovery of his earliest unconscious conflicts. This was put into practice and the patient abandoned his ruminations. When last contacted, about three years after the last visit, he was free of symptoms and had been continuously active in his business.

In America during the past ten years a number of analysts have proposed greater elasticity in the psychoanalytic method to decrease unfavorable results. It has been advocated that only a few hours a week be given to those who are psychologically flexible or are suffering from relatively minor symptoms. This has been called 'brief psychoanalytic therapy', which is not a miniature psychoanalysis, but an adaptation of psychoanalytic principles to symptomatic relief without the objective of structural change in the personality.

Ernest Jones *(4)* ascribes the advocacy of brief psychoanalysis in America to what he considers a national characteristic—'. . .

quick returns being rated higher than plodding work'. However, the psychoanalytic manipulations which Stekel began employing in Vienna about 1912 are in some respects akin to those published in 1947 by the Chicago Psychoanalytic Institute. About 1923, also in Vienna, Otto Rank, once a favored pupil of Freud, conceived and practiced the method of setting a time limit for the termination of analyses with the idea that such a threat to the patient would stimulate him to quicker response. As is well known, this maneuver did not succeed.

About the same time Hans von Hattingberg, working in the leisurely atmosphere of Munich, hoped to speed therapy through the introduction into psychoanalytic technique of the 'startle reaction' (psychological shock). Ferenczi's emphasis on sympathy for and indulgence of the patient during psychoanalysis to hasten recovery depended rather on his own friendly nature than on his Hungarian surroundings. Perhaps no more meticulous, strictly conforming psychoanalyst existed than the late Dr. Horace Frink, of purest Yankee background, practicing in the hurried atmosphere of New York. The divergencies in application of psychoanalytic technique are due, it would appear, not to environmental influences (social, racial, political) but to the disappointment of various analysts with results they have obtained by the use of the classical psychoanalytic method in the many varieties of mental disorders to which psychoanalysis has been applied and which they are called upon to treat.

At times too continuous and too penetrating analysis may tend to perpetuate the neurosis. Both analyst and patient may become so concerned with the past that relatively little attention is given to current disturbing realities, and the analysis stagnates. On the other hand, I know of no other way to resolve a deeply entrenched narcissistic neurosis than to see the patient five times a week. Among these patients the attitude of the analyst in many instances might profitably be more 'positively active'.

It is generally not regarded as good psychoanalytic technique for the analyst to interfere in reality situations. In child analysis, where the child is still under the jurisdiction of its parents,

a good deal of direction and coöperation from the parent is necessary if results are to be obtained. Severe degrees of emotional immaturity, however, are present in many adolescent or adult patients who come for psychoanalysis and are dependent upon their parents for the expense of their treatment. Often in the analysis of a married person the protraction of the illness is intimately interrelated with the psychopathology of the mate. In such instances the psychological situation does not differ materially from that encountered in the analysis of children The authority and power to thwart the analyst's attempts to convert neurotic resistances, symptoms, and defenses into more constructive, healthier activities are shared by someone else. It may be therapeutically advantageous to take these circumstances into consideration and in appropriate instances draw more frequently into consultation the persons closely involved in the patient's life.

As a practical proposal to lessen the therapeutic uncertainties of the psychoanalytic method, Freud in 1937 advocated that every analyst be analyzed periodically (about every five years) on the assumption that greater technical skill would lead to better results. Even if disappointments with psychoanalytic therapy depend upon difficulties in the technical application of the theory, which is questionable, I doubt that this plan is likely to be followed, desirable as it may theoretically be. If the psychoanalyst is not severely beset by personal problems, his self-esteem is apt to be consolidated by years of practice in the course of which he can point to a sufficient number of favorable results which convince him that the sacrifice in time and expense of periodic analysis is unnecessary.

One of the best ways to enhance therapy in psychoanalysis is to study cases in which progress has been slow or has failed. French *(2),* commenting that a 'therapist's first obligation is to his patient', maintains that research in psychotherapy is '. . . often confused with evaluation of therapeutic results' and that the 'task as a scientific investigator is not to evaluate but to try to understand quite objectively what has happened as a chain

of cause and effect'. To experiment in therapy, he suggests that 'a group of therapists meet at specified intervals to discuss their handling of a series of more or less similar cases' and 'each therapist . . . propose a therapeutic procedure. . . . The therapist responsible for the case carries out the procedure that seems best to him' and 'reports to the group the patient's reaction to the therapy . . .'. In regard to this plan it seems to me that the question is not of procedure but how it is carried out, the state of the transference at the time, as well as the external influences bearing upon the analytic situation. If the object of psychoanalysis be to cure, we cannot divorce research in therapy from an evaluation of therapeutic results.

In 1942 I proposed that it become a custom endorsed as good practice that a case be reviewed in consultation if the patient has been under classical psychoanalytic treatment four to five hours a week for more than, let us say, three hundred hours. Schematically such a consultation might occur with a group of three experienced psychoanalysts organized by a psychoanalytic institute. Such groups might reach an opinion as to whether the case should continue with the same analyst, be discontinued as not well adapted to psychoanalysis and some other method attempted, or be referred to a second analyst because of transference difficulties leading to therapeutic stasis. Of course, the analyst would be under no obligation to follow the recommendations of the consultants; but the opinions of the group might serve in some instances to reassure the analyst that his efforts had attained all that the method could contribute and release him from continuing with a case simply from his sense of obligation to the patient, or from narcissistic pride in success which might impel him to continue indefinitely.

If consultation became a recognized practice, it would be no more a reflection on the ability of the physician than personal analysis of the therapist, to which there was originally considerable resistance. Personal analysis is not regarded as a depreciation of the character or reflection on the competence of the analyst and has been unquestioningly accepted. Further, if the

idea of consultation conference were established it might eventually be regarded as bad practice to continue a psychoanalysis for more than five hundred hours without resorting to it.

Cases having been treated by psychoanalytic therapy, as is in many instances preferable, let us say two hours a week for two or three years should also be reviewed in consultation. This should be done in order to discuss the advisability of giving the patient an objective toward which he can concentrate his efforts, or alter the one toward which therapy has been directed; to consider the extent to which moral and ethical values have been emphasized; to estimate the degree of understanding of which the patient is capable; to confer about the desirability of the type of emotional integration to which therapy has been aimed.

The following incident will illustrate this point although the entire situation is not in any sense typical of what arises in psychoanalytic practice.

Four years ago I was present at a long, informal discussion, something akin to a conference as three analysts were participating, between two psychoanalysts who are accredited and experienced. It concerned a case which analyst A, after initial consultation, had referred to analyst B in 1926. The patient, at that time aged about twenty-seven, was a married, childless, Catholic woman, suffering from a fear of leaving her home, marked anxiety, depression, and with a compulsion to collect rubbish and to conceal her childlessness. Both analysts agreed that the patient had never been an ideal case for classical psychoanalysis because of her intellectual limitations. Analyst B had treated the patient for about eight years three times a week, had gradually tapered off to once a week, and then for a year or two the patient had no treatment although she had not improved.

About 1936 she returned to analyst B and was seen by him about twice a week until 1943 when she insisted upon another consultation with analyst A who had originally referred her. Following this consultation analyst B readily agreed that it would be best that she be treated, as she insisted, by analyst A with psychoanalytic therapy. This was finally arranged. The patient at once developed a very strong transference to analyst A

as she had previously had to analyst B, and soon began to make marked strides toward symptomatic cure. Analyst A reported at the time of the discussion that the great improvement in the patient symptomatically and otherwise had been maintained for two years. To follow up on the progress of the case I recently contacted analyst A who reported that the improvement has continued, that the patient has made long auto trips and social contacts, but that he still sees her two or three times a month.

This improvement with analyst A, however, is not the point which I wish to stress. During the initial discussion analyst B remarked, 'What could anyone do with such a woman: her husband was completely passive; she, a Catholic woman with no chance for divorce'. Analyst A seemed surprised and said that he had never thought of the husband as a passive, subservient man but one who had been willing to make great sacrifices for his wife because he was deeply in love with her; the idea of divorce had not entered analyst A's mind. Analyst B retorted that no one but a completely passive husband could love a woman of that type and so the analysis could not progress.

It would appear in this instance that the approach of analyst B was possibly due to a philosophy that only certain types of love are normal, or that a strong negative countertransference blinded him to the potentiality of adapting the patient to her husband. Again the correctness of these assumptions of a cynical, perhaps slightly sadistic attitude on the part of analyst B (which, in common with other bias, should not exist in the psychoanalyst but nevertheless sometimes may) is not the essential point. Had this case been reviewed by a group at the end of three years, in the discussion analyst B's pessimistic attitude might have been discovered and brought to his attention, and he might have changed his aim or decided to transfer the patient some ten years earlier.

It should be recognized that one analyst may fail to achieve satisfactory results with a patient where another with lesser intellectual grasp and experience may succeed. The importance of the analyst's characteristics is tacitly taken into consideration

when one analyst has to refer a patient to another for treatment. He is apt to select a physician whose personality and presumptive approach seem best fitted to the patient rather than necessarily to the type of neurosis from which the patient is suffering. At times the judgment of the referring physician may be erroneous. For example, two years ago a neurologist came to make a personal plea that I undertake the analysis of a college student who he thought would be a difficult case. Following his visit the patient's father came to interview me and approved the neurologist's choice. Then the patient came, not reluctantly. His personality and problem interested me so much that I was very willing to treat him. After two hours he decided that I was not the man for him and refused to continue. The neurologist then referred him to another, somewhat younger man, who told me that after a year and a half the patient was making slow but moderately satisfactory progress and that the patient had identified me on the first visits with his father whom he did not trust and so discontinued treatment with me.

What measures may be advanced to throw light on the reasons for disappointing outcomes with psychoanalysis? The statistical approach to this challenging problem does not seem likely to yield constructive information. The variables in all cases are so numerous and multiform that mathematics alone is not enough and is not only unlikely to give clues as to causes, but may be actually misleading. A questionnaire addressed to analysts as to their experience and opinion with regard to a few salient aspects of disappointment with psychoanalysis is more promising. The value of the questionnaire will be dependent upon the willingness of the respondents to sacrifice some complacency and pride, to discard a considerable amount of prevalent secrecy, and to devote adequate time and thought to their replies. The questionnaire method might eventually also be extended to patients who have completed their analyses and whose retrospective reactions might supply much valuable insight and data. However, I believe that the fairest and probably the most productive approach is the study of each unsatisfactory psychoanalytic therapy by the analyst in conference with his colleagues.

In a paper read over thirty years ago *(6)*, in which sexual perversions were discussed, I quoted from the preface of Thackeray's Pendennis. This novel is a study of the struggles of adolescence and young manhood and contains many interpretations which today would be regarded as psychoanalytic. The preface is dedicated to Dr. John Elliotson, Thackeray's own physician, a man who about 1840 courageously advocated the study of hypnosis as an instrument appropriate for medical investigation. In this preface Thackeray says, and I substitute the word 'colleagues' for 'sons': 'You will not hear—it is best to know it—what is the life and talk of your colleagues. A little more frankness than is customary has been attempted in this story, with no bad desire on the writer's part, and it is hoped with no ill consequence to the reader.' I would add, it is hoped from the presentation of these observations to bring to greater fruition some of the unfulfilled promises of the subtle art and incomplete science of psychoanalysis.

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The Psychoanalytic Quarterly

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

The Oedipal Legend in Christian Hagiology

Anne Freemantle

To cite this article: Anne Freemantle (1950) The Oedipal Legend in Christian Hagiology, The Psychoanalytic Quarterly, 19:3, 408-409, DOI: 10.1080/21674086.1950.11925812

To link to this article: https://doi.org/10.1080/21674086.1950.11925812

Published online: 07 Dec 2017.

THE OEDIPAL LEGEND IN CHRISTIAN HAGIOLOGY

BY ANNE FREEMANTLE (NEW YORK)

Judas has always been accepted as the most perfidious of human beings, type and symbol of the traitor for all time. In the 'ages of faith' he was also saddled with the crime of Œdipus. Medieval legend has it that he came to Jesus to gain forgiveness from him for having, unwittingly, killed his father and married his mother. The story is best told in Jacobus de Voragine's The Golden Legend. This was for centuries a record 'best seller'. It was written about 1260 and contained a life of a saint for every day in the year. From its first appearance until the Reformation, it was the most popular book extant: after the Reformation, it went into complete eclipse in English-speaking countries until rediscovered by revivalist-minded episcopalians in the nineteenth century.

The story is told in the entry for February 24th, the feast day of St. Matthias, who, after the death of Judas, was chosen by lot to succeed him as one of the twelve Apostles. In Jerusalem lived a man named Reuben (St. Jerome says his name was Issachar), of the tribe of Dan, with his wife Ciborea. One night, after they had had intercourse, as Ciborea slept she dreamed she had of that night's begetting a son 'so evil that he would be the downfall of our race'. When she told her husband, he was furious, but she said, 'If in nine months I bear a son, mark my words'. She did, in nine months to the night, and she and her husband, not wishing to kill the child, put him in a little basket and set it on the Jordan River. Baby and basket were carried out to sea, to an island called Iscariot, whose childless queen, walking by the seashore, picked up the boy, hid him for nine months, and then gave out that he was hers. Later, she had a son of her own, and when the children grew up to play together, Judas was always rough and cruel to his little brother. The Queen could not bear to see it, and one day confessed the whole story to her husband. Judas, learning the truth, was so enraged that he killed his foster brother and fled to Jerusalem. There he became a 'boon companion' of Pontius Pilate. One day Pilate, seeing some apples in a nearby orchard, exclaimed that he would like them to eat. Judas sneaked out to rob the orchard.

While he was doing so, the owner, who of course was his own father, Reuben, came out to stop the theft. From arguments they came to blows, and Judas killed his father. Judas escaped unobserved, and Pilate gave to his friend the dead man's garden, and his wife too: none other than Ciborea. One night she woke Judas with her sobbing: 'Unhappiest of women that I am', she exclaimed, and told of her son's exposure, her husband's death, 'and now I am given to a stranger'. Judas, shocked at last, leapt from his mother's bed and presently sought out Jesus, who was preaching the forgiveness of sins.

'Shall we', asks Jacobus de Voragine, 'put faith in this strange story? I, for one, deem it more worthy of being rejected.' Yet there it is—if not true historically, at least infinitely plausible symbolically, for it really contains everything—dream, basket, sea, foster brother, perversion, apples, and incest.

Voragine, the author of The Golden Legend, born in Lombardy in 1228, became Dominican Provincial for that district, died in 1298, and was beatified by the Church in 1816.

The Psychoanalytic Quarterly

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

Repression as a Factor in Learning Theory

Herbert I. Harris

To cite this article: Herbert I. Harris (1950) Repression as a Factor in Learning Theory, The Psychoanalytic Quarterly, 19:3, 410-411, DOI: 10.1080/21674086.1950.11925813

To link to this article: https://doi.org/10.1080/21674086.1950.11925813

REPRESSION AS A FACTOR IN LEARNING THEORY

BY HERBERT I. HARRIS, M.D. (CAMBRIDGE, MASS.)

In addition to the widely accepted factors of practice, reward and punishment *(1)*, it is proposed that the learning process involves other important elements, among which is the efficient use of repression and repressive mechanisms. 'Repression is the process by which a mental act capable of becoming conscious is made unconscious and forced back into the unconscious system' *(2)*. How this process goes on we can only speculate, but we infer that, while more complex, it is elaborated from the processes of suppression and inhibition that can be observed in animal and man. For the purpose of this discussion the three terms are used interchangeably.

The well-adjusted, effective adult appears to be one who represses efficiently his primitive impulses *(3)* in such fashion that excessive quantities of energy are not used up in the process but are, by the efficiency of the repressive mechanisms, freed for use in the expression of the individual's life activity. Life activity is in essence an exchange of energy between the organism and its environment *(4)*. The expression of energy by the organism is optimal when it achieves mastery of the environment. Any repression of outpouring energy by the organism is of value to it only if greater mastery of the environment is thereby accomplished.

In man, the prototype for such repression of energy may be in the activity of the agonist and the antagonist muscles *(5)*. All movement is the resultant of forces of expression and repression of energy, skilled movements appearing to involve the acquisition of very selective repressive as well as expressive muscular actions. The purposeless movements of the infant, for example, disappear as it acquires increasing coördination between hand and eye. Such coördination contains elements of neuromuscular repression of tendencies to express energy diffusely. It is possible that with maturation these primary neuromuscular repressive patterns are elaborated by progressively higher nerve centers.

Similarly in autonomic nervous system impulses, repressive mechanisms appear to be employed constructively to accomplish max-

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imal environmental mastery. Defecation and urination are found to be vehicles for the expression of deep and primitive emotional impulses. Repression of these impulses efficiently accomplished enables their valence of emotional energy to be discharged into the environment with minimal waste. Toilet rituals, constipation and emotional diarrheas are all examples of the waste of emotional energy in which inefficient repressive as well as expressive mechanisms are involved.

Students who learn with difficulty often show similar patterns of inefficient repressive activity. In a large number of students under treatment, striking improvement in learning and habits of study has followed the expression of anger and resentment toward the parent in the permissive atmosphere provided by the psychiatrist. These students unwittingly transferred feelings of anger and rage from fathers to fatherlike teachers. The resulting rebellion (often revealed only by daydreams and procrastination) was but part of the inefficient repressive activity exerted to stifle the feelings of anger and rage that caused it. Under such conditions a highly intelligent student may function at a level far below his potential one. This form of behavior indicates a serious need for the reexamination of the theory of learning *(6)* and, in fact, the entire process of education.

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The Psychoanalytic Quarterly

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

The Distinction Between Loving and Being Loved

Leon J. Saul

To cite this article: Leon J. Saul (1950) The Distinction Between Loving and Being Loved, The Psychoanalytic Quarterly, 19:3, 412-413, DOI: 10.1080/21674086.1950.11925814

To link to this article: https://doi.org/10.1080/21674086.1950.11925814

THE DISTINCTION BETWEEN LOVING AND BEING LOVED

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Freud's conclusions as to the major forces in the human mind—in fact in all life—came finally to be dualistic. His original libido theory became subsumed in the concept of Eros, the life force, which operates to preserve and build up life, forming organic living matter, reproducing it, and bringing units together in social forms. Working against this life reproducing, preserving, spreading, amalgamating force, Freud saw Thanatos—the tendency to destroy life, through killing and through dying. These forces are usually mixed in reality: for example, hostile aggressive drives are used to kill for food or to master a sex object and so result at least in some part in furthering, preserving, and reproducing life. 'The wages of sin', said Cabell, 'is life'. Whatever the accuracy and implications of this formulation, certainly in everyday work the analyst deals with two forces which seem to supersede all others in power and significance for the entire existence of each patient. The one force is hostile aggression—impulses toward hate, cruelty, assault, violence. The other is the demand to be appreciated, helped, valued, praised, in a word, to be loved.

The distinction between the receptive, egocentrically directed, being loved, the need to be loved, as opposed to the active, giving loving, has not generally been made explicit. Freud repeatedly pointed out the importance of the need to be loved. In the case of Dora, he mentions, as he did repeatedly, the neurotic's exaggerated need for love. In The Dynamics of the Transference he shows the role of the intense unconscious longing and expectancy. In the Future of an Illusion he attributes an important source of religious faith to the persisting need in adults for the love, care, and protection of strong, omniscient parents. The importance of the centrifugal direction is implicit in the concept of oral dependence. Thus Freud saw this force clearly. But in his clinical writings he speaks chiefly of ways of loving, without explicitly making the distinction between loving and being loved. The need to be loved was the clue to Freud's Wolf-man, whose dramatic reaction and subsequent improvement dated from the moment Ruth Mack Brunswick pointed out to him that he did not in reality bask in Freud's love and favoritism.

Although appreciated in certain quarters, the clinical importance

of the passive-receptive need to be loved is great and warrants this differentiation. The importance lies in the fact that to be loved is the basic need of childhood. It contains elements of parasitism and dependence. This is the powerful force behind oral demands. Only through the vicissitudes described by Freud does the infant growing to adulthood finally achieve the capacity for responsible, productive object interest: for genitality and mature loving. To receive love is easy; really to love another, child or adult, for its own sake, unselfishly and not for what one gets in return, is an achievement of emotional maturity. It means outgrowing the child's insatiable demands for attention and love, in favor of the adult's power to give the love the child craves.

Few adults have outgrown their childhood needs for parental love; hence the fateful force of such needs in human affairs. It is of central importance in every neurosis. Regression is always largely a return to childish forms of the insatiable need to be loved. Self-love (vanity and narcissism) partially satisfies the craving for love and adulation from the parents. Ambition, prestige, competition are often largely strivings to win from the parents, later from society, love and approval. As Napoleon said, men will go through hell itself for a bit of ribbon; therefore a man can sell his best friend for a bon mot; hence, some people can, for their own prestige, devastate the world.

Neuroses and much of mankind's sufferings arise not from loving, but from infantile demands for love in some form. It is this which motivates excessive jealousy and other manifestations of hate. Its great importance is as a source of hate, hostility, and violence. Too strong needs to be loved, especially when colored with childhood needs for dependence, conflict with our cultural standards of self-reliant individualism and also with the biological forces of development to independence. In so doing they hurt self-esteem and can thereby generate, out of these feelings of inferiority, intense and unremitting rage. Rage is engendered by failure to satisfy excessive needs to be loved which are predestined to failure because the adult cannot satisfy needs which belong to childhood.

Thus in human problems, from sibling and œdipal rivalry and childish behavior disorders through all forms of neuroses, to wars and to the utmost limits of brutality, a central role is played by the excessive and inappropriate craving to be loved and, because of it, by hate and hostility.

The Psychoanalytic Quarterly

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

The Psychoanalysis of Elation. By Bertram D. Lewin. New York: W. W. Norton & Co., Inc., 1950. 200 pp.

G.Z.

To cite this article: G.Z. (1950) The Psychoanalysis of Elation. By Bertram D. Lewin. New York: W. W. Norton & Co., Inc., 1950. 200 pp., The Psychoanalytic Quarterly, 19:3, 414-442, DOI: 10.1080/21674086.1950.11925815

To link to this article: https://doi.org/10.1080/21674086.1950.11925815

BOOK REVIEWS

THE PSYCHOANALYSIS OF ELATION. By Bertram D. Lewin. New York: W. W. Norton & Co., Inc., 1950. 200 pp.

This book cannot be reviewed in the ordinary manner in which reviews are written. A review must by tradition or necessity contain a summary of the contents of the book. Lewin's book is so compact, so condensed, so tersely expounded with such economy of words, that it defies summarizing. One must read it and put it aside for further (and frequent) reference; for the one hundred eighty-two pages of text will have to be read and reread until they become part and parcel of one's psychoanalytic armamentarium. There is a bibliography of about fifteen pages, which means that a rough seven percent of the pages, not counting the index, represent bibliography. The titles in this vast bibliography are not there to garnish the scarce dish of the text, as is the case with so many books. The books and articles listed by Lewin are either actually and pertinently referred to, or quoted from, in the text. In other words, we have here a product of many years of study, of quiet gathering of one's thoughts, and of contemplating the thoughts of others.

We have, especially of late, a great many new books on psychoanalysis. A number of them are more or less skilful but not always original, or they are repetitions of old things we all know or ought to know. Lewin's book is speculative without being recondite, and it reiterates old and established psychoanalytic truths without being trite, and without that verbal juggling and intellectual journalism which many opponents and 'reformers' of psychoanalysis prefer to associate with psychoanalytic orthodoxy.

Lewin's thesis is that elation—so familiar in all varieties of psychopathological reactions—is a special form of defense reaction which heretofore has been rather poorly understood, and that that defense reaction is intimately related to sleep, or rather to the reactions which produce or induce and preserve sleep. The wish to sleep, to eat, and to be eaten are here psychologically reconstructed and resynthesized in their intimate interrelationships, and Lewin uses rather happily the term 'the oral triad' to describe the particular constellation of the oral libidinal elements which play the determining role in elation. Characteristically enough, the term—which is as useful as its concept is sagacious—is outlined with almost irritat-

ing brevity in less than five pages as a part of a chapter, Addenda to the Theory of Oral Eroticism. This economy of words, an otherwise enviable attribute of a writer—particularly of a scientific one—does not always serve Lewin in good stead, for in the lucidity and serenity with which he considers and elaborates his ideas he runs the danger of giving the impression of a bit of casualness of expression which is regrettable. But it is fervently hoped Lewin will not make us wait too long for another book in which he will again share with us his many and valuable clinical experiences, his thoughts and scientific syntheses.

Despite its almost extreme compactness and simplicity, this book is extremely significant—particularly in the history of psychoanalysis in America. From this point of view it is a real and important landmark, because Lewin happens to represent a small nucleus of American psychoanalysis which has played an especially significant role.

Around 1911 to 1913, when psychoanalysis was first introduced in America, it stood on the outskirts of the main streams of official clinical psychopathology, and it quickly entered a phase of development which I would call that of propaganda, or deliberate diffusion of psychoanalytic ideas. It does not mean that I cast aspersions on that period if I say that for almost twenty years that phase of American psychoanalysis, more through personal influence than creative scientific work, tried to engraft the views of Freud on clinically unreal psychology. This was the time during which some translations of Freud were made in this country, and during which psychiatrists were initiated into psychoanalysis by means of personal contacts, conversations, attendance at psychoanalytic meetings, and sometimes more and sometimes less extended pilgrimages to Vienna, where personal contact with Freud or a brief period of study with him enabled one 'to get at the core' of psychoanalysis. We might call that period the period of propaganda, of public relations, or of limited, practical indoctrination.

Late in the twenties and during the early thirties, new accretions to psychoanalysis took place. By way of traveling abroad to study in the newly organized psychoanalytic institutes the 'younger' generation of European-trained American psychoanalysts were of a somewhat different brand or cast. First of all, most of them had good training in clinical, more or less old-fashioned, but solid psychiatry before they ventured into psychoanalysis. Then, too, they studied and learned and came back to propagate psychoanalysis not

so much by means of purely personal influence but—to American psychoanalysis—by almost totally new means: learning, studying, and teaching to learn and to study. As a result, the New York Psychoanalytic Institute was born, with most of the 'younger' European-trained students as its true spiritual founders and first real teachers. Bertram D. Lewin belongs to this generation whose method and tools of psychoanalytic propaganda were the library, the lecture room, the seminar, the colloquium.

The war and many other factors did not permit this period of erudite clinical psychoanalysis and psychoanalytic psychiatry to last very long. We soon entered a phase of dissension, 'reforms', revisions, in which almost every man became a Freud. And thus we entered the phase of fragmentation of psychoanalysis in which the 'progressive reformer', standing out against 'entrenched orthodoxy', proclaimed *urbi et orbi* that Freud, having been a very great man, his errors were proportionately great in the very matters which made him great. Today we live in this paradoxical atmosphere, in which there are so many who claim that Freud's greatness is both incontestable and erroneous, and that his psychoanalysis is one of the greatest landmarks in the history of medical psychology, but a landmark on which the arrows ought to point the way to various 'schools' of dissension rather than to the clinical observations and the writings which Freud left to us, and which were enriched by the studies and observations of those of the all-too-brief erudite period to which Bertram D. Lewin belonged and belongs.

The Psychoanalysis of Elation is the product of this period of erudition, during which clinical work was never crowded out by speculations, and the furthering of theoretical thought never pushed clinical observations out of sight. And all this was without contentiousness and without that form of iconoclastic missionary verve in which what one fights for is lost in the clamor of what one fights against. The history of science shows, of course, a great many intense, passionate, internecine struggles—but it is doubtful whether there are many, or whether there is even one example of a struggle better (or worse) than the one we find in psychoanalysis today. In contradistinction to the erudite period of psychoanalysis, the present one might be justly called political.

It is the unique characteristic of Lewin that throughout the pages of his compact book he has remained completely *au dessus de la mêlée*. He is fully aware of all the dissensions which gnaw at and

undermine the scientific progress of psychoanalysis—but without being haughty he remains above it all. In a manner simple and incisive Lewin disposes of a number of controversies without even mentioning them. Yet with generosity and dispassionateness he quotes freely from the many 'dissenters' without joining them in their controversial claim to a special, independent psychoanalytic principality.

Here is one of the many typical examples of Lewin's manner and style: 'Following Freud's implications in The Problem of Anxiety, I am inclined to assume a libidinal rather than an aggressive or anxious primary form and to say that a wish to die or be devoured precedes the fears. The wish would be an expression and formulation of the desire for the relaxation and sleep that originally followed upon uninterrupted nursing. This wish for sleep and rest would be the bedrock of the idea, and the aggressive and anxious versions would represent later deposits' (p. 128).

Here we have a concise and clear conclusion (on the basis of ample observations and descriptions stated in many pages), which disposes with ease and dignity and terseness of the Rankian, Adlerian, Kleinian controversies, and some others, too. Yet Lewin does not hesitate to disagree when the facts he observed seem not to fit established theoretical tradition. He disagrees with Abraham and with many others. He is no slave of orthodoxy for orthodoxy's sake. He is probably the best example of what a thoughtful analysis of the data of the libido theory can offer.

Lewin's oral triad, his dream screen, and most of all his emphasis that pathological elation is not a disease entity and that it is not a proprietary, exclusive part of the so-called manic-depressive psychosis, all these are valuable contributions—contributions which will be understood only in days to come when the tenets of formalism will be fully shed by so-called academic psychiatry. How difficult it is to shed this devotion to phenomenology and its formalism (which are in the final analysis subjectivism or impressionism, rather than scientific objectivism), one may judge from Lewin's own slips here and there, when he refers to 'affective disorders', which he himself (the elation part of them at any rate) tries to reformulate and split off from the phenomenological, formalistic dragnet of traditional psychiatry. He also speaks of the 'benign stupors' of August Hoch, and refers to them in the book, as if they really were an independent or actual entity. As a matter of fact, this is one 'incomplete-

ness' which I am able to find in The Psychoanalysis of Elation. Lewin still speaks of the benign stupors, apparently without being aware that this work of Hoch was followed up in recent years by Rachlin on the very material of the Psychiatric Institute which Hoch studied. Rachlin failed to find that Hoch's stupors were really benign and showed that they all (as was to be expected) have turned out to be schizophrenias. There is essentially no difference between the psychodynamics of the so-called benign or catatonic stupors. I would also feel that Lewin's own thought would remain fully in harmony with itself and with the facts which he describes if he omitted references to the 'schizoid manias' which Bleuler allegedly singled out. It was Brill who ascribed to this alleged entity a nosological importance of some significance, for Bleuler referred to them without benefit of prognosticating nosology, so to speak. Schizoid connotes no pathology according to Bleuler. The term 'benign stupor' also carries a prognosticating connotation of which Lewin himself seeks to liberate us in favor of true psychological dynamics.

I deliberately refrain from discussing the details of Lewin's thesis in connection with his clinical dynamic concept of the oral triad, of the fusion of the ego and the superego in favor of the restoration of or regression to the pleasure ego. One cannot discuss these things without merely paraphrasing the book; moreover, such paraphrasing would take more than the one hundred and eighty-odd pages which the book itself contains. I would not (very few would succeed) even attempt to emulate Lewin in brevity and terse simplicity in the expression of extensive and most complex thoughts.

One feels that a note on this book would be woefully incomplete without stating that the book reflects the best freudian tradition, a cultured mind and a well-read and eager scientific intellect. The reader will find references from Oliver Wendell Holmes to William James and many others. All references reflect the studious and contemplative mind, of which there are not many to be found in this age of digests and pragmatic 'go-getterism' in the world of science in general—and this includes psychoanalysis too, of course.

Lewin's book will make all very grateful even for those parts which seem to become more descriptive than truly dynamic or, to use an expression of one keen thinker, dealing more with psychomechanics than with psychodynamics. But then this is how science

develops, psychomechanics corresponding to the descriptive phase of science which is a natural and necessary forerunner to the causal phase—which in analysis corresponds to psychodynamics.

G.Z.

PROBLEMS OF BISEXUALITY AS REFLECTED IN CIRCUMCISION. By Herman Nunberg. London: Imago Publishing Co., Ltd., 1949. 83 pp.

In this reprint of a lengthy article,[1] Dr. Nunberg renders a considerable service to psychoanalysis by raising in a new form issues which have perplexed and to some extent divided psychoanalysts ever since Freud described the castration complex of the male. The subsequent discovery of the 'female castration complex', together with more detailed study of the negative œdipus phase in both men and women, merely exacerbated psychoanalytic reactions which had already been provoked by the postulation of penis envy, and which are at times difficult to distinguish from more superficial manifestations of feminist or antifeminist feeling.

Dr. Nunberg is insistent that the term castration complex should, as Freud maintained, be restricted to the association of deprivation with the loss of the male organ. This insistence on the importance of the phase of 'phallic primacy' is open to the objection that it ignores to some extent the importance of passive zonal components in the male, and of both active and passive zonal components in the female. But at least it focuses attention on the paramount importance of genital elements in development. The modern and in itself legitimate tendency to concentrate on traumatic pregenital frustrations has had the unfortunate result of depriving the term castration of specific meaning and thereby diverting attention from the overriding importance of genital anxiety in human development. And the same may be said of attempts to establish major genital anxieties during the oral phase. Dr. Nunberg reminds us that whatever may have been the phylogenetic importance of pregenital components, the specific issues of incest and parricide must have determined the mental development of man.

Dr. Nunberg also follows Freud in insisting that in the last resort the problems of bisexuality can be traced to an irreducible

[1] Originally published in the Int. J. Psa., XXVIII, 1947, Parts III–IV.

constitutional factor, but maintains that this biological factor can be influenced decisively by experiences undergone during the infantile genital phase. Studying the case of a man who was circumcised at the age of five, he came to the conclusion that his masculinity, as well as his femininity, was increased as the result of the operation. The prepuce represented the female part of the man, and its removal with consequent uncovering of the glans penis strengthened the boy's masculinity, first, through identification with the father (who apparently was himself circumcised) and, second, through the desire to regain the prepuce through union with the mother. On the other hand, his homosexual dependence on the father was definitely increased for the time being. The author gives an elaborate account of the unconscious fantasies produced by the interaction of these two tendencies either at purely genital levels or when pregenital regressions ensued; also by the defenses of the ego against both tendencies. But except in so far as the regressional fantasies were strongly influenced by pregenital traumata (e.g., the boy had a painful tonsillectomy when two and a half years old), these elaborations are of lesser interest. As Freud remarked, every competent analyst is entitled to a certain amount of elaboration of his interpretations. The main point is that Dr. Nunberg, while emphasizing the homosexual regression consequent on circumcision—a fact which is in keeping with general analytic experience regarding the effects of genital traumata—stresses the developmental value of the procedure in promoting masculinity. And following anthropological speculations, he maintains that circumcision is not, as is usually held, solely a symbolic or substitute castration designed to oppose positive incestuous wishes, but provokes a temporary negative œdipus reaction which, however, is canceled out by the masculinity drives themselves stimulated by circumcision.

Here it should be remarked that Dr. Nunberg's views on these points were anticipated some years ago by C. D. Daly, who indeed advanced a phylogenetic reconstruction to account for them. According to Daly, the repression of positive incestuous drives through actual castration represented a primary phase in racial development which was followed by a pathological inhibition of heterosexual reproductive impulse and a pathological inversion, an exaggeration, that is, of constitutional homosexual elements. Circumcision, in Daly's view, was a much later development in prehistory, and,

since it symbolized the removal of the female element (prepuce= vagina), countered the pathological tendency to inversion and thereby promoted heterosexual adaptation and survival. Daly maintains further that these two stages of repression are repeated in ontogenetic development, a primary repression of the positive œdipus complex being followed by repression of a secondary negative œdipus complex, which, although constitutionally influenced, is nevertheless in its genital form a psychopathological reaction phenomenon. Incidentally, Daly also maintains that, *mutatis mutandis,* female circumcision or clitoridectomy has phylogenetically an identical function, namely, of promoting adaptation by counteracting the induced homosexuality of the female.

Regarding anthropological speculations, it can only be said that their value varies in accordance with their psychobiological plausibility. Psychoanalytic anthropologists have already distinguished themselves by finding racial parallels for any clinical theories, however contradictory, that may have acquired current popularity. Hence, in the last resort, we must fall back on clinical evidence taken from a consensus of individual analytic observations. The anthropological theories of Daly and Nunberg—for there seems to be no reason why Nunberg, having gone so far, should not adopt Daly's more sweeping conclusions—may or may not be plausible, but there is no doubt that symbolic substitution (of circumcision for castration or killing) must have had considerable adaptive value in group development. Nevertheless the ultimate assessment of the importance of bisexuality and in particular the distinction between innate and environmental factors promoting homosexuality, either latent or manifest, is certainly a matter that calls for organized clinical research and repeated reassessment. Indeed it is to be regretted that Dr. Nunberg did not, in the present instance, throw his net wider and give us a detailed analysis of the whole case, rather than isolate those particular aspects that excited his interest. In any case a systematic analysis of the pregenital phases is an essential prerequisite of accurate valuation of genital phases.

In the second part of his essay Dr. Nunberg seeks to apply his findings to the problem of masculinity and femininity. Following to some extent the views of Jekels and Federn, and attacking the problem through the nature of instinctual aims and the morphological differences between two main groups of erotogenic zones, he finds himself compelled to 'agree with the popular view that mas-

culinity is characterized by activity and femininity by passivity. . . . Active and passive instinctual aims are inherent in the sexual life of both man and woman and for this reason form the basis of their bisexuality.' The problem, says Nunberg, 'cannot be solved by psychoanalysis because it is a biological problem'. Here Dr. Nunberg seems to have lost faith in his own discoveries. His conclusion means no more than that the constitutional factor in development is in itself irreducible. The history of human development is in a sense the history of *modification of instinctual aims.* Dr. Nunberg should not therefore be discouraged. He should limit his terms of reference and try again. What are in fact the *developmental* (ontogenetic) influences, both endopsychic and environmental, that are responsible for what are 'popularly' regarded as *different types* of masculinity and femininity? A Herculean research, no doubt, but Dr. Nunberg is just the man to attempt it. And, incidentally, should he make the attempt, it would be desirable to test carefully as he goes some of the assumptions regarding the relation of clitoral to vaginal zones which tend to pass unexamined through psychoanalytic literature.

In his final essay, the author, using both clinical and anthropological material, deals with man's attempts to accept or reject circumcision, attempts which appear usually to end in compromise. The contrasting reactions are 'the consequence of a basic biological conflict which seems to be formed by man's homosexual attachment to the father'. Dr. Nunberg would have been on more promising ground had he kept to his earlier generalization that the psychobiological basis for neurosis as well as for primitive rites and more civilized religious systems lies in the *conflict between* homosexuality and heterosexuality.

One captious comment may be permitted the reviewer of this stimulating series of essays. Dr. Nunberg adds a short 'Afterthought' in which he compares the respective guilts of the Jews and of the Germans. The Jews through circumcision entered into a covenant with God which enabled them to identify with him and thereby to master their own aggression from within. The Germans are, it seems, 'least able to endure the restriction of aggression as demanded by Jewish Christian ethics'. They rejected accusations of guilt after the first war and had no moral inhibitions against starting the second. They submitted unconditionally to their kings and later to their Fuehrer. By licensing murder the

Fuehrer relieved them of a sense of guilt. The Germans were never regicides and were psychologically justified in not accepting the guilt ascribed to them in the first war. And by their war trials the victors in the second war have prevented the Germans from abreacting their pent-up aggression against their leaders and from developing a new sense of guilt. The victors by destroying German leaders seem more and more to identify with the vanquished. All this is as may be: and Dr. Nunberg is certainly entitled to his opinion. But he would have done better to air it in a separate volume where it could have been dealt with on its merits. Bisexuality, as the author himself emphasizes, is a universal and everlasting human problem, and conclusions drawn from hasty historical comparisons of Jews and Germans only weaken his otherwise strong argument, that the main unconscious modifications of bisexuality occur not only irrespective of race but irrespective of whether circumcision is actually practiced or not.

EDWARD GLOVER (LONDON)

THE BASIC NEUROSIS. ORAL REGRESSION AND PSYCHIC MASOCHISM. By Edmund Bergler, M.D. New York: Grune & Stratton, Inc., 1949. 353 pp.

In this book the author presents his views on psychoanalysis, views which have all been published in previous articles and books. It is manifestly impossible in a short review to survey critically the whole content. The main thesis proposed by the author is that '. . . there exists but one neurosis, though one with many rescue stations in later development, erected intrapsychically for the purpose of escaping the deepest of all mortal dangers—psychic masochism'. The 'deepest of all mortal dangers' as constructed by the author is that 'The genetic picture comprises the sequence of early infancy: offense to megalomania incurred by a libidinous frustration, fury, motor helplessness, external, later internal, inhibition of aggression —boomeranging of aggression—libidinization of guilt'.

With this as a basis a series of defenses is elaborated upon which rests the clinical picture. 'The clinical picture is based on the fact that the inner conscience (superego) objects to this peculiar type of infantile pleasure. The result is that the unconscious ego creates new secondary defenses. These secondary defenses comprise the "triad of the mechanism of orality".'

Oral neurotics are people who constantly provoke the situation of the 'mechanism of orality' which is described as follows: '(1) I shall repeat the masochistic wish of being deprived by my mother, by creating or misusing situations in which some substitute of my preœdipal mother image shall refuse my wishes. (2) I shall not be conscious of my wish to be refused and initial provocation of refusal, and shall see only that I am justified in self-defense, righteous indignation and pseudo aggression because of the refusal. (3) Afterwards I shall pity myself because such an injustice "can happen only to me", and enjoy once more psychic masochistic pleasure. This triad induces the ego-strengthening mirage of aggression, while in unconscious reality the wish to be refused, deprived and mistreated is foremost. Under the disguise of pseudo aggression the oral neurotic enjoys masochistic self-pity and the pleasure of being refused.'

With this thesis as a springboard, the author roams the field of psychoanalysis showing where it comes into play nosologically as well as therapeutically. Titles of some of the chapters suffice to reveal the wide scope of the presentation: The Nine-Point Basis of Every Neurosis, The Underestimated Superego, Orality and the Myth of the Superior Male, Twenty-Seven Clinical Pictures of Oral Regression. Under the last heading are included such syndromes as premature ejaculation, writer's block, gambling, criminosis, male homosexuality and lesbianism.

It is regrettable that the author did not simply rely on presenting his thesis with arguments for its validity instead of permitting his 'pseudo aggression' to infiltrate almost every page. He attacks, accuses, vilifies, ridicules, and criticizes all and sundry who have opposed his viewpoints in the past or whose criticism he anticipates in the future. These features lend the book a polemic quality which, while making for amusing reading, hardly does justice to the more serious contribution the author might make. The credibility and validity of the author's contribution will ultimately rest with the collective experiences of other analysts rather than with the forcefulness and dogmatism of the author's presentation.

For those who are not familiar with the author's viewpoints through his many publications, this book will acquaint them in no uncertain terms.

JOHN FROSCH (NEW YORK)

EMOTIONAL SECURITY. By Milton R. Sapirstein. New York: Crown Publishers, 1948. 291 pp.

This belated review in no way lessens the value of this provocative book. It contains a wealth of material. The bibliography bears witness to the author's extensive knowledge of the psychoanalytic literature. In his presentation he uses graphic illustrations to clarify the discussion of psychic processes. For the most part the book reads well, is well organized, and the concepts used are clearly defined.

Dr. Sapirstein attempts an integration of the libido theory with the more recent modifications of psychoanalytic theory, which emphasize the role of interpersonal factors in emotional development.

In the first part of the book the author deals with the causes of emotional breakdown, and discusses the roles of possible constitutional inadequacy and overwhelming environmental demands, as well as individual psychic factors. Fear and withdrawal, self-assertion or hostility, and dependency are posited as the three basic defenses against anxiety. Maladjustment is defined in terms of the inappropriate use of these defenses.

The second section deals with psychosexual development as seen against the background of contemporary cultural attitudes toward sexuality.

The third part, Special Applications of Psychoanalytic Theory, discusses such problems as hostility, aggression, traumatic neuroses of war, psychosomatic disorders as manifestations of neurosis, creativity and psychoanalytic therapy. The reader may come away with the impression that all that is said in the chapter on therapy is psychoanalysis. Indeed, the role of the analyst and the attributes ascribed to him, as well as many therapeutic procedures presented, go far beyond the accepted concept of psychoanalytic therapy. It is to be hoped that in a future edition this confusing ambiguity will be eliminated.

PAUL FRIEDMAN (NEW YORK)

THE NEUROSIS OF MAN. An Introduction to the Science of Human Behavior. By Trigant Burrow, M.D., Ph.D. New York: Harcourt, Brace and Co., 1949. 428 pp.

This ambitious volume describes the theories and experiences of Dr. Trigant Burrow and his associates of the Lifwynn Foundation.

Originally a psychoanalyst and president of the American Psychoanalytic Association in 1926, Dr. Burrow broke away from psychoanalysis shortly after that date, espousing a system which he describes in this volume as 'Phyloanalysis'. He hopes to re-educate man in such a fashion that not only disease but social conflict can be eliminated. Essentially, he regards the 'symptoms of individual and society as but the outer aspect of impaired tensional processes that affect the balance of the organism's reaction as a whole'.

Because of the diffuse presentation and a very pronounced use of neologisms, some of them very confusing, the book is difficult for the psychiatrist to read and understand. For example, the term 'affect', in contrast to its customary use, is employed here to mean a reaction closely related to prejudice, and is regarded as pathologic. Allergy is defined as 'disturbances in man's interrelational functions'. The terms 'cotention, cotension, ditention and ditension, and "I" persona' are used constantly and are distinctly confusing. Some of the flavor of the book can be indicated by the fact that a human being is here generally called a 'hominid'. The value of this is very doubtful. In a book which tends to put forward a new hypothesis of human behavior, it is a distinct drawback, since its audience is necessarily severely limited.

Phyloanalysis is not easily summarized. It might be described analytically and rather roughly as an attempt to deal with human behavior, in group terms, and in terms of the superego and some ego functions, with rather complete elimination of the id and its strivings. Sexuality, particularly childhood sexuality, is for the most part ignored. The unconscious is hardly mentioned, except for one point at which he says, 'The moment is at hand for us to take conscious hold of our own unconscious processes by recognizing the false cerebral plane upon which they rest'. Certainly one of the salient points of the technique appears to depend on the repression of fantasy, rather than its understanding.

Dr. Burrow's attempts to correlate behavior with certain physiological functions are not especially convincing. The protocols and the statistics given are not impressive, since the standards for 'ditension' and 'cotension' are not clearly stated, the number of subjects is very small, and the findings in terms of physiological function are very difficult to relate to the massive sociopolitical problems earlier stated.

The rejection of psychoanalysis is only part of the criticism of

all modern psychiatry expressed here, and is subject to a good deal of the 'affect' which Dr. Burrow deplores. For example, psychiatrists are criticized for not recognizing the prejudice or 'affect' which hinders their objectivity. Actually, psychoanalysis has dealt with this problem from the very beginning. While still far from accomplished, no other discipline has made such energetic and successful attempts to deal with the scotomata and distortions of the physician. Dr. Burrows' book omits reference to modern anthropology and such writers as Kardiner and Róheim, nor does he mention so basic a volume as Freud's Group Psychology and Analysis of the Ego. Modern analytic work on character disorders is entirely ignored.

MARTIN H. STEIN (NEW YORK)

ADAPTATION. Edited by John Romano, M.D. Ithaca: Cornell University Press, 1949. 113 pp.

In the introduction to this beautifully printed book, John Romano states: 'Psychiatry, like social anthropology, is currently engaged in attempting to bridge the gap between the physical and biological sciences on the one end, and the social sciences on the other'. Adaptation to life on various levels has been chosen as the theme, because this central concept is a girder in the bridge between these fields of science.

Paul Weiss, the zoologist, Homer W. Smith, the physiologist, Howard S. Liddell, the psychobiologist, and Clyde Kluckhohn, the anthropologist, present four interpretations of the phenomenon of adaptation in four different chapters. Of special interest for the analytically-minded reader is a contribution by Lawrence S. Kubie, who diagnosed himself as a 'doubting Thomas' and as such, carefully and cautiously picks his way through the thorny bushes of analytic theory. Under the title of The Neurotic Potential and Human Adaptation, Kubie concludes that when most of the determining psychological forces are conscious, the resulting conduct will merit being called *normal,* because it will be free to learn and capable of adapting flexibly to changing external realities. Where unconscious forces dominate, or where conscious and unconscious forces pursue incompatible goals, the behavior which results will deserve to be called 'neurotic'. Such behavior will be a rigid, repetitive, *unadaptive,* ineffectual compromise. It will not serve the needs of the conscious nor the unconscious human potentials.

MARTIN GROTJAHN (LOS ANGELES)

CHILD PSYCHIATRY. By Leo Kanner, M.D. Second Edition. Springfield, Illinois: Charles C. Thomas, 1949. 752 pp.

Even though it is a second edition, this is an entirely new book. The resemblance to the first edition (1935) goes little further than the title and author. Comparisons with the first edition are, therefore, out of order because the organization of the material and the approach are totally different. It is significant mainly as an example of the maturing of a point of view in little over a decade. Whether this change refers to the author alone or the field of child psychiatry in general is an interesting but really immaterial question.

One must admire this book for its wide and extensive coverage; its systematic organization; the knowledge of the literature; the wise selection of significant contributions; the common-sense approach; the broad practical experience; the sympathetic understanding of parents, children and physicians as people; and the easy style of writing (except for occasional words like 'encopresis' [p. 47], 'iatrogenic' [p. 373]).

Yet it falls somewhat short as a modern book on psychiatry in that it does not go far enough in applying the principles of psychogenicity which are basic to modern dynamic psychiatry. A hundred pages are assigned to neurological and other organic conditions. The approach is still considerably symptomatic rather than holistic. Thumb-sucking, nail-biting, nose-picking, and the like are discussed as habitual manipulations. Psychotherapy is presented along lines which might be more useful to the general practitioner and pediatrician than to the well-trained psychiatrist interested in the specialty within a specialty. Psychiatric social work, so important in parent-child guidance, receives only a chapter of two pages. Many psychoanalytic studies of children, except for the classical works of Anna Freud and Melanie Klein, are overlooked, as are also many of the contributions of the child guidance movement.

In this reviewer's opinion, a current book on child psychiatry—or any other psychiatry for that matter—has to be psychoanalytically oriented. The author seems to be on the way to a more tolerant view of psychoanalysis and a better understanding of its indisputable findings, with less emphasis on the finer debatable points found in every branch of science.

The book is well constructed and set in large readable type; the

many interesting case histories are in smaller type. The bibliographies at the end of each section are very handy. The author and subject index is full and adequate.

The book is recommended for general practitioners and pediatricians. For psychiatrists, it offers a good introductory over-all view of the range and problems of child psychiatry.

ABRAM BLAU (NEW YORK)

CHILDREN IN CONFLICT. Twelve Years of Psychoanalytic Practice. By Madeleine L. Rambert. Preface by Jean Piaget. New York: International Universities Press, 1949. 214 pp.

This book was written to explain child analysis to parents and teachers. It does so admirably. It would be too bad, however, if analysts of both adults and children should miss reading this book. It is full of interesting material, giving insight into the neurotic child, its conflicts and struggles; it also opens the door of the therapist's office, allowing the reader to observe Mlle. Rambert at work. She says somewhere that 'to understand another human being . . . is not only scientific work, but an art'. In reading this book, one feels time and again the admiration which one usually reserves for artists. Her intuition, her tact and her forthright courage in dealing with her patients are a rare combination. The atmosphere is one of complete tolerance, love and understanding. She takes parents into her confidence, if she can, and deals with them as she finds it necessary. Sometimes she finds no coöperation and then either seeks to remove the child from the home or resigns herself to the fact that this is all she can do for the child at present and that her patient may need treatment after adolescence. Treatment of the parents is considered as a cure for the child's troubles only rarely. 'We must not exaggerate this aspect', Mlle. Rambert warns, 'it is the child who must be treated'.

Mlle. Rambert divides the treatment into three phases, starting with a series of tests to determine the emotional and intellectual status of the child, and the diagnosis. The beginning of treatment aims at an 'exteriorization' of the child's conflict; the second phase is concerned with a 'conscious realization and liquidation of the neurotic conflict'. These two phases coincide with what the Vienna School of child analysis considers insight into the illness, and working through. The third and final stage is devoted to the re-

education of the child. Sometimes it seems that Mlle. Rambert makes too great demands upon her patients. A nine-year-old girl is made to feel quite guilty by the analyst's story that 'the little hand' of the patient, who hates her limping mother, should help her walk (p. 78). The phases of treatment are not so clear-cut in practice as one is led to believe by their presentation in this book.

Mlle. Rambert uses puppets a great deal in her play with children. She seems to be a master at creating and using them; yet, the emphasis which is put upon this means of expression is perhaps somewhat exaggerated. Surely others may do without puppets, and play with children in ways which are more within their line of thought and action.

The third part of the book concerns itself with some theoretical questions which we feel are directed more toward the professional child analyst than the lay reader.

A chapter on children's dreams is particularly interesting because of the wealth of hard-to-get material; equally interesting is a chapter on children's drawings and their use in therapy. The chapters on transference and on the management of aggression deal with some of the most controversial problems of child analysis. Mlle. Rambert coördinates different forms of transference (p. 192, ff.) to the forms of expression (p. 38, ff.) which she establishes for different age levels: for instance, small children under six who express themselves in 'symbolmiming' make, according to her, a full transference. During the age of 'symbol identification', i.e., between five and six, the children 'enact' their conflicts in the analyst's presence. Children between ten and sixteen very often cannot be truly analyzed, but only treatment based on analysis is feasible. According to the author there are children of all age levels who 'transfer all their feelings upon the analyst. Generally these are children who have little imagination and are poorly developed intellectually' (p. 150). They are usually found in 'poorer homes' and are extremely aggressive.

This last statement convinces us that our concept of transference and that of Mlle. Rambert are not the same. In our experience a 'transference' is not dependent upon intellectual development and imagination, but on the form of the emotional disturbance, the diagnosis, and the age. We also consider the dramatizations of children under six as play acting in contrast to their relationship to us, which is not always a transference. Similarly

we consider expressions with puppets, dolls, drawings or stories a form of communication which may or may not be an expression of transference.

Mlle. Rambert seems to allow her patients to maltreat her to an extent which, in our opinion, would heighten the child's feelings of guilt and thereby increase its anxiety; also this method cannot be recommended to all analysts of children for the reason that they may not have the tolerance to take as much punishment without getting angry as Mlle. Rambert.

The theoretical differences between the author and this reviewer are in a field which has so far not been sufficiently clarified. In reading Mlle. Rambert's books one has the feeling of being in agreement with her on most questions of practice; her theories are attempts at organizing the material and her ideas, to which, however, she does not rigidly hold herself. The scientist in Mlle. Rambert may be sometimes carried away into somewhat schematic thinking. The deep humaneness of her personality together with the intuition of the artist lead her in her therapeutic work.

EDITH BUXBAUM (SEATTLE)

ADOLESCENT FANTASY. By Percival M. Symonds. New York: Columbia University Press, 1949. 397 pp.

This book represents a painstaking effort to penetrate the personality and conflicts of the adolescent. The method used is picture stories, first used by Murray in the Thematic Apperception Test. Forty adolescent boys and girls were presented a set of forty-two pictures carefully selected to stimulate fantasies. They were asked to make up stories of what was happening in the pictures. The study adds a good deal of information about ways adolescents fantasy. The adolescents selected were said to be relatively normal, well-adjusted youngsters. Excerpts from the records, however, suggest that some of them were quite unhappy and had conflicts beyond what might be expected in mature, well-adjusted individuals even during adolescence.

The subjects of this investigation were, in addition, interviewed by the tester. They submitted brief autobiographies, and one or both parents and teachers who knew the adolescents intimately were interviewed. A correlation was then made between these findings and the material obtained from the picture stories. An attempt was made to divide the material of the stories into a large

number of themes which were culled out by several people who subjected the stories to study. As might be expected, in many instances the stories clearly revealed the structure of the personality and the conflicts of the adolescents. Frequently, however, there were inconsistencies. For example, many of the adolescents who were withdrawn and passive in their everyday life produced stories in which there were many more instances of aggression than would have been expected. Some of the pictures were expected to elicit aggressive themes, while others were not. Because the relatively passive group often saw aggression in pictures that in most instances did not produce this reaction, Symonds concluded that they had conflicts around the subject of aggression. Many of the most aggressive adolescents saw less aggression in these pictures because their aggressive needs were satisfied in reality and did not seek outlets in fantasy. Such conclusions could not have been reached if the added information about the subjects had not been obtained. Some of the commoner themes were aggression, anxiety, guilt, punishment, feelings of inferiority, love, dependency.

Symonds found that boys' stories included more violence, crime, and death, while girls' stories expressed aggression by coercion and rebellion. Boys tend to fantasy love themes while girls more often fantasy friendship and the birth of children. The tendency to fantasy is somewhat greater in boys in this study; they are also more prone to fantasies of wealth and ambition. The pictures which produced the largest number of themes were those that were simple and least encumbered with detail: also those which were vague and mysterious. One of the pictures contained a nude adolescent boy and girl. Many adolescents reacted with surprise or embarrassment. Several referred to them as statues to avoid discussing frankly sexual subjects. Others were very frank in their discussion of sexual activity. Some said they did not wish to discuss the picture.

It is apparent that a good deal of significant material was stimulated by the pictures which could be very useful in psychotherapeutic interviews. The tests would be more revealing in psychotherapy because the therapist is in a position to elicit associations and to trace the source of the fantasy, after having obtained a trusting relationship with the subject.

In spite of the fact that there were so many revealing fantasies in this study, this test has not the advantages of the Rorschach Test

in which the subject is totally unaware of the nature of the material he is revealing. Its advantage is the stimulation to discuss subjects generally avoided which produce conflict.

Symonds found that the characters in the stories were seldom replicas of real life. More often they represented longings and fears—someone one would like to be or feared to be. He assumes that the stories are projections of trends which can be understood only through further work if one is to learn how the material is transformed and disguised.

Symonds acknowledges his debt to psychoanalytic research. In several instances references to the dynamics involved in the stories seem forced and unclear. This may be due to the fact that material is omitted for brevity. It would seem to the reviewer, however, that such references should not be made unless the evidence for them is clear and unmistakable. The author wisely states in his conclusions that the interpretations at best are hypothetical, and subject to revision. When the master of a technique concludes with such a statement, it is to be hoped that his less well-trained followers will use correspondingly greater caution.

Adolescent Fantasy is a book well worth reading. The picture method will probably be used extensively and, as time goes on, may help to reveal important factors concerning the complex fantasy life of young people.

HYMAN S. LIPPMAN (ST. PAUL)

EPILEPSY AND CONVULSIVE DISORDERS IN CHILDREN. By Edward M. Bridge, M.D. New York-Toronto-London: McGraw-Hill Book Co., Inc., 1949. 670 pp.

The book is based on the records of seven hundred forty-two children seen over a period of fifteen years in the Epilepsy Clinic of the Johns Hopkins Hospital. The Clinic was founded in 1927 by Drs. Edward A. Park and Adolf Meyer. Dr. Bridge was Director of Research from 1928 and Physician-in-Charge from 1935 until 1944.

The author states the book differs from the ordinary textbook: the description of signs and symptoms is minimal, whereas the main emphasis is put on the underlying factors. The difference, however, seems to be that it is written for physicians, nurses, social workers, parents and educators; to satisfy such a varied audience

defeats its own purpose. The endless repetition of statements, opinions, descriptions, and figures, probably intended to make the book more understandable to the layman, makes it tiresome reading for the specialist. It seems doubtful that the layman will learn much from it because of the unavoidable use of technical terms, detailed discussions of physiological mechanisms, laboratory procedures, etc.

The author defines epilepsy as 'a symptom of sudden and recurrent lapses of consciousness often associated with convulsive movements' rather than a disease entity. The symptom is a result of disturbances in the functional state of cerebral nerve cells. The varied etiology includes one or several of the following factors: (a) heredity; (b) structural defects in the brain; (c) physiological disturbances; (d) personality maladjustments; (e) environmental strain.

Part I is devoted to the discussion of these five factors, which are rated on a scale of 0 to 4 plus. The descriptive summary of each medical history includes an evaluation of these factors with their ratings. Bridge found heredity to be the least important. It is safe only to conclude that a certain functional status of the central nervous system predisposes to a heightened susceptibility to convulsive disorders and is inherited like any other neurophysiological tendency. Structural damage to the brain (birth injuries and vascular occlusions in the order of frequency mentioned) appears to be most important. Evidence of it was found in the majority of cases. The more extensive the brain damage, the less important are the other factors. Factors c, d and e are definitely correlated. The damaged area of the brain interferes temporarily with the function of adjacent cells. Most likely a state of anoxia produced there is responsible for a condition of hyperirritability in these cells, making them subject to explosive discharges. Bridge comes to the conclusion that two mechanisms, either singly or together, induce seizures. One is related to local conditions within the brain, the other (if evidence of brain damage is absent) to physiological disturbances within the body (fever, menstruation, etc.) that affect the susceptibility to seizures and precipitate them under certain circumstances. (Encephalographic studies show that fifteen percent of the general population are susceptible.) The mechanism by which physiological disturbances affect the convulsive tendencies is unknown. They operate most

likely by way of the autonomic nervous system. H. Jackson's theory that damage to the brain results in an inhibition of higher levels of brain organization and a corresponding release of an archaic type of reaction is not mentioned, nor does his name appear in the bibliography. Bridge stresses the necessity of a psychosomatic approach, yet his chapters on personality and environmental factors are the most disappointing.

The surprising statement is made that in children 'difficulties are simpler, less fixed and more understandable'. The problems encountered do not differ from those in children with or without any physical handicap. There are charts where the disturbances are listed: insecurity reactions, 'spoiled child reaction', antagonism toward parents, etc. The so-called epileptic personality is a result of the same underlying disturbances as the seizures themselves. All of this seems to be estimated mostly from the point of view of Adolf Meyer's psychobiology, although his terminology is not used. Bridge observed that most epileptic children live in constant fear of dying in an attack and get into a panic at the approach of a seizure. Apparently none of the author's patients described an experience of rebirth after the seizure which a good many epileptics describe. Nowhere is there an attempt made to understand the underlying dynamics. Freud's concept, elaborated by numerous psychoanalytic writers, that a convulsion may be a way of discharging tension, derived from organic or psychological disturbances, is not even alluded to. It is not mentioned that aggressive and self-destructive tendencies may operate. Another list enumerates such reactions to the seizures as fearfulness or bravado, hypochondriasis, disregard of instructions, etc. Bridge states that cases in which psychological factors were thought to be responsible for the seizures were not discovered at his clinic; however, he agrees that the investigation to uncover such causes was not adequate. The only observation made was that emotional conflicts can aggravate the condition and can lead to an increased frequency of seizures. The initial causes for seizures in children under the age of three or four are largely physiological. Around puberty the initial causes may be psychological. Hystero-epilepsy or affective epilepsy is not discussed.

Part II deals mainly with the symptomatology of major and minor seizures (petit mal, akinetic seizures, etc.), their treatment and outcome. The incidence of convulsions in children in the

course of various diseases is very high (one out of fifteen in the Johns Hopkins Hospital). The differential diagnosis can be made only after long observation. Only chronic recurrent seizures without a chronic self-limited neurological disease can be called epilepsy. The seizures themselves change cerebral functions and produce more extensive damage to the brain. The whole brain may become sensitized and the slightest irritating influence (a conditioned reflex) may provoke a seizure. Localized seizures may become generalized. These organic factors, as well as psychological ones, like the patient's fear and his environment, result in an increased frequency. On the other hand, the prognosis in children is better, because physiological functions tend to become more stable upon reaching adulthood and the sensitization may thereby be lessened. The necessity of long term treatment (for at least two years after the cessation of seizures) is stressed. Treatment should be carefully planned with due consideration to the family's attitude. Various drugs and diets are discussed. Operative removal of epileptogenic foci in children has been rarely performed. In every case some kind of psychotherapy should be applied. The pediatrician should limit himself to preventive or symptomatic psychotherapy; major problems should be left to the psychiatrist. A great deal of space is devoted to describing how the pediatrician should approach the child and the parents, the technique of the initial interview, etc. The role of the caseworker should be to study the environment and interpret the physician's viewpoint. Controlled play therapy is mentioned, as advocated by Lewy and Conn (no mention is made of Anna Freud). Play therapy can shorten the time of treatment from a year to ten or fifteen interviews (*sic*!). Several pages are quoted from F. W. Allen's Psychotherapy With Children to illustrate the use of undirected play therapy. The case quoted is not one of a child with epilepsy. Psychoanalysis is defined as 'a technique for studying and treating psychiatric problems and a viewpoint from which human behavior is judged'. Child analysis is exemplified by quoting several pages from Editha Sterba's Excerpt from an Analysis of a Dog Phobia. However excellent this paper, it is surprising that Bridge could not find a single psychoanalytic paper dealing with epilepsy. Not one is mentioned in a bibliography of some four hundred papers and books.

Part III describes diagnostic procedures like encephalography, artificial induction of seizures, and pneumo-encephalography.

There is no question that the author has put a great deal of work into this book, backed by many years of experience. However, this reviewer gets the impression that while it may be of limited value to the pediatrician and medical social worker, it is of little interest to the neurologist or the psychoanalyst. The only valuable part for the layman seems to be the really excellent pictorial tables of contents (in the style of posters) preceding each chapter.

ELSE PAPPENHEIM (NEW HAVEN)

COURTS ON TRIAL. Myth and Reality in American Justice. By Jerome Frank. Princeton: Princeton University Press, 1949. 441 pp.

Those who remember the author's book, Law and the Modern Mind, published in 1930, will here expect trenchant discussion and balanced argumentation—and they will not be disappointed. This is a more mature extension of that earlier work, many references to which are unblushingly cited. The intervening years have seen Jerome Frank as chairman of the SEC and latterly as judge of a federal court of appeals, but his greater experience has not led him to become more conservative or less of a critic of legal practices and, in particular, of courtroom procedures. More than ever he sees weaknesses that to a considerable extent are eradicable and in proclaiming them he says that he is willing to dub himself a reformer. The book fairly bristles with hardheaded concrete points at issue while the hundreds of quotations from authorities, classical, philosophical, and literary, as well as legal, are so aptly interspersed that they serve to impart great vigor to the text.

It must be clearly understood that Judge Frank is not adversely critical of our entire legal system. He is mainly concerned with the fundamentally important fact-finding practices of the trial courts. The higher courts rarely have anything to do with deciding the validity of the alleged facts in a case; their function is mainly to pass upon the legality of the procedures and rulings of a lower court. The myth that these so-called upper courts have relatively greater importance for the administration of justice and that consequently to them should be appointed the best-trained and ablest men, this myth should be exploded.

That 'finding the facts' is crucial in a large proportion of cases the author insists, not only in his chapter, Facts are Guesses, but

elsewhere through the book. Actual events 'do not walk into court' to be observed there. They are mainly phenomena of the past and the court usually learns about them only through the oral testimony of witnesses. At once psychological issues appear which, indeed, in one form or another, mark the tenor of the whole book. In their decisions judges and juries act as 'witnesses of witnesses' and their subjective attitudes and prejudices are added to those of the original givers of testimony. 'A trial court's finding of fact is, then, at best, its belief or opinion about someone else's belief or opinion.'

Of course, much is involved: human fallibilities of memory and observation and, even if honest, the conscious or unconscious desire on the part of a witness to present testimony in a favorable or unfavorable form. Then there is interpretation of what was said, truth or falsehood in a contested case, judged perhaps by the appearance of a witness and his behavior—and striking illustrations are given.

To correct this as much as possible Frank calls for special training of trial judges, particularly in all that psychology can offer. Indeed they should undergo at least a short period of psychoanalysis that they may acquire knowledge of themselves and thereby learn to control to some extent their own otherwise unavoidable preconceptions and biases. Law school education with its main reliance on books is largely at fault; students should frequent actual trials as medical students attend clinics.

The virile chapter on The Cult of the Robe shows what Judge Frank is after, namely, to have an intelligent public understand 'that the springs of decision in judges' do not 'differ from the springs of decision in other men'. The wearing of the robe and legal jargon tend to becloud that fact.

There is such rich treatment, for example, of the criticisms and defenses of the jury system, of the psychology of litigants, of the philosophy of 'Natural Law'—wherein Erich Fromm's conception of a universal ethics is strongly approved—that the reviewer finds it difficult to keep his comments within bounds. All put, the book is more interesting reading than many best-seller novels.

WILLIAM HEALY (BOSTON)

THE FEMININE CHARACTER. History of an Ideology. By Viola Klein, Ph.D. New York: International Universities Press, Inc., 1949. 228 pp.

This book attempts 'to discover . . . whether there are traits which can be called typically feminine'. An integrative approach is attempted through studying the notions of a number of 'authorities'. One chapter each is devoted to representatives of 'the biological, the philosophical, the psychoanalytical, the experimental-psychological, the psychometric, the historical, and the sociological methods of approach'.

An introductory historical background illuminates women's changing social status from the time wives were bought and sold in England, through the industrial revolution and the era of Victorian gentilities, to the radical changes that followed World War I and the present 'emancipation'.

Havelock Ellis (biologist) debunked many fallacies regarding sexual differences, but was cautious in describing particular feminine traits. Otto Weininger (philosopher), apparently a schizoid personality (a suicide at twenty-three), seems to doubt that women are human. Although the author presents his views as typical of the very end of the nineteenth century, they seem rather to represent psychopathology. Nevertheless she finds similarities with Freud and concludes they were both victims of their conservative era and similar social backgrounds. The chapter on Freud is one of the longest in the book. The author finds a 'peculiar irony in the fact that the very theory which was chiefly responsible for a more enlightened outlook in matters of sex' is influenced by 'Victorian morality . . . in its dealing with women'. She seems to think penis envy a concoction of theory rather than an inescapable fact of observation and states, 'contempt of women is taken for granted'. Vexed by Freud's statement that women's 'capacity for sublimation is less' because, 'translated into ordinary language this means that women are, by their organic nature, excluded from participation in cultural and creative activities', she quotes Horney's contention that man's creativity is a compensation for his 'envy of motherhood'. Detecting a bid 'for supremacy between . . . competitors', she makes clear the reason for psychoanalysts' confusion (p. 86): 'it is the inability to understand that woman no less than man has been equipped by nature with a sexual instinct

and the means to gratify it, and that, if she has any reasons for envying man, they are not likely to be of a physiological character'! Margaret Mead (anthropologist) and W. I. Thomas (sociologist) are considered the most objective observers, although none of the eight 'authorities' is credited with having described a single typically feminine characteristic. One does not get the impression that the author is disappointed in this, even though her final paragraph states the belief that some 'residue of typically feminine traits, connected with woman's specific constitution' may achieve scientific validity when 'these [her own] and many other approaches . . . have been exhausted'.

An appendix analyzes a novel about 'three consecutive generations of women of one bourgeois family'. Apparently an interesting story concerning the social status of women in Holland between 1840 and 1923, it contributes no more than did the specialists toward fulfilment of the author's thesis.

There is a bibliography of over three hundred titles dealing with the history and social status, biology, psychology and sociology of women. The name index and subject index are adequate.

WILLIAM G. BARRETT (SAN FRANCISCO)

WOMEN IN MARITAL CONFLICT. A Casework Study. By Florence Hollis, Ph.D. New York: Family Service Association of America, 1949. 236 pp.

In this readable and thoughtful study Miss Hollis examines the potentialities and limitations of casework in the growing problem of marital conflict. One hundred cases chosen from the files of eleven large family service agencies and handled by twenty-odd caseworkers serve as material for study and evaluation. Questions asked are: how wide is the gap between present knowledge and that required for effective work in dealing with this problem?; how often are situations really untreatable and how often are these an indication of limited casework skill?

The families represent a fair sample of American urban population, with wide divergencies in nationality, race, income and social status, religious and educational background. One is struck, in view of this fact, by the surprising similarities in complaints and the lack of variation of norms to which these people aspire, or from which they rather guiltily deviate, and one wonders whether

this is due to the client's desire to please or to the type of data collected. As a large percentage, not too surprisingly, shows a tendency to excessive dependency, it would seem that this would lead to an overwillingness to conform to a preconceived idea of the caseworker's standards, which would tend to confirm these standards in an evaluation of what is to be considered 'normal'.

Factors contributing to marital conflict are discussed in freudian terms, with increased emphasis on personality or 'intrinsic' factors and the need for more highly skilled workers to evaluate and treat them. 'Extrinsic' factors, such as interfering relatives, cultural differences, economic pressure, are shown to be often more symptomatic than causative, which does not however mean that they can be ignored.

There is an excellent chapter of constructive criticism, with examples of errors and pitfalls most likely to occur, and a number of concrete suggestions for attaining a generally higher level in casework practices. Among these are longer training for new workers, plans for increasing knowledge and skill of workers now in the field, closer coöperation with health and medical centers, more psychiatric guidance, and greatly increased research. Recent findings in the field of cultural anthropology will also, it is to be hoped, help caseworkers to modify and evaluate cultural pressures and gain a clearer view of the great variety of standards from which the individual must choose and by which he is influenced.

There is a bibliography, a case index and a subject index.

WILLIAM G. BARRETT (SAN FRANCISCO)

STALIN: A POLITICAL BIOGRAPHY. By I. Deutscher. New York and London: Oxford University Press, 1949. 600 pp.

The author of this study of the Russian dictator admits in the preface that he is inclined to study the politics rather than the private affairs of public men. In accordance with this basic interest, the bulk of his attention is devoted to the intricacies of Stalin's political development and activities, and consequently to a very thorough study of Bolshevism, international Communism and Russian foreign policy. His knowledge of all these matters is quite profound and based on firsthand sources and minute research.

Nevertheless, almost despite his own intentions, many significant

trends emerge to serve as the basis for a future psychological biography. Avoiding any psychological analysis of Stalin's personality, the author gives such masterly characteristics of Stalin's political techniques that psychological conclusions follow quite naturally. The development of such traits as dissimulation, deception and violence are traced back to conditions of Stalin's individual development as well as to social oppression to which this 'son of ex-serfs' had been subjected from early childhood. His political beliefs served as a natural rationalization for his hostility. 'His class hatred was not his second nature—it was his first. Socialist teachings appealed to him because they seemed to give moral sanctions to his own emotions.'

Profound knowledge of social and historical conditions enables the author to follow various identifications of his hero with autocratic rulers of old Russia as well as with his master and teacher Lenin, the revolutionary leader par excellence.

Although at times the author almost comes to admire Stalin, more often he is deeply aware of all the limitations of his personality which have imprinted themselves in so many ways on Russian and international politics—limitations such as lack of appreciation of psychological *imponderabilia* or rigid adherence to some prevalent ideas that curbed even Stalin's famous shrewd 'realism'. Neither Stalin's cruelty nor his fanaticism is given adequate emphasis. The drama of his personality remains in a shadow because the drama of the Russian Revolution is given a breath-taking expression.

To the student of social psychology the book offers a great deal of valuable material. In several instances, writing of dissensions within the Bolshevik party as a struggle between fathers and sons, the author comes close to psychoanalytic formulations. Yet nowhere does he exhibit any explicit knowledge of psychoanalysis nor does he mention any existing attempts at a dynamic understanding of Stalin's personality.

GUSTAV BYCHOWSKI (NEW YORK)

The Psychoanalytic Quarterly

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

American Journal of Psychiatry. CVI, 1950.

Mark Kanzer

To cite this article: Mark Kanzer (1950) American Journal of Psychiatry. CVI, 1950., The Psychoanalytic Quarterly, 19:3, 443-451, DOI: 10.1080/21674086.1950.11925816

To link to this article: https://doi.org/10.1080/21674086.1950.11925816

Published online: 07 Dec 2017.

ABSTRACTS

American Journal of Psychiatry. CVI, 1950.

The Nature of Neurotic Reactions. Leon J. Saul. Pp. 547–548.

Saul sees neuroses and psychoses not as disease entities but as reaction-formations which are prevalent in all people to varying extents. Nervous disorders represent increased quantitative use of various normal mechanisms, which are regressively employed. Phobias, for example, are exaggerations of childhood timidities; compulsions, of problems appropriate to the age of toilet training. Saul links his concepts with the ideas expressed by Adolf Meyer in developing the terminology of the ergasias.

Sculpture and Depression. L. Bryce Boyer. Pp. 606–615.

Boyer reviews the literature on sculpture produced by psychotic persons and describes the relationship between such art and the life history of a woman subject to depressions. Her subjects and her associations provide insight into her mental state and her problems. 'Lot's wife', for example, reflects a reluctance to go forward; 'Cassandra' foresees future sorrow; the breasts of 'Diana' are concave and mutilated. Work was sometimes impulsively created or as impulsively destroyed—notably, the head of the therapist. The article is abundantly illustrated.

MARK KANZER

Psychiatric Quarterly. XXIII, 1949.

Lying: A Minor Inquiry into the Ethics of Neurotic and Psychopathic Behavior. Ben Karpman. Pp. 1–25.

The universality of lying is discussed in its manifold variety. The socially desirable takes precedence over truth. The primitive though truthful expression of our thoughts would not have allowed the formation of a well-functioning social order. Lies may be used as a neurotic defense against feelings of insecurity and inferiority. Subconscious self-deception and unconscious rationalization are lies to oneself. Lying is also related, in the grosser forms of psychopathology, to memory disturbance in confabulation, retrospective falsification, amnestic states, pseudologia phantastica and pathological lying. Generally, psychotics do not lie while neurotics lie defensively or for reasons of hostility or compensation. The true psychopath lies consciously for gain or to protect himself against punishment.

The Trauma of Bearing. Nandor Fodor. Pp. 59–70.

Fodor attempts to relate parturition and its attendant anxiety to the unconscious memory of the trauma of the mother's own birth. The frequency of this fear is stressed. The common occurrence of miscarriage is attributed to this anxiety; postpartum complications and illness, to the guilt engendered. These theories, reminiscent of Rank, will be especially interesting to his fol-

lowers, though they are not borne out by anthropological research which stresses cultural attitudes toward childbirth as the important factors in the fear of it. The paper is an excerpt from Fodor's recent publication, The Search for the Beloved.

Re-Analysis of an Alleged Telepathic Dream. Albert Ellis. Pp. 116–126.

Some two years ago, in the Psychiatric Quarterly, Ellis first published a critique of the then recent publications by Eisenbud and others on telepathy and its relationship to psychoanalysis. Last year Eisenbud retorted with a presumptively telepathic dream of one of his patients, with which he tried to meet Ellis's criticism by showing a coincidence between the affairs of the analyst and the dream material of the analysand. In the present rebuttal Ellis attempts to prove that he could apply telepathic significance to Eisenbud's dream by referring it to events in 1, Ellis's own life; 2, the life of a patient known to him, undergoing analysis; and 3, the life of a character in fiction. In spite of this *reductio ad absurdum,* Ellis obviously fails to prove that the dream was not telepathic.

In an editor's note Eisenbud states that without having seen the above paper he declines to reply. Since Ellis also writes 'enough is enough!', this may well mark the end of an enlivening series.

JOSEPH BIERNOFF

Bulletin of the Menninger Clinic. XIII, 1949.

A Biographical Comment on Freud's Dual Instinct Theory. Rudolf Ekstein. Pp. 172–175.

This paper is an attempt to explore certain personal problems of Freud which may have contributed to his formulation of the death instinct theory. This theory was first published in Beyond the Pleasure Principle in 1920, shortly after the first World War. Freud was sixty-four years old at that time and concerned with the problem of ageing. Also in this period he underwent the first of several operations for cancer of the jaw. Freud was an inveterate smoker and Ekstein believes he felt guilty about his oral strivings. The death of his second daughter, Sophie, is also advanced as a factor which influenced this train of thought on the death instinct despite the fact that Freud himself stated that Beyond the Pleasure Principle was written, in the main, before Sophie's death.

Ekstein uses Puner's rather questionable book on Freud as the authoritative source for some of his material. He concludes that the most powerful source of psychological discovery seems to be an awareness of inner struggle and conflict and the constant search for inner mastery.

On the Etiology of 'Shared Neuroses': Remarks in Extension of a Freudian Observation. Robert M. Lindner. Pp. 176–184.

This paper is an attempt to amplify Freud's finding that two people sharing what seem to be the same childhood traumata may develop different neuroses. Lindner analyzed a brother and a sister and found that the brother had developed

an obsessional neurosis while the sister developed hysteria although both had shared in common traumatic experiences.

The difference is explained by the fact that one patient was a seven-year-old male and the other a five-year-old female when they both observed primal scenes and engaged in fellatio and cunnilingus. Although the experiences were mutual, the boy perceived these acts as sadistic whereas the girl felt them as acts of love. The brother regressed and became fixated at an anal-sadistic level, while the sister retained her phallic orientation.

The Initial Phase of Psychotherapy. Jules V. Coleman. Pp. 189–197.

Coleman describes some of the differences between psychoanalysis and psychotherapy in the initial phases. Although both deal with problems of conflict, resistance and transference, the methods employed are different since the aims are different. He stresses above all the avoidance of 'intensive dependency reactions' in psychotherapy, as though this need not be avoided in psychoanalysis. Coleman then describes certain technical maneuvers like consistent attention to the current situation, spacing of interviews, superficial interpretations, etc., which are useful in strengthening the defenses without stirring up infantile conflicts.

The Creative Arts as Therapy. Mary Huntoon. Pp. 198–203.

At the Winter Veterans Administration Hospital a department of art was set up which was found therapeutically helpful for many patients. Some patients first became aware of previously important unconscious conflicts in the studio, while others showed clinical improvement without consciously recognizing the significance of what was painted. Sometimes it was necessary for the physician to interpret the painting to the patient. Painting seemed to serve as a useful aid in the development of the patient's mastery over his inner conflicts.

A Psychodynamic Analysis of the Crimes of Prejudiced and Unprejudiced Male Prisoners. William R. Morrow. Pp. 204–212.

It has been found that highly prejudiced people tend to have a poorly internalized superego, rigid ego defenses with much use of projection and reaction-formation, and to be defensively concerned with morality and the seeking of external status and power as reassurance against feelings of inner weakness. The prejudice appears to involve an external symbolization of the prejudiced person's unconscious struggles to keep his repressed feelings 'in their place'. Relatively unprejudiced subjects tend to have more internalized values and less suppressive defenses; they are apt to be more concerned with seeking love, and are more often openly ambivalent.

Morrow studied a group of prisoners at San Quentin in order to determine whether any significant correlation existed between the underlying motivational structure of a crime and the democratic versus anti-democratic orientation. By using certain psychological tests, Morrow was able to separate the prejudiced from the unprejudiced criminal. He found the prejudiced criminals motivated by a need for some external proof of their toughness, strength, power and

masculinity. Their offenses were attempts to deny feelings of weakness and nonmasculinity. What superficially appeared as the direct expression of impulses was actually a defensive denial of impulses and feelings. It was found that the crimes of the unprejudiced criminals seemed to involve direct expressions of underlying feelings of jealousy, hostility, a need for love, etc.

It is Morrow's hypothesis that the unprejudiced criminal whose offenses express mother-oriented needs for love and dependence will be more responsive to psychotherapy than the prejudiced inmate whose crimes express antiweakness themes.

RALPH R. GREENSON

Psychiatry. XII, 1949.

Medical Opinion and the Social Context in the Mental Hospital. Alfred H. Stanton and Morris S. Schwartz. Pp. 243–249.

Stanton and Schwartz point out the inadequacy of available guidance and proper criteria for the administrative psychiatrist in carrying out the particular type of work demanded of him in running a mental institution or ward. The problems encountered in the rendering of opinions and decisions by such psychiatrists are analyzed in relation to two social science concepts—'stereotypes' and Malinowski's 'functional theory of culture'. The hospital administrator generally harbors within himself a distorted stereotype of the hospital as an ideal haven built around the needs of the patient. Psychiatric reasons are used as rationalizations for decisions which are actually based on an allegiance to this stereotype. Similarly, many procedures are performed for the function of fulfilling certain 'needs' of the hospital, as the need for safety, and are couched in other terms which make them seem for the benefit of the particular patient. Psychiatric theory and diagnosis may thus be misused and may be quoted to any purpose. It must be enlarged to include and accurately integrate the institutional setting.

The Germinal Cell of Freud's Psychoanalytic Psychology and Therapy. Paul Bergman. Pp. 265–278.

Bergman attempts to study and understand Freud's work on the basis of an original experience or germinal observation which occurred to Freud's creative and rich mind and which then served to illumine the path of development of psychoanalysis. The essence of this germinal observation, which was first made by Freud as he approached the zenith of his life, consisted of several parts. First, a traumatic event in a patient's life left memory gaps which could be filled under certain conditions such as hypnosis. Second, certain symptoms disappeared when these gaps of memory were filled. Third, frequently these lost memories had to do with sexual conflicts.

The author traces the gradual widening and step by step evolution of Freud's psychoanalytic psychology and his psychoanalytic therapy, and he shows how the germinal observations mentioned above were adhered to in each succeeding step of the developing theory and therapy. Although there were changes

of emphasis and newer approaches and techniques, such as a shift of attention from the unconscious material to the resistances, or the discovery of the role of transference, Freud always considered these as changes of tactics and not as a change of goal. The goal remained always in line with the original observation: to help the repressed past emerge into consciousness where it had to be accepted not only intellectually but emotionally.

Study of Resistance and Its Manifestations in Therapeutic Groups of Chronic Psychotic Patients. Irving M. Rosen and Mignon Chasen. Pp. 279–283.

Rosen and Chasen describe various manifestations or indications of resistance in their psychotic patients during the course of group therapy. The issues which provoked the various resistances concerned ideas of physical danger, of rejection, and of feelings of attraction to the therapist. Many of the issues stemmed from the therapist's own unconscious attitudes and for these an outside observer was frequently helpful.

LEO RANGELL

Psychosomatic Medicine. XI, 1949.

Mind, Unconscious Mind, and Brain. Sandor Rado. Pp. 165–168.

The use of the term 'unconscious', according to Rado, has a serious drawback in that 'To the emotionally inspired imagination, unconscious mind appears like a department of mind working "below" or "outside" awareness; as it were like another, mysterious mind, a thing in itself'. He proposes the adoption of the term 'nonreporting', as equivalent to 'unconscious', to avoid this metaphysical implication. Much of the activity of the central nervous system is physiological in that it has no direct effect upon consciousness; this activity Rado designates 'nonreporting'. The psychological meaning of nonreporting nervous activity can be arrived at only by a process of psychological inference—as when speaking of an unconscious or nonreporting desire, a missing causal agent is referred to which acted as if it had been a desire but was in fact a physiological event. Unconscious mind is therefore nothing mysterious or metaphysical. 'It is merely a nonreporting organization of causative links between processes of which we are aware.' Rado restates a number of psychological and psychoanalytic data in terms of their relationship 'to, from, and at nonreporting levels'.

S. CABE

Psychologic Correlations with the Electroencephalogram. L. J. Saul, H. Davis and P. A. Davis. Pp. 361–376.

Electroencephalograms were recorded over a five-year period on one hundred thirty-six adult patients at the Chicago Institute for Psychoanalysis. No appreciable changes which could be attributed either to the lapse of time or to emotional alterations during or following psychoanalysis occurred in the EEG of any individual. Three correlations have been observed: Very 'passive' individuals have A type EEG's with high alpha indices. Women with strong masculine trends have

B type or low-alpha EEG's. Frustrated, demanding, impatient, aggressive, hostile women have mixed types of EEG. In the entire series of patients there is a preponderance of men who show A type, high-alpha EEG's and a corresponding preponderance of women with mixed types of EEG.

The Role of the Mother in Psychosomatic Disorders in Children. Melitta Sperling. Pp. 377–385.

From a psychoanalytic study of twenty mother-child relationships certain features seem to emerge as characteristic for those mothers whose children suffered from various psychosomatic disorders: 1, the carry-over of an unresolved emotional conflict from the mother's childhood and the acting out of this conflict with the child (The child may represent an unconsciously hated sibling or parent.); 2, projection of part of the mother's own person onto the child; 3, a need for control over the child so intense that in some of these cases the child is regarded and treated as if it were a part of the mother's own body.

In the case of a seven-year-old girl with ulcerative colitis, the mother had the idea that she could not let the child grow up to be like one of her husband's family, although she destroy both the child and herself. She almost did destroy the child. Treatment of the mother and child as a unit is rewarding practice both for research and therapy, in spite of the technical difficulties.

MARTIN GROTJAHN

Archives of Neurology and Psychiatry. LXII, 1949.

Observations on Criminal Patients During Narcoanalysis. Carl P. Adatto. Pp. 82–92.

Adatto investigated the effects of intravenous sodium pentothal on fifty criminals considered insane. He found that his patients talked more freely when under the influence of this drug. He also observed that some patients had a recurrence of their delusions and hallucinations under narcosis while others could deny delusions in this state. Three of the fifty patients fabricated new stories while under the influence of the drug—which contradicts the popular 'truth serum' idea. Almost all the men spoke with great affect about their parents, and frequently the nature of their relationship to the parent and the nature of the crime could be connected. Adatto concludes that the use of intravenous barbiturates is helpful in studying criminals, particularly since it aids in breaking down resistance and helps in establishing a predominantly positive transference.

Comparison of Adjunct Group Therapy with Individual Psychotherapy. Robert E. Peck. Pp. 173–177.

After more than two years of experience in a Veterans Administration Mental Hygiene Clinic, Peck comes to the conclusion that a combination of individual therapy with group therapy is more effective in treating patients than either of these methods alone. Group therapy is particularly effective with combat veterans.

Use of Potassium in Protracted Insulin Coma: Preliminary Report. William Stark and S. Eugene Barrera. Pp. 280–286.

Stark and Barrera have found that in cases of protracted insulin coma which do not respond to the administration of dextrose there is a dramatic return to normal with the slow, intravenous administraton of potassium. The protracted coma produced no discernible effect on the clinical progress of the patient.

Brain Wave Patterns During Hypnosis, Hypnotic Sleep and Normal Sleep. Wayne Barker and Susan Burgwin. Pp. 412–420.

There has been some controversy on the relationship between hypnosis and sleep. The authors were able to demonstrate that trance states can be achieved in hypnosis without any significant alteration in the brain wave pattern. However, if the suggestions were aimed at producing sleep in the hypnotic state, there occurred typical changes in the electroencephalogram characteristic of normal sleep.

RALPH R. GREENSON

Journal of Nervous and Mental Disease. CX, 1949.

Diagnostic Problems in Early Schizophrenia. Norman Mace, Salmon A. Koff, Irving Chelnek, and Sol L. Garfield. Pp. 336–346.

Case material is used to demonstrate the difficulties of differential diagnosis in schizophrenia. The authors are involved in making such a differential in purely descriptive terms, with necessarily more subjective than dynamic formulations, and without such concepts as projection, object relation, and reality testing. They recognize the fact that Kasanin, Zilboorg, and Sullivan used the terms 'neurotic schizophrenia', 'ambulatory schizophrenia' and 'incipient schizophrenia' respectively and that these terms may describe the same group of cases which they now wish to designate by 'chronic incipient schizophrenia'.

Mass Action versus Mosaic Function of the Frontal Lobe. Walter Freeman. Pp. 413–418.

From the study of lobotomized patients, Freeman concludes that motor skills seem to depend on the convexity of the frontal lobe while awareness of self and orientation seem to depend on the base. Recognizing that both motor skills and sensory functions are products of many factors which can be related to the development of the individual from infancy to maturity, Freeman discusses these two groups of functions as they are affected in lobotomized patients. He points out that '. . . simple movements known to be under the control of the frontal motor cortex are elaborated into mechanical skills, social, occupational, recreational and creative skills. Simple visceral sensations are elaborated into internal and external orientation, and on into social and spiritual self-consciousness, with creative ecstasy as the highest achievement of the functioning individual. Since this creative ecstasy is the only function apparently destroyed by transorbital lobotomy, it may safely be attributed to the most anterior portions of the frontal lobes.'

Intravenous Alcohol and Early Convulsive Shock in the Treatment of Exhaustion Due to Mental Disorder. H. A. Perry and Sol Levy. Pp. 497–501.

Exhaustion accompanied by hyperpyrexia and dehydration due to overactivity in mental illness is treated by the intravenous administration of 5 percent alcohol in dextrose-saline solution followed within twenty-four hours by electroshock. The rationale is borrowed from the recent use of alcohol intravenously in postsurgical cases. The authors state that they have treated eighteen patients in this way with good results in all but one.

NORMAN REIDER

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

Clinical and Electro-Encephalographic Studies on Prisoners Charged with Murder. D. Stafford-Clark and F. H. Taylor. Pp. 325–330.

Sixty-four prisoners charged with murder were studied clinically. A high statistical correlation (seventy percent) was found between nonspecific electroencephalographic abnormalities and the apparently motiveless crime. The cases who fall into this category (motiveless crime, EEG abnormality) may show no clinical indication of insanity, either legal or medical. The plea for further study is made on the basis that the EEG records may serve to provide a more enlightened attitude toward this group of criminals. The implication is that a more objective means of recognizing mental illness and therefore nonresponsibility on the part of the criminal will be possible from EEG studies. The authors are not curious about the 'motivelessness' of the crimes.

NORMAN REIDER

American Journal of Psychotherapy. IV, 1950.

Emotionalism in the Discussion of Psychotherapy. Martin Grotjahn. Pp. 80–84.

Difficulties of scientific communication that are not encountered with individuals may be met in a group because of the facility with which hostile opposition and destruction, rather than tolerance and coöperation, are activated in a group. Except for religious groups, a group feels its strength in hating and fighting. There are some specific features in the emotional reaction to the discussions of questions in psychotherapeutic technique which are defensive in nature. Grotjahn attributes the difference between the more flexible individual opinion and the rigid collective attitude—both expressed in all honesty and scientific integrity—to the increasingly insecure feeling of the therapist of today in his humanistic traditions and ethics. In this insecurity he develops defensive rationalizations.

The therapist, who is impressed by what he does not know, who is aware and not ashamed of the empty spaces in his scientific technique, will be more modest, humble, and tolerant toward his patients and his fellow workers in the field of psychotherapy. He is aware of the limitations of his scientific technique which, as a tool, must be supplemented by his personality, his 'style'. The therapist must have the maturity and security to show these individual

variations to a group and not to defend himself against them with emotionalism and rationalization. Grotjahn feels that it is time to use the methodology of psychoanalysis to investigate scientifically the different forms of psychotherapy.

HELEN TAUSEND

The Quarterly Journal of Child Behavior. I, 1949.

Problems in Analysis of Children with Psychosomatic Disorders. Melitta Sperling. Pp. 12–17.

This paper deals with some of the major difficulties encountered in analytic work with children suffering from psychosomatic disorders. The reluctance of parents to obtain such psychoanalytic help for their children stems not alone from ignorance and lack of insight. An important factor is the mother's fear of exposing her motivations. The illness of the child is essentially an expression of the mother's unconscious death wish toward the child. Unless the destructive drive of the mother can be ameliorated, the child often cannot be saved.

Diet and hospitalization are often employed by the mother as weapons against the child. The child, sensing the hostile component in the imposition of the special diet, resists and fights the food restriction. Once the child becomes convinced of the sincerity of the motivation, it will accept even severe dietary restrictions without protest. Since dietary transgressions are equated in the child's mind with sexual transgressions and hence carry a threat of castration, it is usually advisable for the physician who prescribes the diet to lift it, thus taking away the castration threat.

Hospitalization is regarded by the sick child as an abandonment by the mother, which unconsciously it often is. If the overanxiousness of the mother can be lessened, hospitalization may be warded off and the mother may be induced to bring even an acutely ill child to the analyst's office. 'The psychoanalytic treatment may go on for years, but the analytic interpretation of an acute attack equals surgical procedure in promptness of effect and can be considered emergency treatment.' The author adduces illustrative case material to document her views.

S. GABE

The Psychoanalytic Quarterly

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

Meetings of the New York Psychoanalytic Society

Charles Brenner, Sidney Tarachow & Joseph Lander

To cite this article: Charles Brenner, Sidney Tarachow & Joseph Lander (1950) Meetings of the New York Psychoanalytic Society, The Psychoanalytic Quarterly, 19:3, 452-454, DOI: 10.1080/21674086.1950.11950874

To link to this article: https://doi.org/10.1080/21674086.1950.11950874

NOTES

The seventeenth INTERNATIONAL PSYCHOANALYTIC CONGRESS will be held in Amsterdam, August 7, 8, 9, 10, 1951, preceded by a reception the evening of August 6th.

The AMERICAN PSYCHOANALYTIC ASSOCIATION held its annual meeting in the Hotel Statler, Detroit, Michigan, April 28–30, 1950. The following officers were elected to take office at the opening of the next annual meeting in Cincinnati, Ohio, May 2–6, 1951. President: Robert P. Knight, M.D., Stockbridge, Massachusetts; President-Elect: Ives Hendrick, M.D., Boston, Massachusetts; Secretary: LeRoy M. A. Maeder, M.D., Philadelphia, Pennsylvania; Treasurer: William G. Barrett, M.D., San Mateo, California; Councilors-at-Large: Leo H. Bartemeier, M.D., Detroit, Michigan, Grete L. Bibring, M.D., Cambridge, Massachusetts, Douglass W. Orr, M.D., Seattle, Washington, Emanuel Windholz, M.D., San Francisco, California. Miss Anna Freud, London, was elected an Honorary Member. The current officers continue in office until the opening of the annual meeting in 1951. They are, President: M. Ralph Kaufman, M.D., New York, New York; President-Elect: Robert P. Knight, M.D., Stockbridge, Massachusetts; Secretary: LeRoy M. A. Maeder, M.D., Philadelphia, Pennsylvania; Treasurer: William G. Barrett, M.D., San Mateo, California. The next meeting of the Association will be held at the Waldorf-Astoria Hotel, New York City, December 7–10, 1950.

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

December 20, 1949. THE CONCEPT OF DEFENSE. George Gerö, M.D.

Defense is defined as unconscious ego activity directed against the id impulses. Criteria are given for deciding when one instinctual impulse is used as a defense against another. The most general of these is the release of tension and diminution of anxiety or superego pressure. Problems of technique related to defense are discussed. The importance of analyzing the patient's defenses is emphasized, and the complexity of defenses illustrated. A technical rule is given for analyzing defenses: begin by analyzing the aspects of the defense which are near consciousness; thus the analyst can eventually make conscious what had previously been an unconscious ego activity. Another technical rules is proposed: as long as a regressive process causes neurotic suffering, the defensive purpose of the regression should not be analyzed; this should be done only when the regression is the source of satisfaction. Defense is considered synonymous with resistance. Repression is felt to be the basic defense mechanism —the *sine qua non* of neurotic symptom formation. The importance of analyzing defenses first and of seeking hidden defenses is emphasized. Focusing on the defenses intensifies the transference, which is of the utmost value. An exception would be a patient with a strong tendency to act out. It is pointed out that analysis of defenses represents nothing new in psychoanalysis. The

supreme task, facilitated by this technique, remains the genetic reconstruction of the past.

Dr. Edith Jacobson remarked that character traits, which Dr. Gerö called hidden defenses, are really more nearly symptoms and that during analysis symptoms may be replaced by character traits. She suggested that some defense mechanisms are directed against ideational content, and others against the drive itself or its affect. She emphasized that repression is important in normal devolpment as well as in neurosis and raised the question whether the same is true of all other mechanisms of defense. Dr. Bertram D. Lewin compared Dr. Gerö's paper to a work on surgical anatomy: in it defenses are studied not from the theoretical point of view, but with the object of solving the technical problem of the analysis of the defenses. He added that this is nearly, but not quite the same as the analysis of resistances. Dr. Géza Róheim said that the data of anthropological field work, if gathered by an anthropologist who is also an analyst, afford ample evidence for conclusions concerning defenses and instinctual gratification. Dr. Fritz Wittels felt that Dr. Gerö's approach is too complicated, and emphasized that the essential mechanisms of defense are repression and displacement of affect. He added that in certain cases repression might take place independently of the ego: ' . . . the id attacks objects and forces them into repression by absorbing them'. Dr. Ludwig Eidelberg agreed with Dr. Wittels about the desirability of simplicity but felt that the complications introduced in the last forty years were not arbitrary but had been forced upon us by increased knowledge. He stressed the technical importance of the patient's attitude to his symptoms or character traits, and also the importance of differentiating between defense mechanisms and instinctual vicissitudes.

In closing, Dr. Gerö repeated that the increased complexity in psychoanalytic thinking had been demanded by the new facts observed since 1908. He agreed with Dr. Jacobson as to the complexity of the relationship between symptom formation and defense mechanisms, adding that he had intended to say only that every symptom formation presupposed somewhere the breakdown of defenses.

CHARLES BRENNER

February 14, 1950. SOME PROBLEMS IN FEMALE SEXUAL DEVELOPMENT. Phyllis Greenacre, M.D.

Dr. Greenacre believes that genital stimulation may occur earlier than, as usually accepted, in the phallic stage, particularly in situations of extreme stress with diffuse tension discharge using the vaginal among all other possible avenues of discharge. Her discussion covers several topics. 1. Vaginal sensation may precede clitoral. This is supported by the evidence of vaginal autoerotic sensations, hypochondriacal delusions and vaginal orgastic explosions of psychotics. Vaginal sensations may be derived from anal sensation in infancy, and may be stimulated by the mouth-bowel reflex. Women have a mouth-vagina equation. 2. There are prephallic clitoral sensations but this is not as frequent as prephallic vaginal sensation because the vagina borrows stimulation from surrounding organs. 3. Clitoral stimulation in the phallic phase is usual. The masturbatory pleasure becomes envy of the boy. The penis envy remains through the œdipal period because of the frustration of the wish for a child. This may lead to a

belief in an illusory penis which at the same time helps overcome castration guilt. 4. There may be early bipolarity between clitoris and vagina. Although there is a certain amount of normal bisexuality, the two sensations may remain unfused especially if there have been both strong prephallic vaginal stimulation and strong phallic experiences leading to penis envy. 5. The late sequelæ of this bipolarity may be a hallucinated penis, states of unreality, or one zone may be disowned, usually the vagina. 6. Vaginal dominance may be premature through such factors as early anal genital stimulation, or weak stimulation of the masculinity complex such as being surrounded by females. The clitoral interest may have undergone complete repression.

Dr. Edith Jacobson agreed that early vaginal sensations occur more frequently than formerly thought, though she doubted the importance of tension overflow in this regard. She felt there was a true early vaginal cathexis. She had observed cases of full vaginal sensation with little clitoral sensation. The withdrawal of interest in the clitoris was due to their castration conflict with regressive orality. The vagina was then used as a passive oral organ with pleasure. These women refused to masturbate. Dr. Heinz Hartmann questioned the overflow of tension as a cause of early vaginal sensations, though he agreed as to the frequency of it. He was not sure psychotic material could be used as evidence. He was impressed by the fact that feeding led to bowel and vaginal stimulation. Concerning bisexual identification and bipolarity of clitoris and vagina, Dr. Hartmann added that identification and activity depend also on the various identifications with the mother, and that the fate of the aggressions is important. He agreed that the bipolarity may disturb the sense of reality.

SIDNEY TARACHOW

March 14, 1950. BETTY M AND THE SEVEN DWARFS: A CONTRAPUNTAL ESSAY ON RAYNAUD'S DISEASE. Bernard C. Meyer, M.D.

Dr. Meyer describes a number of points of interesting parallelism between the story of Snow White (and other fairy tales) and the clinical history in a case of Raynaud's Disease. The patient, seen only for three short interviews, apparently used the disease to symbolize her sexual conflict: the vasoconstriction, with consequent coldness and 'whiteness' (purity, chastity) presumably represented a rejection of 'redness' (sexuality, life, passion, femininity). The denial of femininity was further amply demonstrated by her frigidity and in other ways. The 'red-white polarity' is discussed, with reference both to the patient and to the characters of several fairy tales. Dr. Meyer's patient had had ten operations, two accidents, removal of parts of seven organs, and two 'finger prickings' with serious consequences, all (except a hymenectomy) after attaining motherhood. 'The picture is one of systematic dismemberment, a sort of organ scuttling with particular emphasis on feminine functioning.' Her masochism represented introjection of the image of the cruel stepmother.

In discussion, Dr. Schur urged caution in drawing inferences, no matter how ingenious, from so few interviews. Dr. Róheim expressed the opinion that the Snow White theme is to be viewed as a fantasy of return to the womb, with acute (projected) hostility to the mother who is pregnant. Body destruction fantasies are prominent, and based on this hostility.

JOSEPH LANDER