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# SLEEP, NARCISSISTIC NEUROSIS, AND THE ANALYTIC SITUATION

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In the first part of this paper I continue a previous train of thought, comparing dreams and the narcissistic neuroses; in the second part I follow a different path and comment upon sleep and its relation to analysis as a technique and therapy.

## I. DREAMS AND NARCISSISTIC NEUROSES

I begin with a reference to two papers of Freud, published in the same volume of the *Zeitschrift* (IV). One is The Metapsychological Supplement to the Theory of Dreams, the other, Mourning and Melancholia, both of which powerfully affected psychoanalytic thought. To unify theory and combine the work on dreams with that on the neuroses, in the Supplement, Freud formally introduced into dream theory the concept of narcissism. The dream was treated in theory as if it were a variety of psychosis: sleep was an expression of primary narcissism to which the libido had regressed, while in dreaming the ego expressed itself regressively in hallucinations. The purpose of dreaming was to rechannel leftover disturbers and impulses, so that they should not waken the sleeper but, instead, come to hallucinatory wish fulfilment. The dream, accordingly, was a psychosis due to the wish to sleep. In the fact of the dream, Freud takes pains to point out, there is evidence that the narcissistic regression is not complete, or, as he puts it, 'the narcissism of sleep has to admit an exception'. The dream is evoked by and attests to the fact that there is a certain amount of leftover waking libidinal or ego interest.

Presumably, therefore, the less there is to a manifest dream and the nearer it comes to being blank, so much the nearer

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The 1954 A. A. Brill Memorial Lecture.

is the sleeper to a state of consciousness expressive of primary narcissism; that is to say, the blanker the dream, the fewer impurities are there in the narcissism of sleep. Therefore, I call attention to an unusual class of dreams, described in previous publications of my own and of others, where there is relatively little or no visual content, which if present is amorphous and is called *misty* or *vague,* and in which the optical projection effect is imperfect because the dream screen is not sharply externalized. Sometimes the whole dream remains unprojected and feels to the dreamer as if it took place within him or inseparably from him rather than somewhere before him in his visual field. Such dreams come very near representing what Freud means by narcissism in this particular paper, for they approximate concretely his idea of narcissistic sleep, with very little of the 'exception' indicated by the text of ordinary dreams. This was immediately recognized by Rycroft (1951), who calls them *sleep dreams,* and by Scott (1952), who speaks in this connection of *narcissistic dreams,* both of which designations apply very accurately. Hoffer (1952), explicitly aligning himself with me, writes, 'I should exemplify primary narcissism . . . by the infant's state of deep sleep'.

In the other, contemporaneous, essay, Mourning and Melancholia, Freud brought the same concept, narcissism, to bear on depression and elation, which he interprets by two assumptions, namely, that they operate like the process of grief, and that there is regression from object relationship to narcissism. Most of Freud's exposition in this and later papers stems from the grief-melancholia comparison; nevertheless, he apparently believed the regression to be more central, perhaps crucial, for he wonders whether a 'loss to the ego apart from the object (a purely narcissistic injury to the ego) might not suffice to produce the clinical picture of melancholia, and whether an impoverishment of ego-libido directly due to toxins would not result in certain forms of the disease'.[1] He thus distinguishes

[1] *Cf.* Edward Bibring (1953).

two sets of factors in melancholia, one related to object loss and grief, the other to narcissism. His tentative formulation of mania as a sort of recovery from depression also arises from the comparison with grief.

All in all, the essay on Mourning and Melancholia, devoted to instinct and ego psychology, diverges from the line taken in the series of metapsychological papers that Freud had just published and from the Metapsychological Supplement, which was still to appear, for in Mourning and Melancholia Freud dropped the explicit comparison of dream and neurosis. Subsequent studies were to continue the new direction, so that dream psychology and clinical psychopathology developed as two separate interests with two separate literatures. The two fields that Freud was eager to unite in the Metapsychological Supplement were divorced. Dream interpretation became subordinated to technique—*'gehandhabt'*. Freud's statement in The New Introductory Lectures (1933), that analysts in the main were neglecting the dream, is true enough so far as it refers to this particular point—the bringing together of neurosis and dream. Analysts had followed the direction that Freud took in Mourning and Melancholia, and later in The Problem of Anxiety (1926), rather than the direction of the Metapsychological Supplement. An exception, noted by Freud, was Alexander's study of dream pairs (1925). More recently, some of my use of dream psychology in studies of elation and the phobias returns to the older path (1950, 1952).

There were, to be sure, obvious reasons for not beginning the study of melancholia by comparing it to a dream. Unlike Meynert's amentia or schizophrenic visual hallucinosis, there was no immediately evident point of similarity, no regression to hallucinatory wish fulfilment or to a dreamlike state, whereas the comparison to grief and the new instinct and ego concepts were very clarifying. However, I believe that other reasons participated in the general trend away from the combination of neurosis and dream, including certain historic ones which I shall indicate later.

The first formulation of depressions and elations contained several obscurities. Thus, ordinarily neurosis and psychosis are based on conflict, but mania was stated to depend on an absence of conflict between the ego and the superego. It is not clear offhand why this should not represent mental health; at any rate, no distinction is made between the two.[2] Again, the theory seems to call upon us to assume that mania is always preceded by depression, which is contrary to fact; and a theory that explains among the elations only those that follow a depression does not cover the field, which includes 'simple' manias and 'simple' depressions with no signs of the opposite state. Then, the cardinal idea, due to Rado (1928), that mania is a state of satiated oral bliss, although it has support in clinical observation and is latently correct, does not suffice to explain many findings collected by analytic observers. Complete satisfaction in the nursing situation leads to sleep, and the elations of the drug addictions, from which Rado transferred the idea, are much nearer to this end-state, whereas manic and hypomanic are manifestly very much awake; hence, it was necessary to say a good deal more about the state of affairs in mania and in the nursing situation before the relationship of the two became intelligible.

Newer clinical observations came to our assistance here, for there are two types of elated states, and what we see clinically may be one or the other or a combination of the two. The same observations forced us to introduce dream psychology into the study of the elations. To economize I shall be somewhat diagrammatic, referring my readers to my other publications for detailed descriptions. I saw a young woman go through four elations. In each of them, first came the state of *ecstasy,* an absorbed, rapt, blissful state, quite similar to what religious mystics have described, which culminated in a blank dream with orgasm, and was then followed by the second state, *hypomania proper,* the typical overactive, jocose, ebullient textbook

[2] *Cf.* Maurits Katan (1953).

picture. Ecstasy is indeed a state of bliss, and its interpretation as a union with the breast and the superego is very evident empirically. Rado, I suppose, was influenced by his experiences with the drug-*Rausch* when he wrote of the bliss that attends the fantasied union with the breast, following upon the hungry craving of the depression. Abraham and others, including Helene Deutsch (1933), were looking more at hypomania proper, which shows the active cannibalism and the defensive devices of denial and projection more violently at work.

My later study gave me a forceful impression of the relationship between dream life and the clinical waking picture. For the eroticized blank dream—the 'sleep dream' or 'narcissistic dream'—was so much part of the ecstasy, and the ecstasy and ensuing hypomania were so much a part of the dream (if one cared to look at it that way), that neither of them could be interpreted fully without the other. Both ecstasy and blank dream had to be formulated in terms of sleep; the mover of both of them was a special variety of a wish to sleep—that is, the wish to enjoy the narcissistically blissful sleep of the satiated nursling. This wish persisted into the distractible, overactive, overvigilant hypomania that followed the dream, where it was denied and disguised. The hypomania was like that part of a manifest dream text which denies the latent thought, and here it neatly denied not only the meaning of the waking ecstatic state, but of the blank dream as well.

A few words may be said of the sequence: ecstasy (or blank dream) and hypomania. It appears that blank dreams need not be followed by clinical hypomania according to Rycroft's observation, although in the case he reported a blank dream was followed by 'manic defense'. On the other hand, it seems plausible to me that, conversely, an ecstasy or its equivalent may be a constant forerunner of a hypomanic state (Lewin 1950, 1953), and I shall assume at least this potentiality in the following discussion.

After this clarification, it is easy to formulate the structure of the two elated reactions in the terminology of the dream. The

dream formula for the *ecstasy* is the same as that for the blissful blank dream: the latent thought in the ecstasy, as in the blank narcissistic dream, is the satisfaction of the nursing triad of wishes, culminating in erotic sleep at the breast. Typically this is expressed not in visual, formed images; instead, the thoughts regress to amorphous feeling memories, so that the typical ecstatic patient and the dreamer say that they cannot put in words what they feel and know, and that the pictures and verbal descriptions which come to mind when they try to communicate are to be understood only as allegories or metaphorical approximations. In the ecstasy, the person relives and reproduces affective qualities—the thrill or the 'kick', to put it colloquially—and not primarily pictorial or verbal memories. The memory traces to which the latent thoughts regress and which then come to consciousness are those that were perceptions in very early infancy during the nursing situation on the way to satiated sleep, and they are the vague, deep, feeling sensations that enter into emotional states—in this particular instance, those of intense pleasure.

The sense of reality that comes with them is quite in line with that which enters a dream. Freud remarks that we accept the hallucinations of ordinary dreaming as real because they come before our eyes in manifest pictures with visual impressions that originated in real experiences, intensified in the dream by the characteristic energetic shift to them. The same holds true for the nonvisual or unformed impressions of pleasure and excitement in the ecstatic state, for they too reproduce sensations and qualities, intensified by condensation, that once really existed, and they too have the convincingness of immediate presentation. I think the situation in ordinary dreams may be more complex than Freud's statement of it, since the oldest oral elements may contribute here too to the sense of reality; yet, in the ecstasy it might be said that a person relives an intensified hypnagogic, partly asleep, or dreaming state that was suffused with pleasure, and the dream formula for

ecstasy is that of a blank dream or near-blank dream, in which the return to the blissful nursing sensations is accomplished.

Hypomania proper is a somewhat more complicated formation in terms of the dream. Its basic latent wish to return to the nursing situation and to enjoy narcissistic bliss and sleep is the same as in the ecstasy, but the expression of this wish is distorted. The wish does not come to consciousness directly, for its fantasied fulfilment is barred by anxiety or attended by terror. The wish is therefore fulfilled only in the way a dream wish which cannot be faced starkly is fulfilled, i.e., in disguise. Hypomania proper is all activity, eating, and independence in its manifest text. To consider the hypomanic manifest picture as if it were the second member of a dream pair, of which ecstasy was the first member, we should say that in ecstasy the wish was fulfilled with little or no disguise, in hypomania with very much. The hypomania displaces and rationalizes the pleasure that comes from the repetition of the breast situation, at the same time denying its true source. Euphoria is attributed to a quite false or, at any rate, irrelevant motor or mental efficacy. The latent dream thought or its analogue extracts cathexis from the same memory traces that figure in the ecstasy; the cathexis is displaced to later, mainly motor memory traces, and after the distortion and the revision (elaboration) that it receives from the later traces, it is accepted by consciousness. Consciousness believes that other wishes, erotic or ambitious, are being fulfilled, whereas the secret fulfilment is still of the wishes of the oral triad. Thus, hypomania too yields to the terminology of dream interpretation. The unconscious wish is for the nursing situation; the preconscious wishes (many of them from the actual situation and analogues of 'day residues') are intensified and come to consciousness in the various enterprises, and the regression is disguised in the manifest picture. If it were not for the disguises and revisions, the manic too would be acknowledging his wish for the breast and for sleep and would be yielding to the bliss or the anxiety that attends the wish.

At the beginning of this paper, in connection with my discussion of the Metapsychological Supplement, I referred to the dream as a psychosis originating in a wish to sleep. I have presented ecstasy and hypomania proper as dependent on a wish to which the same name was applied, a wish to sleep. The ordinary wish to sleep is not represented in the ordinary visually projected dream text, except for that usually invisible or unnoticed part which I have called the dream screen, an undynamic element on the whole. Contrary to this common situation, in the infrequent dreams to which I have been referring, this is not the case. The wish to sleep is important and it is expressed in the sensations of the dream which are hallucinations of nursing and of sleep at the breast. This is why Rycroft could refer to such dreams as 'sleep-dreams'. The wish to sleep that appears in the ecstasy and as the latent wish in hypomania proper is the same that produces the 'sleep-dream'. The desired sleep is the blissful narcissistic sleep which repeats that of the nursing situation. The wish for this sleep is fulfilled directly in the blissful dream or the ecstasy and in a distorted form in hypomania proper.[3]

In referring to Mourning and Melancholia, I mentioned that it was not easy to see immediately where the wish to sleep, the state of sleep, or dreaming, made any logical contact with the symptomatology of depressions or with the formulations given by Freud in this and later papers. We are so accustomed to think of the ego and the superego and of the two classes of instincts in this context that the use of other terminologies seems strange. It seems artificial to ignore the standardized,

[3] In Robert Fliess's valuable survey (*The Revival of Interest in the Dream*), the author criticizes me for not accepting Freud's early statement that the wish to sleep is 'biological' and letting it go at that. I should not think however that Freud meant the term *biological* to exclude psychology, for sexuality too is biological, and later Freud calls sleep a state of narcissism, which introduces a psychological interpretation. Fliess also questions the existence of the dream screen and by implication that of the blank dream too. It is not known whether Freud was acquainted with the type of dreams that I have reported. They do, however, exist, as many colleagues have become aware.

familiar terms and formulas that have dominated the literature, where certainly they have often been debased and oversimplified. Let us, however, begin with Freud's conception of depression as a regression to narcissism, which, he speculates might in itself be a sufficient cause. I should like to use the blank dream, which represents the nursing situation, as the concrete indicator of such a regression, and I shall take up first of all Freud's idea that toxins might produce a depression regardless of object loss and the grief processes. Many toxic depressions are encountered clinically, due to drugs or to the presence of known infectious agents. In such cases, familiar to us from many psychiatric studies (e.g., Bonhoeffer's, 1910), the patient is obviously in a state that approaches or resembles sleep, half-sleep, or a dream; hence, to say that the 'toxin' has acted to cause a narcissistic regression is correct in the very sense that Freud uses the phrase in the Metapsychological Supplement, when he calls sleep a state of primary narcissism. The true toxic depression (or elation) is narcissistic in the same sense as sleep, and the psychological content is the same kind of 'exception' that Freud recognizes in the case of the dream.

But this simple situation does not test the general validity of putting the depression into dream terminology. We must turn to the more complicated picture, always remembering that the first step remains the narcissistic regression. The basic unconscious wish in the depression, therefore, is the same as in the other narcissistic neuroses, to wit, the wish for the breast, including narcissistic sleep. Since the direct fulfilment of the triad would result in the 'sleep-dream' or ecstasy, we must take into account that the clinical picture of depression is a manifest picture, like a dream text, which distorts and conceals the fulfilment of the latent wish. Our theoretical problem then is reduced to the following task: to construct a manifest picture of depression, beginning with the unconscious wish for the breast, which becomes distorted and revised according to the processes of dream formation outlined in Chapter VII.[4]

[4] Freud: *The Interpretation of Dreams.*

Our task of diagraming the depression will be easier if we fit the superego into the scheme of Chapter VII by determining the location of its memory traces. The superego is an arouser; it is an opponent of blissful sleep at the breast. External wakers that arouse the dreamer are often in the final moment of the dream translated into superego injunctions (Cf. Freud 1900, Isakower 1939 and 1954). Isakower, commenting on the meaning of words in dreams, pointed out that they often give the superego's opinion of the latent dream wish, which is exemplified in Freud's paradigm of the dream, that of 'the burning child', where the child whispers reproaches and seems to wake the father through them, although the real arouser is a real fire. The superego in dreams may also be represented by significant sounds, which serve as signals, as I indicated in my article, The Forgetting of Dreams. Thus, a patient who forgot her dream (i.e., awoke completely) when her telephone bell rang, associated this bell to the rising bell at school, to the bugle at camp, etc., and in general to disciplinary signals and injunctions. In the interest of guarding sleep, its chief concern, the dream may for a time depict and hallucinate an external arousing stimulus as a superego command.

However, many stimuli, coming from the external or internal environment, may disturb sleep. Many of them are present from near the beginning of life.[5] These are loud noises, bright lights, cold, pain, hunger,—to mention the more conspicuous. The iconography of dreams and myths readily combines them with superego action. Thus noises and lights figure as thunder and lightning and the wrath of God. The waking brightness of a new day figures as the sun and God's all-seeing eye. The watery cold of an enuresis is depicted as God's punitive Deluge. Hunger pangs become the punitive bird that gnaws at Prometheus's vitals. The earliest arousers form ready alliance with the superego when it tries to waken or wean the sleeper from his sleep at the breast. Between the precœdipal arousers

[5] *Cf.* Zetzel (1953).

and the superego injunctions and punishments, somewhere along the line is the father in the œdipal situation, who is a waker and in the full fantasy a weaner too; for it is the hungry, jealous father that becomes the wolf or the animal that takes over the mother's breast and prevents the infant's contented sleep (Lewin 1952).

The superego's punishments have preœdipal roots in the earliest weaners and wakeners, and it is also the heir of the jealous, devouring, sleep-disturbing father. The memory traces of these superego precursors persist in the unconscious. Later memory traces that enter into the superego are verbal, according to Freud, a point emphasized in Isakower's studies of the 'auditory sphere' in dreams; hence the *mem* traces of the superego are to be found in at least two locations in the diagram of the psychic apparatus. One set of *mem* traces is very near those revived in the ecstasy, but this is a set of unpleasant memories of being awakened and weaned, such as hunger, pain, etc. The other superego *mem* traces are further to the right in the diagram, among the early verbal impressions, and in line with certain analytic suppositions and certain observations, the words would be in the imperative mood. For our present theoretical purposes, it suffices to assume that the latter set belongs to the unconscious system of the ego or superego. If some of them are preconscious, the scheme needs no alteration.

If then we approach the depressive picture as though it were a manifest dream text and if we inquire how well it preserves the narcissistic state (as the dream preserves sleep), we see first of all that it is an unpleasant dream, in which the latent unconscious wish for sleep at the breast is disturbed in its fulfilment by an opposite intruding tendency, that is, by weaning and wakening. As in the dream of the burning child, the representation of this tendency to a certain extent serves the regression. As the real, arousing fire became a superego command and in this form operated to preserve sleep, so the verbal forms of the superego injunctions tend to guard the analogous

regression in the depressions. The narcissistic sleep analogue in the depressive person is constantly beset by the admonition, 'Get away from your mother's breast! Wake up!'. The persistence and repetition of the injunction over a considerable period shows that it is heard but not obeyed. The depressed ego listens but it does not move. Like the Cornish Constabulary in The Pirates of Penzance, the depressed hear the commands and repeat, 'Yes, yes, we go!', on which the irritated General Stanley in the operetta comments, 'But you *don't* go!'. As long as the depressed patient is being admonished, he is evidently secretly or unconsciously still regressively at the breast. This statement, I believe, simply amplifies Freud's thought that the depression is a narcissistic state, and the pleasure premium is hidden while the unpleasure is blatantly manifest.

The dream-formation scheme, then, can be applied somewhat as follows: the latent unconscious wish in the depressive picture is to remain in the nursing situation, narcissistically; the latent thought includes the idea of being wakened and weaned; the manifest text pictures the unsuccessful weaning and waking injunctions, disguised and revised. Since the manifest content consists largely of painful feelings and auditory impressions, the analogue of the visual text of ordinary dreams is to be found precisely in these two fields. We have a painful and auditory text rather than a visual one. The manifest picture is painful weaning and waking; the latent wish fulfilment is pleasure and sleep at the breast.

The depressive picture presented here is didactically oversimplified. The 'father-superego' figure who wakens the infant from the breast may be called upon to supplant the mother and the breast as soother and provider. And suicide may serve symbolically as a return to sleep at the breast. But such complications deserve more complicated treatment. (See Lewin 1950, discussion of suicide.)

If we compare the three narcissistic neuroses (ecstasy, hypomania proper, and depression) with the dream, we may say

that ecstasy is like a blank or nearly blank, narcissistic, satisfying dream. Hypomania is like a dream in which the same regression is effected but unconsciously and is covered by denials and other disguising defenses, especially displacement to action. Depression also unconsciously maintains the regression, but consciously uses the auditory and painful impressions as manifest cover. In both hypomania proper and depression, the cathexis of the breast is maintained; in the first picture it is revealed consciously by the pleasure qualities, in the second by qualities of unpleasure that go back to the same situation.

I should like to take exception to occasional misunderstandings of my views on elations and depressions. I do not subscribe to the idea that 'elation covers depression', or that when a person is elated there is an 'underlying' depression. This seems to me too gross a formula to fit the deep psychological situation. I do not think that interval obsessional neuroses, as described by Abraham (1924), 'cover' the depression between attacks; surely a more accurate statement would be that different defenses are brought into play, e.g., reaction-formation instead of identification. As to the narcissistic neuroses, the idea of 'cover' is extremely loose. Genetically and topographically, ecstasy is in all probability the earliest state, hypomania and depression later ones, for ecstasy is 'purer' in its narcissism, so that even the father-superego becomes a feeder and provider, and rapturous saints imbibe directly from the breast of God. But hypomania is rarely pure ecstasy; when it alternates with depression it is hard to say which state 'covers' which. Empirically, there are cases where a prolonged oral indulgence is followed by a difficult and resented weaning, so that pleasure elements in later hypomanias are older for the most part than the painful elements that appear in the depressions. A 'manic defense' after such a weaning would, I believe, be a regression. The earliest factors cannot be treated in such an isolated fashion, however, for the relation of the precœdipal and œdipal events provides opportunities for several possible combinations. In the main, from the genetic and topographical points of view

inherent in the diagram of the psychic apparatus, ecstasy would be the probable primal state that contained the earliest memories, and both hypomania and depression, in a very loose sense, would be the 'covers'. Certainly one of these does not cover the other; different memory traces from many age levels are revived in the two states.

This exposition does not seek to elevate dream psychology into a sole mode of formulating the narcissistic neuroses. I wished to demonstrate again the essential identity of dream and neurosis as wish fulfilments, and particularly the role of the wish to sleep as a narcissistic aim, thus picking up the thread relinquished after the publication of the Metapsychological Supplement.

## II. SLEEP AND TECHNIQUE

I have mentioned without comment that there may be historic reasons for our having abandoned some of our interest in sleep and the dream. In daily practice, our analytic activity deals with neurosis, and when we formulate it, we speak naturally of the transference *neurosis,* and of transference *symptoms,* indicating thereby our preference for the theory of the neuroses. We do not primarily think of the patient as a dreamer, and we do not use the terminology of dream psychology in formulating the psychological events on the couch. Only occasionally, for didactic purposes or as a play of virtuosity, do we find in the literature attempts to interpret the transference in terms of what goes on in the three psychic systems. It is then often incidental to other matters, as in Nunberg's 1951 paper, but even this variety of treatment is unusual, and it rather looks as though we may have some resistance to the idea that analytic therapy and technique are related to sleep . As analysts know better than most, the human tendency is to put away childish things and to belie our infantile past once we have reached maturity, and since psychoanalysis, as a science, has come of age and wishes to appear mature, we may be denying or ignoring the fact that when it was still growing up, its tech-

nique consisted in putting the patient into a sleeplike state, and that it encouraged the dreamlike productions of the talking cure.

Freud's Collected Papers V contain Hypnotism and Suggestion, written in 1886, in which he tried to overcome the resistances of the medical profession and of the public to the therapeutic use of hypnosis, a method he was then using to uncover repressed memories. In perspective, his arguments are still interesting, for the resistances he dealt with are not limited to hypnosis, and they were to be repeated many times in reference to psychoanalytic therapy. Freud had to assure his readers that the hypnotist did not create symptoms nor put ideas into his patient's head, but his arguments furnish deeper insight into the resistances Freud was combating. He states that the fear of harm from being hypnotized is unfounded, as much so as the fear of being harmed by chloroform anesthesia. Hypnosis and anesthesia are both comparable to natural sleep, he argues, and as the resistance to chloroform was overcome by familiarity and reason, so, one might expect, would the resistance to hypnotism be overcome. He emphasizes the naturalness of hypnosis, adducing the fact that persons not necessarily neurotic have been known to fall asleep accidentally when a bright light was thrown into their eyes during a medical examination of their eyes or throats. (Such persons were to be called 'suggestible', but dynamically and more simply, they had a wish to be put to sleep.)

It is instructive that in defending hypnotic sleep, Freud used the same arguments and comparisons as the early anesthetists. Anesthetists and hypnotists alike assuaged the anxieties of prospective patients and members of the medical profession by calling their method a way of inducing sleep. Since psychoanalysts no longer regard their method as dependent on sleep, it is interesting to note the resistances of those who were opposed to anesthesia and hypnosis. Certainly, many of these resistances have been heard in regard to analysis too. Patients dreaded what they might say when they were relaxed by

hypnosis or the anesthetic, and what they might do if they abandoned voluntary control. The erotic danger was alluded to. Tales were rife of nuns unexpectedly breaking out into vulgar language when they were given chloroform, and in France the illustrious and neurotic Magendie, often called the Father of Physiology, told a medical audience that he would never permit his wife or daughter to be given chloroform because, he said, certain surgeons might be tempted to take advantage of an anesthetized female patient.[6] His assertion is all the more interesting because Magendie did not have a daughter, and his remarks caused embarrassed laughter; but not so many years ago a distinguished American neurologist and a professed fellow student of Freud expressed the opinion that analytic patients should be treated by a therapist of the same sex, presumably to obviate the same danger.

Thus, so far as the resistances go, we find anesthesia, hypnosis, and psychoanalysis lumped together, the public and even doctors projecting to the practitioners of a new technique the Svengali and Dr. Caligari fantasies of the œdipus complex. It is indeed true that therapies are invented from time to time which combine two or more of these methods. Many analysts have turned again to experiment with hypnosis in connection with psychoanalysis, while others, especially during the recent war, combined catharsis or hypnosis with partial anesthesia by means of drugs. In the general field of psychotherapy, broadly speaking, we evidently have a choice as to the extent to which we may put our patients to sleep. Some patients, like the 'suggestible' ones Freud mentioned, appear to have a wish to be put to sleep; others (perhaps 'Miss Anna O') fear this or have a strong resistance.

Psychoanalytic therapy, as it evolved, came more and more to prefer the patient awake. One indication of this is the increasing interest in ego psychology; another, perhaps, the neglect of the dream to which Freud referred. In practice, the

[6] Lewin, 1946; Olmsted, 1944.

unconscious must certainly be presented properly to the patients' waking ego, so that they may, when awake, recognize what they are like when they are asleep or partly asleep. But gradually, since the beginnings of analysis in hypnotism, we got away more and more from the sleeping or partly asleep patient, and we rejected a good deal of the technique that depended on the patient's partial sleep. It is worth examining whether, along with this rational development, we may not have erected an unconscious defense as well, so as to live down our suspect history as hypnotists and our mythical prehistory as anesthetists. If we have, we may not be aware of all the traces of hypnotism and anesthesia we have unwittingly carried along with us.

Traditionally, we state that the recumbent position is an atavism, a reminder to medical historians that psychoanalysis had its origin in hypnotism. But if we ask why the hypnotist used the couch, we come upon the obvious reason: to accommodate the patient hypnotically asleep. Many of our patients remark on, or indicate, the suggestive effect of lying down. I do not refer to those who go to sleep. Many others take the couch as a bed for sleeping, for dreaming, or for dormescent fantasy; they loosen their clothing, take off their glasses and ornaments, perhaps kick off their shoes, or they make other trivial and abortive preparations for sleep. They complain or comment pleasantly on the pillow and the mattress, and sometimes bring a bed into their initial transference dreams. On the psychological level, our patients assume with us that what they say on the couch is not to be taken as a sworn statement of a fully aroused and critical person, but more like what they are apt to think of when they are alone and relaxed, as when they are in bed; this point is the basis of one of Freud's comments on the nature of free associations, in The Interpretation of Dreams. He writes (Standard Edition IV, p. 102):

> What is in question, evidently, is the establishment of a psychical state, which in its distribution of psychical energy (that is, of mobile attention), bears some analogy to the state before falling asleep—and no doubt also to hypnosis. As we fall asleep, 'in-

> voluntary ideas' emerge, owing to the relaxation of a certain deliberate (and no doubt also critical) activity which we allow to influence the course of our ideas when we are awake. (We usually attribute this relaxation to 'fatigue'.) As the involuntary ideas emerge they change into visual and acoustic images. . . . In the state used for the analysis of dreams and pathological ideas, the patient purposely and deliberately abandons this activity and employs the psychical energy thus saved (or a portion of it) in attentively following the involuntary thoughts which now emerge, and which—and here the situation differs from that of falling asleep—retain the character of ideas. In this way the 'involuntary' ideas are transformed into 'voluntary' ones.

Many associations refer to the similarity of bed and couch, and some patients reproduce the process of going to sleep, occasionally including the characteristic Isakower phenomena (Rycroft 1951, Lewin 1953, Heilbrunn 1953). Again with many patients the couch as bed and hence an early substitute and symbol for the mother, enters into the transference situation, for the analyst's remarks become the equivalent of the noises and wakers, and are equated with the father's or superego's wakening and weaning injunctions (Stone 1947). Thus it happens that patients with oral problems may automatically react to the analyst as a disturber or even a noise they must ignore.

One sometimes encounters a fear of being asleep on the couch, which is related to a fear of dreaming. A patient brought a dream the first day of her analysis, in which she entered a motion picture theater where she saw the most terrifying things on the screen (she did not know what), and she rushed out to keep from seeing them. She immediately recognized that this was her reaction to beginning her analysis, and that the screen showed her her 'unconscious'. The screen did not show her her 'unconscious' really; it was her dream screen and it showed her fear of dreaming, a matter which came up almost immediately. This is the more exact interpretation, but it is noteworthy that the uninstructed patient naïvely used the words 'my unconscious' to mean *my dreams.* In most patients'

experience, the nearest thing to what they are asked to do on the couch is what they have sometimes done in bed, when, with a fluctuating state of consciousness somewhat influenced by the anticipation of sleep, they have let idle thoughts run through their mind, with whatever consequence.

The equation of the analytic work to being in bed is very evident in some patients. Years ago, a patient made a remark which I have always remembered but apparently did not fully understand at the time. Toward the end of her analysis she went to her physician for a physical examination. To his surprise he found that a gastric ulcer of some years' standing had healed, and he asked her what she had been doing for it. 'Oh', she said, 'I have been lying down for an hour every afternoon'. This was a joke; it was long before the term *psychosomatic* had gained popularity, and I was amused. Retrospectively, I see that she was stating a deep analytic verity, one particularly clear to me since Stone's report (1947) of the duodenal ulcer patient who fell asleep on the couch. My patient is the one I referred to in my paper on claustrophobia (1935), who assumed the 'fœtal posture' on the couch and anxiously blurted out, 'Don't touch me!'. Her conflict was between her genital wishes and her attachment to her mother, and she was saying to me (ambivalently), 'Don't wean or waken me!'. But her joke was psychologically penetrating: her ulcer had been cured by 'lying down', by a form of therapy which enabled her to relive and understand infantile sleep.

A male patient could not lie down for several months at the beginning of his analysis. Finally, he lay down with marked pleasure, rationalized as a realistic triumph, but which was certainly also a libidinal repetition, for, as he told me many times, his life and his analysis involved a constant struggle against spending all his time in sleep. The ability to assume the recumbent posture was not the brilliant technical achievement it might seem; for long after he was settled on the couch, he came to realize that he automatically 'closed his ears' to what I said to him, as if to guard against being disturbed in his sleep,

and after an upsetting analytic session he would often react by taking a nap.

Patients have some inkling of the historic secrets of psychoanalysis when they ask to be hypnotized or to be given drugs. Aside from the various transference implications of the request for passive indulgence, the patient senses in himself a resistance and a conflict that would be solved in one way if he were asleep and could forget, or which could be solved perhaps in a disguised form if he dreamed. At this point, the waking ego can admit the repressed impulse only with the reservations that a dream censorship might impose or that a half-sleep might excuse. If the analyst accedes to the patient's request for a drug, the action could be interpreted from the standpoint of psychoanalytic history as a return of the repressed.

It has been said that the effectiveness of psychoanalytic therapy depends on a split. The patient on the couch is as if aware of two realities, and we speak loosely of psychological and objective reality. Since ordinarily the patient has not been indoctrinated in psychological theory and is not much affected if he has been, how is it that he comes to distinguish between the two during his analytic work? Elsewhere I have remarked that the first split which all of us know from experience is that which comes with going to sleep or waking up, the more or less sharp division between the 'me' as a waking person and the 'me' as a sleeper or dreamer. This is a normal, persistent discontinuity throughout life. All of us in a way are Peter Ibbetsons who lead two parallel, though often interacting, lives and we assume that this duality is based on an evolution from an originally undifferentiated state. Freud has taught us how the reality principle enters human development to separate for us what goes on in our head from what goes on in the world about us. Part of our life continues to go on only within us, and one very early result of the functioning of the sense of reality is our appreciation of the fact that we are awake, or, in retrospect, that we have been asleep and dreaming. The most

obvious and palpable outcome of 'reality testing' is everyone's normal, reasonably assured knowledge of this split.

It is this split which the analytic patient understands from experience and which he repeats when he works through analytic material. Naïvely the patient differentiates not between the 'real' and the 'unreal' in what he says and feels, but between that which can stand the light of day and that which is real only in sleep. As the recumbent posture is an adumbration of being in bed, so the patient comes to judge his ideas not in the old Aristotelian categories of *true* and *false,* but metalogically in the noncontradictive categories: (a) 'true (or false) when I am awake', and (b) 'true when I am asleep'. Freud recognized this in the example he used in his paper on Negation where the patient says, 'I do not know who the person was in the dream; surely, it was not my mother'. Whereupon, Freud says, we emend this: So it was his mother! The patient in the dialogue means 'false when I am awake', Freud means, 'true when you are asleep', and there is no contradiction.

> 'Many a man ere now in dreams hath lain
> With her who bare him. He hath least annoy
> Who with such omens troubleth not his mind.'[7]

says Jocasta, displaying a perfect comprehension of the two realities.

As a sort of mental experiment, let us look aside from the content of the analyst's interpretative remarks and regard them solely as some patients have done from, so to speak, a musical standpoint, as tending to soothe or to arouse. It sometimes happens that a patient strips the analyst's words of logical sense and treats them as if they were simply pleasant or unpleasant perceptions. At this primitive level, the patient simulates the baby that either smiles happily or cries with displeasure according to whether the adult is cooing or making an unpleasant noise. But since the analyst is articulate, an affective response to the content of what he says is also registered and regressively put into the category of pleasant or unpleasant, and in the

[7] Lewis Campbell's translation in the Standard Edition of Freud, V, p. 264.

context we are considering here, treated as either arousing or producing sleep.

Patients differ in a wide range and with great fluctuation in their degree of awakeness, from the extreme of going to sleep on the couch to the other extreme of complete vigilance. Ordinarily their state is an intermediate one, or they would not be analyzable. In a sense, the wish to be awake and the wish to be asleep are both present at the same time, and the interpretations given by the analyst play on one or the other. From this narrow angle, interpretations can be classified as those which induce the patient to favor one or the other side of the analytic split. Some induce him to be more awake, others to be more asleep; they shift the 'quantities' of energy from one to the other side. To give what Anna Freud calls an 'id interpretation' would produce a shift in the direction of wakening. It would be the equivalent of stripping the disguise off a manifest association and revealing that the latent idea is of the kind that holds only in sleep. One implicitly has said to the patient, 'This is true of you when you are asleep', and his waking part tends to become more alert. On the other hand, an 'ego' or 'defense' interpretation tells the patient that he is being unduly vigilant and on the qui vive against the sleep-suitable class of ideas. It says in effect, 'Relax your attention', and the quantities are shifted toward the sleep side. Here, of course, one notably operates with small quantities, and this fact further differentiates psychoanalysis from hypnotism and the drug psychotherapies, where massive quantities are shifted in this direction. Leaving aside the important quantitative difference and the other differences implicit in the various methods, all three methods at some point agree in favoring the switch toward the sleeping side.

In psychoanalytic technique the wish to sleep plays a role which bears an interesting similarity to its role in dream-formation. In both cases, it is a silent *sine qua non,* for there is no dream-formation without a wish to sleep and no analysis without its weaker counterpart, the wish to associate freely. In

ordinary dreams and dream interpretation, the wish to sleep rarely needs explicit interpretation, or at any rate is rarely given it, and the extent to which he is asleep is not often brought to the attention of the analytic patient. Yet, in dream analysis and in the analysis of the analytic situation, there are occasions (and these not only the dramatic ones referred to) when the wish to sleep becomes represented in the manifest content of the dream or of the analytic communications and when its meaning must be brought home to the patient. In other words, the background 'couch' of the analytic situation, ordinarily as inconspicuous and as subordinate practically as the background dream screen, may dominate the manifest picture. As there are the rare blank 'sleep dreams' so there may be the blank 'analytic couch' of the transference sleep during the analytic session.

This may be more than an analogy. The earliest memory trace that can be represented as a manifest element in the dream is the screen, especially in its purest form when it appears as a blank unprojected dream. Similarly, the earliest memory that can appear as a manifest element or 'symptom' in the analytic situation is the sleep on the couch. Both repeat the nursing situation and both indicate a wish for narcissistic sleep. The analytic situation, therefore, can be diagramed too according to Chapter VII. The analysand is in a quasi dream, making accessible to consciousness (which is the manifest analytic picture) memory traces from all parts of the psychic apparatus, even those near its topographical and chronological beginning.

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# Observations on Blank Dreams with Orgasms

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# OBSERVATIONS ON BLANK DREAMS WITH ORGASMS

BY MARK KANZER, M.D. (NEW YORK)

Current interest in blank dreams with orgasms has been initiated by the studies of Bertram D. Lewin *(4, 5)*, who traces such dreams to earliest recollections of nursing at the breast followed by sleep. Clinically such dreams are of significance in denoting the onset of hypomanic conditions as well as in other crises within the personality *(8)*. Recently Lewin has applied his observation of the blank dream and the related dream screen to illuminate the problem of forgetting dreams. 'The forgotten dream is a concrete object, which has been as if physically lost or misplaced', he states. Although of the opinion that the forgetting of dreams must always, or practically always, be interpreted in oral terms, he concedes that 'some day some additional interpretation may be discovered and empirically substantiated' *(6)*.

Clinical evidence is presented which provides additional interpretations that may be attached to the forgetting of dreams, particularly when such forgetting is associated with blank dreams accompanied by orgasm. This forgetting is related to defenses of the ego against anal and phallic sexuality. Perhaps the fact that our analysand was not suffering from a severe disorder permits a clearer demonstration of the dynamics in later stages of personality development.

A thirty-year-old man, with a tendency to premature ejaculation, had the fantasy during intercourse that he was raped by the female and sought to withhold the semen which she

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actively sucked from him. This surrender of control was regressive, and averted the danger of castration by the father as punishment for aggressive masculinity. An anal determinant of the sexual fantasy was found in occasions in childhood when his mother forced him to submit to enemas. He would retain the fluid as long as possible until it burst forth against his will with physically and emotionally shattering consequences.

In the transference the analyst was to be seduced into becoming a similarly raping mother. A period of teasing and of provocative conduct ushered in the 'blank dream with orgasm'. The patient reacted to the analysis as unreal and pictured it in dreams as a burlesque or television show. Once he fell asleep on the couch and dreamed that his younger brother was passing a yellow pencil to him. Impulses to flee and to move to other cities revealed the terror beneath these defenses; at the same time, exhibitionistic and pregenital drives combined to develop a positive transference that seemed to be especially dangerous.

These drives began to break through in witty but anxious overtures that bore some resemblance to a mild hypomanic attack. The patient recounted jokes and smutty stories, ostentatiously acted at ease, and at parties attemped to attract attention to his entertaining qualities, for example by blowing smoke rings. The first of the blank dreams occurred when he was awakened by the ringing of the telephone. He discovered that he had had an ejaculation and, on becoming aware of this, recalled sensations as of urine trickling out. An excessively anxious reaction followed in which he feared that his defenses were breaking down, that he would be unable to control himself, and that he would become entirely impotent through analysis.

A few days later three dreams occurred in one night. In the first, he stood at the edge of a swimming pool watching airplanes racing and making a turn about a tall landmark. One plane was heard to throttle its engine and then crashed into a building, ejecting the pilot who fell into the pool. His body was fished out, stiff as a board and with the left leg severed at

the knee. Then came a dream which just 'slipped away'. In the third dream, the patient in his sleep seemed to be straining to move his bowels but could not do so. The thought came to him to get up and take a laxative, yet at the same time he had the contradictory misgiving that if he continued to strain, a bowel movement would take place in bed.

Associations led to childhood experiences of bedwetting and also to an involuntary bowel movement in school when the teacher ignored his pleas to leave the room. Our interest attaches particularly to the forgotten middle dream. Taking it as a real object, in the manner suggested by Lewin, it may be equated with the lost leg of the pilot who was killed in the first dream. In its middle position between the other two dreams, it is a phallus replaced by a gaping hole; it is also feces that have slipped away. The first dream warns of a turning point which will result in a crack-up and death by a phallic attack; anal and birth fantasies are contained in the image of the body falling into the water; a stiff penis is equated with a corpse and castration. The crack-up itself proves to be an orgasm which splits the body of the patient just as it splits the dream. This catastrophe is inhibited by awakening, however, and is followed by a regressive substitution of anal sensations in the third dream, which further serves to deny and repress the entire erotic fantasy. The contents of the body have not been lost, according to this formula, but have been returned to the rectum and placed under control.

Freud described the forgotten portion of a dream which the analysand reported as 'wiped out'; analysis revealed infantile reminiscences of listening to someone wiping himself after defecation *(2)*. Conversely, an act of anal defiance broke through the amnestic dream screen of the Wolf-man and restored in disguised form the repressed memory of the primal scene *(3)*. During his development our patient had sought to control his oral and genital impulses by invoking anal sphincter mechanisms as a means of defense. As in the formula adopted by the Wolf-man, the shutting of the sphincter was paralleled

by a shutting of the eyelids, with corresponding inhibition of voyeuristic impulses. The inability to see, represented sensorially by the blank dream, may thus be an expression of motor paralysis and conflict, just as is the inability to move in other dreams that portray the restraint placed upon voluntary motor processes. Actually, quivering of the eyelids became a disturbing symptom during the 'blank dream' phase of our patient's analysis.

Further observation showed that blank dreams with orgasm were likely to follow his sexual relations with his wife and, as in the third of the dream fragments described, had the significance of denying the coital experience and permitting it to merge with the blacked-out components of the seminal emission that occurred during sleep. Progress in the analysis revived an earlier adolescent phase when nocturnal ejaculation had been accompanied by visually perceived images which were remembered. Characteristically, these dreams consisted of foreplay with nude women; at the moment of contact between the genitals, however, ejaculation occurred and the patient believed that he induced this deliberately, even in sleep, to avoid the dangers of penetration. Analysis of these dreams and their associations showed strong fetishistic interest in breasts and legs which were equated with maternal phalli. By contrast, the sight or touch of the female genitals resulted in terror and ejaculation; it is likely that our patient's blank dream itself stemmed from a visual concentration upon the 'nothingness' of the vagina (Medusa reaction).

It appears possible then that the equation of dream screen with breast described by Lewin may sometimes be regressive, covering underlying fantasies of a maternal phallus. Correspondingly the 'lost dream' as a real object refers to the castrated condition of the mother. In another tripartite dream sequence of our patient it is possible to trace such a reference, as well as the more infantile attachment to the breast.

The first of this series was an anxiety dream in which the sleeper drew from his mouth a whole row of teeth. Associations

brought to light habits of sucking on fountain pens and other objects, and of scraping off and swallowing fragments of tartar from the teeth. The tartar suggested semen and milk to the patient; the teeth themselves served correspondingly in his fantasies to represent not only breasts but also part of a dentate vagina which drew nourishment from phalli. The teeth were also words uttered during the analysis which the dreamer wished to revoke and put back into his mouth. Lorand has suggested that the dream of losing teeth ultimately expresses the desire to return to infancy; in the same sense, through the equation of teeth with words, safety might be attained through regression to the preverbal period *(7)*.

Our analysand's dream of losing teeth was followed by a blank dream with orgasm (the blankness perhaps representing the mouth from which all teeth have been drawn) and then by a third dream in which the equation of legs with teeth permits insight into the completion of the underlying processes of thought. In this last member of the series, the dreamer was lying on a football field while two teams of players, including his brothers, swept back and forth over him. He seemed to have no feelings except of intellectual detachment. Glancing at a scoreboard, however, he noticed that one team was beating the other twenty-seven to twenty-two, and he was surprised that so many points had been made.

This dream, like the concluding portion of the earlier tripartite series, shows a reparation of defenses that have broken down in the first and are followed by an orgastic eruption in the second portion. A state of rest is restored after a catastrophe and the dreamer is able to project the active conflicts away from himself and return to sleep. Using the formula 'legs equal teeth', he is being eaten by the two teams of brothers (jaws) that sweep over him alternately. His own body is a breast placed at their disposal; nevertheless he remains unconsumed and free of affect—a triumph of the repressive functions. Nursing at the breast, projected in this way, again becomes a preliminary to welcome sleep, not castration or death.

The numbers on the scoreboard proved, through analysis, to be related to the loss and acquisition of teeth; yet in another context they have symbolic meaning in terms of pregnancy and of competition with the father over the size of the family (as well as grudging tribute to the analyst over the points scored). In terms of the leg symbolism, the patient submits masochistically to being trampled on by his brothers and—in his reclining position—has lost the use of his own legs as well as his teeth. He is castrated and must submit to his brothers in intercourse. Fear of being kicked in the genitals did in reality deter him from playing football at one period of his life.

In both tripartite dreams, it may be noted, the first instalment deals with upper regions of the body or world, from which there is a fall; the third deals with lower regions; in between and associated with orgasm are obviously the genitals. The interest in the oral zone, which is regularly associated with the complex breast and dream screen, is therefore probably often an upward displacement from the dreaded yet fascinating maternal vulva. The blank dreams, in our case, seem to have their origin in adolescent dreams with seminal emission in which vision and dreaming were both arrested at the moment of penetrating the vagina. In this sense is to be understood the mythological blinding of Œdipus, of Perseus, and of Orestes when, in various symbolic forms, they made their entrance into the darkness of the mother's body.

A similar reaction, more limited in extent and without orgasm, was reported by Freud *(2)* when he translated the comment of a patient, 'at this point [in my dream] there was a gap' which meant, 'at this point I saw the female genitals'. The blank dream seems to represent an extreme instance of visual block which in milder forms merely blurs and partially obscures elements of the dream field. The extent and intensity of the obliteration correspond apparently to the degree of shock associated with the sight of the maternal genitals, as in the familiar castration fears that give rise to nightmares

and other disturbances following the primal scene *(9, 10)*. Partial blocking out of the dream field has been observed, for instance, in which only the heads or faces of dream figures have been thus affected. In Ferenczi's opinion, incestuous motives lay concealed behind such phenomena. In one case that he described *(1)* the dreamer would awaken in time to prevent sexual union and ejaculation; this patient, with fetishistic inclinations and disturbances of potency, showed distinct resemblances to the one here reported. It is not unlikely, moreover, that the typical dream of nakedness, in which the faces of the spectators are dim, has the same meaning; the 'faces' represent displaced and visually repressed genitals.

Memories of the maternal genitals—which would disturb sleep—can therefore be warded off by a series of defenses which include inhibition of the visual function and regression to earlier stages of libidinal satisfaction in relation to the mother. Just as the fetishist clings to the recollection of the hair or garment that occupied his attention at the last moment before the shocking sight of the vulva, so in retrospect the eyes fix upon the breasts before repeating their descent to lower regions of the female body, a process that is represented as a lowering (of vision) which encounters only blankness as it passes over the genitals. The ensuing visual isolation of this region is reproduced in the blank middle portion of the tripartite dreams described. The concomitant orgasm, however, is evidence of the repressed voyeuristic impulse and testifies, moreover, to the œdipal basis of these psychic mechanisms; furthermore, by ridding the body of tension, the orgasm supplements the visual block as a defense against the perpetuation of dangerous instinctual excitement.

The severe curtailment of both sensory and motor functions associated with these reactions is indicative of a momentous crisis. What takes place is the confrontation of the œdipal drives at their moment of strongest expression (conjuring up and imaginatively participating in the primal scene) with the most unrelenting threat of castration. An important element

in the ensuing symptoms is the bisexuality of the dreamer's identifications. The masculine desire to penetrate is warded off at the crucial moment by feminine components which, by contracting sphincters and eyelids, shut out the penis and its phallic equivalent, light. Both tendencies achieve release in the act of ejaculation.

The balance between sleeping and waking is drawn into the struggle; feminine and masculine interpretations of the wish to sleep vie for dominance. Sleep as an aggressive and masculine activity is delineated in such symbols as the crashing airplane and the triumphant scoring of touchdowns in the dreams of our patient. Metapsychologically, this aspect derives from the defusion of instincts as the ego, pursuing the wish to sleep, moves to rejoin the id. The image of the infant at the mother's breast offers a satisfying point of transformation from the active to the passive disposition that is required for sleep.

Similar imagery permits actual penetration of the vagina during intercourse, as in the case we have reported. By means of foreplay and reversed positions (the female above) coitus is transformed into oral and anal pantomimes which relieve the castration threat and deny the existence of the vagina; the male, when beneath, is the woman's phallus. Of interest is the divided identity thus achieved with the partner. Before the orgasm, the man is the mother feeding the voracious child; afterwards identifications are interchanged and he is the satisfied child. In anal terms, he is forced to yield the contents of his body which, after the ejaculation, are found deposited in his own body through the same reintrojection of the partner.

All active impulses may be thus projected and indirectly satisfied. The suppression of active perceptive and motor functions is most completely attained in the blank dream, which marks the extinction of the ego as it surrenders the capacities that distinguish it from the id. Fantasies of death and rebirth naturally adhere to this event. The orgasm then may represent the last convulsive effort of the ego to cling to life, with

the ejaculatory spasm isolated from and a signal for complete reorganization within the remainder of the personality. When, because of such dangerous implications, the ego dares not relinquish sufficient control to permit sleep, the tensions may be carried over into a dreamlike awakening in which the identifications and the instinctual goals remain confused.

As in the Schreber case, and in others reported by Lewin, such states may usher in a psychosis. The orgasm then becomes conducive not to a discharge but to an intensification of anxieties, and the disposition noted by Ferenczi and Lewin to a succession of ejaculations during the night may prove to repeat and take on aspects of the original trauma. Like a manic attack, an orgasm serves to deny the threat of castration; with the failure of this defense, sexual fulfilment and castration become increasingly as one. In milder disturbances, however, the resultant symptoms are much attenuated and may consist only of such relatively innocuous disturbances as a tendency to premature ejaculation, transient feelings of unreality, or euphoric moods.

## SUMMARY

Forgotten dreams, particularly blank dreams accompanied by orgasm, are traced in their multiple significance through various levels of personality development. Their relationship to shock at the sight of the mother's genitals is stressed and linked with milder and partial obliterations of the dream field that occur in other disorders. Premature ejaculation, for example, may be the waking equivalent of a blank dream with orgasm.

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# Acting Out and Ego Development

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# ACTING OUT AND EGO DEVELOPMENT

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The term acting out is rather loosely applied to repetitive compulsive behavior in the service of gratification of unconscious impulses. It occurs during selective suspension of reality testing. In the genesis of habitual acting out, Fenichel *(1)* postulates first, a heightened constitutional motility or 'alloplastic readiness'; second, oral fixations, highly narcissistic needs, and intolerance of tensions; third, an infantile trauma which produces an abreactive repetition similar to that which characterizes traumatic neurosis. Greenacre *(2)* adds two more: 'a special emphasis on visual sensitization producing a bent for dramatization' and 'a largely unconscious belief in the magic of action'. She goes on to say, '. . . the common genetic situation which combines with or sometimes partly produces these characteristics, and the accompanying general tendency to act out, consists in a distortion in relation of action to speech and verbalized thought, arising most often from severe disturbances in the second year'. She notes that the frequently distorted speech serves the motor discharge of tension rather than the establishment of communication or any distillation of a situation into thought. 'The capacity to verbalize and to think in verbal terms seems to represent an enormous advance not only in the economy of communication, but also in a focusing of the emotions which are associated with the content thought . . . . An incompletely developed sense of reality has appeared characteristic of many of these patients. But chronic or habitual acting out is a repetition of past events and an establishing of transference relationships with too great a burden, from the second year of life. Both are lived out and presented without the sufficient emotional equipment or the methods of communication that belong to later development. This symptom complex is intensified when, in addition, a

weak and narcissistic ego persists due to other causes. In most instances this very narcissistic weakness of the ego, with its accompanying overdependence on dramatic activity rather than on work-directed activity as a means of expression, is associated further with tendencies to exaggerated and somewhat detached fantasies which, in turn, impair the sense of reality or at the very least jade the perception of reality.'

This paper is concerned with elaborating Greenacre's remarks and adding one point: that the severe disturbances in the second year center about conscious, gross duplicity between the parent figures to which the child is made an accessory, with concomitant distortion of the developing function of language. This duplicity is evident in the case material given by Greenacre though it is not explicitly emphasized by her. 'Even earlier this child had frequently been taken by her nurse on daily walks to the nurse's home, and had been the passive witness of sexual scenes. She was warned not to tell, and gained much praise from the nurse for keeping the secret. A precocious and attractive child, predisposed anyway to an excess of adulation, she spoke early, well and clearly; but under the pressure of keeping the secret, she developed a special tendency to amusing prattle in which she made shrewd remarks, doubtless "half-revealing and all-concealing" her secret.'

A patient seen several years ago first suggested to me the role of gross deception in the etiology of acting out. This man with a marked propensity for acting out was a debonair and ingratiating person who for six years had been shuttling back and forth between two women, one of whom was first his mistress, then his wife, and the other first his wife, then his mistress. He was the only son of a family long established in society. The father was small, anxious, unsuccessful, and perplexed. The mother was determined to maintain the family fortunes and social position by the inexorable force of her will. A staunch fundamentalist, she knew that any sensual pleasure was wicked and any display of affection evidence of

vulgarity. From infancy, any fondling he received from the governess, or from the family nurse, the patient had to conceal from his mother. The father was sympathetic, but he too lived in fear of the mother and had consoled himself with an understanding mistress for forty years. The deception in the family and the mother's self-deception were monumental. Analysis was unsuccessful in halting the acting out and was discontinued.

A colleague has provided a dramatic illustration of my thesis in a young woman who habitually acted out; during the course of her analysis she was involved in about twenty automobile accidents. Her earlier acting out included deliberate enuresis, soiling, running away, stirring up controversies within her family, and later a hostile, biting, provoking of rejection, and many minor accidents. When she was a young child, her father repeatedly first came to her bedroom, then proceeded to an anteroom where he had intercourse with the child's nurse. While aware of this with all her senses, the child had to keep the secret from her mother. The father also had much rough, seductive play with the child, which she provoked. When she was five and a half years old, the father was about to leave on a hunting trip without her. She provoked him and he beat her. She told him she wished he were dead. The following day, he met violent death by a self-inflicted gunshot wound. The major motivation of her automobile accidents was provocation of attack by a man.

Let us now consider how such duplicity in parents or parent substitutes affects the development of the child's ego.

In the infant, boundaries of the self are unknown and there is a lack of differentiation between inside and outside. The ego functions have to be performed by the mother, and the environment consists largely of what she does. The better the mother as the 'outside' ego performs these functions, the better organized is the 'inside' ego as it develops *(3)*. In the communication between mother and infant there is first a body language. Twisting, turning, writhing, jerking, and crying are forms of movement that bring forth responses of the

mother, which in turn act as stimuli to the infant. Thus these movements come to involve communication functions, emotional meanings, and social values.

Movement comes to have a more direct communicative value between mother and child in the second half of the first year when imitative behavior and playful mimicry come into prominence. For a considerable time, noises and verbalizations are part of this type of gesture communication, before words acquire specific meaning of themselves and language communication begins. This is illustrated by such mother-child games as peekaboo, patty-cake, and bye-bye. There is first imitation of simple movements and sounds, later of more complex behavior; and there is identification with the model. The child, for example, rolls across the floor and is a ball, rocks on hands and knees with huffing and puffing and is a train, mews and laps up milk and is a kitten, turns its plate to drive an automobile and is Daddy, or feeds its baby doll and is Mama. Much play is hard work carried out with grim determination. It seems to be the anticipation of the development of some capacity, persistently practicing it, finally mastering it, and making it a part of one's repertoire *(4, 5, 6, 7)*.

As the child grows, the initial sensorimotor, self-centered individual play gives way to group motor play. This, in turn, is replaced by group play with much emphasis on rules and rituals and a greater participation of language *(8)*. In these various stages, regardless of how engrossed the child may be in its fantasy play, there is always the awareness that it is just 'make believe'.

With adolescence comes increased self-awareness. There is preoccupation with one's sexual role, with status in the family and in society, and choice of a vocation *(9)*. The drive for independence brings problems of responsibility, and the 'make believe' world is more and more invaded by reality. The failure to distinguish clearly between 'make believe' and reality facilitates acting out, which is so typical of adolescence. In adolescence there is also greater use of language to explore

and test the world. To the extent that this is successful, reality acquires a more solid structure, acting out is reduced, and there is more mature action. The person who habitually acts out, however, does not complete this last step. He remains the perpetual adolescent with faulty distinction between 'make believe' and reality.

It is my thesis that a person who habitually acts out does so because the participation in duplicity in the second year gave rise to a distortion of the function of language. While the disorder may be seen earlier, it becomes clearly manifest when the expected maturation in adolescence fails to occur. Because, early in life, real facts have seemed to the child to differ from what is said about them, orientation to reality through action and orientation to reality through language have developed relatively independently of each other and without adequate integration between them. In the normal person, in whom proper integration has occurred, thought and language are used to sample and test reality and action. In the person who acts out, failure to assimilate language as a concise method of conceptualization and communication is associated with a tendency to act out complete dramatic sequences rather than to select some detail for symbolic representation. The weakness of ego of the person who habitually acts out calls to mind the 'as if' character, described by Helene Deutsch, whose severe ego disturbance causes him to act out a complete identification with an object *(10)*. The more secure the identity of one's own ego, the less total will be one's identification with someone else.

This lack of integration of sense of reality, of language, and of symbol-formation seems to be related also to other characteristics of the person who acts out. For him there is a chasm between reality and fantasy. Many such persons have a rich life in fantasy, but the fantasy exists almost as a thing apart, and they are incapable of converting it into actuality by such means as artistic creativeness.

The normal person is not averse to deliberation; he can

sustain states of tension or mild anxiety. He anticipates, tastes, and relishes various aspects of a situation, prolongs it, and enjoys it. The person who acts out has a low tolerance for tension and anxiety; he must discharge such tension at once. He is likely to be passive, dependent, and conforming except in the area of his acting out, which is often a counterphobic tempting of fate.

Thus far I have spoken of the person who habitually acts out, who would be diagnosed as having an impulse neurosis or character disorder, or as being a 'psychopath'. But it should be kept in mind that acting out may also be the expression of demands of the sugerego and may be part of various neurotic and psychotic disturbances. In general, I should say that the disturbance of language integration causes acting out, the specific form and content of which are determined by early or later conflicts. Of interest in this respect are the reports of Adelaide Johnson and her associates who, by collaborative therapy of children and parents, have demonstrated that many instances of delinquent acting out by children are the direct vicarious expressions of the unconscious conflicts of the parents *(11)*. They believe that the specific superego defect in the child is a duplication of a similar defect in the psychological organization of the parents.

The psychoanalytic treatment of persons who habitually act out is difficult; many analysts consider it impossible. In analysis, such patients may respond readily to what they feel the circumstances demand of them, often lie immobile on the couch, and produce vast quantities of material tailored to please the analyst. The patient never really 'gets into' the analysis and the procedure becomes a shallow exhibitionistic intellectual gratification. Meanwhile, the analyst becomes weary of repeatedly interpreting the patient's behavior to him and increasingly alarmed as the patient continues to act out outside of analysis.

In the therapy of such disorders, as in other severe ego disturbances, there must be an extensive period of ego edu-

cation before analysis can begin. As in child therapy, this should be face to face with toleration of the patient's motility in a treatment session so long as it remains within sensible bounds. Considerable time must be given to 'feel each other out' and 'come to grips with each other' in a mutual exploration of reality and of the ego defenses. The therapist's attention must be focused on motor and visceral behavior, and he must constantly check the relevancy of the verbal productions against the behavior. It is only as communication becomes concrete that the magical components of words and gestures are reduced and words become increasingly real and meaningful. If this process is successful, there is less need to act out either in therapy or outside. The acting out tends to be replaced by regressive psychosomatic anxiety equivalents and by verbal communication. It is only then that the standard procedures of analysis can gradually be introduced.

Many patients who act out do not weather this initial exploratory period of analysis. Sometimes it is revealed that their coming to analysis is only a ruse. Others become alarmed by the prospect of becoming honest and discontinue treatment. In either event, the decision is faced much sooner than if analysis had begun immediately.

Often in the literature on this subject no clear distinction is made between the person who habitually acts out and one who begins to do so while in therapy. In the latter, the acting out is used as a regressive defense and can be resolved by the usual techniques of analysis.

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# Ego and Superego in Obsessional Character and Neurosis

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# EGO AND SUPEREGO IN OBSESSIONAL CHARACTER AND NEUROSIS

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In 1913 Freud stated that '. . . premature advance of the ego development ahead of the libido development contributes to obsessional disposition. Precocious development of this kind on the part of the ego instincts would necessitate the formation of object choice before the sexual function has reached its final configuration and would thus leave a legacy of fixation at the pregenital stage of sexual organization' *(4)*.

This formulation with reference to the state of libidinal development remains unaltered: in the genesis of obsessional neurosis the primacy of the genital zone has not been established and the component impulses which govern the sexual life are the anal-erotic and anal-sadistic.

The stage of ego development is the other most crucial factor in the predisposition to obsessional neurosis. Freud's observation, 'premature advance of ego development', is subject to scrutiny in terms of our present knowledge of ego psychology. His knowledge of ego instincts and ego development at that time was limited and self-acknowledged.

Referring to Freud's Narcissism—An Introduction (1914), Annie Reich noted that it was 'a forerunner of ego psychology and a number of problems which later are dealt with from the point of view of ego psychology are treated [here] on the basis of the libido theory' *(10)*. This is equally true of the 1913 paper on obsessional neurosis. Knowledge of ego development at that time was rudimentary, and the total organization of the superego remained unformulated for another decade until the publication of The Ego and the Id *(6)*, after which the role of ego development in obsessional neurosis was re-evaluated and established the importance of the superego in obsessional neurosis.

Hartmann, in elaborating upon his concept of autonomous ego function (1950), criticized the unmodified concepts of precocious and retarded ego development. He stated, 'it seems often feasible and useful to replace the global use of terms like "precocious" or "retarded ego development" by more detailed statements on what ego functions have actually undergone a precocious or retarded development in relation to their drives and in relation to one another' *(7)*.

It is worth-while to review current formulations on the role and status of the superego in obsessional neuroses. Fenichel stated (1945) that in obsessional neurosis the ego governs motility and does not feel free in using this governing power. It uses its power in response to a strange command of a more powerful agency. This formulation suggests that the superego in obsessional neurosis is more powerful than the ego. He described the relative preponderance of the ego's dependency on the superego in this neurosis, in which the ego is obliged to obey the superego but also rebels against it; or the ego behaves toward the superego as it did previously toward its educators; or the ego is ambivalent toward the superego *(2)*. He stated that the regression to anal sadism modifies the superego which becomes more sadistic, presenting automatic and archaic features, and that the superego operates according to the talionic principle and obeys rules of magic.

Alexander wrote (1930) that the superego is archaic and corruptible because it has a pseudo morality *(1)*. Freud had noted (1924) that 'sadism no longer directed against objects is turned inward as superego's aggression against the ego', further stating that the 'sadism of the superego acts on the ego's need for punishment and if combined with masochistic sexual wishes then morality which arose from an œdipus complex has regressed and become œdipus complex again' *(5)*.

The first group of descriptions, which relate to the power of the superego over the ego and of the ego's dependency on the superego and how the ego behaves (and rebels) in its attitudes toward the superego as it previously did toward its

educators, is partly a dynamic, without being a genetic, description; also it is partly anthropomorphic. The second group of observations, which refer to the superego as becoming more sadistic or as reacting archaically, is slightly genetic but mainly dynamic.

At this point a differential comparative study of the organization referred to as the archaic precursor of the superego and the superego proper will be considered from dynamic and genetic points of view. The function of the archaic superego is to provide the ego of the infant with a means of sharing the power of its parents and their protection against its instinctual prephallic demands. The function of the genital superego is to bring about the resolution of the œdipus complex.

The archaic superego consists of introjected images of parental attitudes and prohibitions in the ego. The cathexes of these images are transient and reversible and their position in the ego is undone by the mechanism of projection. The developed superego is formed by identification with parental images representing both parental ideal and parental superego and contains the highest level of parental prohibitions.

The cathexes of the mature superego objects are more permanent or, put another way, are more permanently internalized. The internal object of this superego is relatively more independent of the external object and the ego. The archaic superego's images are part of the ego and are not independent, or relatively less so, of external objects. The earlier the object is introjected developmentally, the less the distinction between internal and external objects. In the archaic superego the aggressive energy attached to the 'prohibiting' introject is least neutralized and more closely approximates instinctual qualities. In the mature superego the aggressive energy attached to the internal parental objects is more neutralized, and the object libido attached to the ego ideals is desexualized.

The archaic superego threatens with dangers of loss of the love object and the loss of love. The mature superego threatens annihilation or castration as well as the loss of self-esteem.

The mature superego has the positive aspect of producing feelings of self-approval; well-being under the archaic superego seems to be the absence of unpleasure.

In normal development the archaic superego diminishes in significance and its function is taken over by the developing superego. In pathological development the archaically introjected objects are not predominantly replaced by the objects of the mature superego. It is such predominance of an archaic superego that may be of importance in the genesis of obsessional neurosis.

In normal development the postœdipal superego is modifiable. Object relationships to individuals in the environment who represent parental images, and with whom identifications continue to be made, modify the superego correspondingly. The modifications of the superego which take place in adolescence have been well described. In pathological states the superego may be usurped by new or old introjects, as has been described in mania, depression, and schizophrenia.

In pathological development archaic objects internalized in the ego may shift their position in relation to the mature superego. When this occurs, the archaic identifications retain their original type of cathexis, that is, unneutralized aggression. They now function like a permanent part of the mature superego, influencing ego and instinctual drives. These early introjects operate along with more mature identifications. The early introjects have a priority over the more mature identifications in governing phallic and prephallic (anal-sadistic) drives and the ego's mode of reacting to these instinctual representations. It is this particular vicissitude of the archaic superego in relation to the later developed superego which is considered characteristic of the obsessional neurotic.

A man of thirty, unmarried, had typical compulsive and obsessional symptoms. One of his obsessions was, 'What would my mother think if she knew that I masturbated; if she knew that I drank; that I had sexual activities with girls; if I were to have sexual intercourse before I were married, or if I were to

marry a girl of a different religion?' These obsessions were accompanied by threatening consequences such as, 'My mother would die'. These obsessions were literally repeated in the analytic transference, and with the same obsessional intensity they had had with his mother as object. His general knowledge about psychoanalysis, however, gave him the contradictory belief that the analyst was supposed to help him overcome feelings of guilt. With great difficulty he began to recognize that his confusion of the analyst with his mother was a distortion. The task of learning that his distorted concept of his real current mother stemmed as well from the archaic image of his mother was more difficult.

He remembered that at the age of three he visualized his mother as the Dutch Cleanser woman with the broom. The broom (aside from its phallic meaning) he associated with her alerted attitude of detecting and correcting every unclean eventuality (prephallic strivings). With Dutch, he associated Pennsylvania Dutch, Quakers, and rigid morality. His New England parents were active church members. Dutch was also associated with Scandinavian, his mother's origin. His mother's alcoholic father had beaten her severely, and she would tell her son of her hatred for her father and of her fears of marrying a drinking man; hence the patient's conflicts about his own conservative social drinking. Of other incidents of misbehavior connected with his mother before he was three years old, one was of urinating in his bathing suit at which his mother became angry and walked away from him, which he felt as a desertion; another, in which he had created some disorder at home, caused his mother to threaten that she would send him away. Here he began to fantasy that he would be sent to a parochial school where he would be cared for by nuns. His mother was also sometimes a threatening nun who abandoned him to the care of another nun.

Here we see the introjected object and its reprojection in the outer world accompanied by the fear of loss of love object and the loss of love. It would seem that the earlier fantasy

of the nun progressed with some slight realistic modifications into the image of the Dutch Cleanser woman. He then recalled that throughout his life, when he was intensely involved with the obsession, 'What would my mother think if . . .?', there would occur on rare occasions a re-evocation of the image of the Dutch Cleanser woman and the nun.

This confirms the permanent cathexis of these internalized objects and their representation. The instinctual demands contained in such things as social drinking, sexual activities, divergent political beliefs, although acceptable to his own ego and to his real parents, remained under the influence of his obsessional distortion. The archaic image coexisted with the mature superego, mature identifications and ego ideals, and not infrequently prevailed over the latter.

Another patient, a woman, would occasionally visualize, whenever there was a very severe exacerbation of her obsessional symptoms, the image of the muscular arm of her father threatening her with physical punishment.

A typical obsessional idea or act may rigidly relate to a number of instinctual expressions (phallic and prephallic) so that it is permissible for theoretical purposes to examine some classical compulsive variations, such as the typical command in a washing compulsion, and a typical threat for punishable acts from the point of view of the superego.

In the washing compulsion let us choose the classical construction, 'go and wash yourself for your dirty thoughts'. The component 'go and wash yourself' is usually referred to as a superego command. It is really a primitive identification with parental attitudes and prohibitions and is more an archaic than a mature superego command. The washing is performed because the individual feels that if the parents knew his dirty thoughts they would tell him to wash. This command and its execution seek the protection of the parents' power against instinctual demands. This is characteristic of the archaic superego, but in its effect on the ego and the instincts it functions as the mature superego does.

Another classic compulsion has the content, 'If you do this or omit that, you or your parents will die'. The dangers warded off can readily be seen to contain fear of death wishes toward the parents: 'If you are bad or have bad thoughts (death wishes), your parents will leave you. You will die or your parents will die.' It is an archaic superego which threatens loss of the love object.

Leaving aside for the moment the recent observations of obsessional symptoms in precœdipal infants, it is well known that obsessional symptoms usually first appear during latency. Hartmann, Kris, and Loewenstein have stated that obsessional symptoms appear early in latency because the newly formed superego tends to be too rigid *(9)*. While this may be true, it does not take into account that prior to the development of the genital superego an obsessional symptom is then not theoretically possible since the superego representation is an essential ingredient of the symptom itself. What, we may also ask, is the state of affairs in a child prior to the period of latency that may lead this superego to become a participant in an obsessional symptom? It would seem that factors other than its intrinsic qualities of being overly rigid would have to be considered.

One prominent aspect of the obsessional neurosis which usually makes its appearance chronologically before the advent of the mature superego is the failure of the repression of the œdipal conflict. In normal development we assume that the œdipal conflict is successfully repressed. If repression has failed and in latency conversion or other hysterical symptoms fail or are insufficient to bind the libidinal contents of the œdipal conflict, then the maturing superego has the additional task of binding these regressive instinctual energies. At this point a number of solutions are possible. Variables in two organizations are crucial to the outcome. One is whether or not the libidinal organization has undergone regression, and the second is the extent to which the superego has replaced its archaic predecessor. When precœdipal libidinal regression has not

occurred in the presence of a more mature superego, the œdipal conflict may be resolved by a hysterical neurotic compromise. When libidinal regression to the anal level has occurred in the presence of a more mature superego, resolution takes place in the formation of an anal character, with a predominance of reaction-formations and sublimations, and no transient obsessional neurosis occurs; here the superego is more involved with problems of self-esteem and real morality. 'Anal character' here refers to the traits Freud originally described in Character and Anal Erotism, and not to the compulsive character neurosis or disorder which is a reaction-formation against a compulsion neurosis. The latter is a true compulsion neurosis and is here to be considered as such. When regression to the anal level occurs in the presence of a less mature superego, obsessional neurosis and obsessional character neurosis make their appearance. The superego here is predominantly magical and pseudo moralistic.

The last consideration in connection with the development of an obsessional neurosis has also two possibilities. It may be a transient or a persisting neurosis. This depends on whether the less mature superego is transiently or permanently more archaic. In chronic obsessional neurosis, it is to be expected that the superego is permanently immature. When the symptoms of a transient neurosis disappear, the superego has undergone a development to greater maturity, and then predominates over the archaic superego. All descriptions of the superego emphasize its continuous modifications by environmental experiences. In my opinion, it is in this developmental phase in latency—when repression and hysterical symptoms have failed to bind the œdipal conflicts and anal regression has occurred—that obsessional symptoms are frequently needed to protect the ego against the continued œdipal onslaught; hence the frequency of obsessional symptoms in latency.

The immature superego of the transient obsessional neurosis differs from the superego of the chronic form, in that in the

first the parents' superegos with which the child must identify are immature themselves and superego maturity must await further testing of reality. The immature superego of the chronic obsessional neurosis would seem to be a more rigid, unchangeable state of affairs which experience does not alter.

Perhaps we can now more concisely differentiate among the transient obsessional neurosis, the chronic obsessional neurosis, and the anal character, which arise during the period of latency. With libidinal regression to the anal level, a supremacy of the archaic superego produces a temporary obsessional neurosis which subsides with the later establishment of a delayed predominance of the mature superego. When the latter fails to occur, the obsessional neurosis becomes chronic. In a theoretically pure case of obsessional character, partial anal regression does not produce true obsessional symptoms because the mature superego predominates. In clinical practice, obsessional neurosis and obsessional character are always present together in varying degrees. When we speak of an anal character, we usually refer to characterological traits rather than to obsessional symptoms.

These symptoms and traits are of course not limited to the period of latency; and when anal regression occurs, not only the superego but the total ego as well is involved in the obsessional syndrome. Transient symptoms and chronic obsessional neuroses have their inception also in adolescence under the impetus of the physiological and psychological changes of puberty; and in adult life, a sudden alteration of libidinal demands may evoke such symptoms. For example, the loss of a sexual partner may renew conflicts about masturbation which evoke an obsessional neurotic compromise.

Fraiberg has reported a mixed neurosis in a two-and-a-half-year-old child with many compulsive symptoms, one of which was to make sure that all water faucets in the house were shut. In evaluating the relative strength and the character of the ego of the child in its attempt to cope with the instinctual demands made upon it, Fraiberg states that this genetically undeveloped

ego was weakened by the loss of the parents as allies in the defense against instinctually dangerous demands. The child's grandparents, acting as substitutes for the parents, had intercourse which was witnessed by the child. 'We are impressed', says the author, 'by the fact that the parents who normally serve the child as its allies against danger had lost their vital function. No amount of reassurance or demonstration of love [from the parents] could diminish the child's anxiety during the early months of the neurosis' *(3)*.

In many ways, the ego of this infant was relatively in a similar position to the ego of a postœdipal child whose parental objects have been replaced mainly by the internal organization of the superego which, in such a young child, is the archaic superego. The instinctual drives are predominantly prephallic, and anal-erotic and anal-sadistic drives are prominent at this stage of development. The loss of the parents as allies to the child's ego leaves the immature ego with only its archaic superego to control its instinctual drives. A preœdipal compulsion neurosis is the pathological outcome of such a struggle. Obsessional behavior in psychotic or retarded infants has also been described as an attempt to organize a bewildering world which is insufficiently invested with energy *(8)*. A world insufficiently invested with energy means the psychological loss of a love object; the attempts to organize such a world by way of obsessional symptoms would be the expression of archaic identifications. Whether such preœdipal obsessional neurosis has been present in all cases of the more typical postœdipal neurosis has to my knowledge not been studied.

Obsessional neurosis is certainly characterized by magical thinking, including feelings of omnipotence. Magical thinking in obsessional neurosis is without doubt characteristic evidence of the early operation of the ego, according to a modified pleasure principle. The illusion of omnipotence, however, is more complicated. At the point of development of obsessional neurosis, the primitive omnipotence of the ego has been replaced by the introjection of the omnipotent parental

objects. While this is evidence of an aspect of ego development, it is more closely related to the archaic superego which is a specialized area of the ego.

It has been questioned by many authors whether the genital superego can be differentiated as a structural and functional unit from the superego of early infancy. Melanie Klein, for example, finds the beginning of the superego in the early infantile period when the 'death instinct-cathected' breast is introjected. I believe the need for distinction is not only a valid one but a most vital one.

Freud's original description of the superego was that of an autonomous parental image functioning independently of the ego, the id, the environment, and objects. This conception led him to give it the name superego. It is still valid that the postœdipal superego fulfils these requirements and that the name fits the description. In the preœdipal period, however, there is functioning an autonomous parental image which structurally is certainly not independent of the ego but rather a distinct portion of it, one which is not clearly delineated from the environment nor from object relationships, and not so clearly separated from the id; hence, it would seem that whether it be called 'early', 'archaic', or 'immature' superego, from the structural point of view it is a misnomer. The confusion arises from the fact that the preœdipal and postœdipal superegos share some common functional grounds. However, they are not alike structurally. The earlier organization is not a superego structure at all.

It would clarify matters if this earlier organization of the superego were given a proper name. To say that it is the *forerunner* or the *precursor* is, in my opinion, least incorrect. In the limited sense that they mean something that precedes, they are acceptable; in the ultimate sense of a sign of things to come, they are less so. The term superego should be restricted to the ultimate, genital superego because of structural and developmental differences.

Perhaps a better name for this early organization would be

the undifferentiated ego conscience, as the introjected parental images are not sharply delineated or differentiated from the real objects and are introjected and reprojected objects of the outside world. In the absence of a better term, 'conscience' suggests itself. Historically, Freud used the term conscience before he used the word superego. The term superego first appears in The Ego and the Id. A few years prior, in Mourning and Melancholia, he used the term 'conscience' as a structure in conflict with the ego. Fenichel stated that the concept, superego, was born with these two papers. In referring to the formation of the superego, Freud stated, 'The broad general outcome of the sexual phase governed by the œdipus complex may, therefore, be taken to be the forming of a precipitate in the ego. . . . This modification of the ego retains its special position; it stands in contrast to the other constituents of the ego in the form of a superego' *(6)*. Extending Freud's analogy to a physicochemical process, could we not say that the outcome of the prephallic phase may be likened to the formation of a 'suspension' or a 'crystalloid' in the ego which also modifies the ego and retains a special position; that it too stands in contrast to the other constituents of the ego in the form of an archaic superego? A name such as 'introego' would seem to have the advantage of brevity. It is only because of structural differences between the superego and its archaic prototype that terminology is of importance in understanding developmental differences.

The fundamental process in superego formation—be it the very early breast superego, archaic or mature form—is the introjection of the parental object (partial or whole) which becomes an identification. It is unlikely that such processing occurs in very early infancy when the breast superego is supposedly formed. If not, then the presence of any structure comparable to the superego at this time is questionable. Inner psychic representation is here mistaken for introjection.

The very young infant perceives its parents as being all powerful, punishing-wise and protective-wise, attuned to its

perception of an overwhelming world which its ego is attempting to master as well as attempting to master its inner world of oral and anal drives—erotic and sadistic. These progressively revised perceptions of the parental objects are introjected as cathected images in the ego and then projected to the parental objects. The cathexis of these introjected images may then be directed in support of or against the strivings of the ego and the instinctual drives. In a cyclic fashion this procedure repeats itself, the newly established representations and the corresponding external object receive and exchange this newly arranged cathexis which secondarily is directed in favor of or against the ego and the id and, in this way, becomes an organized autonomous introjected parental image which represents the archaic superego.

The process is the same, but the perceptive ego of the child at the time of the œdipul conflict sees its parents and the world in relatively less exaggerated terms than it did in the pregenital period. In normal development, object relationships of this period replace the object relationships of the pregenital phase. It is these later object relationships which, ultimately shorn of their exclusive sexual and aggressive aims, become internalized as the mature superego.

A final ego consideration in obsessional neurosis should not be overlooked. The degree of regression of the total ego as well as the capacity for ego development contribute significantly to obsessional pathology. Schematically the greater the capacity for ego maturation, the milder the obsessional pathology; where ego regression is extensive the symptoms are more severe and merge with borderline and psychotic states.

## SUMMARY

To clarify some of the obscurities of the interaction of ego and superego in the genesis of obsessive-compulsive disorders, it is necessary to distinguish more precisely between the postœdipal, mature superego and the pregenital or archaic superego. Introjected parental images from the infantile period of ego

development are directly related to obsessional and compulsive symptoms, and these images of omnipotence are representatives of the archaic superego. Omnipotence in obsessional neurosis is a quality of the archaic superego, while magical thinking, a derivative of the pleasure principle, is the property of the ego itself.

In obsessional neurosis, the archaic superego has a relative supremacy over the mature superego. The obsessional character, on the other hand, appears to be the result of molding by the mature superego in the face of a libidinal regression to the anal level, whereas the same libidinal regression in the presence of an archaic superego results in an obsessional neurosis.

It is necessary to distinguish between the genital superego and the pregenital (archaic) superego because the application of 'superego' to both promotes confusion. A sharper delineation of the organizations of the archaic and of the mature superegos, from functional, structural and developmental aspects, leads to a clearer understanding of the roles of the ego and of the superego in obsessional neurosis and obsessional character. Severe obsessional psychopathology is related to more extensive regression of the total ego; the milder obsessional syndromes to minor regressions of the total ego.

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# PSYCHOSES IN CHILDREN: THEIR ORIGIN AND STRUCTURE

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## I. INTRODUCTION

Freud's major interest was in the neuroses and perversions; this interest produced as a by-product his study of the vicissitudes of instincts and of psychosexual development. During the past two decades 'atypical' psychiatric disorders have been increasingly studied. Here we examine the 'atypical' or psychotic disorders of infancy and childhood, a study which we hope will aid in the decipherment of the riddle of schizophrenia.

Examination of psychosexual development alone will not lead us very far in the problem of childhood psychoses. Fortunately we are today able to think in terms of four aspects of development. This multiple view has made more meaningful many symptomatic manifestations which hitherto seemed unclassifiable when studied only in terms of libido development. Our attempt to understand the varied clinical pictures that psychotic children present becomes possible only by appraisal of development, and disturbances in development, in these four areas: (a) ego functions (motility, perception, intellectual function, testing of reality, synthetic or integrative function, and defense mechanisms); (b) object relationships (including consideration of recent concepts such as pre-objects [Spitz], part objects, auxiliary ego [Mahler, Spitz], relationships with inanimate objects, and symbiotic objects [Mahler]); (c) affectivity; (d) sexuality.

The telescoping of so much of our psychic destiny into the first year and a half of life has caused many researchers to try

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to illuminate this early crucial period. A combination of direct observation (Spitz, Anna Freud), reconstructive clinical investigation (e.g. Melanie Klein, Anna Freud), and theoretical reconstruction (Hartmann, Kris, and Loewenstein) has done much to clarify early development.

A major point of departure in the study and treatment of psychotic children has been careful evaluation of the various ego functions with respect to their failure to develop, their impairment, and their occasional uneven hypertrophy. Kanner, in his pioneering excursions into this field of research, showed clearly that as a result of such severe interferences in ego development his 'autistic' children were often indistinguishable from feebleminded and deaf children and, we may add, children with organically damaged brains. Recent research has shown that to classify the complex determinants of ego pathology one must consider constitutional and congenital, biological and instinctual, and environmental factors. We are primarily concerned with the environmental factors. Maternal influence is the most overwhelming of the environmental forces that determine the form, quality, and content of infantile experiences. Benedek, Bowlby, Anna Freud, Fries, Ribble, and Spitz, among others, have made fundamental contributions to the assessment of this maternal factor in shaping the psychiatric diseases of infancy and childhood.

## II. EARLY PSYCHIC DEVELOPMENT AND ITS DISTURBANCES

During the first eighteen months of life, the ego and its functions, the form and nature of object relationships, and the flavor of affective life are established. Psychosexual development takes longer; but although five years are required for its completion one may say that in this area too the die is cast within the first eighteen months. For it is well recognized that the particular type of oral experience may lend its specific quality to the anal and genital libidinal phases that follow it. Some recent studies of hysteria, moreover, recognize the importance of initial oral traumas as predisposing to hysteria *(1, 2, 3)*. We may therefore

say that major disturbances during this period essentially shape the psychiatric disorders of later life.

A genetic principle from embryology lends weight to this statement. A pin prick administered to the developing chick embryo results in major anatomical deformities, whereas the same physical trauma applied to the hatched chick has inconsequential effects; similarly, the earlier the psychological trauma, the more devastating the resulting psychopathology.

Erikson's *(4)* brilliant description of psychosexual maturation in the child can be broadened so that it applies equally to maturation of the ego and of its object relationships. Erikson believes that 'proper rate' and 'normal sequence' are crucial for a healthy outcome of the psychoembryological schedule of events. Referring to Stockard's conceptions, he quotes: 'The organ [or, we might add, the ego and its functions] which misses its time of ascendancy is not only doomed as an entity; it endangers at the same time the whole hierarchy of organs'. As we study in the psychotic child the arrests in development of the ego, of object relationships, and of affect, we appreciate the consequences of interruptions in the timetable of psychic maturation. The laborious clinical efforts necessary to set these arrested maturational processes in motion again, and the seeming irreversibility of psychotic psychopathology attest to the importance of such 'missing the time of . . . ascendancy'; moreover, the specific therapeutic techniques to be utilized in the treatment of the 'atypical' disorders of childhood must always take into account this aspect of arrested development.[1]

In what environmental factors are we to seek for the severe dislocations in the developmental schedule of the infant's psychic structure? Recent research has stressed the relationship with the mother. Spitz in particular has attempted to correlate the type of disorder in the infant with certain types of psychopathology in the mother. He has classified the various infantile psychiatric disorders as related to either 'deficiency experiences'

[1] The total psychotic picture must, however, be explained in terms of regression as well as of arrest.

or 'psychotoxic experiences' with the mother. His studies *(5)* have dealt predominantly with the depressive and psychosomatic disorders of infancy without emphasis on the psychotic disorders. Other clinicians, including Kanner *(6)* and Rank *(7)*, have tried to define the nature of the maternal and parental forces that have shaped the psychotic picture in the infant. We attempt here to define some common features of the pathological interaction between mother and infant that cause such malignant illness in the child.

Erikson writes: 'Parents who are faced with the development of a number of children must constantly live up to a challenge. They must develop with them. We distort the situation if we abstract it in such a way that we consider the parent as having such and such a personality when the child is born and then remaining static, impinging upon a poor little thing. For this weak and changing little being moves the whole family along. Babies control and bring up their families as much as they are controlled by them; in fact we may say that the family brings up a baby by being brought up by it. Whatever reaction patterns are given biologically and whatever schedule is predetermined developmentally must be considered to be a series of potentialities for changing patterns of mutual regulation.' With this understanding, we now ask, what are the disturbed patterns of mother-infant regulation during the first eighteen months and the complementary sets of factors involved which predispose to the severe psychiatric disturbances of infancy and childhood?

Intrauterine existence gives the fœtus a harmonious homeostatic period of physiological equilibrium. Birth causes it to experience a sudden dislocation of this *physiological symbiosis.* The infant makes hopeless, frantic attempts to re-establish its ideal intrauterine experience. Freud referred to this as the initial anxiety which is the prototype for all later anxiety. Gradually this birth anxiety is resolved by establishment of a *psychophysiological symbiosis* with the mother which is a biological approximation to the intrauterine symbiosis in so far as it achieves a good deal of physiological regulation. It differs,

however, in the addition of a new 'psychic dimension' to the relationship of mother and infant.

Toward the end of the first eighteen months, the healthy infant experiences, figuratively, a psychological rebirth when it undergoes another major disengagement from the mother.

Let us evaluate more closely *the development, the consolidation, and the resolution of this mother-infant symbiosis;*[2] for on its vicissitudes depends the basic formation of psychic structure. Disturbances in this symbiotic evolution cause both psychotic and neurotic disturbances in childhood.

Unless the maternal buffer can successfully regulate, modify, and increase or decrease appropriately the intrapsychic and environmental tensions and stimuli impinging on the infant, adverse complications result. The two extremes are an overanxious and overintense mother-infant symbiosis, which gives rise to parasitism, and an inadequate, unstimulating, and excessively diluted mother-infant symbiosis which causes autism.

It is imperative to ascertain in more detail the kind of mothering that makes for uncomplicated symbiotic maturation. We also must determine which infantile and maternal pathological qualities create disturbances by upsetting the normal evolution of this symbiosis. Therefore let us consider in turn: (a) presymbiotic phase—the gradual development of the symbiosis (birth to about six months); (b) symbiotic phase—the concrete consolidation of the symbiosis (about six to about twelve months); (c) postsymbiotic phase—the gradual resolution of the symbiosis (about twelve to about eighteen months).

(a) *The Presymbiotic Phase.* During this period the infant reaches out actively to create a 'second best' extrauterine symbiosis. This arrangement cannot compare with the constancy of nutritional, thermal, and postural relief characteristic of its intrauterine existence. These attempts to restore the intrauterine physiological quiescence further healthy ego develop-

[2] 'Symbiosis' means, in this paper, a normal maturational phase of infantile development. Mahler *(8)* uses the term to refer to a psychopathological condition, whereas the author prefers the term 'parasitism' (also used by Mahler) for the latter.

ment, for they are an active reaching out into, and contact with, the environment (mother). If the mother responds with satisfying rewards to this 'demandingness' she becomes heavily cathected within a period of approximately six months[3] and is transformed from a poorly circumscribed nonentity to a most vitally needed external object serving the psychophysiological needs of the infant.

We have come to recognize that in this phase virtually all infants demonstrate some degree of active reaching out; nevertheless they differ in accordance with their congenital activity type so that some are almost constantly in quest of experiences that satisfy or relieve tension. Others are seemingly more apathetic, indifferent, and almost too quickly resigned to their unrelieved states. They vary according to their *object-seeking activity*. The complementary maternal factor in this phase of development we refer to as the *affective availability* of the mother.

An infant with a congenital activity type of 'low sending power' (Erikson) or 'low voltage' (M. Gildea) can perhaps be saved from autism by a contagiously empathic mother. An infant with an adequate congenital activity type, however, whose mother is affectively unavailable may ultimately resign itself to an apparently self-sufficient state of autistic withdrawal (Mahler) in spite of its own active attempts at establishing contact with reality.

(b) *The Symbiotic Phase.* By refinement of its perceptive functions and with the help of a stimulating mother, the infantile ego differentiates the mother by tactile, auditory, and visual perceptions from the rest of the still indistinct environment; but she remains incompletely differentiated from the infant's ego. This differentiation of mother is well on its way by at least six months of age. Certainly by eight months the infant has been able clearly to differentiate the mother or mother substitute from the stranger, to whom the infant reacts

[3] In his studies of anaclitic depression, Spitz emphasizes that the child first reacts depressively to a loss of its object at the age of five or six months.

with the well-named 'eight months anxiety' *(10)*. The consolidation of this symbiosis is only gradually achieved and seems to be conclusively established by nine to twelve months of age. By this time an exclusive mother-infant relationship has been well developed. This development is a desirable, healthy symbiosis characterized by a mutually satisfying give and take, an interaction relatively free of anxiety and not too intense. When the maternal stimulation and anxiety have been excessive in the presymbiotic as well as in the symbiotic phase, the infant is quite unprepared for the next step. The symbiosis becomes a parasitic inseparability. On the other hand, when the relationship has been a distant one, autistic trends manifested during the presymbiotic period become more clearly evident during this phase.

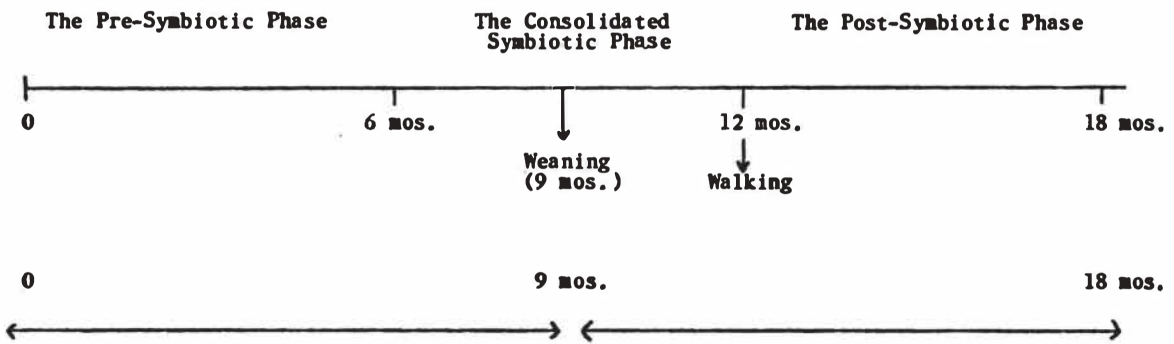
(c) *The Postsymbiotic Phase.* By the end of the first year, the developing ego shows another trend. The infant as it is weaned becomes free of its oral dependence and acquires locomotion, thus taking an active part in separating from its mother; but it is ambivalent about this venture and is at times reluctant to proceed with it. Maternal encouragement and support of the budding physical and psychological autonomy may determine whether the one-year old can walk with relative security and with some freedom from anxiety. The smoothness of this disengagement depends essentially on the degree of trust (Erikson) and confidence (Benedek) in the relationship up to this point.

Let us examine the new set of complementary factors involved in this later phase of mutual regulatory processes within the mother-child relationship. Although infants vary in congenital activity, by this time they vary also in the intensity of their quest for physical and psychological individuality. Mothers vary widely in their attitudes toward the infant's attempts at separation from actively supportive encouragement to devastating discouragement which mobilizes anxiety in the infant and intensifies its parasitic tendencies.

It is apparent that major transformations of the mother's

Chart #1

## OPTIMUM AND NEGATIVE MATURATIONAL CONDITIONS IN THE MOTHER-INFANT SYSTEM




**Infant**

**Congenital Activity Type**

Object-seeking tendencies
+ + + + ——— health
+ ——→ autism

**Mother**

(1) Degree of affective availability
+ + + + ——→ health
+ ——→ autism

(2) Presence of overintense involvement & Excessive anxiety ——→ parasitism

(3) Attitude toward autonomous Infantile Development
If encouraged ——→ health
If discouraged ——→ parasitism
If premature and excessive ——→ autism

**Infant**

**Congenital Activity Type**

Inherent Quest for Autonomy
+ + + + ——→ health
+ ——→ parasitism

**Mother**

(1) Degree of Affective availability
+ + + + ——→ health
+ ——→ autism

(2) Presence of overintense involvement & Excessive anxiety ——→ parasitism

(3) Attitude toward autonomous Infantile Development
If encouraged ——→ health
If discouraged ——→ parasitism
If premature and excessive ——→ autism

Chart #2

## CHART DEPICTING EARLY STAGES OF PSYCHIC GROWTH AND FIXATION POINTS FOR FUTURE PSYCHIATRIC DISTURBANCES

| | | Pre-Symbiotic Phase | Consolidated Symbiotic Phase | Post-Symbiotic Phase |
|---|---|---|---|---|
| (1) | Period of Normal Occurrence | 0 to 6 mos. | 6 to 12 mos. | 12 to 18 mos. |
| (2) | Ego Boundaries | Ego Boundaries Diffuse | More Established-Fused with mother (auxiliary ego) | Good Differentiation From Environment |
| (3) | Body Image | Mouth ego (Hoffer) Arms and legs also cathected | Most of body cathected | Virtually complete |
| (4) | Nature of Object-Relationship | Pre-object (Spitz) or Part objects- Mother's breast Mother's face Parts of infant's body Inanimate objects | Mother as a symbiotic object | Disengagement from object begins |
| (5) | Diagrammatic Representation of 2, 3, & 4 — Infant — Mother |  |  |  |
| (6) | Ego Functions | Increasing but partial visual, auditory and tactile perception of environment (mother) | Complete perception of mother | Locomotion begins |
| (7) | Stage of Libido Development | Polymorphous perverse; beginning oral primacy | Oral primacy | Anal primacy |
| (8) | Erikson's "Eight Stages of Man" | Trust vs. Mistrust | Trust vs. Mistrust | Autonomy vs. shame and doubt |

attitude are vitally necessary to insure the progressive, uninterrupted maturation of the infant's psyche (see charts 1 and 2). She must at first, by an enticing stimulation, try to establish an exclusive fusion with the infant; she must thereafter begin to encourage its relatively autonomous existence to the extent that the maturity of the infant's ego and its degree of freedom from anxiety will permit. This increase in autonomy continues throughout childhood and adolescence; ideally, it is fully achieved with the approach of adulthood. The change, which must occur within a short period of time, in the quality and intensity of her relationship is full of difficulties and is successfully achieved only by mature, empathic mothers. The loose term 'dependency' so prevalent in psychiatric literature attests to the central importance of faulty disengagement from symbiosis as a cause of psychiatric illness. If the mother interferes with the 'proper rate and normal sequence' of this symbiotic evolution, psychiatric disorders are in the making. When major interferences occur we are faced with psychotically autistic and parasitic complications in development.

## III. MATERNAL FACTORS IN THE PSYCHOSES OF INFANCY AND CHILDHOOD

(a) *Autistic Psychotic Disturbance (A Deficiency Disease of Infancy).* During the early infantile months (presymbiotic phase), the mother by making herself emotionally indispensable to it gives early direction to the infant and establishes pathways for the archaic ego in its primary, diffuse attempts to establish contact with the environment and with reality. Consequently she is in a most strategic position to exploit any early tendencies of the infantile ego to establish 'bridgeheads' into reality. By providing appropriate, well-regulated stimulation she can make such strivings of the ego profitable, pleasurable, and meaningful to the infant. With contagious enjoyment she encourages the infant's early discoveries of part of its own and her body and she provokes its smile.

It is well understood that mothers differ greatly in their emotional involvement in their infants. Maternal affective

availability varies in three factors. 1. Period of onset: the earlier the traumatic experience, the more devastating its consequences. 2. Duration: the longer the trauma continues, the more far-reaching the resulting psychopathology *(11)*. 3. Degree: the more extensive this specific emotional disability in the mother, the graver the infantile trauma.

Beside this crucial factor, two other conditions must be considered in order to determine the extent of the psychiatric disorder resulting from maternal unavailability. First, the congenital activity type may determine the strength of the infant's struggle for proper maternal care, and in many instances a persistent infant may finally mobilize a mother who would otherwise not have become available. Second, the presence of substitute maternal objects such as other members of the family or nursing attendants may frequently save the infant from an otherwise serious outcome.

Bearing in mind the three variables—maternal availability, congenital activity type, and availability of substitute maternal objects—we can now understand the findings of an interesting study by Beres and his co-workers *(12)*. Thirty-eight children who in infancy suffered deprivation in an institution all were found to exhibit in later life one of three forms of psychopathology, varying greatly in degree of severity: schizophrenia, character disorder, and neurosis. It appears likely that such different outcomes can be understood on the basis of the three major variables. The assumption that such an institutional experience should of necessity result in one particular type of psychiatric syndrome seems invalid with these variables in mind.

In the majority of Beres's cases the traumatic infantile experience of maternal unavailability (physical absence) occurred after five to six months of age, a fact that accords with Spitz's observations of anaclitic depression. It seems justifiable to suppose that had this experience occurred earlier (within the first five months) autistic features would have been an important part of the symptoms. As we follow Spitz's description of the march of clinical symptoms in many of his depressive children

who continued to suffer from absence of the mother over an extended period of time, it seems that some of the later symptoms, such as apathy and withdrawal, become difficult to distinguish from autistic phenomena. These facts underline the importance of taking into account the three aspects of the trauma of maternal unavailability, its period of onset, duration, and degree.

The basic symptoms of autism can be clearly related to major disturbances of affect, object relationship, and ego. Most characteristically the child withdraws from reality into a preoccupied state of seeming self-sufficiency. Its fantasies serve the principal purpose of removing it further from reality. The ego functions of motility, perception, intellectual performance, and language have been arrested in development; frequently one function or part function of the ego (musical or scientific ability, for example) seems to have escaped and, in contrast, is precociously hypertrophied. Anxiety is profuse and abysmal (Mahler) and appears in acute panic states (with or without accompanying rage) as well as in severe disturbances of sleep. Affect is usually absent, impoverished, or seriously blunted. The mother has no special importance for the child, who in fact seems to choose and prefer contact with inanimate objects. If determined attempts are made to separate the child from such inanimate objects to which it has become attached, there occurs a precipitous, disorganizing state of panic or rage.

How does such a clinical picture come about? From the beginning the infant invariably seeks relief from unpleasure, and it seeks some external object that can bring such relief. This seeking for an object first occurs to satisfy physiological needs. When the mother fails to exploit and encourage the reaching out of the ego, no affective interpersonal contact is established. The infant at this point resigns itself to its motherless state and turns to substitute objects (or part objects) and to its fantasies about them with a tenacity that would otherwise have been directed to the mother. These substitute objects are parts of its body or inanimate objects in its environment.

Any attempt to separate the child from the inanimate object or from its excessive autoerotic activity is met by a 'stonewall defense', characteristically a state of rage accompanied by an underlying abysmal anxiety. Instead of an exclusive symbiotic relationship between mother and child, we see unremitting autoerotic activity and inseparable relationships with inanimate objects. These latter relationships exist in place of symbiotic ties; they exclude reality, and are accompanied by distortions and dislocations of the ego and its functions, of object relationships, and of affective life.

Many of these autistic children who have turned too much to autoerotic activity suffer another complication of disturbed object relationships: they are subject to intense preoccupation and fantasy about their own bodies. Hypochondriacal disturbances and somatic delusions probably in part originate from this condition.

Our studies have indicated that autistic psychotic disturbance is invariably to be accounted for by affective unavailability of the mother. This maternal unavailability to the infant seems, however, to result from a variety of psychopathological conditions in the mother. 1. Specific maternal neurotic inhibition: (a) hysterical type (the mother unconsciously reacts to the infant as to a product of incest [7]); (b) obsessive type (characterized by their isolation of emotions, caused by fear of their sexual and aggressive impulses, for example, a 'mechanization' of motherhood which they frequently refer to as 'going through the motions'—much intellectualization and heavy reliance on pediatric instruction and literature is the mother's only safeguard in child rearing [6]). 2. Severe narcissistic disturbance: the mother has very little capacity to mobilize interest in other people. 3. Depressive disturbance: this may be a chronic depression or a postpartum depression. 4. A severe negative identification with the infant (called by Spitz global hostility), the acting out of rejection experienced by the mother herself as a child. 5. Borderline psychotic disturbance, particularly the 'as if' type of personality disabled by serious impoverishment

of affect and lack of capacity for genuine object relationships (7). 6. Schizophrenic disturbance, particularly of that type characterized by extensive withdrawal and accompanying disorganization. 7. For completeness, we may add to this list the lack of any mother or suitable substitute, a condition to which infants are exposed in some institutions.

(b) *Parasitic Psychotic Disturbance (A Psychotoxic Disease of Infancy).* In the normal course of psychic development the approximate period of six to twelve months of age is characterized by a healthy consolidation of the symbiosis. Faulty resolution of the symbiosis after that period can determine another set of disorders, the parasitic psychotic or neurotic type, commonly referred to as phenomena of overdependence. These are mothers who cannot allow their infants to grow and develop a relatively independent existence, mothers who react to the maturing of the child with a form of intense separation anxiety. This type of mother clings desperately to the infant whom she perceives as a part of her own body image. She experiences this otherwise normal disengagement as if it were the loss of a physical appendage without which she is no longer physically and psychologically intact. By attempting to preserve the fusion of the two egos, the mother can to some extent externalize her numerous anxieties by perceiving the child as subject to a host of internal and external dangers. The relationship is charged with excessive anxieties which are transmitted to the infant who finds a temporary and unsustained solution in parasitism. It feels safe only in close proximity to its auxiliary ego (Mahler, Spitz); with the absence of its parasitic host, the child is thrown upon the resources of its own inadequate ego, and it develops panic over separation.

Although the parasitic psychotic development is often conclusively fixed by these interactions in the postsymbiotic phase, earlier events have played a part. Frequently, in fact almost invariably, the presymbiotic and symbiotic phases also have been characterized by excessive anxiety and overinvolvement by the mother. Development of the ego is arrested principally by its

being 'flooded with anxiety'; any beginning signs of autonomous development are consistently checked by the maternal mobilization of further anxiety, with the result that the processes of the ego are quickly overwhelmed and stalled. The infantile ego undergoes an 'anoxic' stifling which causes its arrest. Affect, on the other hand, is fairly well preserved; in these infants emotional impoverishment is not an important part of the picture as it is in autistic children, probably because an overintense relationship with the mother is the central problem of the parasitic child.

## IV. SEPARATION ANXIETY AND THE ORIGINS OF THE OBSESSIVE COMPULSIVE DEFENSE

Kanner in his excellent studies of autistic children made mention of their 'obsessive need for sameness'. For these children it is imperative that parts of their inanimate environmental setting be preserved unchanged. The psychodynamic explanation for this need for sameness seems to be the importance of the inanimate object in the emotional economy of such a child. We have commented on the tenacious quality of the infant's quest for an external object. When the mother, the animate object, cannot be obtained for what should be an exclusive symbiosis, it turns instead to inanimate objects. This zealous search for an external object is essentially a search for relief from anxiety of physiological origin. The infant's eventual mastery of its natal separation anxiety seems to depend upon its achievement, in the course of normal development, of a psychophysiological symbiosis with some type of external object. Any premature attempt to separate the infant or autistic or parasitic child from its symbiotic or parasitic object, animate or inanimate, causes 'separation panic'. It is therefore understandable that the autistic or parasitic child obsessively and desperately strives to preserve its relationship with this inanimate or animate object. The obsessive compulsive defense seems to arise from this early threat to its *object constancy*. Later in psychic development this same defense may serve a somewhat similar purpose in preventing loss of control over

instinctual impulses. Constant ritualistic practices may prevent such a break-through. The manipulation of ideas of time and space to control and preserve the external object may later be used in the regulation of aggressive and sexual impulses.

## V. THERAPY

Therapy depends on understanding the three phases of the symbiotic evolution and the nature of the fixation, with consideration of the forms of the arrest of development of ego, object relationship, and affect. The specific therapeutic techniques for autistic children differ widely and have different objectives from those for parasitic children.

Clinical experience indicates that most frequently we find an admixture of autistic and parasitic components in a psychotic child *(8)*. As the autistic child grows older, the exclusive and possessive relationship with inanimate objects is replaced by a similar belated and tenacious relationship with the mother. Now, however, the child rather than the mother seems to be the active agent in the establishment of the parasitic tie, in contrast to the development of the usual parasitic disturbance, in which the mother is the active agent and the child an accessory. Frequently the parent, becoming increasingly aware of the autistic disability of the child, begins frantically to be more active with the withdrawn child. This behavior produces parasitic features in the otherwise autistic child.

(a) *Treating the Autistic Components.* Most autistic children demonstrate severe arrest in development of language because of failure to make emotional contact with people in the environment. Until such contact is established, the common avenues of access to the child are closed and the usual procedures of play therapy cannot be utilized. The infant who resigned itself to a seemingly self-sufficient existence in which animate objects are virtually excluded from its interest must be enticed into a profitable and pleasurable human relationship. The first step therefore is to establish communication, and it is rare to find among such children one who has not preserved fairly well *some* functions of the ego; they are not totally uncommunicative.

The primary goal of therapy for a child with an autistic disturbance is to create *affective stimulation*[4] by a good relationship between therapist and child. At first the autistic child will turn away from any such stimulation, and a gradual approach which at all times respects its need for social isolation is therefore imperatively required. It must be a therapy of replacement or substitution *(8)*—for autism is a deficiency disease—whereby the therapist attempts to establish belatedly the type of maternal affective contact that was not made available to the patient in infancy. With the achievement of an adequate 'affective bridgehead to reality' for the child, the process of psychological maturation may be set in motion once again. Many of these autistic children begin to make verbal and nonverbal demands for gratifying infantile experiences, to be bottle-fed, for example, or to be diapered or taken for a stroll. As playful 'make believe' these wishes can be gratified by the therapist. They can *actually* be provided by the mother. The more passive type of autistic child, whose tendency to seek out objects is congenitally less, often responds favorably to the active initiation of such infantilization by the therapist; it takes readily, for example, to being comfortably held. Such a therapeutic technique becomes especially important to relieve panic. Gradually one hopes to construct a relationship resembling the symbiotic one that failed to develop. With this relationship as a foundation, exploration of 'islands' of preserved ego function becomes possible. Most autistic children have favorite activities in which the ego functions well—such activities as singing, mechanical interests, and drawing—that offer opportunities to the therapist for a close relationship. A good many children, however, have much more primitive and undeveloped ego interests, such as blowing out match flames and aimless hurling of objects, which equally are to be used to stimulate development of a relationship and growth of the ego. A further step, when the relationship allows, is to offer opportunities for *ego exercises* to strengthen existing perceptive, motor, and intellectual functions. These

[4] B. Rank *(7)* uses the expression 'sensory stimulation'.

may involve such primitive attempts as the child's successful imitation of the therapist's naming of objects or building with blocks. The discouragement of too much production of psychotic fantasy by denying the child opportunities for its elaboration is essential in attempts to foster the development of the budding ego.

B. Rank and her co-workers have correctly emphasized the threefold approach to treatment for the atypical child as consisting of individual psychotherapy for the child, individual psychotherapy for the mother, and group therapy for the child. In our experience, it has been established that the best arrangement is for the same therapist to treat mother and child. Only such firsthand experience with both parts of the psychopathological unit allows a comprehensive understanding of the disturbance of relationship. The two sides of the coin are less easily observed by the use of co-therapists, as is usual in child guidance clinics.

Psychotherapy with the mother for the most part means changing her affective unavailability to the child. This task varies in complexity with the severity of her affective disturbance, which may be a symptom of neurosis, psychosis or character disorder. One's success in rousing the mother to establish an initial symbiotic relationship with her child will in part determine the success of the treatment program.

At best one can expect the autistic child to fit only very gradually into a program of group activity, which should not be recommended until after the patient has been able to take the first step by establishing a relationship with mother and therapist.

(b) *Treating the Parasitic (Symbiotic) Components.* Our primary goal here is essentially the dissolution of the overintense parasitic mutual control by mother and child. The child is increasingly provided with substitute object relationships that do not mobilize anxiety. Such dilution of the pathological mother-child relationship is often well achieved by introducing the child into activity in groups and arranging its program so

that there is much less contact with the mother. The crucial difficulty with the mother is to help her keep hands off her child. Giving up unconditional control over the child is likely to cause severe separation anxiety and depressive reactions. This relinquishment can be achieved by mothers with neurotic disturbances but is desperately and successfully resisted by psychotic mothers. What must be resolved is the maternal resistance to the development of physical and psychological autonomy by the child. Frequently we observe a sudden maturational spurt in the parasitic child's progress when such a separation from the mother is largely accomplished. It then becomes necessary to work with the stunted ego of the parasitic child by procedures similar to those described for the autistic child, namely exploitation of preserved ego functioning and use of ego exercises.

When substantial growth and consolidation of the ego have occurred, autistic and parasitic children begin to show a mixed neurotic and psychotic clinical picture resembling borderline disturbances. At this point, more usual therapeutic methods of dealing with the underlying anxiety, which include the elicitation of fantasy and interpretation of content, defense, and transference, are put into use. Simultaneously the child can be transferred from the play group to an educational group.

It appears that outpatient therapy for psychotic children who continue to live with their families should not be attempted unless the parents are able to cope with the intensely distressing experience of living with a psychotic child. Some stability of the family is a primary necessity for such nonresidential treatment. Certainly if the mother has psychotic tendencies, an institution is the only choice for rehabilitation of the child. For best results the mother must have the capacity for basic change, and one must rely heavily upon her as an auxiliary therapist. The atmosphere of the home gradually is changed according to psychiatric prescription so as to provide the child with further constructive and corrective experiences. Often it becomes imperative to help the family by suggesting methods

of handling as well as by interpreting the meaning of some of the child's psychotic behavior. Such interpretations in many cases preserve patience and tolerance in the parents without which an outpatient plan cannot be maintained. For the best results the psychotic child and its mother should be seen three or four times a week.

## VI. PROGNOSIS

Several factors must be considered in determining prognosis of psychotic children.

1. *Congenital Activity Type.* Those children who evidence the strongest inherent tendencies to seek out objects and to establish autonomous existence seem to be the best candidates for therapy.

2. *Nature of Maternal Psychopathology.* The reversibility of the mother's affective unavailability and of her resistance to the child's development of autonomy is an important determinant of the outcome of therapy. When these qualities in the mother are of neurotic rather than psychotic origin one can be more hopeful that the mother will be an important therapeutic force.

3. *The Autistic-Parasitic Ratio.* Since the parasitic psychosis is a step ahead of the autistic in development of ego, affect, and object relationship, a predominance of parasitic over autistic symptoms is more promising for treatment.

4. *The Fixation-Regression Ratio.* The child whose psychotic disturbance follows a period of apparent maturation during which the ego functions and object relationships have become fairly well established offers us more opportunity for therapy than the child whose psychotic features are largely an evidence of the arrested development caused by fixation. These regressive elements in the illness usually suggest opportunities for uncovering an underlying good development of the ego.

5. *The Psychotic-Neurotic Ratio.* It clearly follows that those borderline disturbances that are heavily weighted with neurotic components respond much better to therapy. These children

vary in prognosis in direct proportion to the degree of involvement of the ego in the psychotic process.

6. *Age When Treatment Is Begun.* If the natural evolution of various components of the psychic structure has been delayed for many years, it may be difficult to set maturation in motion, as Stockard's concept implies. 'Too little, too late' applies here both because our therapeutic means are limited and because the psychopathological forces are great. If the mother and the child can be involved in therapy within its first three years of life, the opportunities are greatest. Prophylactic help for mothers likely to produce such children may be too much to hope for.

## VII. SUMMARY AND CONCLUSIONS

In 1919 Freud *(13)* wrote, 'in our opinion the œdipus complex is the actual nucleus of neuroses, and the infantile sexuality which culminates in this complex is the true determinant of neuroses'. It is my suggestion that the symbiotic union of mother and infant is the analogous nucleus of the psychoses, and that the disturbed development of ego, of object relationship, and of affective development which culminates in this union is the true determinant of the psychoses. The vicissitudes of development, consolidation, and resolution of the symbiosis determine a host of the more serious psychiatric disturbances including psychoses, borderline disturbances, character disorders, and severe neuroses.

Psychoembryological study of this central event in the infant's psychic life seems likely to clarify the psychotic disturbances of infancy and childhood. The problem concerns disturbances in the mutual regulatory processes between mother and infant. Infants vary in congenital activity type—in the degree to which they seek for objects and for physical and psychological autonomy. Mothers vary in a complementary way in their affective availability and their attitudes toward autonomous development in the infant. It is these variations in mother and child that determine the existence and nature of childhood psychoses.

In keeping with Spitz's classification of psychogenic disease of infancy, autism may be called a deficiency disease and parasitism a psychotoxic disease.

Planning therapy and evaluating prognosis of psychoses in childhood is made possible by these genetic, structural, and dynamic considerations.

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# Some Factors Influencing the Œdipus Complex

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# SOME FACTORS INFLUENCING THE ŒDIPUS COMPLEX

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Quite often in the psychiatric and pedagogical literatures, the term 'œdipus complex' is used as if it alluded to a simple, immutable situation corresponding to the dictionary definition: 'The wish of the child to kill the parent of the same sex and possess the parent of the opposite sex'. Such oversimplification especially neglects the importance of the precœdipal factors in determining the outcome of the œdipal situation, as Freud himself stressed. It is our purpose here simply to point up one aspect of the œdipal situation, namely, the influence on the outcome of the œdipus complex that results from the interaction between the two parents; making no claim to originality, the justification lies in the emphasis on the additive effect on the child of the parents' mutual adaptation rather than the consideration of the parents as separate objects. I am referring only to personal forces acting at a critical period in the child's development, and such selective emphasis does not ignore intrapsychic or biological forces which obviously form the substratum of the child's development.[1]

The clinical material presented to demonstrate one kind of œdipal triangle is obtained from six female patients who

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1 Since this paper was written, Grete L. Bibring has published a paper entitled, On the Passing of the Œdipus Complex in a Matriarchal Family Setting (In: *Drives, Affects, Behavior.* Edited by Rudolph M. Loewenstein. New York: International Universities Press, Inc., 1953, pp. 278-284). Her interest in the family situation that influences the œdipus complex is similar to mine, but her paper deals largely with the effect on the male. Another relevant contribution that has recently been published is a paper by Judd Marmor, *Orality in the Hysterical Personality* (J. of the Amer. Psa. Assn., I, 1953, pp. 655-659).

appear to show striking similarity in their manner of integrating with their parents. Two patients were in analysis, and four in long term, analytically oriented psychotherapy. The interaction of the parents seems notably alike in all six families, and in some cases the data were verified by interviews with one or both parents, or by an outside source such as the family physician. The patients ranged in age from nineteen to forty, and the diagnoses from schizophrenia to anxiety hysteria.[2] On the whole, they were attractive, slender, appealing women given to childlike joy and sadness. Superficially they appeared gentle and malleable with a certain apologetic manner. Shortly after therapy commenced, they manifested marked seductive and manipulative behavior, with great vulnerability to being hurt and serious difficulties in becoming aware of, or expressing, anger. Their apparent passivity and desire for a 'strong man' to guide them underwent during therapy a transformation that included rebelliousness, envy, feelings of being used, marked acting out, and an open contempt for themselves as women. Not one of them in any way lived up to her potential artistically, professionally, or socially. Their sexual inadequacy was marked, as was their inability to recognize their intellectual capacities. They shared many symptoms in common: anorexia and insomnia, dysmenorrhea and menstrual irregularity, frigidity, headaches, eye symptoms, and migrating aches and pains. They suffered excessively from shame and embarrassment, had fears of pregnancy and of being alone, as well as phobic and counterphobic attitudes, especially street and bus phobias.

The childhood of these women was characterized by a poor relationship with the mother and a marked attachment to the father.[3] In general, their relationship with the mother im-

[2] These patients have much in common with those described by Noble *(22)* and the group discussed by Blitzsten *(2)*.

[3] There was a significant third person in the homes of all cases but one, the psychotic patient. It appeared in general that the more benevolent was this individual (e.g., grandmother) toward the patient, the less serious were her emotional difficulties.

proved to varying degrees after the menarche while that with the father became more strained and distant. One patient's father died when she reached puberty, and in three others there was a well remembered, inexplicable retreat on the father's part especially with regard to any hint of physical intimacy. Kissing became strained and awkward, the father avoided their rooms, and two patients recalled that highly prized automobile trips with their fathers abruptly ceased. One father became rabid on the subject of bobby pins and forbade his daughter to go about with her hair 'put up' because it made her look older, but he continued to rub her chest when she had a cold until she was nearly fifteen and rebelled despite her mother's encouragement. Both parents made 'dating' extremely difficult for the girl; the mother with moral innuendoes, the father with jealousy (usually recognized as such by the girl) and domination. Not one of these girls missed the unconscious cues which encouraged behavior in the opposite direction; hence all of them engaged in promiscuous sexual activity during their teens. Poor scholarship, lying, and truancy were troublesome problems. As long as the girl was in difficulty, the parents functioned as a team. The father felt important and the mother felt that her dislike of the girl was justified. One father frequently commented: 'What would you do without me?'; whereas the mother accused her daughter of being tricky. This patient was living at home during her therapy and this afforded current observation of the parental interaction. The parents' behavior toward this girl was outlined in bold relief as their responses to the changes in her during therapy were noted. Both parents became remarkably upset, quarreled openly and violently for the first time, and veered from their previous restrictive behavior to that of ignoring her completely.[4]

[4] The whole question of what I choose to call 'family homeostasis' is worthy of further study since during the therapy of one member of the family there is laboratory evidence in the counterreactions of the other members for some of our speculations about human behavior. Johnson, Szurek, and others have made significant contributions to our knowledge of this area.

Realizing the inadequacies of the method thus far pursued, I would like briefly to outline some of the more important aspects of the parents' personalities, to summarize their interaction, and to indicate the effects on the patients.

## THE FATHERS

The fathers as a group were uncommonly successful in social prestige as well as in business, and were considered handsome and attractive to women. They seemed quite close to their mothers and sisters, and to have taken family responsibilities seriously from an early age. Among the younger brothers of these men there were several psychotics and alcoholics, and two suicides. The patients regarded their fathers as frightening and humorless, but much given to teasing. They tended to be inconsistently moralistic and strict, and with all but one patient there was the distinct impression that this behavior on the father's part was reserved for home consumption. The exception occurred in the only patient who recalled no suspicion of extramarital affairs, but her father had been married previously and her mother worried about the father's attitude toward the former wife. Naturally, as far as the patients were concerned, evidence of the father's interest in other women heightened the possibility of his being interested in them rather than in the mother.

These fathers were invaribly drawn toward that aspect of a situation which was flattering or somehow gave prestige. Their daughters responded to this aspect of the father's character and learned to flatter him by mimicking his behavior and interests and, by their helplessness, to make him feel indispensable. One patient described a weekly game during her preadolescence. The father would flip a coin to decide whether he would take the patient or her older sister to the movies. Invariably the patient lost, would resort to tears, be teased about being a poor sport, and would end up going to the movies. She used this example to demonstrate her bad luck, and was incredulous when it was pointed out that the father, and not chance, controlled the coin. It became apparent to

her that there was mutual gratification in this and similar 'games'.

In one patient's history actual incest had occurred; in another, there had been sex play between father and daughter. The seductive aspect of the relationship to the father seemed apparent in all the patients as demonstrated, for example, by care on the part of the girl to deny or keep quiet about her interest in other men. Being unintelligent, helpless, or in difficulty was calculated to increase the father's godlike propensities. This particular integration was useful when the patients got married in managing their husbands' more superficial needs. In the case of the psychotic patient, the technique was carried to such a fantastic extreme that she constantly traded good for evil with her husband. One night when he was drunk and had intercourse with another woman on their living room floor, she tenderly ministered to his subsequent hangover. Naturally, these matters when brought up during her treatment were so fraught with humiliation that they almost could not be mentioned. To a lesser extent, humiliation was a necessary ingredient in any relationship with a man for the other patients in this series.

Another common difficulty was the fear that something would happen to the father, often commencing at quite an early age and later felt to a less intense degree in relation to the husband. Such fears, usually associated with rituals and phobias, were not only hostile wishes but were in part based on the fear of being alone with mother without father as a buffer and on mother's feeling of weakness which was tacitly expressed: 'How could we get along without him?' These fears would be abetted by the girl's helplessness through which she attempted to renounce the dangerous relationship with father. This helplessness, sometimes cloaked by 'ultrafemininity', also furthered the identification with mother and in each case became more marked at puberty. One of the gratifying results of therapy was the discovery of latent interests, hidden talents, and a general increase in activity.

Concisely, then, these were men who had not resolved their attachments to their mothers which, as is frequently the case, were displaced to a daughter. In several instances the father's selection was made on the basis of a resemblance of the daughter to one of his sisters. Such fathers are exploiters of other people's dependency; they depreciate femininty because they are afraid of it, and substitute success for more human values.

## THE MOTHERS

The mothers of these daughters had all of the semblances of motherhood—if none of the feelings. They seemed to have been rather dependent on their own mothers and the maternal grandmother usually was an important figure in the home during the patient's childhood. The mothers married men who gave them material security and from whose success they gained reflected glory. They tended to be zealous housekeepers and to be overly interested in possessions. Four of the mothers discussed their fear and loathing of sex with their daughters while the latter were still preadolescents. In no instance was the mother the father's social equal, and though some of the daughters could appear as adequate socially as their fathers, they did not feel equal.

Harris *(14)* has shown that the failure to recognize a resemblance between herself and her daughter by the mother is associated with emotional disturbance in the daughter. It is of probable significance that four patients had brothers (whom the mothers preferred) and their preference was for male children. The fifth patient had a preferred older sister and her desire was for a girl child. The sixth patient was an only child and she also wished for a girl, with the same name as her own. It was rather as if each of these patients served as a repository for unacceptable feelings on the part of both parents. The mother of the psychotic patient was the one in this series who most obviously hated in the child those things she hated about herself. The patient was the third-born, as had been her mother, and she repeated with her third-born

girl many features of her mother's behavior toward her. However, even in this situation it was possible to see the protective aspect of the relationship to the father: the patient who had three daughters and no sons gave them boys' names, the eldest daughter's being composed of her father's and her husband's initials.

It was generally true that these patients were not allowed to participate in feminine activities around the house. There is evidence to indicate that the mothers used the daughters, in part, to play a role with the husband in which they did not themselves feel comfortable. One of the choice epithets hurled in anger at the daughter was, 'You're just like your father', or 'You are a typical Jones' or whatever name was that of the father's family. The fact that the mother had no interests in common with the father aided the girl in believing she would make the father a more suitable wife. The patient who had several incestuous experiences with her father felt pushed by her mother into taking trips with him, and it was on one of these trips that the sexual experiences took place. At one point during treatment she burst out furiously with: 'She couldn't satisfy him herself so she had to turn him loose on me'.[5] Almost without exception the mothers were pleased only if the daughters had male children, and cautioned them against having more children after the first pregnancy. The typical comment for the patient to make to the therapist about such recollections was: 'If I had any doubts about my being unwanted, I knew then it was true'.

## THE FAMILY INTERACTION

On the surface the parents presented a picture of serenity, orderliness, and religiosity. Despite the lack of intimacy, their mutual dependency decreed that there be no divorces and no separations. The psychotic woman's mother returned to her family's home on her wedding night, but was persuaded to resume the honeymoon three days later. In general, the surface picture of parental harmony was seen through by the little

[5] I feel it would be unwise to regard this comment strictly as a projection.

girl although the majority of her perceptions were not within awareness.

During the course of therapy the patients were confounded by their own discrepant statements, such as (in two cases) becoming aware that the mother had made suicidal attempts, yet describing her as a contented, self-sufficient person. In these households people did not really communicate. The fiction was prevalent that father was tired, worried, or busy and could not be bothered. The mothers got satisfaction out of abetting this myth, at least in part because it excused their own need for distance. It is no wonder then that the girl's troubles provided a vicarious outlet for the parents, as well as a common emotional meeting ground. Despite the unconscious turmoil, the parents tended to stick together in disciplinary matters. The girl was literally unable to talk to one about the other regardless of how unfairly she felt she had been treated, but there were many instances in which the daughter could get something from the father that the mother had refused or had been doubtful about. It does not appear to have been entirely a parental disagreement, but rather a further illustration of the mother encouraging the girl into seductive behavior and the father going along with it. The great discrepancy between surface behavior and unconscious emotion in the parental interaction seems to have been a major factor in the impulse-ridden and acting-out aspects of these patients' personalities. They were warned to be good, yet incited to rebellion; they were shown parental compatibility, yet invited to intervene and alienate. One mother who remarked frequently, 'If you don't stop bothering him, he won't have anything to do with you', was covertly encouraging her daughter into activity that led to sexual encounters with her father. The tendency of the parents to appear to be in agreement seems to have encouraged acting out, partly as an attempt to reach them and also to split them.

That this kind of integration was necessary for the parents is verified by two remarriages after the deaths of the spouses.

The father of the psychotic patient remarried a year after his wife's death, and the stepmother's traits of character were exaggerations of the major emotional difficulties of the mother; her father's second marriage was one of the chief factors in the patient's own hasty marriage. The mother of another patient remarried some years after the father had died, and at a time when her two oldest daughters would no longer give her bed and board. She frankly told the patient of her feelings of revulsion toward physical intimacy, yet she encouraged the daughter to kiss the stepfather and to 'butter him up' so he would buy her things. The fact that these mothers felt like children in their marriages is supported by a number of clinical items: there was an age difference of fifteen years between two sets of parents; several of the mothers did not have children for some years after marriage; a surprising number of spontaneous and induced abortions occurred; frustration, tears, helplessness were frequently the response to their children's obstreperous behavior; and neurasthenia pervaded the atmosphere of the mothers' bedrooms.

In general, the patients themselves made surprisingly durable marriages. Only one, the psychotic woman, was divorced after nineteen years of marriage. She was also the only one of the group who married a man like her father, and the only one in the group whose husband was obviously unfaithful. The others married men who took maternal attitudes toward their wives,[6] and tended to be moderately successful, nonaggressive men who helped about the home and were exceedingly patient with their wives' sexual ineptitudes. The patients were generally fond of their husbands, but with an admixture of contempt. It became apparent that they were experiencing alternating fear of the husband's success and masculinity, and a desire to show him up. One patient symbolized the dilemma by the

[6] Since this paper was written the young unmarried patient has become engaged. Her fiance is reported to be: 'The only boy I ever brought home that mother had anything good to say about'. Her father was unable to veil his jealousy and arranged for a three months' pleasure trip for himself, without his wife.

fantasy of a huge penis that attacked and split her in two, and by imagining that she ripped off her husband's penis and beat him over the head. I believe that a factor in not having to marry men similar to their fathers was the fathers' dependence on their wives; though this attachment was denied in the father's surface behavior, it became increasingly apparent as his sexual life declined with age. The daughter's awareness of being used by the father seemed to be another factor in picking someone he did not like.

Toward their children these women showed much conscious effort to provide what they had not had, and male children posed fewer problems. They were partially inclined to take a father's role, that is, to play the kind of games with the children that would more customarily be allotted to the father. Beneath the surface there was resentment against the husband for not doing more, which seemed to be displacement from their dissatisfactions with their mothers. The psychotic patient, for example, decided impulsively to pack up her three children and ship them to their father since she was such a poor mother. When it was pointed out that her real motive in part was to get even with the husband, she had a series of associations about her mother's indifference to her children and that she had mothered her younger siblings and, as a result, had had to give up a good deal of social activity.

In summary, the salient features of the tripartite interaction are:

1. None of the mothers was completely rejecting. In all cases but the psychotic patient, the mother permitted a third person to manifest tenderness toward her daughter. As the girl grew older, the mother invariably evinced dependency needs toward her which produced a variety of feelings in the daughter, including superiority, guilt, and contempt. Most of the patients had occupations or activities that brought them into contact with 'helpless' women who needed them.

2. The father's closeness to and overt interest in his daughter was the reverse of the mother's in that it tended to decrease

as the child grew older and, in some instances, was abruptly terminated at the menarche. The father's narcissism forbade signs of aggressiveness in the girl, and his incestuous fears produced alienation and sporadic hostile, seductive behavior toward his daughter. These elements in the father's personality caused a characteristic response in the girl: 'I can overcome father's indifference if I provoke him and make him angry'. This, in turn, led to manifest fear about the consequences of the provocation.

3. To say that the daughter clings to the father because the mother rejects her is an oversimplification. As Ferenczi said, 'You cannot renounce that which you have not had'. These women never really rejected their mothers, though on the surface they appeared remarkably unfriendly toward them. The daughters were scapegoats for both parents. One set of parents quarreled openly before the patient was born, but following her propitious arrival they no longer even disagreed. Another set of parents were not known to quarrel until their daughter had been in therapy approximately a year. One of the obvious kinds of interaction is the mother's encouragement of the girl to do what she cannot; namely, be seductive with the father and get the better of him. One mother laughed delightedly at the sight of her daughter seated on the father's lap and stated, 'You are going to be an old man's darling'. The father, in turn, may depreciate his wife by demonstrating to her that his daughter is more feminine, or a more satisfactory companion, than she.

4. These patients have been trained symbiotically to feed on triadic involvement. This is most apparent when they are interacting with only one person and must in fantasy involve a third, as though they feel no 'ego wholeness' without a collection of 'part egos'. One of the prices paid for this need to interact in two directions at the same time is a multifaceted inferiority feeling. For example, these women equate head and penis, hence intellect and maleness. Regardless of their actual performance, they question their ability. Associations

during therapy reveal a connection between intellectual ability, exhibitionism, humiliation, and castration, and an accompanying sexual excitement and fear when competing intellectually. There is a need to appear stupid, and yet a fierce intellectual competitiveness. These reactions may be accounted for by noting that father's narcissism encourages the little girl to show off for him, but strictly limits any performance that threatens him. On the other hand, he is constantly fostering helplessness. Mother is subtly encouraging in the hope that father will be defeated, but she cannot back up the child if there is a clash. In addition, there is a natural resentment and rivalry if the daughter shows her up and wins the father's praise. Doubtless this kind of description appears unnecessarily awkward, but it is essential to stress the tripartite aspect of the patients' interactions; in effect, father's interest in her makes her miss mother less—especially if she can have his child—but this unconscious solution increases the fear of the mother's retaliation.

In adolescence, five of the six patients acted out their infantile fantasies. There was a 'good guy', attentive and reliable, and a 'bad guy', fascinating, seductive, and unreliable. With the first they felt secure, but contemptuous and guilty; with the second, hurt and angry, but always hopeful of reform. With the unreliable man, pregnancy fantasies were frequent and accompanied by amenorrhea. The fantasies of pregnancy were not only of wanting a penis, of wanting to take the mother's place, or of wanting to possess the father; they were also related to becoming a mother rather than being a girl who needed a mother. The fantasy is thus in part an attempt to gratify an oral need in the relationship with the father. As these women were disappointed by both parents, the feeling of deprivation was augmented by their own biting and castrative wishes. The oral fantasies of being poisoned by the mother were represented in fears which equated semen with being soiled, and the like.

Pregnancy fantasies were among those most recurrent and, like memories of playing with dolls, were associated with lone-

liness and the need for 'something' to love. All of these women had had irregular menstruation prior to therapy, and during therapy each had at least one period of amenorrhea associated with the fantasy of being pregnant. Five of the six had at least one sudden, unexpected onset of menstruation. Four recalled similar delayed and premature menstrual periods associated with their adolescent sexual experiences. The father's seductive attitude toward the daughter (and other women) gave a basis in reality for these fantasies. The replacement of loneliness by the fantasy of being a mother, instead of a child needing a mother, is an identification with the baby as well as a fulfilment of the œdipal fantasy.

## TECHNICAL IMPLICATIONS

The first patient in this series was in many ways the most difficult. Mistakes made in her therapy led to disturbing, dangerous acting out. For a time hospitalization was considered. However, the intensity of the expectation of punishment, sexual fears, fear of being trapped (father), and of being abandoned (mother) dissuaded what, in this case, might have been ineradicable intervention. The obvious, intense sexual fears (wishes) were interpreted time and again, and such interpretations were apparently successful during the sessions, but the wispy tie between patient and therapist would dissolve in the aloneness of the world outside the psychiatrist's office. At last it was discovered that the sexual material was intense and threatening because the hatred of mother and need for her created a desperate clinging to father; but father, as a protector, was unsatisfactory because he could not stand the patient's demands and hatefulness nor his feelings toward her. The therapist, naturally, came to occupy a similar role, and similarly was not put to the test. For example, in a dream of one patient she usurped the analyst's chair and he started to tuck a blanket about her (as one would in putting a child to bed) but became greatly uneasy and fled from the room. He returned in a few moments chagrined and angry and ordered the patient out.

In this case, as in some subsequent ones, the therapist's rendering it possible to bring out the feelings about mother was most effective in controlling the acting out. Learning to deal with the bad mother inside one means the need for father is less profound and the sexual fears correspondingly less intense. Freud pointed out that a male therapist would be less suitable for understanding the 'mother' transference and predicted we would learn more about the œdipus situation as more women become analysts. To some extent this difficulty can be overcome technically by the male therapist's being alerted to his role of a masculine love object and a *mothering* one. There are many opportunities for male-female interpretations in dreams, fantasies, etc., such as objects being eaten that are not only father's testicles but are also breasts. Especially in regard to material dealing with pregnancy, the analyst should not take the easy way out and settle for 'penis'; but should remain alert for the shadow of mother behind the father transference, in contrast to our usual tendency to deal first with one and then the other.

A further aid in the technical management of these patients was to regard the fear of abandonment not as fear of retaliation alone, but also as the result of the patients' real experiences; hence, questioning about periods when the mother was absent either physically or because of withdrawal did not fail to produce important recollections, especially of depressions and mysterious illnesses on the part of the mothers.

## SUMMARY

Clinical material from a group of six female patients is presented to characterize a type of reaction related to emotional difficulties in their œdipal situations as a consequence of the special circumstances of their rearing. This communication attempts to emphasize the specific character of the parental interaction as a decisive factor in the patient's personality.

From their behavior, these women appeared to have a strong sexual attachment to the father and they were constantly

creating triangular situations in their personal relationships. Beneath this lay an unresolved longing for the mother that kept them from genuinely relating to men or to women. Their lack of identification with the mother and overcompensatory attachment to the father made them feel like boys who despised their femaleness and were afraid of and competitive with men. The main devices for escaping their unbearable dilemma were pregnancy fantasies or actual childbearing. The parental interaction constituted a nidus for the development of the girl's hysterical and phobic symptoms, and acting out.

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# Drives, Affects, Behavior. Edited by Rudolph M. Loewenstein, M.D. New York: International Universities Press, Inc., 1953. 399 pp.

Gert Heilbrunn

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# BOOK REVIEWS

DRIVES, AFFECTS, BEHAVIOR. Edited by Rudolph M. Loewenstein, M.D. New York: International Universities Press, Inc., 1953. 399 pp.

These twenty-one essays by twenty-three authors discuss 'the theory and practice of psychoanalysis and its application'. Although the contents have been arranged without obvious plan, all are concerned with the theoretical constructions of psychoanalysis and their applications. Depth and originality of thought appear on nearly every page.

The first contribution, by Hartmann, Kris, and Loewenstein, establishes the spirit of the book. It condemns the widespread 'suspicion of theory in psychoanalysis' and the mere 'collection of clinical data in therapy', a trend that has become 'an unhealthy form of compartmentalization within psychoanalysis'. A dangerous oversimplification of theory, 'theories by reduction' to use Hartmann's expression, owes its existence at best to 'energetic but tempestuous attempts', but more often to the superficiality and sterility of ambitious but mediocre workers in many disciplines.

Nearly all the other essays display broad knowledge and scope. New ideas and valuable reformulations are built on solid tradition. Although the book does not present us with a systematized outline of psychoanalytic theory, all major theories receive adequate treatment. The first part deals with the theory of instinctual drives and its relation to affects, particularly anxiety, and to aggression and sublimation. The clinical contributions that follow correlate theory with analytic investigations of early development, physical illness, depression, dream interpretation, the œdipus complex, homosexuality, masochism, and other problems.

This is no book for the novice. It challenges the advanced student and the expert. It is profound and diverse. Its publication is well-timed, for it reminds us that true progress in analysis depends on the total personality of the analyst and not simply on a three to five year training program with the standard minimal requirements.

The book is dedicated to Marie Bonaparte. It is a tribute to its patron and to those who created it.

GERT HEILBRUNN (SEATTLE)

PSYCHOANALYSIS AND CHILD PSYCHIATRY. By Edward Glover, M.D. London: Imago Publishing Co. Ltd., 1953. 42 pp.

From an article published in Samiksa (Vol. VI, No. 3, 1953), Dr. Glover has developed this lucid, thoughtful, and concise outline of theoretical and clinical applications of psychoanalysis to child psychiatry. He declares that 'despite the failures of its frontal attack on general psychiatry, psychoanalysis executed an outflanking movement and ended by capturing the field of child psychiatry'. To keep to the military metaphor, Dr. Glover uses this conquered territory as a base for the subsequent operation, the effort to use analytic principles for the diagnosis, classification, and treatment of emotional disturbances of childhood and for the even greater task of validating the genetic reconstructions and hypotheses of psychoanalysis.

He begins with a description of what he has termed Freud's 'master concept of the mental apparatus', to which, he says, any subsequent description of later developmental stages must conform. He lists three groups of factors—dominant instincts, dominant mechanisms, and structural differentiation—which he feels must be correlated clinically and theoretically for specific ages. The importance of constitutional factors during the first two and one half years of life is stressed. He suggests that 'functional disorders' are essentially disorders of excitation and discharge, and he differentiates them from more 'canalized' forms of psychosomatic disorders. The classification then proposed divides psychiatric disorders of childhood into 1, functional and psychosomatic, and 2, symptom formations, which include neuroses and prepsychotic and psychotic states. The criteria for diagnosis and differential diagnosis are discussed in greater detail than are the indications for and technical aspects of treatment.

This is a most valuable contribution to a much needed correlation and integration of the clinical findings and theoretical principles of psychoanalysis, child development, and child psychiatry, and to a psychoanalytic nosology for psychiatric disorders of children and adults. Such a nosology will, we may expect, result in more scientific selection of cases, better prognostication, and better appli-

cation and evaluation of therapy. Dr. Glover's occasional clinical comments need to be greatly expanded and it is hoped that the author will find time to do so in the near future. This monograph can be read with profit by all psychoanalysts.

ISIDOR BERNSTEIN (NEW YORK)

THE PSYCHOANALYTIC STUDY OF THE CHILD, VOLUME VIII. New York: International Universities Press, Inc., 1953. 412 pp.

These twenty-two papers vary markedly in their approach to the development and behavior of the child. All the contributions are valuable; only a few can here be singled out for mention.

Western Reserve University initiated a new medical curriculum in 1952. The fortunate student begins his medical training by being introduced to an expectant mother in a prenatal clinic, attends her during pregnancy and delivery, and follows the newborn and its family as long as the student remains in medical school. Anna Freud's address to the first group of students to begin such training constitutes the brief opening paper of this volume. In a splendidly lucid and succinct presentation, Miss Freud remarks upon the meaning and importance of the phenomena the students will observe in the unfolding of the infant's emotional development during the first year of life.

This exciting trend toward study of the child as part of its environment is carried on by The Child Study Center of Yale University. By longitudinal studies in a nursery school, Coleman, Ernst Kris, and Provence clearly demonstrate that attitudes of a parent vary with the developmental progress of the child and with the impact of the changing behavior of the child upon the parent. Such terms as rejecting, overprotective, punitive, hostile, so frequently applied to parents, are misleading if not understood as describing changing reactions to the child's changing behavior.

Six papers evidence the great interest in 'ego pathology'. In a metapsychological study of schizophrenia, Hartmann stresses 'the common economic aspect' of the defenses and object relationships. Ego functions are not only dependent upon neutralized libido for their source of energy, but also require neutralized aggressive energy. Workable defenses require aggressive energy in its neutralized form to maintain countercathexes. Capacity for such neutraliza-

tion is dependent upon object relationships which in turn demand the presence of workable defenses. Kurt Eissler in a long paper discusses the emotionality of a schizophrenic patient. He emphasizes the inability of such a patient to 'tame emotions' into signals which might serve ego functions. Because the structure of the ego is impaired, emotions once engendered threaten to engulf it; the ego can counter this threat only by summoning up a stronger emotion which then drives the threatening emotion from the ego. This mechanism is not clearly defined. Eissler compares it to a physical force that is driven away by the impact of another force. He believes that emotions can be divided like instincts into emotions of the id and emotions of the ego, and suggests the interesting theoretical possibility that some defense mechanisms are 'genetically congealed emotions'. In his comments on therapy Eissler suggests utilizing with a schizophrenic, at the appropriate time, the technique used with phobias, — asking the patient to give up a symptom as an aid to reality testing and subsequent analysis.

Rochlin describes how a four-year-old boy substituted a fur coat for a mother who severely traumatized the child by repeated disappearances. Greenacre discusses fetishism and its relation to disturbances in the development of body image. Both authors point out that an inanimate object, by its qualities of stability and immobility, serves to diminish anxiety. Rochlin's little patient substituted for the traumatizing mother an object that could not disappear. Greenacre emphasizes that because it is tangible, stable, and immobile the fetish helps counteract severe castration anxiety engendered by sensations or change of size and shape in the phallus and body.

It is surprising that results of other methods of investigation are published so much more often than those obtained by psychoanalysis of neurotic children. This most fruitful of practical and theoretical methods is exemplified by Berta Bornstein's study of a fragment of the analysis of an obsessional child. This brilliant paper focuses upon 'the vicissitudes of the patient's aggressive impulses, her defenses against them, and the ways in which they were approached'. Drawings made by the child during the analysis are reproduced and psychoanalytic technique and theory are woven together with consummate skill. This paper may well serve as a model for other investigations of the psychic life of the child.

As are the previous volumes, this book is marred by frequent and gross errors in spelling. Perhaps in the future the series will be free of this annoying defect.

The book ranks with the best of its predecessors and like them is indispensable.

BERTRAM GOSLINER (NEW YORK)

THE PSYCHOSOMATIC CONCEPT IN PSYCHOANALYSIS. Edited by Felix Deutsch, M.D. New York: International Universities Press, Inc., 1953. 182 pp.

This book, with contributions by fourteen authors, opposes the concept of 'psychogenic' disease as well as that of specificity of personality types for psychosomatic symptoms. It emphasizes psychophysiological development. Physiological changes occur parallel to psychological development, and so do regressions when initiated by stress or conflict. The functional reaction in time gives way to change in tissues; regression in the structure of a tissue results in the appearance of cell forms and of functional properties which had existed previously in the process of differentiation. Thus the psychosomatic pathology is explained by Sydney Margolin in terms of 'physiological regression' and 'repressed fantasies of function'.

Roy Grinker sees the core of the psychosomatic problem in the period of differentiation from totally hereditary to individually learned patterns and their integration into a new personal system. The development from the undifferentiated functional whole to the integrated mature individual determines the formation of healthy, sick, or potentially sick organisms. Lawrence Kubie, opposing the assumptions of specificity, shows how regressive and dissociative processes occur in the course of the decompensations which take place when any latent neurotic process becomes manifest. A great variety of psychosomatic disturbances may result from a constant neurotic process.

The late Margaret Gerard stresses the importance of emotional difficulties resulting from traumatic situations in the first months of life. Organ pathology may start here and may be regressively revived in later life. The early relationship of mother and child may create an environment that 'insults' the infant organism and

is particularly noxious to the functioning of certain organs. Ives Hendrick refers to 'physiologic infantilism'.

The therapy, as outlined by M. Ralph Kaufman and Dr. Margolin, takes cognizance of the regressive character of psychosomatic disease. It has to be prevailingly anaclitic, exploiting and gratifying the patient's unconscious infantile tendencies which are genetically and characterologically related to his disease. Psychoanalytic treatment proper, mainly in the form of character analysis, can be instituted only after a sufficient strengthening of the ego has been achieved.

Felix Deutsch re-emphasizes the concept of physiologic regression which invalidates the term 'psychogenic'. 'From the analytic point of view, all biologic functions are continually governed psychodynamically.'

BERNHARD BERLINER (SAN FRANCISCO)

FASHION AND THE UNCONSCIOUS. By Edmund Bergler, M.D. New York: Robert Brunner, 1953. 305 pp.

You'll be surprised! And the *You* refers to everybody likely to read this book: the wearer of clothes (and that of course means really everybody), the historian of costume, those who design, make and sell clothes, the psychologist, and to a lesser extent even the psychoanalyst. The last named will be less astonished, because Dr. Bergler deals with unconscious motives, and the psychoanalyst already knows that, in Dr. Bergler's words, 'an element of "improbability" is one which is common to all theories concerning the unconscious'. Nevertheless even he will probably be somewhat surprised (and all the more interested), for, as Dr. Bergler points out, analysts have devoted comparatively little attention to clothes and fashion. Though there have of course been a number of articles on special points, such as fetishism (and how little we really know about that), there has, it appears, been only one 'full dress' attempt to deal with the subject by an analyst, in a book published some twenty-five years ago; and as regards even that, at least one (friendly) reviewer felt it necessary to say something by way of justifying its appearance in a 'Psychoanalytical Library'.

The stimulus to Dr. Bergler's new attempt seems to have come from the fact that he had occasion to analyze a considerable number

of male homosexual dress designers. It is on the basis of this extensive material that he elaborates his chief theory: that clothes owe their origin and function to the castration complex, which, as he rightly points out, is itself only the last developed (genital) crystallization of a whole set of earlier pregential anxieties, 'the septet of baby fears'—fears of being starved, devoured, poisoned, choked, chopped to pieces, drained, castrated. It is the fear of the female body that leads men to insist that women be clothed. But in the homosexual this fear amounts to 'panic', and is predominantly based on the earlier precursors of the castration complex, especially on the ambivalent attitude toward the breast. 'The "improbable" but clinically provable answer to the riddle of every man's admitted or unadmitted qualms about his sex organ is the "unfortunate" comparison he made in infancy between the very same organ and his mother's breasts. . . . "Something enormous" is pushed by "something enormous" into his mouth. And later he learns to call that giantess "mother".' This comparison of penis and breast is the first stage; thereafter the developmental process, as envisaged by Dr. Bergler, seems to be somewhat as follows: second, penis pride as compensation, this leading to the He-Man fiction and causing the boy to look askance at the 'castrated' female; third, the fear of a showdown of this fiction in intercourse, where the penis might once again reveal its inferiority; fourth, insistence on privacy lest this inferiority become publicly conspicuous; fifth, consequent development of shame and modesty (the whole attitude of only partially concealed anxiety and failure being at the same time secondarily endowed with masochistic pleasure).

Phallic attributes or symbols in women's fashions of course 'make good' the lack of the penis—both to the wearer and to the male beholder—while 'mutilating fashions' (such as the bound foot, the constricted waist, or the hobble skirt) can, it is suggested, be explained as due to the unconscious repetition compulsion (p. 123). Changes in fashion can, at any rate to some extent, be explained by the need to accentuate in turn various parts of the body, according to the view previously adumbrated by the present writer and subsequently christened by James Laver (whose interesting contributions to the subject are not mentioned by Dr. Bergler), 'the doctrine of the shifting erogenous zone'.

Besides this major theoretical contribution, there is much else of interest in this book. In particular we may mention a treatment of the psychological significance of color, the reaction to which, the author finds, is intensely individual and can in many cases be explained analytically. There is also an account of the results of a questionnaire on taste in dress (which the reader may feel should have been better summarized and predigested for his benefit, as is customary in the presentation of experimental findings), as well as data supporting the author's view that lack of taste in women is always the result of more or less specific inhibitions,—he therefore calls it 'sartorial antitalent'.

Dr. Bergler is critical of the present reviewer's The Psychology of Clothes (the book referred to above) because too great weight, he thinks, was placed upon the twin factors, scoptophilia and exhibitionism. No doubt much of this criticism is justified, though it should be noted that Dr. Bergler's own position seems to imply an important revision of the classical view of these factors, as found in the Three Contributions and so often elsewhere. In his opinion these factors are secondary, and, in so far as we can generalize from his findings, can hardly be looked upon as 'component instincts' in their own right. Voyeurism or 'peeping' is, he considers, a compensation for, or reaction-formation against, the fear of the 'castrated' female body. The would-be He-Man pretends he wants to *look,* thereby concealing his fear of the terrifying spectacle. This applies perhaps especially to the breast—that second tabooed, but much accentuated, region of the female body, concerning which we might perhaps have hoped for a more detailed treatment than the all too brief mention made of it. For the taboo appears to fit in well with the author's theory since we have here to do with the original alarming 'enormous thing' itself.

Exhibitionism, the author thinks, is a 'lesser crime', designed to hide the greater one of peeping. In women also it serves the same fundamental purpose of denying castration. It contains the unspoken feminine invitation: 'Look at every part of my body but the "mutilated genital" '; and in this connection Dr. Bergler points out the absence in women of 'perverted vulva exhibitionism' comparable to penis exhibitionism in men.

Most psychoanalytic readers will probably be ready to accept the view that castration fear plays an important part in clothing. Now that Dr. Bergler has put it before us with such clarity and emphasis, the step from the alarm connected with the female genital (already well recognized in psychoanalytic theory) to its influence on clothes seems a natural one. Other features of his theory, such as the outstanding influence of the breast-penis comparison, the 'compensatory' function of voyeurism, and the indulgence in exhibitionism as a 'lesser crime', are more novel, and many readers perhaps will be inclined to wait for further confirmation. But the observations and theories contained in this book, which is undoubtedly a highly suggestive contribution to a subject unduly neglected by psychoanalysis, certainly deserve to be diligently followed up. There are, of course, many other important factors operative in fashion which the author has not mentioned, but in view of the 'Unconscious' in the title and of his obvious endeavor to deal with the psychologically deepest determinants, it would not be fair to make complaint on this score; though perhaps a fuller treatment of woman's reaction to the suggested male insistence on clothes would have been welcome. What light does the author's theory throw on the question of how far the female castration complex is one that is imposed on women (like their clothes, according to this theory)—a view which has been adumbrated by some writers? Or, assuming it to exist in its own right, what are its interactions with the corresponding male complex where sartorial matters are concerned—a question on which the author is rather tantalizingly casual?

One little point, not directly connected with Dr. Bergler's main thesis, deserves perhaps to be mentioned. The book abounds with fairly long conversations purporting to be extracts from actual analytic sessions. In this, and in other contributions containing clinical reports, should not the reader be informed as to how they were recorded—from notes taken at the time, by mechanical reproduction, or from the analyst's memory; and if from memory, after how long an interval? If psychoanalysts desire to avoid criticisms from really or allegedly more scientific fellow workers, it is surely desirable that such information be given.

J. C. FLUGEL (LONDON)

CYBERNETICS. Circular Causal and Feedback Mechanisms in Biological and Social Systems. Transactions of the Ninth Conference, March 20-21, 1952. Edited by Heinz Von Foerster. New York: Josiah Macy, Jr. Foundation, 1953. 184 pp.

This fourth published series of transactions of the annual Conferences on Cybernetics seems somewhat less well put together and less provocative than its predecessors. Of the ten papers presented only three are fully discussed. Since it was the purpose of the formal papers merely to provide a skeleton for the discussion, the skewing of the discussion around the first three papers, and especially around the first, results in a fairly diffuse manuscript in which a central theme fails to appear. Of the one hundred eighty pages in the book, forty-seven are devoted to the presentation and discussion of The Position of Humor in Human Communication by Gregory Bateson. It is proposed to approach the whole subject of humor afresh and to make a significant advance by consideration of its function as a mode of communication. There is no serious reference to Freud's extensive monograph on wit. The result is that both paper and discussion succeed in describing only the most superficial aspects of humor, those that Freud lists completely but dismisses as the formal prerequisites for humor rather than its essence. For example, the paradox is considered to be the paradigm, and the reversal of figure and ground a frequent device for humor. There seems to be no awareness that both paradox and reversal are used merely to provide occasion for the expression of an unconscious wish. There is concern only with the form of the joke and not at all with its affective meaning. Two discussants, Pitts and Gerard, mention that the essential part of a joke is its being addressed to a specific listener. This important point is not mentioned by the author of the paper nor does anyone mention the fact that a joke has not only an individual—implicit or explicit—as its object, but also an implicit or explicit audience. To anyone thoroughly familiar with Freud's monograph, this paper and its discussion are elementary. One exception should be mentioned. At one point in the discussion the use of the word 'tension' becomes the center of interest. This common word is rather imprecise in ordinary usage because it is used with so many meanings. Several of its meanings were mentioned in the discussion and Kubie was

able to lead the discussion back from a concern about the peripheral manifestations of tension to a concern about its source. It seems to me that this term needs a great deal more discussion and I believe that it would be profitable at the outset to distinguish between the subjective sensation commonly called tension and the psychic state responsible for the subjective sensation.

The second paper, by Kubie, on The Place of Emotions in the Feedback Concept is a demonstration of how a psychic phenomenon such as affectivity can and should be investigated experimentally. In a series of questions, Kubie draws attention to the very large number of variables generally taken for granted and not examined explicitly. In a remarkable though almost unnoticeable way, Kubie tends in this paper as in many others to avoid making distinction between psychoanalytic methodology and theory on the one hand and academic psychology on the other; he has the knack of dealing with psychoanalytic theory as a part of his general scientific approach. This accomplishment all who work in psychoanalysis and other scientific fields should attempt to achieve. The discussion of Kubie's presentation suggests that the audience followed his argument and seriously considered it. Transcripts of previous conferences suggest that there has formerly been less good contact. In this connection I quote remarks by Julian H. Bigelow, a mathematician who is a regular participant in the Conference on Cybernetics, appended to his discussion of Kubie's paper.

> Because it is true that the methods of mathematical-physical sciences do successfully reduce situations of apparently great complexity to simple formalizations, it is difficult to persuade nonmathematicians that these successes are due to essentially simple artifacts and apply to special situations not generally found in the real world of experiment. Sufficiently general mathematical-physical techniques, capable of handling complex, heterogeneous, and interrelated data and of reducing them to concise and information-preserving formalisms, do not exist today and may still be a long way off. Those methods that do exist are quite special, and are informative only when the particular artificial assumptions and processes involved are understood and are constantly held in view against the background situation concerning which inferences are to be drawn. . . . Measurement (and metric method) is not the only avenue, even in the physical sciences; frequently, identification of objects, their enumeration, and the exploration of their interconnection is a very successful observational procedure and may profit from the application of special, nonmetric, combinatorial or topological branches of mathematics.

W. Ross Ashby, in a paper entitled Homeostasis, describes a device he has constructed with which he endeavors to simulate animal behavior. The device attempts to neutralize any stimulus presented to it by testing one random solution after another until one that fits is found. Although the device is apparently successful in accomplishing the task for which it was devised, discussion raises the question of its relevance for human behavior. However, in another sense, the orientation of the entire group of cyberneticists is open to the same criticism. With the exceptions of Norbert Wiener, Margaret Mead, and Dr. Kubie, the cybernetics group in attempting to understand behavior seems to be especially interested in the problem-solving function of the brain. The motivational and emotional aspects of behavior are for them merely disturbing influences which introduce a note of randomness and arbitrariness into cerebral function. For many of them behavior seems to consist merely of finding the best response to an environmental stimulus; there seems to be little appreciation of the idea that behavior might be understood as a mode of using the environment for the attainment of instinctual goals.

An interesting paper on the ability of the octopus to learn and discriminate and the relation of this ability to certain gross portions of his nervous system is given by J. Z. Young. Other papers include The Nature of Neural Inhibition by Ralph Gerard; the possibility of constructing an automatic chess player that will outplay its author by Ashby; investigations on the nature of synaptic transmission in the spinal cord by Walter Pitts; and an interesting paper by Henry Quastler on cellular biology. This last paper discusses the mode by which the rate of enzymatic reactions is controlled by the amounts of substrate, of enzyme, and of end product. It continues by illustrating enzyme activity in the reproductive biology of the Paramecium, and finally offers some interesting speculation on the amount of information needed for the construction of any living organism in general and of human beings in particular. It concludes that $10^4$ bits of information are required for independent life. (A bit of information is defined as that amount of information necessary to make a decision between two equally likely alternatives.) For the construction of the human being, Quastler estimates that $10^6$ or $10^7$ bits of information are required.

In general, this volume seems to convey less of the enthusiasm and ambition discernible in the previous conferences. The presentations and discussions seem more diffuse, and there is a little evidence of narrowing of the spiral. On the other hand the group as a whole seems to show a greater understanding and sympathy with the psychoanalytic approach than previously. As a record of discussions with some brilliant thinkers, on the borderlines of biology, this book will command the interest of many psychoanalysts.

MORTIMER OSTOW (NEW YORK)

COMMUNICATION. THE SOCIAL MATRIX OF PSYCHIATRY. By Jurgen Ruesch, M.D. and Gregory Bateson. New York: W. W. Norton & Co., Inc., 1951. 314 pp.

The purpose of this book, as described in the text, is to bridge in some measure at least the gap between the natural and humanistic sciences. The authors observe that a human being exists within the framework of various social situations in which his relationship is with one other person, or with a group of other persons, or with his culture. They deplore that these various relationships have been studied by different disciplines which do not share each other's concepts and language. To remedy this, the authors 'propose to use one single system for the understanding of the multiple aspects of human behavior'—the study of communication. This 'link that connects psychiatry with all other sciences' includes all processes by which one person influences another; it includes the perception and production of sensory impressions, and awareness of memory traces as well.

In establishing this premise, the authors make many statements which this reviewer must question. Speaking of 'the limitations of man's communications', they say: 'Beyond a certain maximum any increase in the number of messages in transit leads to a jamming of the network, and so to a decrease in the number of messages which reach their appropriate destination. This . . . the psychiatrist calls anxiety.' Later, 'Insecurity is the direct result of anonymity of origin or destination of messages'. Finally, 'The task of the modern therapist can be compared to the task of the maintenance engineer—who repairs the great overland power lines'. These partial truths lead the reader to ask if the authors, a psychiatrist

and an anthropologist, are not talking of cybernetic devices rather than of human beings.

When the authors treat of 'specifically American features of the social matrix and their relationship to present day therapeutic practices', many assertions concerning the United States may be found that are even more true of European countries. 'The number of forms ordinary citizens have to fill out in multiple copies, the complicated designs of tax forms, and the number of things people have to swear to are unheard of in other countries.' Evidently the authors are not familiar with the restrictions and regulations that encumbered the British after World War II. 'Hence in America, conformance, competition and group membership are always found together.' And so they are in most other places. Again there are observations true of some Americans but quite inapplicable to others. 'The American will gamble for the sake of success; he will play the horses and the stock market.' On the other hand, hundreds of thousands of Americans acquire comfortable fortunes by the security of plodding toil and government bonds. Then there are effects of which the obvious causes have been ignored in order to prove a theory. 'A caste society with its limitations of success and social mobility promotes mastery and virtuosity as an end in itself. The result of this tendency [is that] almost all artisans and skilled workers in America are of immediate European descent. . . . American skilled workers will strive for mastery only to the point where success is assured.' The authors do not take into account the widespread mechanized mass production in the United States which tends to make extreme proficiency in a craftsman an anachronism.

Except for these chapters, 'about Americans and about psychiatrists', this reviewer does not presume to question the contents of the book. Others may be better informed to appraise and challenge the passages that deal with digital, analogic, and Gestalt codification by electronic machinery; the similarity if not the identity of negative entropy, value, and information; selective and progressional integration; the Russellian paradox and its mechanical model, an oscillating electric circuit; semantics; the concept of deutero-learning; and Whitehead's Principia Mathematica. As to the worthiness of the authors' aim, the extent to which they have achieved their goal, and the soundness of certain of their observa-

tions, there can be differences of opinion. However, there can be no doubt that the intellectual excursion on which the reader is taken leads him to ideas and comparisons which are extremely interesting. These deal with nonclinical origins of modern psychiatric, especially psychoanalytic, thought, and speculations as to the directions in which psychiatric thinking tends to go. The interaction of theory and practice in psychotherapy is discussed from a point of view that seems to be equidistant from Freud, Jung and Sullivan. The exposition of widely differing ideas is brilliantly lucid. The reader may argue with some of the contents of this book, but they will reward his studying and pondering.

GERALDINE PEDERSON-KRAG (NEW YORK)

PSYCHOTHERAPY OF PSYCHOSIS. By Gustav Bychowski, M.D. New York: Grune & Stratton, Inc., 1952. 328 pp.

This book clearly fulfils the author's stated aim, 'to outline a synthesis of our present knowledge in order to have a clear basis on which to build further research and study'. He offers it 'to all students of psychiatry who have not had the opportunity to share his observations or were too young or too far away to be exposed to the great teachers of our century, Bleuler and Freud'. Its thirty-four chapters, presented in lecture form, are characterized by their directness, readability, and conciseness. They contain many interesting historical observations on the preanalytic and analytic phases of psychiatry, much valuable theoretical and clinical information on psychotic illness, and detailed case material from the author's wide range of experience with the hospital treatment as well as private care of psychotics, — and besides all this, much food for thought on the present status of our conceptual and clinical approach to mental illness. The scope of the book may be most readily conveyed by listing some of the chapter headings: 1, The Personality of the Psychiatrist; 2, Bleuler and His School — Their Role in Dynamic Psychiatry; 3, Special Practical Problems Presented by the Psychotic; 4, Theories of Schizophrenia; 5, Libidinal Regression, Body Ego Changes and Hypercathexis of Organs; 6, Regression of the Ego. In further chapters the dynamics of ego strength and ego weakness, the mechanisms of depersonalization, splitting and denial, problems of transference, therapeutic handling

of hostility, and interpretation are discussed. The difficulties of the treatment, problems of prognosis, and the complexities of the transference — 'the ego of the patient is not a punching bag and his feelings, especially those concerning us, have to be handled with great tact and delicacy' — are fully stated and impressive clinical histories are presented, the study of which will help the analytically trained therapist in his own difficulties with such patients. The reader will also find a comprehensive account of the contributions by Freud, Bleuler, Federn, Frieda Fromm-Reichmann, John N. Rosen, Mme. Sechehaye, Schilder, and other authors to the understanding and management of the psychoses. A separate chapter deals with the problem of latent psychosis, its diagnosis, clinical evaluation, and technical handling in therapy. These so-called 'borderline' patients constitute a large proportion of those seeking psychiatric care today — up to fifty percent according to some authors. Psychoanalytically oriented therapy of frankly psychotic states is discussed with regard to the nature of the therapist's approach, the type of interpretations given, the flexibility and timing of therapeutic interventions, the patient's reactions to them, and the goal of the treatment. Specific auxiliary procedures in relation to the patient's environment, the handling of the family, impulses to act out, suicidal tendencies, the therapist's frustrations, and other factors which so frequently complicate work with psychotic patients are well presented in a spirit generally in accordance with the indications of the late Paul Federn. Full bibliographical notes and references at the end of each chapter enhance the value of the book.

Dr. Bychowski stresses the importance of the therapist's 'respect for the patient and his mental productions, the unrelenting desire to understand him'. The constructive, helpful attitude expressed in this volume attests its author's dedication to his therapeutic task.

WILLIAM G. NIEDERLAND (NEW YORK)

INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS. New York: Milbank Memorial Fund, 1953. 262 pp.

This volume, the third of a series (the first was on Epidemiology of Mental Disorder and the second on the Biology of Mental Health and Disease), presents the results of a conference held in 1952 on

what is often termed social psychiatry. Nearly fifty workers from such fields as public health, sociology, anthropology, psychology, animal psychology, and social psychiatry participated freely in the discussion of the several papers. Brief descriptions of nine research projects in the epidemiology of mental disorders are also presented here by the respective principal investigators; they are of value in that they collect in one volume data concerning actual projects of a varied nature in this important field. A comprehensive survey of such a wide-ranging discussion is difficult in a brief review, so a few points only are mentioned here.

In the opening address, Surgeon General Scheele of the United States Public Health Service notes particularly the impact on mental hospitals of the increasing numbers of older persons in the community, pointing out that the rate of admissions for persons over sixty-five increased in fifteen years (1933-1948) from one hundred forty-eight to two hundred twenty-five per one hundred thousand population. He also points out the vital necessity of prevention and of teamwork in all aspects of public health.

Professor Eugene Schneider discusses sociological concepts and psychiatric research, enumerating no less than thirty-two separate factors worthy of being tested in their relation to mental disease. He discusses in some detail the importance of disorientation between the personality and society.

A case study in Guatemalan folkways by Dr. Benjamin Paul raises the questions whether the dynamics of mental disorder remain constant from culture to culture and whether the roots of psychopathology lie in the social process or originate in hereditary predispositions. Dr. William E. Henry suggests the desirability of studying the processes of development into health as opposed to those of development into ill-health, including such problems as the adaptation of the normal individual to situations of stress.

The process of socialization in higher animals is discussed by Dr. J. P. Scott as offering clues to the basic information needed in understanding the process of human socialization. Dr. Marie Jahoda, presenting the point of view of social psychology, suggests two behavioral criteria of mental health, namely, the mode of ad-

junct and need-free perception; she discusses these in some detail.

The general discussion entitled Definition of a Case for Purposes of Research on Social Psychiatry is an interesting exercise in nomenclature and semantics. It is worthy of study, as indeed is the whole volume.

WINFRED OVERHOLSER (WASHINGTON, D. C.)

EMOTIONAL FACTORS IN SKIN DISEASES. By Eric Wittkower, M.D. and Brian Russell, M.D. With contributions by Peter Edgell, Desmond Irwin, and John Slorach. New York: Paul B. Hoeber, Inc., 1953. 214 pp.

In the preface the authors state, 'Two ways were open to us: either to write a book predominantly intended for psychiatrists or one predominantly intended for general physicians and dermatologists. In accordance with our view that dermatologists should deal with their own patients and consult psychiatrists only in exceptional cases, we decided in favor of the latter course. For this reason we have deliberately avoided technical terms' (p. x).

This intention could not have been suspected without reading the preface.

The authors begin their General Discussion with an introduction to 'psychosomatic' concepts, quoting liberally from Alexander, Cobb, Halliday, Weiss and English, and others. This is followed by a review of the evolution of 'psychosomatic' concepts in dermatology, written by the 'dermatological writer' and dealing mainly with the dermatological literature. The extensive psychoanalytic literature is mentioned only in the second part of the book, in the chapters dealing with specific conditions, written by the psychiatric partners of the team. The authors do not lay claim to completeness; yet one misses in the discussion of the psychoanalytic literature Freud's classic description of what was obviously a case of acne and his stress on the basic difference between the structure of such symptoms and the common conversion symptom,[1] a difference which can be verified in a great number of dermatoses. One also misses the name of Felix Deutsch. The authors proceed with an excellent chapter on physiology of the skin, reviewing our present-day knowledge of the transmission of various impulses to the skin.

[1] Freud: *The Unconscious.* Coll. Papers, IV, pp. 131-132.

In the special discussions the authors deal with a great variety of dermatological diseases. Their main goal is to establish the importance of emotional factors in the etiology and course of the disease. Their method consisted mainly in a two-hour psychiatric interview, although some conditions like pruritus vulvae and ani seem to have been studied for more extended periods. Several cases of eczema were observed 'even' during 'psychotherapy' for about ten sessions over a period of three months.

Knowing from extended experience how difficult it is in most chronic dermatoses to trace the first outbreak or any recurrence with any degree of certainty to a specific life situation, one is impressed by a number of convincing case histories. This can perhaps be explained by the fact that the authors during the war studied a great number of army personnel who were exposed to very traumatic experiences. The greatest value of this book is in these case histories.

The authors try to go beyond establishing the relative impact of emotional factors; in most chapters they linked specific illnesses with specific personality types ('profiles') or specific 'conflicts'. This hunt for specificity, which is so prevalent in 'psychosomatic research', leads to classifications such as 'undisguised' and 'disguised eczema personality', the 'specific personality type of seborrhea', and the 'psychodynamics of rosacea'. Of this tendency to classification and subgrouping, the following is an example. Patients with pompholyx are classed as 1, vain and conceited; 2, ambitious, afraid of failure; 3, afraid of getting hurt; 4, afraid of showing fear; 5, afraid of their own impulses. The author of this chapter claims that 'emotional disturbances of a specific nature preceded the onset of the skin complaint' (p. 108), a conclusion based on two hours of psychiatric interview. Statements such as 'the weeping of the eczema like the weeping of a child re-enforces his appeal' (p. 99), or 'various writers have contended that urticarial eruptions are equivalent to a suppressed cry. This may be true, yet the tears shed into the skin seem to be tears of fury rather than of sadness', tend to exemplify how secondary symbolic elaboration of any symptom can be confused with attributing a 'meaning' to certain physiopathological phenomena.

The chapter on pruritus vulvae and ani stands apart from the others. It seems to be based on longer observations. It is less

insistent on 'specificity' and more successful in fitting the syndrome within the structure of the underlying neurosis. To some extent this applies also to the chapter on alopecia.

One chapter, The Skin and Psychosis, deals with a study of thirteen thousand four hundred sixty-eight psychotic patients. An interesting difference is noted between the incidence of certain dermatoses in psychotics as compared with that in out-patients of a dermatological hospital; differences in the incidence of specific dermatoses are also found to exist between schizophrenics and manic-depressives.

The main value of this book is its presentation of a rich and diversified case material of numerous dermatological diseases. It may convince some recalcitrant dermatologists of the great importance of psychological factors in pathology and therapy and may perhaps stimulate research based on more rigorous methods.

MAX SCHUR (NEW YORK)

ANGUSTIA, TENSION, RELAJACION (Anxiety, Tension, Relaxation). By E. Eduardo Krapf. Buenos Aires: Editorial Paidos, 1952. 93 pp.

The author compares the approaches and attitudes of various peoples to mental tension and relaxation. Fromm, for example, has noted that Latin Americans would rather have free time than make money. From Germany—the country that set up postural rigidity as a social ideal—comes Schultz's system of teaching physical relaxation. Jacobson evolved his 'progressive relaxation' in America, known to the world for its 'nervousness'. Techniques of relaxation originated in the Orient. They have taken root and flourished in highly competitive and industrialized civilizations because such civilizations are most productive of anxiety and tension.

The author reviews the many methods of relaxing the body, including mysticism and Yoga. He agrees with Freud that motivation and motility must both be taken into account when we study the unconscious. The human being is a unit. We can act upon his body through his mind, and upon his mind through his body. These two ways of dealing with psychogenic manifestations do not exclude each other. Psychotherapy that works upon motivation, as does psychoanalysis, is not the only possible approach. We

must achieve a more complete understanding of man. The inhibitions of motility are more primitive and older defense mechanisms than the inhibitions of perception. Denial of perception is a special 'demotilized' form of the original defenses, which pertain to motor activity. In all psychogenic disturbances, whether or not inhibition of perception is present as a defense, there will always be signs of defenses against motility which block or fatigue the ego.

Such defensive inhibitions of motility the author divides into two groups: symptoms of tension and symptoms of defense. Tension 'will produce negative or positive inhibitions of the ego' (Fenichel). The state of tension 'is clinically a state of tension of the whole person'. Some syndromes that can be benefited by techniques of relaxation are acute and chronic neuromuscular hypertension, neurasthenia, tics, spasms, insomnia, stammering, peptic ulcer, mucous colitis, and cardiopathies.

GABRIEL DE LA VEGA (NEW YORK)

PSYCHOLOGY IN THE NURSERY SCHOOL. By Nelly Wolffheim. New York: Philosophical Library, Inc., 1953. 144 pp.

The findings of psychoanalysis have been applied in many nursery schools for quite a number of years. Much that is good has come of this—and much that is not so good. Psychology in the Nursery School may, one fears, contribute to the not so good.

The author commits the very crime she warns teachers and parents against throughout her book. She severely scolds the authoritarian adult and then in the most authoritarian tones tells us what is wrong and what is right, and apparently we are to accept her word for it, for she has little room for explanation in her short book. If the book is intended only for psychoanalytically trained teachers, it raises false hopes, for 'œdipus complex', 'infantile sexuality', 'sibling jealousy', and 'aggression' are familiar concepts. What such teachers need is deeper understanding and further clarification, both of which are lacking here. If the book is used by untrained teachers and parents, the results can be disastrous, as some other books already have been. Because of misunderstanding, children have been exhausted with boredom or excitement and left to their own devices while the unfortunate teacher tells us they

are 'working through the œdipus phase' or 'killing the new baby'. Mrs. Wolffheim speaks of the importance of the passive role for the teacher while at the same time she suggests a conversation 'touching the child's emotional life, loosening its unconscious, and removing repressions'. When we have that kind of skill in the nursery school, children will have come into their own.

The examples of children's behavior cited in the book are certainly provocative of thought, as carefully observed behavior of young children always is; but let us think long and seriously before we attach a label to behavior, whether it be 'œdipal' or merely 'good' or 'bad'.

TERRY SPITALNY (NEW YORK)

THE PSYCHOLOGY OF ALFRED ADLER AND THE DEVELOPMENT OF THE CHILD. By Madelaine Ganz. New York: The Humanities Press, Inc., 1953. 203 pp.

This book consists of an exposition of Adlerian psychology and its application to education as exemplified by the Adlerian Experimental School in Vienna. The school appears to be an approximation of the 'progressive' schools in this country. Emphasis is placed on leadership within the group and development of group feeling. Although the Adlerians disclaim any moralistic approach in their educative and therapeutic methods, the book is replete with remarks concerning 'bad habits' and 'trying to show the child the error of its ways'.

Similarly, in the medicopedagogic councils, which are conferences of psychiatrists or psychologists, teachers, (and sometimes parents) with the child, the method is to determine the secondary gains in symptoms or behavior and explain them to the child. Or the parent is encouraged to withhold such benefits and instead to laud the child for its successes in its efforts to learn.

Its praise for the Adlerian method and teacher tends to make this book propaganda rather than a scientific report; and even the section on Critical Observations hardly serves to dispel the feeling that the author is trying to sell the principles and methods. The language is clear, the style direct, but the message unconvincing.

ISIDOR BERNSTEIN (NEW YORK)

CULTURE: A CRITICAL REVIEW OF CONCEPTS AND DEFINITIONS. By A. L. Kroeber and Clyde Kluckhohn, with the assistance of Wayne Untereiner and with appendices by Alfred G. Meyer. Cambridge: Peabody Museum of American Archeology and Ethnology, Harvard University, 1952. 223 pp.

This survey is intended to clarify the vast structure of ideas built up by philosophers, historians, psychologists, and social scientists. It contains several hundred excerpts from more than three hundred sources on the theory, causality, definition, and function of culture. The two outstanding anthropologists who, with their staff, compiled it have divided their material into its descriptive, historical, normative, psychological, structural, and genetic aspects. The numerous quotations are necessarily taken out of context.

The book has great merit. Although the method of presentation makes reading difficult, the editors' comments and especially their review of the conceptual problem are of particular interest and real value to the theoretician. The reader might at times fail to see the wood for the trees were it not for the illuminating concluding section by Kroeber and Kluckhohn in which they recapitulate the preceding mass of quotations.

The several hundred definitions of 'what culture is' remind one of a remark by the psychoanalyst David Eder, 'We are born mad, acquire morality, and become stupid and unhappy. Then we die. This [is] the natural history of man under domestication.'[1] Freud, writing to Einstein, defined culture as a system of defenses consisting of 'a progressive displacement of instinctual aims and a restriction of instinctual impulses', and leading to 'a strengthening of the intellect, which is beginning to govern instinctual life, and an internalization of the aggressive impulses, with all its consequent advantages and perils'. While this statement is not all-inclusive, it can be considered the basic psychoanalytic thesis concerning culture as a psychogenic phenomenon.

No one interested in systematic theory and the dynamics of personality should overlook this book.

WARNER MUENSTERBERGER (NEW YORK)

[1] British J. Medical Psychology, XII, 1932, pp. 1, ff.

THE NATURE OF PREJUDICE. By Gordon W. Allport. Cambridge, Massachusetts: Addison-Wesley Publishing Co., Inc., 1954. 537 pp.

It is easier – and probably cheaper – to smash an atom than a prejudice. This startling fact can be understood only by a psychologist who specializes in the study of psychoanalysis, psychodynamics, or—at least—the unconscious. Gordon W. Allport, Professor of Psychology at Harvard, editor of the Journal of Abnormal and Social Psychology, and member of the United States National Commission for UNESCO, strongly favors the 'multiple causation' approach. This avoidance of any 'one sided' approach prevents his penetrating his enormous subject to the required depth. History has shown that philosophical considerations have not helped to understand the unconscious. It is, however, theoretically possible that the discovery of the unconscious by psychologists and sociologists will some day advance new scientific achievements on 'multiple' levels. By covering an enormous field, Allport may have supplied the principle of organization for the study of prejudice. His opinions and studies are comprehensive and definitive.

Allport assumes that men everywhere reject in principle and by preference the path of war and destruction; they like to live in peace and friendship with their neighbors. They prefer to love and to be loved rather than to hate and to be hated. So there seems to be hope left in a World of Progress.

MARTIN GROTJAHN (BEVERLY HILLS)

STUDIES IN THE SCOPE AND METHOD OF 'THE AUTHORITARIAN PERSONALITY'. CONTINUITIES IN SOCIAL RESEARCH. Edited by Richard Christie and Marie Jahoda. Glencoe, Illinois: The Free Press, 1954. 279 pp.

Several years ago a group of social scientists began a study of anti-Semitism which resulted in publication of an incomplete report, The Authoritarian Personality. That volume is now continued with a description of the scope and methods of the inquiry, which will perhaps lay a basis for understanding of the relation between personality, social discrimination, and political ideology. The new report attempts to study the effect of sociological method, social theory, and the findings of a major research project on the develop-

ment and maturation of the social sciences. To this end a group of distinguished social scientists, including Else Frenkel-Brunswik, one of the authors of The Authoritarian Personality, has been invited to evaluate the previous work from a variety of perspectives. The entire work is permeated by the theoretical system of psychoanalysis; it is especially significant that the methods of collection of data accord with analytic theory.

Yet the conceptual and methodological problems raised by The Authoritarian Personality are discussed but not resolved in these pages. The goal of the authors as stated in the introduction is modest: 'to facilitate in some small measure the continuous flow of thoughts and studies which is required for the development of a solid body of knowledge in the social sciences'. Only a reader with great patience and tolerance will master this report, such is its wordiness and its shallowness of thought.

MARTIN GROTJAHN (BEVERLY HILLS)

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Herbert F. Waldhorn, Henry H. Hart, Leon L. Altman, William F. Murphy, Milton E. Jucovy, Leon L. Altman, William F. Murphy & Isidor Bernstein

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# ABSTRACTS

**International Journal of Psychoanalysis.** XXXIV, 1953.

**Some Aspects of Transference.** Daniel Lagache. Pp. 1-10.

Lagache attempts a study of transference from the point of view of the psychology of behavior, with special reference to the discoveries of experimental psychology concerning learning and relationships among individuals. Freud initially emphasized in The Dynamics of the Transference, 1912, that repetitive acting out takes the place of remembering and that frustrated and repressed tendencies possess a 'readiness for transference'; later, in Beyond the Pleasure Principle, he emphasized the compulsive character of this repetition.

The traditional definition of transference as essentially a displacement to the analyst of friendly, hostile, and ambivalent emotions is expanded by considering this displacement only one part of a whole cycle of behavior in which motivation, methods, goal, object, and effects are important and specific. The significance or function of the behavior gives to these separate parts of behavior a common direction. Transference, therefore, is not a need to repeat; or at least it is something more than that. It is the reactivation in the psychoanalytic situation of an unsolved conflict which evokes an unconscious demand for reparation. Experimental evidence tends to link repetition with motivation; the Zeigarnik effect (1927), for example, illustrates the fact that unfinished tasks are more easily remembered and more easily reverted to.

The classification of transference as positive or negative does not, accordingly, depend upon the quality of the emotion experienced in relation to the analyst; rather, the positive or negative *effects* of the transference can be established by evaluating its effect on the learning of the fundamental rule. Negative transference corresponds to the prevalence of the defensive habits of the ego, while positive transference corresponds to the formation of new habits based upon repressed needs and emotions and upon the attainment of an optimum level of tension.

The author suggests that the concept of the psychoanalytic field created by the interaction of the psychoanalyst and the patient differs from the classical freudian simile of the analyst as a mirror. Transference, when it is described as a spontaneous phenomenon attributable to the patient and explained in terms of his personality, can be discussed in terms of the psychology of the relationships of individuals. The 'negative' traits of the analyst's role (such as his silence and passivity) should really be considered 'positive', for by them the analyst creates certain positive conditions, among which frustration is outstanding. The author concludes that the successive regressions that become evident in the evolution of transference are induced in part by the frustrations imposed by the analyst, an idea supported by the importance Freud attributes to the rule of abstinence in controlling the motivation of the patient and the progress of his treatment.

HERBERT F. WALDHORN

**Some Reflections on the Ego.** Jacques Lacan. Pp. 11-17.

Anyone expecting a logical synthesis of ideas in a psychoanalytic article will blush with embarrassment over such a scattering of ideas about the body image and the ego as this presents. The author rambles from Hegel to grasshoppers, from Socrates to Socius, with some Latin from St. Augustine thrown in for good measure. In the end he finds it not necessarily advantageous to have a strong ego; the therapist can free his patient by letting the latter do all the talking.

As an example of this 'neo-confusionism', let me quote the following: 'Here we see the ego in its essential resistance to the elusive process of Becoming, to the variations of Desire. This illusion of unity, in which a human being is always looking forward to self-mastery, entails a constant danger of sliding back again into the chaos from which he started; it hangs over the abyss of a dizzy Ascent in which one can perhaps see the very essence of Anxiety.'

I fear the author has slid back.

HENRY H. HART

**An Addendum to Freud's Theory of Anxiety.** Charles Brenner. Pp. 18-24.

In Inhibition, Symptom and Anxiety, Freud proposed the hypothesis that there are two kinds of anxiety: 1, that which arises automatically, without the participation of the ego, as the result of excessive quantity and intensity of psychic stimulation with a resulting state of psychic helplessness; and 2, that which arises as a signal of an approaching danger perceived by the ego. The first type Freud considered to be characteristic of infancy and of the actual neuroses; the second type he considered to be characteristic of later stages of psychic life and of the psychoneuroses. The present paper is concerned with the hypothesis concerning the mode of origin of the first type only. The evidence for this hypothesis is reviewed. The author suggests the following alternative hypotheses. 1. Anxiety is an emotion (affect) which the anticipation of danger evokes in the ego. 2. Anxiety *as such* is not present from birth or early infancy. In such very early periods the infant is aware only of pleasure or unpleasure as far as emotions are concerned. 3. As experience increases and other ego functions, such as memory and sensory perception, develop, the child becomes able to predict or anticipate that a state of unpleasure (traumatic situation) will develop. This dawning ability of the child to react to danger in advance is the beginning of the specific emotion of anxiety, which in the course of further development we may suppose to become increasingly sharply differentiated from other unpleasant emotions. This alternative hypothesis has the advantage of leaving open the possibility that the emotion experienced by the infant in a traumatic situation is also related genetically to other unpleasant emotions of later life.

AUTHOR'S ABSTRACT

**Perception and Object Relation in a Patient with Transvestite Tendencies.** Leo Berman. Pp. 25-39.

A twenty-seven-year-old transvestite came into treatment because of a marital problem. Associated with his sexual difficulties and occasional paranoid tendencies was a remarkable all-pervasive experience of, and preoccupation with, space and direction. Although he was intellectually aware of directions according to the points of the compass, his orientation and movement in the world were according to his subjective experience of space, a private system which he referred to as his 'rectilineal strait jacket'. His mode of dealing with objective space and direction was apparent in practically all perception and learning. As the patient put it, 'Anything in sequence or in series has a spatial aspect'. This aspect was more fixed the more culturally standardized it was; otherwise, much variability existed in the spatial systems. Examples are given of these spatial systems as they pertained to hours of the day, months of the year, numbers, geological periods, musical scales, and masculinity and femininity. He did not regard his preoccupation with spatial orientation as having anything to do with his relationship to people.

An attempt was made to understand the patient's spatial mode of experience through a consideration of his relations with his family, his group, and the world. Schilder and Bender observed that the capacity to perceive rectangular configurations matures at about the age of three and that the function for directional orientation gradually develops after that age. This makes it likely that a fixation of these functions occurred in the patient's ego at the age of three or four in connection with the stresses he was exposed to at that time. Primitive perceptual experience is an experience of multiple curved configurations in motion. It seems likely that the patient used his newly developed perceptual function in an attempt to control the intense ambivalence and fears of retaliation associated with his earlier perceptual experiences of curved configurations related to mother. The hypertrophied development of directional perception was used as a defense, for it became a means of fragmenting *Gestalten* and making them meaningless.

AUTHOR'S ABSTRACT

**Can the Writer 'Resign' from His Calling?** Edmund Bergler. Pp. 40-42.

Dr. Bergler answers 'No'. In his experience, no writer earnestly seeks relief for the guilt and depression accompanying the writing 'block', but instead asks for the restoration of his ability to write because he cannot live without it. The author then asks why writers cling to what one of them called a 'bloody profession'.

Writing is a defense, unique according to Bergler, which denies a masochistic attachment to the precedipal mother and also asserts the infantile megalomanic self ('autarchic image'). The elation and pleasure in writing is a denial of depression; the superego tortures the unproductive writer by inflicting punishment for the pleasure obtained in masochistic gluttony.

All writers are neurotic and achieve a sublimation in writing (not neurotic in itself) which is unique and peculiar to the writer in being temporary and unstable and alternating with depression and guilt. Writing is their only solution and they must continue to write.

LEON L. ALTMAN

**Schreber's Prepsychotic Phase.** M. Katan. Pp. 43-51.

An important cause of Schreber's second illness was his appointment as *Senatspräsident,* the highest court office in Saxony. The ensuing illness reveals Schreber as one of those 'wrecked by success'. Yet Schreber differs from the type described by Freud. In Freud's examples the patients were wrecked by their feelings of guilt after an œdipal wish had been satisfied. In contradistinction to this process, it was a long-standing desire not of the id but of the ego that was fulfilled in Schreber's case. His ego warded off a strong unconscious urge toward femininity by engaging in competition with his rivals. At the moment when his appointment brought him success, the need to compete disappeared. In this way the ego lost one of its strongest defenses against the urge toward femininity.

The well-known dreams during the period between Schreber's appointment and the assuming of his new duties inform us of the marked change in ego strength. Schreber's feeling of relief upon awakening after dreaming that his former illness had returned is interpreted by the author as follows: Schreber was glad that he still was able to ward off his feminine urge (as openly revealed by his dream of how wonderful it would be to be a woman submitting to intercourse) without having to resort to defense mechanisms which would bring about the return of his former symptoms. Yet his illness was merely postponed. Once he entered office, his ego was quickly exhausted in his efforts to perform his new duties, and the symptoms broke out. These symptoms—such as his inability to sleep, his various anxieties, his suspicions of Flechsig, his state of enervation, his suicidal thoughts—were the result of ego defenses formed in anticipation of the danger that lay in the development of homosexual orgastic feelings. Nevertheless these defenses were in vain, and one night his homosexual excitement culminated in a number of emissions. At that moment delusional symptoms made their appearance, which meant that thereafter he had to rely upon psychotic defenses to ward off more successfully this dangerous homosexual phenomenon.

AUTHOR'S ABSTRACT

**Psychoanalysis and Legal Origins.** William H. Desmonde. Pp. 52-63.

An attempt is made to elucidate further Freud's suggestion that an investigation of the secret prohibitions which are the basis of ancient Greek and Roman law would show that they originated in the will of the primal father. Three central legal-religious-political symbols originated in the primal crime, namely, the temple, the scepter, and the crown. The temple is considered the site of

obsessive practices evolved to absolve mankind from the guilt of the primal crime. It represents the universe in microcosm and is the place where the priest, the omnipotent father figure, manipulated the universe magically through such practices as animal sacrifice or prayer. Its evolution is connected with the holy grove and with tree worship, features of which have appeared in all the world's great civilizations. The king of the wood at Nemea personified the oak on which grew the mistletoe. The aspirant to kingship had to cut off this mistletoe, which represented part of the god's body, and through victory in combat with the defender was entitled to win the love of Diana, the mother goddess. Hence, to succeed to the kingship and win the love of the mother goddess it was first necessary to castrate the father. The bough from the sacred tree is the original priest king's scepter and also the wand of the magician, and represents the father's phallus.

The original crown was a crown of leaves from the holy tree. The origin of the scepter and the crown can thus be traced back to the primal crime by showing that these regalia stem from ceremonies in connection with the castration of the oak tree god, who is a displacement of the father image. The sacred pillars of the temple are related to the ancient holy trees which survived in the columns of the Greek temples. The horns of consecration are architectural representatives of the heads of sacrificial animals placed in close juxtaposition to the capitals of the column. The habit of placing mementos under corner-stones is evolved from the expiatory sacrifices at the foundation of the temple.

WILLIAM F. MURPHY

**Transitional Objects and Transitional Phenomena. A Study of the First Not-me Possession.** D. W. Winnicott, Pp. 89-97.

An intermediate phase may be observed in early infancy between the first use of fingers and thumbs in autoerotic activities and the later playing with toys and dolls. The author introduces the terms 'transitional object' and 'transitional phenomena' to designate this area of experience which includes early babbling sounds and the use of objects, such as bedclothes, not yet clearly recognized as belonging to the external world. Out of random activity there usually emerges a specific object or pattern of behavior which then becomes vitally important to the infant in warding off feelings of anxiety or depression. It is through the relationship with a transitional object, which though it is symbolic of the breast is nevertheless real in itself, that the first steps are taken toward reality testing and the abrogation of magical, omnipotent control. In normal development the fate of the transitional object is to become gradually decathected, and transitional phenomena spread over the cultural field. In pathological development, transitional objects and phenomena may be linked with such symptoms as addiction, fetishism, pseudologia, and obsessional rituals.

The theory of illusion-disillusionment is developed by Winnicott, illustrating what he considers to be the main function of transitional objects and phenomena. At first a mother's complete adaptation to an infant's needs gives the infant the illusion that there is an external reality which corresponds to its own capacity to create a 'something' that can relieve instinctual tension,

the illusion that the breast is part of itself and therefore under magical control. If this illusion is successfully established a good internal object (Klein) is created, and the mother can then begin to disillusion the infant, lessening her adaptation as the infant's capacity to tolerate frustration increases. Transitional objects and phenomena, belonging to a realm of illusion, represent a neutral area of experience allowed to the infant in which no decision has to be reached as to whether something was internally conceived of or externally presented. It is through this use of illusion that a meaningful relationship can begin between the infant and an object external to itself. Throughout life this area of experience provides refuge from the strain of relating inner and outer reality, and contributes greatly to artistic, religious, and creative experience.

MILTON E. JUCOVY

**A Necrophilic Fantasy.** H. Segal. Pp. 98-101.

Being a corpse and having other people behave like corpses are the essentials of a necrophilic fantasy which determined the character structure and personal relations of a forty-year-old man. When others were the corpse, they had to be immobile and compliant and to make no demands. When he was the corpse, he was castrated, lifeless, inanimate, and dependent on others for his existence. In any relationship, he and the other person shared one life between them. The idea of being a corpse also served as a defense against pain, anxiety, and the fear of death.

Segal suspects a fixation in the 'paranoid' phase at the very start of life, when the patient suffered a severe deprivation.

LEON L. ALTMAN

**The Internalized Mother as Harmful Food in Peptic Ulcer Patients.** Angel Garma. Pp. 102-110.

An actual precipitating conflict is of great importance in the genesis of peptic ulcer. In seven analyzed cases two factors were found to coincide: 1, there is dependence upon a woman, but genital life with her is unsatisfactory; 2, professional activity demands great efforts. In the patient's unconscious exist psychic images of an internalized mother that harm him in his digestive tract because he has partially regressed from a genital to an oral-digestive level. The resurrected, hungry, frustrated, infantile ego feels that the mother or breast is doing the exact opposite to feeding it; she is sucking it inside or biting it internally. Such a regression is outstanding in the psychoanalytic explorations of peptic ulcer patients and such imagoes are readily reactivated by exposure to aggression from the outer world. Four detailed cases illustrate this.

The harmful, internalized mother is unconsciously equated with harmful foods. This fantasy occurs not only in patients with ulcer but also in those with other digestive disturbances, as we might expect since between ulcer and digestive normality there are intermediate degrees of ulcer syndromes and other digestive syndromes without organic lesion that antecede the appearance of the ulcer. The aggressive character of the internalized mother is far more pro-

nounced in patients who develop peptic ulcer than in those who have other digestive disturbances. In the fantasies of these patients, the internalized mother cuts the umbilical cord, bites or perforates the digestive tract, or harms it as would bad food. Such attacks seem to be important factors not only in the origin but in the recurrence of the ulcer.

WILLIAM F. MURPHY

**Notes on Ego Development.** Judith S. Kestenberg. Pp. 111-122.

This paper presents a series of thoughts on several questions. What type of raw material in the id lends itself to transformation into ego structure? How are condensation, displacement, lack of contradiction, and timelessness and spacelessness energized by the unbound energy of the id, subdued and utilized in the formation of ego functions? Is it necessary to assume primary autonomy of the ego, as Hartmann and others believe, to understand congenital differences among egos? Or is it possible to trace peculiarities of the ego to inborn trends of the id?

The first part of the paper surveys the main functions of the ego. Clinical illustrations show the complexity of the components of the ego and their interaction with each other as well as with the id and with reality. The author concludes that exploration of the development of basic ego functions (Hartmann's conflict-free sphere) and of early stages of defense mechanisms might help to provide an answer to the questions posed. Speculations on the origin of the controlling functions of the ego from the conservative trend of the id are mentioned briefly and set aside as possibly too farfetched.

The second part of the paper attempts to reconstruct the development of early ego functions from their sources in the id. Early reactions to tensions follow the pattern of the primary process. Early unspecific responses become specific under the impact of specific demands of reality. Bodily equipment present at birth, and amplified by maturation, can be used by the id in a disorderly fashion, by the ego in a controlled one. An infant insists on 'condensation' when it sucks its fingers while trying to drink from the bottle. Limitations of time and space imposed by the nursing situation force the child to modify such a primitive model into a higher form of condensation, used in the conceptualization of the nursing experience as a whole. Similarly unspecific displacement becomes the foundation both for basic ego functions, such as anticipation, and for defensive function, such as withdrawal into fantasy.

The pleasure it experiences in functioning is largely responsible for the infant's ability to displace. Enjoying one's own perceptions and movements becomes an important part of autoerotic gratification. In time functional pleasure becomes specifically associated with end-pleasure, and is thus differentiated into forepleasure. For instance the unspecific pleasure of looking becomes forepleasure when looking is used for the pleasurable anticipation of nursing. The forepleasure period becomes increasingly extended in time and reaches a relative independence from end-pleasure in such activities as play. In play the infant is able to modify and consolidate a variety of ego functions born out of needs at an earlier time. Thus displacement from uncontrolled

drive for gratification to functional pleasure facilitates the child's coping both with reality and with demands of drives.

There is continuous interaction between defensive and nondefensive functions. Condensation is used for ideation and is also used for countercathexis of defense mechanisms. In both instances it is a necessary concomitant of the binding of energy. Displacement is used in such prototypes of defenses as hallucinations, ignoring, denial, and eventually repression. The concept of negation evolves from the experimentation with these early mechanisms.

The impact of time and space modifies unspecific displacement and unspecific condensation, which are present in the id, into specific functions of the ego. The ego borrows both energy and models for its function from the id. A small part of the id yields to the regulating influence of reality; it is no longer a zone of subservience to somatic needs but rather a territory of limited control, the ego.

AUTHOR'S ABSTRACT

**Impairment of the Sense of Reality as Manifested in Psychoneurosis and Everyday Life.** George Frumkes. Pp. 123-131.

The sense of reality must be regarded as a process of shifting equilibrium, and it is relative. Like the erect posture, its maintenance requires work, reality testing. It is always possible for the sense of reality to become dissipated because of the pressure of the pleasure principle and because of the difficulties in maintaining the functions of adequate reality testing. It is also necessary that favorable conditions for the relaxation of reality testing should be furnished at appropriate times; there is need for mental as well as physical relaxation.

The infant at first exists in a condition of magical hallucinatory omnipotence since its desires are gratified by its nurse. As it grows its sense of omnipotence becomes more conditional; it may have to use words, gestures, and other efforts. These frustrations cause development of its sense of reality, which is manifested by such characteristics as strength of ego, intactness of ego boundaries, moderation in instinctual expression, and excellence of object relationships. These and other evidences of good sense of reality are probably all manifestations of a single process. We consider sense of reality well developed when we note ability to defer action and to employ it appropriately (not merely for discharging tension), and ability to distinguish clearly between self and not-self. Reality demands that the individual be aware that wishes and needs do not of themselves bring satisfaction. There must be ability to tolerate tension, alertness to the danger of ascribing omnipotence to anything, a clear distinction between object and symbol, and an ability to abandon reality temporarily in sleep and play in the confident expectation of finding one's way back.

In animistic religion there is identification with such natural objects as the sun and rain by manipulation of one's own body. The obsessional neurotic may mistake wishes for deeds. The phobic patient identifies an internal danger with an external one, because of a common symbol, and tries to deal with the internal one by measures appropriate to the external one. Eccentricities and foibles depend upon the confusion of different phenomena because they have

a common symbol. The failure of the sense of reality may be seen in all neurotic resistances, such as repression when the painful truth cannot be tolerated. Transference is a resistance for the same reason and also because past and present are confused by reason of their possessing a common symbol. The most general expression of defective sense of reality is failure to distinguish between the self and the not-self and failure to give up the sense of omnipotence.

AUTHOR'S ABSTRACT

**Why Œdipus Killed Laius.** George Devereux. Pp. 132-141.

When sexual relations between children and adults occur, the adult is usually the seducer. Yet in psychoanalytic writings counteroedipal attitudes have been neglected in favor of a phylogenetic explanation of the child's oedipal attitudes.

Even the original legend of Œdipus reveals that Œdipus's attitude toward Laius was determined by Laius's own character structure, rather than by Œdipus's spontaneous oedipal impulses. Laius's fate was determined by his homosexual propensities and aggressions against his infant son and against Œdipus. Thus Œdipus's 'oedipal' attitudes were primarily elicited by the conduct of his father.

Pelops, even more than Œdipus, was the victim of paternal aggression, yet he piously revered his cruel father, Tantalus. The myths concerning him—one of an oral, the other of a homosexual relationship—reflect erotized anxiety in relation to a cannibalistic or homosexual paternal ogre.

'Fate' in Greek tragedy means little more than 'character structure'. This is strikingly revealed by the role assigned to *hybris* (excess) in causing man's downfall. Genuine 'psychologizing' is a relatively late literary device; Greek dramatists had to formulate psychological insights in terms which their audiences could accept as plausible literature.

The oedipus complex must be viewed as the result of repression. The child's oversensitiveness to slights should be thought of as epiphenomenal to its sensitiveness to minimal tokens of love. This sensitiveness is one of the chief homeostatic mechanisms of the child. The oedipus complex is the outcome also of parental counteroedipal attitudes, and homosexual conflicts play an important role in its genesis. To overcome it, the male must pass from sublimated passive to sublimated active homosexuality. Women must pass from sublimated active to sublimated passive homosexuality. In the sexual sphere the concepts 'active' and 'passive' may have primarily homosexual pregenital roots.

In mythology, bowdlerized or divergent versions of a myth repeat the same latent basic theme, though sometimes in the language of another psychosexual stage of development. Despite changes in the manifest content, the latent content remains the same. This finding has important consequences for an understanding of the psychology of lying, the problem of forensic cross-examination, and the metapsychological background of the interpretation of partially structured projective tests such as the Thematic Apperception Test.

AUTHOR'S ABSTRACT

**Variation on a Theme.** Nancy Procter-Gregg. Pp. 142-145.

Ahoy, Savoyardian analysts!
'Things are seldom what they seem,
Skim milk masquerades as cream,'—
And Hamlet, Œdipus and more
As Pinafore and Ruddigore.

Dr. Procter-Gregg has analyzed Ruddigore for your edification and entertainment. She develops the thesis that Gilbert displayed his preoccupation with the Hamlet theme by his protests and his works. The story of Ruddigore is a variation on the ubiquitous œdipal theme. The Baronets of Ruddigore have been cursed by witches for the crime of the first Baronet, Sir Rupert Murgatroyd. In an effort to escape his fate, Ruthven disguises himself as a farmer but is unmasked by his foster-brother during their competition for the love of Sweet Rose Maybud. Ruthven therefore has to assume his burden of penance, the execution of a daily crime, which culminates in the abduction of Old Hannah, his uncle Roderic's renounced love. She is the phallic mother from whose attack Ruthven is rescued by his uncle. Ruthven finally hits upon the device of committing a crime by abstaining from a crime, since such abstention is punishable by death and is therefore tantamount to suicide which is itself a crime.

Dr. Procter-Gregg overlooks in her account some further confirmation of her thesis. The original crime for which the line is cursed is the persecution of witches by Sir Rupert. These witches are reminiscent of those in another Shakespearean tragedy, Macbeth, which is a different version of the œdipal theme. As Jones has shown in his book, Nightmare, Witches and Devils, witches represent the incestuous object. The bad wishes are thus projected onto a bad object. The sadistic attacks express, in a regressive way, the sexual œdipal wish for which the punishment is to commit further crimes on pain of death. The importance of the sadism is underlined by the title Ruddigore with its allusion to blood and piercing attacks (Ruddy-gore).

Ruthven's crimes are concerned with money until his alter ego, Adam, abducts Hannah. With this return of the repressed, the danger becomes greater and necessitates the summoning of the father and the neat piece of reversal—making omitting crime equivalent to committing it—thereby effecting a solution and rendering the whole situation harmless through absurdity.

The article is a refreshing and enjoyable combination of musical, literary, and analytic knowledge in which Dr. Procter-Gregg demonstrates understanding of the works of Gilbert and Sullivan as well as of their personalities.

ISIDOR BERNSTEIN

**The Genesis of Man.** Leonard R. Sillman. Pp. 146-152.

There exists a critical need for a completely scientific understanding of the nature of man; this can be derived only through a comprehension of man's origins. From such an understanding a real and objective solution of man's problems may arise. As an animal, man is endowed with instincts to kill and

eat other forms of life. As a mammal, he is endowed with primitive sexual instincts first described by Freud. As a primate, he acquired his manual dexterity from his monkeylike ancestors. In branching off from the higher apes, man became more aggressive, as is shown by his becoming a flesh eater; and he became skilful in creating weapons and tools.

Man as we know him originated in the New Stone Age when he domesticated plants and animals. This was accomplished by the growth of mental faculties and functions to the point where they folded over themselves, part retaining their original direction toward the external world and part becoming directed toward the self. In essence, man originated from a doubling of primatelike activity of the brain, part of which turned inward. By this inward part of his mind man perceives, and then inspects his perceptions or memories; such inspection is thought, by which man becomes more intelligent than animals. Instead of being only outwardly aggressive, he has acquired aggression turned against the self, guilt, which controls his destructive and erotic instincts. Instead of loving only objects, part of his erotic drive is turned inward into himself to create self-love, pride, and narcissism. By these means he has acquired the intelligence and self-control which have enabled him to domesticate plants and animals. His social compliance is also derived from the influence of the restraining instincts on his more primary animal drives. Vocal patterns, known as words, have become internalized to associate themselves with other experiences such as visual or tactile memories to create language which enables him to communicate his experiences to his fellow man.

By virtue of man's twofold mentality,—a primary and a secondary superimposed mental structure, analogous to the telescope and the microscope,—man has been able to create with his mind. Through the double action of idea on image, concept on memory, man is able to extract the truth from sensory perception, to duplicate experience in art, and to acquire intellectual control over nature. It is this power that has originated his art, his science, his industries, and his civilization.

AUTHOR'S ABSTRACT

**Bulletin of the Menninger Clinic.** XVII, 1953.

**Dynamics of the Countertransference** Therese Benedek. Pp. 201-208.

Therese Benedek believes that sitting behind the patient serves the analyst as a defense by permitting him to keep his personality out of the analytic situation and by helping him to keep objective his reactions to his patients. She discusses the analyst's response to being 'recognized' by his patients. Apparently some analysts are blind to this recognition and interpret all their patients' reactions to them as transference reactions. Many analysts are unaware that they stir up transference attitudes in their patients by their own countertransference. It is important that the analyst be able to recognize his own countertransference reactions so that he will neither be inhibited in his imagination nor fail to recognize the role he himself plays in causing his patients' reactions to him.

RALPH R. GREENSON

**The British Journal of Medical Psychology.** XXVI, 1953.

**A General Hypothesis of Psychosomatic Disorder.** J. O. Wisdom. Pp. 15-29.

Existing theories of psychosomatic disorder fail to deal explicitly with the problem of choice of psychosomatic rather than purely psychological disorder. The author hypothecates that 'a purely psychological disorder is one in which the imagination conducts basic conflicts in terms of projective images; a psychosomatic disorder is one in which the imagination conducts basic conflicts in terms of tactile or kinesthetic sensations'. Certain fundamental relations between projective (auditory and visual) images and imagined kinesthetic or tactile sensations are assumed and are discussed with reference to the contributions of Sartre, Levy-Bruhl, and many psychoanalytic writers. A number of suggestions for testing the hypothesis are offered.

**Some Similarities and Differences Between Psychoanalytic Principles and Group-Analytic Principles.** S. F. Foulkes. Pp. 30-35.

'The term group analysis has been adopted by a number of workers, especially in the United States, who see in the method scarcely more than an application of psychoanalysis.' Foulkes, a freudian analyst, prefers the term 'group-analytic psychotherapy' and compares the conditions of the 'group-analytic situation' with the psychoanalytic situation. Both are intended to produce basic change rather than symptomatic relief.

The fundamental concepts of psychoanalysis are modified in certain ways in their application to the individuals in the group. 1. In the group-analytic situation members and therapist are more active and more concerned with the present. It is a special social situation which approximates to, and carries over into, real life, and which leads away from regressive transference toward progressive development. The therapist allows the group to define his position. In this he resembles the analyst; but the fact that his interpretations are directed to several persons who interact upon each other gives him an opportunity for therapy not available to the analyst. 2. Dynamics learned by psychoanalysis are observed in group situations but some dynamic factors are peculiar to groups. Communication is of central importance in the dynamics of a therapeutic group. This process together with the emotional experience and analysis of interpersonal relationships produces basic changes in the individual. Transferences cannot be analyzed as thoroughly as in psychoanalysis but present fewer complications in dissolution. 3. Since every symptom, process, syndrome, and diagnostic category is tested in the social group situation, the most important theoretical contribution of group psychotherapy will be to social psychology.

Psychoanalysis and group-analytic psychotherapy are regarded as 'complementary and mutually illuminating'. The author concludes, 'In the future, psychiatry and psychotherapy and psychopathology will be first of all based on their social grounds, as observable in a group situation. Such group studies as were here described in this intimate, intense, small psychotherapeutic group will be the basic unit of observation. From these one might move further

centrally, as it were, to the individual core and, if and where necessary, to individual methods; or further outward, peripherally, into life itself, into social therapy on a larger scale: mental health, mental hygiene, politics if you like.'

**Follow-Up Study of a Case Treated in 1910 by 'The Freud Psychoanalytic Method'.** Richard A. Hunter and Ida Macalpine. Pp. 64-67.

In 1910, M. O. Eder published A Case of Obsession and Hysteria Treated by the Freud Psychoanalytic Method, which was the first public clinical contribution to psychoanalysis in Great Britain. Forty-two years later Hunter and Macalpine have had the opportunity to restudy the patient.

At the age of twenty-two, the patient complained of a dull aching pain in the back of his neck, a phobia for eating among strangers, a 'bashful bladder', and sexual and social inhibitions. For three months he was treated twice weekly by a technique of word association, free association, dream analysis, and finally hypnosis. When the treatment was terminated Dr. Eder considered the patient 'cured of his difficulties'.

The study when the patient was sixty-four disclosed that the treatment had in fact neither cured him of his symptoms nor enabled him to improve his sexual functions. Nevertheless it is the authors' impression that the patient was helped to live with his symptoms, since he functioned satisfactorily for more than forty years without seeking or requiring further psychological therapy. The early report lacked any reference to transference, which was little appreciated in 1910. The authors demonstrate that the patient took flight from an unconscious incestuous heterosexual danger to an unconscious homosexual transference love for the therapist. They also speculate that countertransference prompted Dr. Eder to choose this case for his first publication.

Although the 'course of psychoanalysis' of 1910 bore little resemblance to psychoanalytic therapy of today, Dr. Eder's 'concept of the psychodynamic structure of the case, as well as his views on the prognosis, have turned out to be substantially correct'.

**Psychoses and Child Care.** D. W. Winnicott. Pp. 68-74.

This paper is addressed to pediatricians to acquaint them with their responsibility for the prevention of psychosis. Some degree of psychosis in childhood is common, but can only be diagnosed when the child 'organizes along a certain defensive line which becomes recognizable as a disease entity'.

The mental health of an individual is determined during the earliest phase of development. It depends on the mother's 'devotion', 'her sensitive and active adaptation to the infant's needs which at the beginning are absolute'. Psychosis occurs when the mothering has been defective from the beginning and has produced in the child distortions in emotional development before the child has become 'a whole person capable of total relationships with whole persons'. Klein and others have developed this theory for depressive and paranoid psychoses; Winnicott attempts to do so for schizoid states and schizophrenia.

The author refers to the earliest, most primitive stages, when the infant is being introduced gradually to external reality and is not yet a unit but rather an 'environment-individual setup'. With good mothering the child creates 'a personal environment' which comes to resemble the external perceived environment sufficiently to enable it to pass from dependence to independence. The infant develops the ability to use illusion, without which no contact is possible between the psyche and environment. If the infant's needs are not met, illusion is impossible for it. In extreme cases a basic splitting of the personality occurs. There then develops a 'secret inner life' but little derived from external reality and truly incommunicable. The individual also may be 'seduced' by the environment into showing a compliant 'false self' which may appear outwardly satisfactory but which cannot mature. Schizophrenia is then latent. Later as the ego becomes integrated the paranoid tendency cannot be overcome, because of the deficiency in the mother's love. Defenses must then be organized against confusion and disintegration, and a schizoid or autistic state develops.

HASKELL F. NORMAN

**Journal of Personality.** XX, 1951.

**The Conceptual Model of Psychoanalysis.** David Rapaport. Pp. 56-81.

The construction of an explicit model of a scientific theory allows the inquiring scientist to survey the breadth and depth of the theory, to discover gaps in the theory that can be filled in, and to note the overlap with other theories. A theoretical model also provides a device for generating new and significant questions for investigation.

The theoretical model of psychoanalysis is essentially intended to account for psychological processes of both the developing organism (the primary model) and the mature organism (the secondary model). The psychoanalytic model considers as aspects of a unitary process all the phenomena characterized in traditional psychology under the headings of conation, cognition, and affection. The primary and secondary models of conation, cognition, and affection are derived by Rapaport from the basic model: *need→need-satisfying object and/or delay→need gratification and/or affect discharge and/or ideation.* It is not necessary that this model be rooted in invariable observational sequences. Its hypothetical character stimulates observation and fruitful experimentation so long as the model systematically coordinates the constructs to be used and holds out the hope that meaningful deductions can be made from it.

The primitive model of conation is: *restlessness→appearance of breast and sucking→subsidence of restlessness.* Restlessness is conceptualized as tension having its source in a drive (motivation); breast and sucking are conceptualized as devices for lowering tension and represent the object and the discharge of the drive. The subsiding of restlessness is conceptualized as reduction of tension, or gratification. The pleasure principle is the conceptual representation of the directional tendency of this motivation.

From this basic model one can deduce the primary model of cognition: *drive→absence of object and/or delay→hallucinatory image of the memory of*

*gratification.* (This sequence of primitive ideation now rests on a foundation of verified observations in situations, for example, of extreme deprivation.) Rapaport refers to the wealth of evidence from developmental and comparative psychology to illustrate the genetics of cognition. He discusses drive cathexis and the quantitative conditions necessary for hallucinations, the problem of bound and freely mobile cathexes (primary and secondary process).

The primary model of affects conceives of restlessness as the charge of affect which comes to expression in motor and secretory discharge. This, however, represents only a fragment of the drive cathexis.

Problems of formation of structures which maintain tension (thresholds) and discharge it are dealt with as the core of psychoanalytic ego psychology. The autonomy of these structures constitutes the secondary model, and it is the totality of such structures that is called ego. Rapaport systematically traces the deduction, from the primary models, of (a) derivative motivations from drive motivations, (b) transformations of mobile cathexis into bound cathexes, (c) relationships of pleasure and reality principles, (d) the conversion of drive discharges into complex affects, (e) the development of simple drive-bound ideation into complex forms of thought.

This article, together with several companion articles published elsewhere, represents a major achievement in systematizing the conceptual basis of psychoanalytic ego psychology which Freud set forth in his metapsychological papers and in the seventh chapter of The Interpretation of Dreams. It ranks with Bibring's similar attempt with instinct theory, and Fenichel's efforts to order the clinical aspects of psychoanalysis. It merits careful study by all psychoanalysts.

PHILIP S. HOLZMAN

**Revista de Psicoanálisis.** X, 1953.

**Psychoanalysis of a Defloration Phobia.** Walderedo Ismael de Oliveira. Pp. 3-36.

A Jewish patient was disowned by her family because one of her two marriages was to a Christian. Both husbands, one twenty years her senior, the other two years her junior, were impotent. She began treatment after the collapse of her first marriage. Her oral fantasies and fears of abandonment were intense. She had been suckled until the age of four and used to sit in a chair to suck her mother's breasts. Her genital impulses were related to great dependency and to an inability to tolerate frustration. A sado-masochistic concept of coitus and fantasies of oral impregnation underlay her phobia. These fantasies were experienced in the transference as well as in her 'phobic paranoid mechanisms' and in her feelings of being unwanted. Her phobia—she had had no sexual intercourse in four years of marriage—arose out of her relationship with love objects and her compulsive necessity to control them.

**Psychoanalytic Observations on a Schizophrenic Patient With Hypochondriacal and Paranoid Mechanisms.** Jorge Enrique Nollmann. Pp. 37-74.

A twenty-three-year-old Norwegian patient reacted by various defense mechanisms to a series of traumas. Regression of his ego became intense and this withdrawal resulted in an episode of schizophrenia. The patient ceased from all activities except taking care of his father's birds. He showed depersonalization and derealization, delusions of persecution, echolalia, and hallucinations. His homosexual libido became predominant. After he had made great symptomatic improvement, some of the patient's psychological mechanisms became clearly understandable.

**Psychodynamics of a Case of Female Homosexuality.** Luis Rascovsky. Pp. 75-89.

The self-reproaches of a woman patient depressed almost to the point of psychosis were actually directed to members of her family. The precarious narcissistic balance of her ego was maintained by thinly disguised homosexual attachments; for example, she became engaged when one girl friend became psychotic and another was married. Various obsessions and reaction-formations acted as defenses against her intense penis envy and urethral sadism. To the patient femininity signified shame, humiliation, and abandonment; it also represented loss of mother, incest with father, and destruction by his penis. Selection of a love object was based on introjective identification with mother and narcissistic projection of herself into the object, accomplished by denial of sexual love and by a distorting idealization of the object.

**Clinical Values of Interpretations in Terms of Identifications.** Jose J. Lemmertz. Pp. 90-102.

The author describes the ego, stressing the importance of identifications in its formation. 'Often it is forgotten . . . that these identifications or parts of the ego can be repressed and can then play an important role in the creation of psychopathological phenomena.' Clinical evidence supports this point. In one case, what seemed to be oral dependency on the mother was found later to be a partial ego identification with a frustrating parent. Therefore 'the interpretation of [the patient's] behavior as repeating an infantile identification [with one of the parents] was more dynamically valuable than regarding the ego as a "unit" reacting to the presence of the mother'. This emphasis in interpretation 'sometimes permits a more genetically comprehensive view of character traits and of ego organization of a complicated nature such as obsessional neurosis or phobic mechanisms'. There is also need for prolonged analysis of the factors which produced the 'internalizations' as well as of the 'repression of bad objects'. 'This externalization of the bad objects, which means, so to speak, the transformation of a depressive situation into a paranoid one, is possible only when the patient's ego has been helped by the introjection of the analyst as an "unconditional" good object.'

**Spasm of the Tubes as Origin of Sterility: Causes, Mechanism, and Treatment.** Marie Langer and Raul Parks Ochandorena. Pp. 103-115.

Research in a sterility clinic is here reported. An attempt is made to correlate structure of the personality, family background, repressed antagonism between mother and daughter, oral deprivation in childhood, severe traumas, especially those occurring in the oral stage of development, high blood pressure, and other factors, with the common syndrome of spasm of the tubes, vaginismus, frigidity, and severe nausea and vomiting during pregnancy. The symptoms are regarded as defenses against the early intense hatred for the pregnant mother, with consequent fear of retribution.

**Introduction to Psychoanalytic Anthropology.** Enrique Racker. Pp. 131-148.

This article in the form of a lecture considers the question, 'What is psychoanalytic anthropology and why should it be studied?' Racker defines the basic concepts and attempts to clarify criticisms and disagreements. In an introductory study of psychoanalysis applied to mythology, he analyzes myths of two types: some clearly œdipal and others that show a dreamlike quality of unreality because of failure of secondary elaboration. He also discusses the importance of myths as 'fundamental and universal types of more or less deformed unconscious fantasies'. Characteristics of the primary process such as use of symbols and the extensiveness of memory traces are essential in the formation of myths as they are in the formation of dreams. Illustrations are given of the application to myths of the concepts of manifest content, latent thoughts, and secondary elaboration.

**Masturbatory Prohibitions and Psychological Development.** Elisabeth Garma. Pp. 149-171.

This article describes the 'incomplete analysis' of a boy of eight. Treatment lasted ten months and consisted principally of release of repressed fantasies and of interpretations of anxieties about masturbatory fantasies. The boy's relationship to school and playmates and his ability to learn and play improved. His insomnia, night terrors, and nausea and vomiting disappeared. Release of repressed masturbatory fantasies 'did not increase his masturbatory activity. Such an increase would have created serious conflicts and difficulties in a boy in the latency period, . . . [because] in this phase of development any sexual activity, even when very mild in its manifestations, causes strong feelings of guilt.'

The interpretations and hypothesis offered by the author are well supported by her clinical data, and a review of the literature is included.

**Reactions of Three Patients to a Situation of Change.** A. Davidson, S. Lindsay, and E. Rodrigué. Pp. 172-196.

In this paper three 'Kleinian' analysts describe the reactions of three patients observed when the British Psychoanalytic Institute moved to its new building.

A man of thirty, in his sixteenth month of analysis, suffered an intense oral conflict, wondering whether the new Institute would be good, and if so whether it would keep him well. His depressive anxieties were primarily related to a 'cold, frigid, sterile mother'. A twenty-six-year-old woman, in analysis for twelve months, was stimulated by the change to re-experience conflicts related to the primal scene. Her anxiety over these conflicts made her unable to assimilate any 'new knowledge'. She suffered from intellectual inhibition, frigidity, nausea, and anorexia. To a seventeen-year-old boy in his seventh month of analysis, the change meant 'imminent death'. Any 'movement' was understood by the patient as a magical defense against the 'dread of death' and of total annihilation.

GABRIEL DE LA VEGA

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# Ernest E. Hadley 1894-1954

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# NOTES

## ERNEST E. HADLEY
**1894-1954**

The death of Ernest E. Hadley on August 10, 1954, at the age of sixty, is a serious loss to the Washington Psychoanalytic Society, the Training Center at New Orleans, and the American Psychoanalytic Association.

Born in Alton, Kansas, Dr. Hadley received his medical degree at the University of Kansas in 1920. After an internship at Walter Reed Hospital he became resident and member of the staff of Dr. William Alanson White at St. Elizabeths Hospital from 1921 to 1929. During this time he received his psychoanalytic training. Since 1929 he has been in private psychoanalytic practice. He was a Charter Member and President of the Washington-Baltimore Psychoanalytic Society, and was President of the Washington Psychoanalytic Society from last year until his death.

With Lucile Dooley and Harry Stack Sullivan, he was a founder of the William Alanson White Psychiatric Foundation and of the Washington School of Psychiatry; he was also a co-editor of the journal, Psychiatry. He was a member and fellow of various scientific associations. He devoted his energies particularly to the American Psychoanalytic Association serving as Secretary from 1931 to 1936 and as Chairman of the Committee on Standards of Psychoanalytic Training from 1947 to 1952; he was Secretary of the Board on Professional Standards from 1947 to 1951, and rendered services on other committees.

He became Director of the Washington-Baltimore Psychoanalytic Institute in 1949, and later was Director of the Washington Psychoanalytic Institute until the date of his death. He was a devoted teacher, training and supervisory analyst at this institute, much loved and admired by his colleagues and students. His inspiring course on Dream Interpretation was memorable.

Dr. Hadley leaves a widow, three married daughters, and a great circle of friends and colleagues mourning his death as an irreplaceable loss.

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## MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

December 15, 1953. A DUALISTIC VIEWPOINT ON ANXIETY. Joachim Flescher, M.D.

This study consists of an examination of Freud's second theory of anxiety and the proposal of a new theory emphasizing the role of aggression. The instinctual drives which are activated in a situation of danger are always of an aggressive nature, be they discharged in active attack or in passive flight from the threatening object. The motor activity supplied by the aggressive energies aims at putting an end to the danger situation. The same mode of reaction is

applied to the internal danger created by instinctual demands. Anxiety appears as a substitute for aggressive action provoked by the dangerous situation. The degree of anxiety will be proportionate to the degree of the damming up of the aggressive drive, from whatever source it may have arisen. Differentiation is made between reactive or frustration aggression (frustration of erotic drives), self-preservative aggression due to threats deriving from external hostility, and the defusion aggression connected with the immediate repercussion suffered by a warded-off sexual instinct in a situation of frustration. The contradiction inherent in the second formulation — that is, Freud's hypothesis that anxiety is the instigator of repression, although it appears even when repression is brought about — is eliminated by this theory. The energies of the non-materialized aggressive action against the frustrating or threatening object in the deprivational situation are used by the ego for the repression. The proposed hypothesis is called a dualistic one because it is based on the fact that instinctual and emotional manifestations usually appear as alloys of erotic and aggressive drives. The anxiety reaction is aggressive in origin even in cases wherein sexual impulses are involved. This is due to the interpolation, between sexual impulse and the appearance of anxiety, of the consequences of frustration seen mainly in the provocation and liberation of aggression. The difference between anxiety used as a signal with minimal physical manifestations, and anxiety with pronounced physical manifestations is one of degree determined by the intensity of the undischarged aggressive energies. The active part of the ego in the anxiety phenomenon consists in the perception and evaluation of a possible danger, in relation to memories of previous danger situations and of the measures which have been undertaken to meet them. If the aggressive cathexes available to the ego and connected with these memories are greater than the discharge offered by their consumption in the defensive measures, against danger, anxiety ensues. The instinctual frustration leads against the pleasure-displeasure principle to the progressive defusion and increase of aggressive tension whereby the danger of an aggressive clash between ego and id, or ego and reality or the superego seems unavoidable. Thus every new frustrating or threatening situation exposes the ego to the task of handling the situation with mounting aggressive energies stemming both from its own structure and from the id. Thus, there is a decrease in the importance of the original traumatic situation.

Dr. Heinz Hartmann stated that the danger aspect of anxiety is the most important, but Dr. Flescher's idea that anxiety relates to aggression could be true without invalidating Freud's general theory of anxiety. If we accept that self-preservation is an ego function, the self-preservative role of anxiety is not to be attributed to a drive but to an ego function. From the concept of the use of aggressive energy in countercathexis (Hartmann) it does not follow that anxiety is fed by aggressive energies. Dr. Max Schur stated that all the arguments against the libido conversion theory can be brought up against the aggression conversion theory. The concept of aggressive energy should not be equated with aggression. According to Dr. Flescher's theory, the intensity of the anxiety is in inverse proportion to the motoric discharge phenomena. Actually, one sees an abundance of motor discharge in the panic

states, while in 'signal anxiety' motor phenomena are nearly absent. The variations of the anxiety response including its somatic manifestations depend on the degree of ego regression. Dr. Rudolph M. Loewenstein pointed out the significant relationship between the concept of anxiety as a signal of danger, the notion of danger, and self-preservation; and self-preservation is somehow linked with aggressive tendencies, since to be attacked provokes counteraggression as a measure of self-preservation; however, he agrees with Freud that self-preservation is essentially an 'affair of the ego'. Despite many good arguments Dr. Loewenstein was not convinced by Dr. Flescher's attempt to establish an almost exclusive connection of anxiety with aggression. The objections advanced against Freud's first theory of anxiety deriving from libido may equally well be raised against Dr. Flescher's theory. Dr. Robert C. Bak stated that anxiety is a reaction to the danger of the traumatic situation in which the object may be lost. Where the object loss plays a role, the libidinal source of the anxiety is more evident. When the self-representations are in danger then anxiety is more related to rage. These are not contradictory because partly the object loss that the individual fears is a self-representation. The possibility is suggested that pent-up sexuality is mixed with the aggressive component; perhaps the threshold of danger arises when the sexual drive borrows enough impetus from the aggressive drive and threatens the ego to enter insoluble conflict (Hartmann). It is Dr. Bak's view that the ego's danger signal is a biological necessity protecting itself from destroying the object or self interdependently. Dr. Mortimer Ostow, quoting Freud, pointed out that anxiety consists of several components: a specific quality of unpleasure, namely, the affect of fear; the autonomic and voluntary motor responses; and the ego's perception of these changes. The affect itself need not be a carrier of energy and, therefore, it may not be useful to speak of the affect consisting of aggressive energy rather than libido. The aggression is a result of the anxiety reaction and not a part of the anxiety itself.

In answering the discussants, Dr. Flescher stated that his aggression-substitution theory is sharply distinguished from Freud's libido-conversion theory because of the inclusion of the ego, of the genetic sequence of traumatic situations which lead to an accumulation of aggression, and the fact that an answer is given as to why anxiety arises when either aggressive or sexual impulses are repressed. Only the necessity to explain anxiety from the economic point of view is retained from Freud's first theory. Dr. Schur's observation that intense motor phenomena are present in panic does not disprove the theory as this motor discharge is not aim-directed and is a last minute regressive attempt to release aggressive energies. The author agreed with Dr. Hartmann and Dr. Loewenstein concerning the role of the ego and self-preservation, but pointed out that his theory clearly reflects this. The ego perceives the danger, mobilizes memories of previously threatening situations and undertakes the necessary measures to cope with the danger. This, he stated, however, does not eliminate the aspect of drive in self-preservation. This would support a static concept of the mental structure and neglect the drive-energic principle which governs action, feeling and thought. Dr. Flescher reiterated that he does not state that self-preservation is a function of aggressive energy but

rather is an alloy of aggressive and libidinal components, and that in a situation of frustration and/or danger the liberated aggressive components supply the energy for anxiety phenomena.

ARNOLD Z. PFEFFER

February 23, 1954. A UNITARY HYPOTHESIS OF ANXIETY AND RELATED DISPLEASURE EMOTIONS. Abram Blau, M.D.

The psychology of emotion has two distinct facets: *affect,* which is an inner kinetic reaction comprising enteroceptive, proprioceptive, and verbal-representational components; and *expression of emotion,* a learned faculty acquired under environmental and cultural influences. The roots of emotion are in the basic vital activities. Homeostatic equilibrium is maintained by intricate and automatic physiological mechanisms through the vegetative autonomic system. It is suggested that anxiety is the primary emotion of displeasure and the basic source of other displeasure emotions. As the child matures, it develops secondary displeasure emotions of rage (aggression), fear (evasion), and depression (submission). Still later, tertiary displeasure emotions arise; guilt, shame, and disgust. These secondary and tertiary emotions are essentially spontaneous attempts by the individual to alter reality, to obtain relief from anxiety. In the first few months of life there is a physiology rather than a psychology of emotion or affect. Only later, with inner awareness of unpleasantness associated with the visceral reaction, is there an anxiety reaction comparable to the adult reaction. The signal reaction of anxiety appears with the growth of perceptive and executive capacities of the ego as it becomes able to anticipate stimuli of anxiety. Anxiety has two components connected with danger to the integrity of the organism. The first, a direct defensive reaction against immediate objective danger, is concerned with the basic visceral economy, includes many autonomic responses, and is in general geared to life and death matters. This is a diffuse defensive reaction of an all-or-none character. On the other hand, the signal reaction of anxiety is a modified reaction, a preparatory arrangement, with more alert reactions in the intellectual and motor organization and lesser reactions in the visceral sphere. The responses are attenuated and the ego becomes alerted to many other provocations for anxiety. Distinction must be made between, on the one hand, the analysis of the basic character neurosis, the defenses and the psychogenic symptoms; and on the other hand, the therapy of the emotion itself, the elements which provoke it, and its intent. This exploration and therapy of the emotion itself 'is probably a tacit part of psychoanalytic practice, but its difference from analysis of psychoneurotic symptoms is not distinctly formulated'. The essential difference between 'true anxiety' and 'neurotic anxiety' is not the manifestation of anxiousness but the perception of the danger. The anxiety is true and real in both cases. 'No essential difference is found between normal and abnormal emotions; the distinction lies chiefly in the relative quality, degree and reasonableness of the provocation from which each arises. Unconscious emotion refers to repressed emotion, but affect

as defined is never unconscious. It is suggested that the emotional component of affective disorders is related to actual anxiety neurosis.'

In the discussion, Dr. René A. Spitz expressed general agreement with Dr. Blau. He disagreed with the equating of anxiety with an innate physiological response. He felt that the term anxiety should be limited to intrapsychic disturbances of physiological balance, or to experiences originating intrapsychically and producing physiological disturbance. The term anxiety should not be applied to birth traumata. Dr. Spitz felt that fear is secondary to physiological and not psychological precursors. He commented also that visceral phenomena vary in the several affects. Dr. Charles Brenner emphasized that there is no clear-cut parallelism between pleasure and parasympathetic function, displeasure and sympathetic activity. He doubted that rage is essentially an emotion of displeasure. He questioned whether shame and disgust are connected with the superego. Dr. Edward E. Harkavy believed that Dr. Blau's formulation failed to solve the paradox that the neurosis, which is meant to control anxiety, itself produces anxiety. This paradox is better answered by Freud's dual theory in accordance with which one sees in each symptom both the wish and the forces opposed to the wish, both pleasure and unpleasure. Dr. Max Stern raised the point that there is no essential antagonism between sympathetic and parasympathetic, as implied in the paper; furthermore, that unpleasure is not necessarily linked with sympathetic function, nor pleasure with parasympathetic function. He suggested that greater attention could properly be paid to the concept of Selye and the General Adaptation Syndrome, in linking the psychological experience of anxiety with physiological states. Dr. Max Schur commented also that in anxiety there are mixed sympathetic and parasympathetic responses. He drew a distinction between rage, secondary to anxiety, and rage as a direct (primary) expression of aggression. He disagreed with Dr. Blau's opinion that anxiety is not subject to analysis in the classical sense. Dr. Mortimer Ostow stressed emphatically the conception of the psyche as an independent agent, and deplored the inference that the psyche is an epiphenomenon deriving significance from its relationship with physiology. Dr. Paul Goolker spoke of the relation between affect and ideation, with special reference to the effect of various drugs on emotion.

JOSEPH LANDER

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The INSTITUT DE PSYCHANALYSE, Paris, was formally opened on June 1, 1954, under the presidency of Monsieur André Marie, Minister of National Education, and of Monsieur Paul Coste-Floret, Minister of Public Health and Population.

Located in the Latin Quarter, the heart of the liberal and University traditions of Paris, the Institute consists of a training center in the theory and practice of psychoanalysis—the only such center in France accredited by the International Psychoanalytic Association—and includes a psychoanalytic clinic for therapy.

Among the officials present were Professor Piedelievre, President of the National Council of l'Ordre des Medecins (Medical Association), the representative of Monsieur Sarrailh, Rector of the University of Paris, many professors from the School of Medicine and the Arts Schools, doctors from Paris hospitals and psychiatric hospitals, as well as eminent personalities of the Bench and Civil Service.

Dr. Male, President of the Societé Psychanalytique de Paris, Dr. Nacht, Director of the Institut de Psychanalyse, Dr. Cenac, head doctor of the Clinic, Mme. Marie Bonaparte, Vice-President of the International Psychoanalytic Association, Dr. Ernest Jones, Honorary President of the International Psychoanalytic Association, all stressed the importance of this institution. In his address, the Minister of National Education emphasized the extent to which the new Institute is being integrated into the general development of the organization of higher education.

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The AMERICAN PSYCHOSOMATIC SOCIETY will hold its Twelfth Annual Meeting at the Claridge Hotel in Atlantic City on Wednesday and Thursday, May 4th and 5th, 1955. This meeting will be immediately preceded by those of the American Society for Clinical Investigation and the Association of American Physicians. It will be followed by the meeting of the American Psychoanalytic Association.

The Program Committee would like to receive titles and abstracts of papers for consideration for the program no later than December 1, 1954. The time allotted for the reading of each paper will be twenty minutes. The Committee is interested in investigations in the theory and practice of psychosomatic medicine as applied to adults and children in all of the medical specialties, and in contributions in psychophysiology and ecology.

Abstracts for the Program Committee's consideration should be submitted in duplicate, and should be sent to the Chairman of the Program Committee at 551 Madison Avenue, New York 22, New York.

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