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PSYCHOANALYSIS AND BLINDNESS

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Psychoanalytic literature abounds in references to the symbolism of the eye, scoptophilia and exhibitionism, hysterical visual disturbances, and Œdipus and his blindness. Abraham's classical paper on scoptophilia *(1)* is most noteworthy. Yet contributions on the psychic problems of the blind are scant.[1]

The factors of psychoanalytic interest underlying the maladaptations and personality disturbances of the visually handicapped are: 1. The unconscious significance of the eye as a sexual organ, including the equation of eye with mouth and with genital. 2. The unconscious significance of the eye as a hostile, destructive organ, including the equation of eye with piercing phallus and with devouring mouth *(11)*. 3. The unconscious significance of blindness as castration, as punishment for sin. Moreover, the blind present the generic problems of any minority group subjected to the prejudices and the acting out of the majority, for example, the unconscious identification of the persecuted with the attitudes of the persecutors. Society is strongly ambivalent toward the blind, about whom the seeing have contradictory and paradoxical beliefs. With an attitude of overprotectiveness and tacit or explicit expectation that the blind must be dependent recipients of charity, there coexists a fantastically naïve belief in their special powers, especially the supposed capacity of the blind automatically to compensate with accelerated development and superior functioning of their other senses. The blind are both saints and sinners, pariahs and prophets. These attitudes are universal because of the importance of vision in early psychosexual and ego development, and the existence in

1 Most of the experience on which this paper is based was acquired during my five-year affiliation with The New York Guild for the Jewish Blind. I am especially indebted to my former co-worker, Mrs. Ruth Rothman, for the clinical data in Cases I and II.

practically everyone of unresolved conflict over scoptophilia and exhibitionism. These attitudes are shared by the blind, the relatives of the blind, and professional workers, including psychoanalysts, when they begin working with the blind. Blindness is an unusually powerful instigator of transference and countertransference *(4)*.

CONGENITAL BLINDNESS

Two contrasting cases will demonstrate the problems of the congenitally blind.

CASE I

There were many complaints about Tommy, age three, but his mother sought help from the agency primarily because she feared Tommy was mentally defective. He was born three months prematurely and remained in the hospital nursery two and one half months. The diagnosis of blindness caused by retrolental fibroplasia[2] was made when Tommy was six months old. His mother had become concerned several months earlier by his slow responses, which she thought might be due to deafness; she herself had had defective hearing from childhood. Tommy's development had been retarded and irregular. During his first ten months he was markedly underactive; if placed on a table he would lie inert for hours. He stood at thirteen months although he could not pull himself up to a sitting position; he sat up without assistance at sixteen months. At seventeen months he walked for several days, then regressed to crawling, and did not walk again until the twenty-sixth month. At three years he had never eaten any food placed in his hands; he ate only when he was fed. He rarely picked up a toy and frequently refused to grasp a

[2] The most frequent cause of congenital blindness has for the past fifteen years been retrolental fibroplasia, a disease associated with premature birth. Recent research has proved the excessive use of oxygen to be the chief cause, and the disease is being eliminated by stringent control of the use of oxygen in hospital nurseries.

toy placed in his hands. He habitually rubbed his eyes with his hands, and sometimes rubbed his eyes against a table top. He slept more than most children but never with regularity, and was frequently awake and noisy all night long.

The mother's anxious helplessness before the child's problems contrasted sharply with her high intelligence and general competence. The parents were orthodox Jews. Their first child, a son, had died at ten months of age, three years before Tommy was born. In view of the family situation, particularly the friction between the mother and the maternal grandmother who dominated the home, it was decided that the psychoanalytically oriented case worker should try to help the mother, the psychoanalyst serving as consultant to the case worker. At first the mother avoided acknowledging her own problems, but she eventually responded, and the therapy was surprisingly successful. During the 'hopeless' phase of her therapy, the mother requested placement of Tommy in a nursery school and was referred to the only available school. There a psychological examination indicated that the child was functioning as a mental defective, and he was rejected—another serious blow to the already severely frightened mother. As her insight increased, however, and her anxiety diminished, the mother's relation with the child improved, as did also the child's symptoms. It became evident that he had at least average intellectual potential, and he was accepted by the nursery school that had previously rejected him.

The difficulties between mother and child resulted essentially from her ambivalent identification with him. Her history revealed marked unconscious derogation of herself as a female, masked by strong masculine strivings designed to win her mother's love in the unsuccessful competition with her brothers. Losing her first son constituted, as it were, a recastration. The blind 'defective' child represented another castration. Identifying herself with the defective male child, she unconsciously transferred her self-hatred and contempt to the child. She defended herself against these unacceptable feelings with exaggerated concern, overprotectiveness, inhibition of spontaneity, and displacement

of anxiety. Reduction of her anxiety and guilt enabled her to be less ambivalent toward the boy, and differentiation of herself from her own mother and her child enabled the boy's ego to become differentiated from hers.

In this case we note that 1, improvement of symptoms and accelerated development took place without direct treatment of this child. Had the mother not received therapy, no amount of 'training' for the mother or treatment of the child would have offered much hope. 2. The child's problems and his potentialities could not be evaluated until the major conflicts in the mother were at least partially resolved. 3. Had we directed our attention chiefly to the child's blindness as the central problem, we should with difficulty, perhaps never, have been able to work with the more urgent problems,—the disturbed relations between parent and child and mother and grandmother. 4. When the relationship between parent and child had been bettered, child and mother were ready to accept help with the specific problems of blindness.[3]

CASE II

Congenital blindness is usually discovered before the infant is six months old. This case is unusual in that the child was regarded as normal by her family until at nine months the parents noticed nystagmus which led to the diagnosis of congenital optic atrophy of unknown cause. Mary R was the fourth child of intelligent, middle class parents, the other children being eight, ten, and fourteen years older. Her birth was uncomplicated and her subsequent health exceptionally good. She was a vigorous, active child, sat up without assistance at seven months, very early handled objects efficiently, stood at nine months, and was walking with little assistance at fifteen months of age. The mother stated that Mary was slower in standing and walking than her

[3] This case was presented in more detail by Blank and Rothman *(6)*. It is especially instructive because the child demonstrated the most common symptoms in severely disturbed, congenitally blind children, and the mother's problems were typical of mothers of such children.

siblings but more precocious than they in speech. All observers agreed that at fifteen months Mary was an active, attractive, intelligent child, with advanced speech and social development. Although her failure to focus her eyes and her impairment of associated facial movements made it obvious that the child was blind, the lack of facial expressiveness was not as prominent as usual in a blind child. The parents, initially amazed to learn Mary was blind (her eight-year-old sister refused to believe it for weeks), handled the ensuing problems well, actively participated in the case work and group work program for parents of blind children, and did not change fundamentally in attitude toward Mary. In fact, the mother required help in accepting from Mary a level of performance lower than that she expected from the other children. We note here, in marked contrast to Case I, a blind child showing healthy physical and personality development with no evidence of gross defect or distortion of ego development.

Congenital blindness per se, like low intelligence, slowness of speech, or smallness, need not inevitably be accompanied by specific defect of the ego or disturbance of the personality. However, the child's blindness, by overtaxing the parents' resources, and by evoking their latent conflicts, frequently precipitates their anxiety, hostility, and guilt, against which they mobilize defense mechanisms and compensatory reactions. The most common are overprotectiveness, a marked displacement of anxiety to blindness as the cause of their difficulties, and other displacements of anxiety. Under these circumstances the relations of parent and child are disturbed, causing in the child overdependence, delayed and distorted differentiation of the ego, and a variety of specific symptoms depending on the particular case.

The request for help by the parent and the complaints of the parent about the blind child must first be examined as indications of the parent's need and emotional disturbance, not as an indication of the child's specific problems, nor as the measure of the child's disturbance. Why is the parent disturbed, what help is he really asking for, and what help does he need? We use

this approach in daily practice, and it sounds trite to emphasize it among psychoanalysts, but it is far too easily neglected when we are ourselves disturbed and confused by blindness (or the threat of blindness) presented as the cause of the child's and the parent's difficulties.

Work with congenitally blind children and their families reenforces the conviction that ego development depends primarily upon the physical contacts, consistent communication, and other components of mother love. These enable the infant to make the positive self-identifications essential to the basic feeling of security and self-acceptance that enables the child to tolerate the inevitable frustrations of life, to learn new and more complex ways of mastering these frustrations, and to develop the curiosity and initiative so fundamental to the fullest development of the sensorimotor apparatus, object relationship, and learning. It should not be difficult to accept theoretically what we have come to recognize clinically, as exemplified in the contrasting cases presented, that vision is not essential to healthy differentiation and development of the ego. We need therefore no special 'psychology of the blind', no mythology of special characteristics of the blind, to aggravate the difficult problems of helping blind people. The developmental, behavioral, and emotional problems of the blind have essentially the same causes as similar problems in those who can see. These causes include 1, the disturbed relation between parent and child in infancy and childhood; 2, traumatic events; 3, organic disease of the central nervous system, which occurs more frequently in the congenitally blind than in the seeing. In the absence of focal or general signs of neurological disease, diagnosis is complicated by the fact that severe psychogenic hypokinetic and hyperkinetic states with other signs of distorted ego development often suggest organic disturbance. 4. Constitutional factors such as those described by Fries and Woolf in their formulation of 'congenital activity type' *(12)*; 5, failure to provide economic, educational, medical, and other professional services needed by the blind child and its family.

Certain conditions occur more frequently among the blind than among those with other physical defects, particularly the group of symptoms unfortunately labeled 'blindisms', and those autistic conditions and severe disturbances of motility to be discussed below. The blind child requires help with reality testing and education, both intellectual and manual; it does not automatically compensate for its blindness by overdevelopment of its other senses. Such compensation is accomplished only by education of the other senses, which remain relatively unstimulated and undeveloped among those who can see because of the economy and prepotence of vision in early reality testing and ego differentiation.

Vision serves more efficiently than the other senses for differentiation of external objects from one another, and of self from others, for classifying and conceptualizing, and for mastering the problems of motility in the second and third years of life. Therefore some delay (but no permanent defect) in the development of ego functions should be expected in the congenitally blind child raised under good conditions. However, most congenitally blind children seen today were born two to three months prematurely, and we must not overlook the fact that a considerable lag in physical and mental development is attributable to premature birth. The age at which visually normal premature infants overcome the lag is said to be two to three years. Blindness as a cause of developmental delay seems negligible compared with the psychogenic causes and the effects of prematurity.

Demko *(9)* states that the teacher of the blind child of nursery age 'must verbalize for it those concepts which its hands are tactually experiencing, or which its tongue is tasting, or which its ears are hearing, or which its nose is smelling. These are the blind child's ways of differentiating objects. . . . It is through taste, feel, and smell that the orange takes on special significance and becomes a truly differentiated object. It will no longer be confused with the ball, but will always be recognized as the orange. . . . It will relate it to its breakfast time and will learn that somewhere in the moisture within the orange is a wealth of

juice which becomes a part of its breakfast. It can recognize the equivalent smell of the orange in cookies and other foods. Other fruits in the fruit bowl will become easier to identify and label. The orange has now become a functional part of its cognitive structure.'

These are the extra demands placed on the teacher by the blind child of three to six. Similar but greater demands are part of the special burden of the mother from the time of the blind child's birth. We must know just what this burden is. An important obstacle to the mother's love for her blind child is the frustration caused by the child's prematurity. The mother who has to leave the hospital without her baby feels inadequate, cheated, and anxious even before she knows the child is blind. The news of the child's blindness is therefore superimposed on the trauma of separation, and anxious rumination results. Moreover the 'preemie' joining mother at home at two or three months of age is not as well developed, active, or responsive as the baby the mother had expected. Thereafter an endless series of problems is caused by the needs of the child. The mother has no experience to help her; she does not know, without being shown, that she can learn to make the long periods she must spend with her child productive for it and as satisfying for her as for the mother of any other infant. She does not instinctively know that this child can grow up with her help to be an adequate and desirable person.

Pre-existing neurosis or character disorders render the mother more vulnerable to these stresses, but every parent of a blind child is anxious, depressed, and bewildered unless he receives professional help. Feeling different, defective, and isolated, the mother cannot identify herself with mothers of normal children, recoils from their pity, feels loath to discuss with any friend or relative the daily problems encountered with the blind child, and shuts herself and her child away from the 'nondefective' world. All this occurs if the blind child is the only child; the problem is less severe if the parents have been 'successful' with older children. When the parents' confidence has been fortified

by experience with other children, they are prepared to give more of themselves to the handicapped child and are less likely to be ambivalent and overprotective. The prognosis is also better when the child has not been prematurely born and a good relation has developed over a period of months before visual impairment is diagnosed. The mother, because of the good relation with her child, is better able to take the shock attending discovery of the infant's blindness.

My experience with severely deprived children and blind children, in private homes as well as in institutions, generally supports Spitz's *(17)* formulation of the psychogenic causes of the severe ego disorders of infancy. Some totally rejecting or very immature and helpless mothers are so overwhelmed by the blind child from the start that they hand it over to an agency for placement in whatever foster home is available. This disposal of the child is facilitated by the commonly held belief that the congenitally blind child is hopelessly mentally defective—a belief shared by some physicians, including ophthalmologists. More frequently, the markedly disturbed, ambivalent mother keeps the child, creating a depriving 'institutional' atmosphere in the home. Such mothers recoil from close, sustained contact with the child or they alternate between guilty overprotectiveness and hostile neglect. The play pen and the rocking chair become the crippling substitutes for maternal love, stimulation, and patient encouragement. The result is the infant's fixation on autoerotic forms of gratification with retardation and distortion of ego development. If the child does not die from the affective deprivation and inadequate tactile, auditory, and other sensory stimulation, one may expect development of a withdrawn, hypokinetic state with apparent mental deficiency, or a psychosis, often of the autistic type. Most of these blind children are institutionalized before they are three years old.

Other parents, particularly those with a strong need to possess and control others, are able adequately to care for the infant as long as it remains a 'baby', an undifferentiated, controlled part of the parental self. But major problems ensue at the end of the

first year and beginning of the second year when the infant begins to defy, revolt, show 'independence', and make demands as a distinct personality. The parent, confronted with loss of control and frustrated by having an obviously unusual child, becomes anxious, alternately hostile and guilty, and overprotective. The usual result is a hyperkinetic disorder in the child with temper tantrums, regressive head-banging, other disturbances of motility and of sleep, and other symptoms. This development frequently occurs in seeing children with inconsistent, unpredictable parents, but the disorder tends to be more severe in the blind child, possibly because the release of tension in active, purposive motor activity is blocked by blindness and physical confinement to crib and play pen.

Another prominent cause of severe hyperkinetic personality disorders among blind (and normal) children is frequent changes of home which, in effect, reproduce the intensely frustrating behavior of the inconsistent parent who alternately seduces and punishes.

The mother is usually the most important person in the child's life, but another member of the family may be influential or vital for the child's welfare by acting as substitute for the mother or compensating for an inadequate mother. Sometimes also the influence of someone else upon the mother may make it possible for her to surmount her problems with the child. For example, in Case I, the relation between grandmother and mother was crucial in the child's problem and its resolution. The child of Case II was triply fortunate in being born at full term and in having two adequate parents, and siblings several years older who enhanced the parents' good influence. I once studied a six-year-old blind girl whose problems seemed relatively mild in spite of her having an almost psychotically agitated, controlling, and guilty mother; the father was a negligible influence. The child fared so well because she had a sixteen-year-old brother who, like a father, protected the girl from her mother's punitive nagging and depreciation. Some mothers of blind children are isolated in despair and guilt by fathers who

disclaim responsibility, but many fathers strongly support their wives and share their physical and mental burdens. An occasional father is more disturbed by the child's blindness than is the mother; the mother then soon has in effect two disturbed children. For prevention and efficient treatment one must study the whole family, not merely the mother and child.

ACQUIRED BLINDNESS

Congenital blindness does not always cause ego defect or personality disorder, but blindness occurring when ego functions are already developed is inevitably traumatic because it disrupts established patterns of communication, motility, work, recreation, and feeling about oneself (body image and other aspects of self-awareness).

The reaction of the healthy personality to sudden blindness can be divided into two stages, immediate shock, and subsequent recovery which may be called the definitive stage. The shock consists of depersonalization followed by depression. The depersonalization usually lasts two to seven days. The patient is immobile, or almost so, facial expression is blank, there is a generalized hypoesthesia or anesthesia, and mutism or speech that is meager, slow, and muted. Superficially, the condition may resemble catatonia.[4] But the patient does not utter the delusional or dissociated remarks of a schizophrenic; rather, he is likely during the acute stage, or more often later, to say that he has no feeling or that he feels as if he were unreal or the world were unreal. Depersonalization seems to be an emergency defense against the threat of dissolution of the ego by eruption of overwhelmingly painful affects *(3)*. The affects are thereafter allowed to emerge bit by bit so that they can be handled by the ego piecemeal.

[4] I once saw a patient (not blind) in consultation two days after amputation of his leg. The provisional diagnosis was catatonia but two days later he was depressed and self-depreciatory and quite without schizophrenic dissociation. This case is cited to emphasize the fact that these acute reactions are not limited to blindness.

This emergence of affects appears in depression, which follows the depersonalization, often imperceptibly blending with it. It may be an acute reactive depression or an agitated depression, and it is a state of mourning for the loss of the eyes. Blind people sometimes refer to their 'dead eyes'.[5] Awareness that this depression is a mourning reaction rather than a psychiatric disease requiring treatment is essential if we are to avoid such blunders as shock therapy or attempts to force the patient to turn his psychic energies to the problems of the external world before he has accomplished the inner work of mourning. At least one of the military rehabilitation centers for the blind missed this point because an enthusiastic and efficient attempt was made there to help the blinded soldier master problems of external reality. I know of three blinded veterans who, upon their return to civilian life, had serious emotional problems which were, at least in part, a delayed type of mourning. They had not been permitted to complete the work of mourning in the rehabilitation center because of the insistence upon high morale and accomplishment. One of these men stated, 'I learned a lot of things that were good and come in handy now, but I didn't learn how to live with myself in this sighted world'.

By sudden blindness is meant not only the blindness associated with combat and industrial accidents but also the blindness resulting from a protracted ocular disease for which the patient has not been prepared by his physician and family. Under these circumstances the realization of blindness can be almost as suddenly traumatic as blindness due to an explosion. To the extent that the individual has been prepared for his blindness (by psychologically sound ophthalmological treatment and in other ways), the phase of depersonalization is eliminated and the depressive phase reduced in severity because part of the work of mourning has been accomplished in advance, and the phase of recovery will be attended by fewer emotional obstacles. To repeat, one should not draw any strong inference about psychiatric

[5] Grace Barstow Murphy, in her autobiographical book, *Your Deafness Is Not You*, refers to 'my dead ears'. New York: Harper Bros., 1954.

diagnosis and ego strength from the severity of the symptoms in the shock stage. In fact, for a patient to seem little disturbed by the onset of his blindness is ominous; such denial suggests the possibility of psychosis, latent psychosis, or gratification of a severe neurotic need for punishment.

Cholden *(8)* independently arrived at conclusions practically identical with these. He limits the 'shock stage' to the phase of depersonalization, which he calls 'a period of protective emotional anesthesia'. He too regards the depressive phase as a mourning reaction for the dead eyes and '. . . indeed the patient must die as a sighted person in order to be reborn as a blind man. . . . In the cases I have seen it would seem that the patient needs to experience this depression before he can accept the reality of his blindness. Thus it is not a poor prognostic sign.' No effort should be made to shame the patient out of his depression or 'rehabilitate' him at this stage.

The concept of rebirth as a blind person is essential to complete understanding of the events of the stage of successful recovery, which are a redifferentiation of the ego and a new formation of the self-image. In his new 'infancy and childhood' the dependent needs of the newly blinded person must be satisfied, and responsibilities and demands must be placed on him gradually and judiciously as one does with a child; one makes sure that he is ready to meet the demands to his own satisfaction. Moreover, in psychotherapy with the blind, this concept of rebirth and regrowth perhaps explains to some extent the remarkable and sustained progress frequently achieved with relatively brief and superficial treatment. To dismiss the phenomenon as 'transference cure' does not do justice to the clinical facts. Perhaps the real dependence of the blind person enables him to identify himself with the therapist and learn from him by a direct 'regrowth' which facilitates the analysis of symptoms and defenses. The ego of the recently blinded person, free of pre-existent neurosis or major disturbance of character, is very modifiable as well as vulnerable; this is probably why we so frequently see the extremes of abysmal demoralization and phe-

nomenal progress. The quality of the total treatment is decisive.

The degree of lasting damage to the ego caused by acquired blindness—the capacity to recover from the shock reaction—depends largely on the degree of ego strength and maturity at the time of the accident or disease producing the blindness. The ways the individual has learned to cope with major problems and emergencies before his blindness are revealed in his definitive reactions to his blindness. But the external factors must be favorable, the blind person must receive the economic and professional help he needs. Unless the external obstacles to recovery and productivity are removed, the potential strength of the ego cannot be realized. The blinded person is at first truly helpless and dependent, and to attend to the inner psychic problems without recognizing the need for much sustained and skilful help with the external obstacles is to be guilty of sheer 'psychologizing'. Unfortunately the help available to the usual blinded child or adult ranges from inadequate to execrable. Case after case of wasted potential in the blind is due to a combination of mishandling and insufficiency of professional services.

The recovery stage is characterized by healthy resolution of the work of mourning; a gradual resumption of object relationships; direction of psychic energy to the solution of real problems of living (re-education in communication, motility, and work); and acceptance of blindness as a handicap rather than masochistic submission to the blindness, or denial that blindness makes one different from others.

The permanent reactions to blindness include almost every kind of psychopathology. The most common reactions are these: 1. Prolongation of the depressive phase of the stage of shock into a chronic state of masochistic depression, with self-recrimination and bitterness toward the world and God. 'What did I do to deserve this?' and 'Why did this have to happen to me?' These people remain dependent, and resentful of those upon whom they are dependent; they never accept the fact that they are permanently blind. Because of the strong unconscious need to deny their blindness they insist on getting the 'right' ophthalmological treatment to restore their vision. Upon stories of

miracle cures, and upon their own variable perception of light, they base hope of eventual restoration of sight, and hostility toward those who treat them. That many blind persons are thus deluded is due as much to unwise medical treatment and unhealthy attitudes of the family as to neurotic predisposition. Often the first ophthalmologist to treat the patient assures him that he will retain or regain his vision. The patient's dependence on this false hope is enhanced by his immediate relatives, who regard blindness as the worst possible thing that can happen to anyone and encourage him in maintaining a state of helplessness and dependence while waiting for the magical cure. Many of these patients can be helped with psychotherapy, especially if the ophthalmologist and relatives are led to regard the blindness rationally. 'Shopping' for an ophthalmologist or looking for magical restoration of vision occurs in many blind people with different personalities and symptoms, just as ambivalent attitudes toward the blind occur in many normal persons. 2. Character disorders which often are an aggravation of pre-existing traits. The most common is chronic dependency; the individual expects to be taken care of as a helpless person because he is blind. This attitude is encouraged by family and friends, as well as by the common belief that blindness is an acceptable reason for dependence. 3. Many successfully 'adjusted' and really productive blind people identify themselves with other blind in a defensive, self-protective minority against the 'hostile', 'inconsiderate', and 'stupid' world of those that see. This is as much a matter of social as of individual psychopathology, for the seeing are often inconsiderate and ignorant about blindness. But the blind person may spend much time with his fellow blind examining the shortcomings of those that see. If the blind person shows a really undiscriminating prejudice toward them, we may be certain that he unconsciously shares the hostile attitudes toward himself that he attributes to those who are not blind.

CASE III

A thirty-five-year-old woman, editor for a publishing house, had been blind for five years because of several ocular diseases.

Having previously cherished an ideal of 'independence', she became profoundly depressed; she could not tolerate the 'inevitability' of her remaining hopelessly dependent. She angrily refused to undertake the study of braille or to associate with other blind people, and spent her time in inactive hatred of others and herself. She had become useless at her job in spite of every assistance offered her by her co-workers. Finally, at the suggestion of a friend, she arranged an appointment with me, and several days before the appointment attempted suicide by swallowing a large number of barbiturate capsules. She slept for thirty hours, then emerged anxious and more depressed, contemptuously telling herself that she really needed a psychiatrist now. During the first session, when I realized that her initial almost defiant resistiveness was softening, and that I must utilize her narcissistic overvaluation of the intellect, I remarked that her depression did not just happen because of the blindness and that it could be understood. Her history suggested, I said, that her suicidal attempt was motivated by a strong wish to join her lover who had committed suicide six years previously. The interpretation produced tears and confirmatory associations. She ended the session with the confession that she had expected to be humiliated by me and was amazed by what actually happened. In weekly sessions we discussed her masochistic reactions to blindness and she soon began lessons in braille, which she mastered with little difficulty, attended recreational and social activities with other blind people, and at the end of a year obtained a guide dog. At this time an ophthalmologist suggested the possibility of restoring partial vision in one eye with surgery (until then regarded as impossible). The patient became depressed and anxious, not about the operation but about regaining vision. She did not want to disrupt her new happiness and productivity; burdensome readjustments would have to be made. She was helped to see that she was really afraid of losing the position of favored child and the awe of her normal colleagues and friends. The operation was successful and some vision was restored,[6] the patient actively coöperating with treat-

[6] On first seeing television she said, 'I'd rather be blind than see such trash'.

ment. One year later she was told that her blind eye must be enucleated because of active disease and for the sake of her appearance. The patient agreed that enucleation was necessary but became once more severely anxious—this time about the operation which was in fact simpler than the first one. 'Even though the eye is useless and I will look better with a glass eye I don't want any part of me cut out.' This idea was successfully analyzed as a manifestation of the castration complex and again the patient mastered the problems of surgery and the use of the prosthetic eye.

ACQUIRED BLINDNESS IN CHILDREN

The definitive reaction of the child to its acquired blindness depends on the following factors: 1. The defects and resources of the child's ego. 2. The phase of psychosexual development during which the blindness is acquired. All other factors being equal, we expect blindness occurring at age nine or ten to be less traumatic to the ego than at age five or age thirteen. 3. The quality of the relationship between parent and child before the child's blindness. 4. The parent's reaction to the child's blindness as determined by a specific predisposition—for example, a strong unconscious scoptophilic conflict in the parent. 5. The ophthalmologist's relationship with the child and parents, which often is the decisive factor. These factors are equally important in the prevention of blindness *(5)*. The following case offers an example.

CASE IV

A twelve-year-old girl with visual impairment was flagrantly uncoöperative with ophthalmological treatment and the program for conservation of her sight. Her mother supported the child's negativism by a hypercritical attitude toward everything that was done for the child. Until her acting out was interrupted by an astute case worker, the mother seemed to be engaged in interminable 'shopping' for an ophthalmologist. The chief problem proved to be the mother's unconscious masochistic identification with her daughter, which was manifested by her

intolerance for the 'ugly glasses'. Her hostility toward the child (and herself) was handled by displacement and projection onto medical and educational personnel and by overprotection of the child. Psychotherapy with the mother produced improvement in the child's behavior and coöperation with treatment and in the mother's attitudes.

DISTURBANCES OF MOTILITY IN THE BLIND AND THEIR IMPLICATIONS FOR EGO PSYCHOLOGY

Excellent systematic studies of disturbances of motility have been published by Lourie *(15)* and Mittelmann *(16)*. Motility disturbances occur more frequently among blind children than among children who see. These disturbances include the severe and bizarre forms pathognomonic of childhood psychosis described by Kanner *(13)*, Bender *(2)*, and Blank, Smith, and Bruch *(7)*. Yet I have encountered no motility disturbance peculiar to the blind; even rubbing of the eyes, which seems to occur in every congenitally blind child during the second year of life, is a common symptom of psychogenic conditions and of ocular and periocular diseases without visual impairment. Because of this fact and because of its uncertain cause, eye-rubbing is best considered apart from the other disturbances of motility in the blind. I believe the symptom begins as a result of changes in the ocular and periocular tissue which create the itch. The symptom is then maintained by local irritation or psychogenic factors. The established symptom serves autoerotic drives and, when it becomes destructive gouging, aggressive drives. There is great variation in the persistence of the symptom; many blind older children and adults do not rub their eyes. It seems probable that, except where there is ocular disease, rubbing of the eyes is rarely an isolated symptom in a blind older child or adult; other signs of emotional disturbance are usually present.

Motility during the first year of life is chiefly generalized and undifferentiated, serving for release of tension and autoerotism, although in the second six months there develops differentiated

purposive activity, especially in the use of the hands for control of objects in play and eating. The full development of motility occurs in the second and third years, with rapid integration of increasingly complex neuromuscular patterns. In fact, what we delimit as the anal stage of psychosexual development may be regarded more comprehensively as the motor stage if we hypothecate the existence of a specific primary motor urge requiring gratification.

The disorders of motility, excluding neurological conditions, form two groups: 1, aggravations of patterns of motility occurring normally as transitory phenomena during the first year of life, or fixations of these patterns or regressions to them—for example, rhythmic rocking, head-banging, and athetoidlike finger movements; and 2, disorders of themselves pathological which represent distortions of ego development.

Twirling consists of slow, rhythmic spinning on the longitudinal axis of the body with the feet pivoting on the floor. It can be kept up for hours and the obviously pleasurable self-absorption points to its autoerotic function. Twirling is frequently seen among blind and visually normal autistic children and is never an isolated symptom. Music often evokes twirling, and the child adjusts the tempo of the twirling to that of the music as long as it remains slow. The twirling may become disorganized and the child greatly distressed when the music becomes fast or unfamiliar in quality. Visually normal children of four and five often play a game in which they spin until they get dizzy, stagger, and fall. This game is not twirling, but rather a transitory autoerotic activity in which exhibitionism is prominent; the pattern of movement is not as rhythmic or refined as in pathological twirling. Moreover—possibly the most remarkable point—equilibratory function in the blind or visually normal twirler is superior to that of the normal child playing the game. I believe this overdevelopment of the equilibratory mechanisms is dependent on the hypercathexis and overdevelopment of the tactile sensibilities in both the seeing and blind twirler.

Head-Punching: I have seen this symptom in four congenitally

blind children between three and five years of age, all hypertonic, explosively irritable, severely retarded in speech and motor functions, and showing no evidence of emotional interest in others except that two of them clung to women caring for them. They responded to the examiner's speech or touch with tortured shrieking, wailing, thrashing, and head-punching. The child repeatedly punches the side of its head with the ipsilateral fist in a hard, rhythmic triphammer motion. In two of these children, a large area over the temple and eye was severely contused and had to be kept bandaged. These children required heavy doses of hypnotic drugs to permit feeding and sleep. The massive frustration and aggression against the self apparent in the symptom I would attribute to poor differentiation of the ego, which cannot distinguish self from external object and is therefore unable to 'localize' (in terms of self-differentiation) the sources of frustration and pain. I also suspect a predisposition in the form of heightened irritability, especially to auditory stimuli. Spitz *(18)* described this symptom in an eight-month visually normal infant, but implied that the child was able to distinguish its self from the outer world and that it did realize that the pain inflicted on its face originated in its own action. I have never seen the symptom in a seeing child, but I have seen it in several adult catatonics.

Cutaneous Swallowing: In this disturbance the child lies prone and in a very slow undulating motion stretches out head and limbs to produce maximal flattening of the skin surface against the floor. In one of two congenitally blind children presenting this symptom, a five-year-old boy, the mouth was opened widely as though to get as much as possible of the mucosa also in contact with the floor. The movement has an 'amœboid' incorporative quality. The child also engaged in prolonged twirling and rocking, and possessed an uncanny capacity for difficult climbing and balancing on the jungle gym and other playground apparatus. His speech was infantile and meager and he showed at first no interest in other children, clinging to the nursery school teacher when he was not absorbed in his motor

activities. Cutaneous swallowing may be the extreme form of the leechlike clinging so frequently observed by many investigators among psychotic children. This extreme form is not limited to the blind; I have seen it in two patients in state hospitals, one a schizophrenic, the other an 'imbecile with organic brain disease'. The latter diagnosis is highly questionable.

Cutaneous swallowing seems to be the opposite of assumption of the fœtal position, in which the subject reduces the body surface to the smallest area in order (hypothetically) to be swallowed by the mother as easily as possible. In cutaneous swallowing, the skin surface appears to be regressively invested with its phylogenetically and embryonically prototypal function of mouth. The one-celled animal eats with its 'skin'. The equation of skin with mouth is no novelty in the psychoanalysis of dermatologic conditions accompanied by itching; the verb to bite in German, *beissen,* also means to itch. Lewin *(14)* in 1930 definitely demonstrated the symbolic equation of skin with mouth, establishing the equivalence of cutaneous (dermal and epidermal) and oral introjection. Fenichel *(10)* confirmed Lewin's findings, and also presented convincing clinical proof of the equation of eye with mouth (and devouring mouth). That cutaneous introjection is equivalent to ocular introjection is apparent syllogistically and this equivalence is obvious among the blind, who substitute the tactile sensibilities for vision in, for example, punctiform reading and the performance of mechanical operations that seem almost impossible of performance without vision. One frequently hears the fingers of the blind called their eyes.

That cutaneous, oral, and ocular introjection are equivalent hardly requires emphasis. It is more significant for the theory of ego development that we have not sufficiently recognized the role of tactile introjection during the first six months of life, that we have minimized the importance of the skin as a whole in our preoccupation with the erogenous zones and special senses. The visual function is not developed sufficiently for meaningful perception before the third or fourth month, by

which time the infant probably has a strong 'protopathic' awareness of itself as containing good or bad objects. It is possible that the development of this protopathic ego is almost as dependent on cutaneous as on oral introjections. Supporting this hypothesis is the clinical evidence that cutaneous stimulation of adequate intensity, frequency, and rhythm is as essential for the infant's physical survival as food. The interrelated development of the circulatory, respiratory, gastrointestinal, and motor functions will not occur if the infant receives only the minimal handling required for feeding it. The introjects derived from the infant's being held, fondled, and bathed are perhaps as vital for healthy early development of the ego as is oral gratification.

In the seeing infant after the fourth month, the increasingly refined and economical visual (and, later, auditory) function soon assumes dominance in the sensory apparatus and becomes the chief modality for learning. The eye is so important in recognition and control of objects of gratification and frustration that it early becomes orally libidinized and aggressivized; I believe this to be the prerequisite for the development of scoptophilia. At the same time, the cutaneous senses become relatively neglected, and their epicritic value for reality testing and mastery remains unrealized. The olfactory sense suffers more from repression and atrophy because of its close association with anality and genitality. Some degree of repression of tactile functioning also occurs for the same reason. It is easier and safer to see and hear than to smell, taste, and touch forbidden things. This is probably the fundamental external reason for the prominence of the scoptophilic drive and the pre-eminence of visual over other forms of fantasy.

In the congenitally blind infant the importance of cutaneous introjects for the formation of the protopathic ego facilitates the continued exploitation of this modality in later growth of the ego. Since the blind infant depends on cutaneous and other senses as substitutes for vision, it is critically important to help the nurse, mother, and teacher utilize to the greatest degree all the child's sensory resources from the time of birth. In acquired

blindness, the latent cutaneous, auditory, and olfactory modalities can be activated and developed to surprising degrees of productivity.

SUMMARY

The applications of psychoanalytic principles to the study and treatment of the psychic problems of the blind were presented, and certain implications of this study for the theory of ego development were suggested. Emphasis was laid on the differentiation of congenital blindness as a direct etiologic factor in personality disorders from other causes, particularly the distorted parent-child interactions and the widespread ambivalence toward the blind. In acquired blindness, it is essential to understand the trauma to the ego, especially the mourning reaction for the loss of the eyes, in order to help the individual to accept himself as a blind person and to utilize his undeveloped resources for optimal recovery.[7]

[7] Many points in this paper are worthy of more detailed presentation and further research, notably re-evaluation of the concept of scoptophilia and the relation of vision and hearing in ego development. The subject of the dream in the congenitally blind will be presented in a separate paper.

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A CONTRIBUTION TO THE PSYCHOLOGY OF BODILY FEELINGS

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SOME PHILOSOPHICAL CONSIDERATIONS

When we think of how we feel *about other people,* we usually order our conceptions according to a purely psychological frame of reference. We love, cherish, or hurt others 'because' of the ways in which they have dealt with us. Even in such cases, however, we sometimes resort to explanations postulating 'organic causes' for the affect and behavior in question: for example, we assert that we are nasty because our stomach is upset or because we have a headache. The dichotomy of mind and body becomes much more troublesome when we consider our feelings *about our bodies.* These we express invariably in terms of the duality 'organic-psychogenic': we try to assess whether the feelings are 'due to' organic processes or whether they are mental. It is a sign of sophistication to go further than this and to try to evaluate how much each of these factors contributes to the actual feeling state. Although this type of orientation may have been useful in the past—particularly in combating a so-called purely organic approach to medicine—its value at present may be questioned.

The philosophical issues involved have changed little through hundreds of years, despite considerable progress in medicine in modern times. The difficulties that can arise as a result of the philosophical conceptions of mental and physical are cogently discussed in Sluckin's recent book, Minds and Machines:

> It is often assumed in medical psychology that some mental disorders are due to physical causes while others are due to psychological causes. Similarly it is thought that physical disorders

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> may be either of physical or of psychological origin (although in practice most physical diseases are due to physical causes). It is clear that to state the etiology of disease in this manner is to proceed from the assumption of the classical dualism of mental and material existences. It is equally clear that such a statement accepts as its premise psychophysical interaction. Dualism and interaction can only be reconciled if the difficulty arising from the dissimilarity of the substances is circumvented or ignored. Medical psychologists may feel that they have common sense on their side if they ignore this difficulty. But by ignoring it, and adhering to the dualistic theory of physically-caused and psychogenetic mental disorders, they present themselves with certain other theoretical and practical difficulties *(30,* p. 210).

The exact nature of these difficulties need not concern us further here.

These remarks are offered to justify the presentation of a purely psychological frame of reference for a better understanding of bodily feelings. No amount of criticism of inadequate or misleading philosophical conceptions has as much effect in changing them as does the development of new approaches more satisfactory than the old ones.[1]

THE RELATIONSHIP BETWEEN EGO AND BODY

The nature of the relationship of the ego to that system we call 'our body' is elusive. The optimal state of ego-body integration

[1] For detailed considerations of the philosophical and epistemological problems pertinent to the present essay, see references, particularly *2, 6, 36, 40.*

Ayer, in a most lucid analysis of the mind-body problem, suggests the following way to circumvent this traditional dichotomy: 'The error . . . consists in the identification of pleasures and pains with particular sense contents. It is true that the word "pain" is sometimes used to denote an organic sense content, as in the sentence, "I feel a pain in my shoulder", but in this usage a pain cannot properly be said to be mental; and it is noteworthy that there is no corresponding usage of the word "pleasure". And in the usage in which pains and pleasures can properly be said to be mental, as in the sentence, "Domitian took pleasure in torturing flies", the terms denote not sense contents but logical constructions. For to refer to pains and pleasures, in this usage, is a way of referring to people's behavior, and so ultimately to sense contents which are themselves, as always, neither mental nor physical' *(2,* p. 143).

in adult life is such that awareness of the existence and functioning of our body remains just below the threshold of consciousness. This so-called normal orientation to the body may be compared to the way we wash and dress in the morning, half-asleep and half-awake, knowing what we are doing, yet doing it without attention, without interest,—in a word, without affects that stir or move us. This mood of taking things for granted characterizes not only such automatic activities; it also accompanies our relation with objects whose permanence and possession seem to us a matter of course. There are times in the life of everyone when the secure possession of his body (as an unchanging entity) is by no means certain: childhood, puberty, the menopause, old age, illness, and injury are situations in which we experience affects other than the 'normal' inattentiveness in relation to our bodies.[2]

Interest in the body may be 'abnormally' great or 'abnormally' small. Great interest in one's body may be expressed as curiosity about its function, but more often it appears as concern: 'Does it function properly? Am I sick?' Many of these phenomena are, of course, called hypochondriasis. Others fit into no nosological group because certain bodily preoccupations (for example, of women with their weight and looks) are socially acceptable and are considered 'normal', perhaps simply because such preoccupations are so common. (Yet an attitude of oblivious acceptance of the body cannot be considered the model of the ego's orientation to this important object.) In this essay we are not concerned with whether bodily preoccupations are 'pathological', as in hypochondriasis, or 'normal', as when accompanying objective bodily disease or when socially condoned for other reasons. Such considerations as these obscure the psychological processes for which we must search.

[2] See in this connection Freud's remark in The Interpretation of Dreams (*13*, p. 33): 'Since we are now engaged in looking for sources of dreams inside the organism instead of outside it, we must bear in mind that almost all our internal organs, though they give us scarcely any news of their working so long as they are in a healthy state, become a source of what are mainly distressing sensations when they are in what we describe as states of excitation, or during illnesses'.

Lack or a decrease of interest or awareness on the part of the ego toward the body appears in the stoic, the person absorbed in religion, and the schizophrenic who mutilates himself, apparently without pain.

In previous papers *(35, 36)* I have discussed the body as an object of the ego, and affects pertaining to this relationship as signals indicating to the ego and to the observer the current status of the relationship. Pain, phantom body parts, and phantom pain have been explained in these terms *(33, 35, 36)*.

ILLUSTRATIVE OBSERVATIONS FROM A PSYCHOTHERAPEUTIC SITUATION

The observations to be cited are in no way novel or unusual and therefore will be described briefly. They were obtained in the course of a psychotherapeutic contact with a schizophrenic woman. The greater part of my relationship with her was direct, while she came to my office. At a later time, when visits had to be interrupted for external reasons, an occasional exchange of letters occurred. Numerous similar observations are described in the psychiatric literature.

PHENOMENOLOGY

The patient was originally referred to me from a medical clinic where she was examined after a long series of medical and gynecological consultations. She complained of numerous disturbances, referred to practically every part of her body. These complaints were such as would strike many observers as bizarre.

This woman's attitude toward her body was characterized by the following features. Almost all her attention and interest was directed toward her body and its functions. The nature of this interest was varied and included a number of affects, such as curiosity, attention, and anxiety. These interests were, however, so all-consuming that she paid little attention to the human objects in her environment (her children and her husband).

The patient's increased interest in her body was inferred from

her inner preoccupation with various bodily feelings and her reports of them to me. These feelings were of great diversity. They included what we often, as allegedly 'neutral observers', regard as feelings reflecting increased perception of bodily events (for example, she believed she knew when she was ovulating). They also included feelings that would usually be judged as 'lack of feelings'. We shall consider such 'lack of feelings' as affects.[3] The experiencing ego's continuing orientation to the body is shown in such situations by the conscious focus on it and, in the psychotherapeutic situation, by the heavy emphasis on speaking about these experiences to the therapist. This patient, for example, felt uncertain whether her feet touched the pavement. She had 'no feeling', she said, in her rectum and could never spontaneously experience the urge to defecate; this led to severe constipation. She also complained of 'tingling' in the extremities, 'bubbling feelings' in the head, 'shocks' through the body, and so forth. The foregoing were actually some of her first complaints, but they are mentioned also because they are paradigmatic of feelings, the variety of which was almost infinite.

RÉSUMÉ OF THE HISTORY

I omit the early history since we are not concerned in this study with a full reconstruction of the patient's personality. She was well, in her social adaptation and in the judgment of her family,

[3] It is important to note that the traditional concept of feeling is closely allied to that of substance: that is to say, it is regarded as something of which there may be too much, or too little, or just the right amount. This is usually the physician's and psychiatrist's orientation to the patient's feelings. (For example, the surgeon may think the patient does not have 'as much' pain as he complains of; or the psychiatrist concludes that the patient has 'too much guilt'.) I want to stress that if we regard affects (feelings) as indicators of the nature of the patient's organization and of his relationships to objects—a notion by no means novel to psychoanalysis—then we can no longer maintain this substantive concept of feelings. The terms 'anesthesia', 'paresthesia', and 'hyperesthesia' reflect the philosophical categorization of feeling as a quantity (of something). The point of view proposed in this essay treats 'anesthesia' and 'paresthesia' as feeling states, just as we are accustomed so to regard states of 'hyperesthesia', such as hypochondriasis.

until shortly after she suffered a miscarriage in the sixth month of her second pregnancy. This occurred after slipping and falling on the ice on a bad winter day when she had at first decided to stay home but finally did go out after being urged by her employer. The patient regarded this employer, an older woman, as if she were her mother. Immediately after the miscarriage she developed a myriad of symptoms which led to numerous medical consultations. Nevertheless, she continued to maintain her personal relationships in such a way that her life seemed not to have been appreciably changed by her symptoms.

She considered the miscarriage a terrible blow for two chief reasons: because it would not have occurred if she had only stayed at home, and because she felt so powerless and helpless before the uterine cramps, bleeding, and the loss of the fœtus. All this she felt, and related with keen emotion, and there could be little doubt that this event rekindled her previous fears of loss of control.

The importance of the miscarriage as a highly specific trauma which precipitated disorganization of her previously brittle but coherent psychological functioning was evidenced further by her single-minded *conviction* that she must become pregnant again. Although she was of at least average intelligence, and had had more than a high school education, her thinking about this wish appeared dull; she simply 'knew' that this would make her feel better. She did become pregnant about two years after the miscarriage and had a normal delivery. This period coincided with her psychotherapy and what effect each of these had on her is difficult to assess. Her improvement following the second successful pregnancy was at best slight.

RECONSTRUCTION

The patient showed excessive sensitivity to the trauma of losing control, of being taken by surprise at the time of her premature labor and delivery. We may recall in this connection Jacobson's analysis of some of the differences between the reactions to object loss in manic-depressives and in schizophrenics: '. . . the

manic-depressive treats himself as if he were the love object whereas the schizophrenic behaves as if he were or believes himself to be the object . . .' *(18,* p. 261*)*. Accordingly, the mechanism lying behind the bodily symptoms of my patient—her sensorimotor symptoms and hypochondriasis—may best be regarded as manifestations of *the ego treating the body* (in contrast to the self) *as the lost object.*[4]

It is as if my patient had become rooted to the trauma, the loss of the fœtus. The ego did not react to this trauma with depression, mourning, and eventual working through; a different process ensued, consisting essentially of a *transference* of the lost object (fœtus) to the body. After this transference the ego continues to relate to the important (substitute) object, fixed in time and in place at the moment of its being overwhelmed and put out of action. (In this respect the process is similar to that of a traumatic neurosis in which, however, the ego remains fixated on the original object, the trauma, and no displacement or symbolic substitution takes place.) This explains the patient's persistent preoccupation with her body, which signified the fœtus about to be prematurely delivered. As in all acutely traumatic situations, the ego is so absorbed in the task confronting it that no interest is left for other objects. Accordingly, the patient's persistent experiences of 'decreased' bodily feelings constitute a re-experiencing of the trauma: 'I do not feel . . . [therefore] I have lost my body [baby] . . . '. The wish for the new pregnancy

[4] Ruth Mack Brunswick had described the foregoing two mechanisms nearly three decades ago in her account of the reanalysis of the Wolf-man. She wrote: 'It is interesting to note the difference between the present psychotic mother identification and the past hysterical one. Formerly the patient's feminine role seemed at odds with his personality; it was evident that he was playing a part. At times he was a man—as in his relation to women—although at other times, toward the analyst and other father figures, he was obviously the woman. But now there was no dissociation: the feminine role had flooded his personality, and he was entirely at one with it. He was a bad, a petty personality, but he was not a dissociated one. A remark of Dr. Wulff, formerly of Moscow and now of Berlin, to whom I described the case, and who knew and attended the patient and both his parents, best illustrates this point. He said: "He no longer plays the mother, he *is* the mother, down to the least detail" ' *(5,* p. 471*)*.

may be further interpreted as a primitive, concrete attempt at mastery. This type of mastery is, however, very different from that associated with the process of working through in mourning. The latter represents a symbolic, abstract process: the lost object, like a physical thing, is replaced by a symbol (image, words, or memory), and further transformations in the nature and function of the symbol occur in the process of resolution of the trauma. In contrast to this, my patient acted as if one pregnancy were like the other, as if she had tried to feel or believe, when she was pregnant once again, that she had never lost a baby at all. The denial of the loss of the fœtus and the substitution of her body for it both signify the need for a concrete way of dealing with the situation at hand *(32)*.

Her conviction that she knew when she was ovulating each month (as well as her conviction that another pregnancy would cure her completely) was another expression of the concrete attitude in her ego orientation to the mastery of the trauma. It also expressed her denial of passivity toward bodily experiences and the need for re-establishing control at all cost. It was as if by 'knowing' the time of ovulation, she was somehow instrumental in bringing it about. The same mechanism was acted out in relation to bowel movements. She was insensible of any spontaneous urge to evacuate. Instead, she complained during each visit to me that she was severely constipated. The only way she permitted herself to have a bowel movement was by inducing it with suppositories. These and many other thoughts and actions dramatically illustrated her need to feel that nothing could happen to her body—particularly in the genital ('cloacal') area—without her knowledge and control. It was as if her ego was interested in but one task, to make absolutely certain that she would never again be taken by surprise by her body.

Although this patient felt a strong relationship to me, it was significantly different from a 'transference neurosis'. Her relation to me was as to one who understood her productions and preoccupations and, most important, who did little to interfere with her attempts to achieve belated mastery of a trauma.

THEORETICAL CONSIDERATIONS

We have categorized a variety of phenomena pertaining to bodily feelings, avoiding the dichotomy between bodily reactions 'due to' physical injury or disease and those not so 'caused'. These phenomena, therefore, cut across not only the customary divisions between 'organic' and 'psychogenic'; they also include manifestations found in 'normals', hypochondriacs, and schizophrenics, as well as symptoms often called 'hysterical', such as anesthesias and paresthesias.

It is useful to look upon bodily feelings as indices of the relationship of the ego to the body as an object. The 'body' in this context signifies an object of the ego which may or may not be the same as the observer's notion of the subject's body. (In hypochondriasis, it is obviously not the same, whereas in a 'normal' reaction to a fracture, the 'body' to which the patient's ego and the observer are oriented are nearly identical.) Moreover, the notion body is not a unitary concept for the ego; at least no more so than is the ego itself a unitary thing. In other words, in a hypothetical normal adult the conscious ego will have one notion of the body, whereas the unconscious facets of the ego will have correspondingly different bodies with which they are concerned—as illustrated, for example, by childhood fantasies of procreation which have become repressed.

From this point of view we can interpret many affects pertaining to the body. The following three categories are suggested: 1, The silent feeling of bodily well-being, mentioned earlier. This requires a preconscious awareness of the body and its various functions without conscious attention to them. 2, Feelings associated with increased interest in the body: this includes all manner of feelings (which may be called affects, sensations or perceptions) such as pain, itching, and burning; the common feature among these is an increased cathexis of the body by the ego. In other words, the ego is interested in and oriented to the body, as an important object in its orbit. 3, Feelings associated with decreased interest in the body: this group

is similar to its opposite, the difference being a lack of interest on the part of the ego for the body. This may be expressed, for example, by a stoical attitude of 'feeling no pain' in the presence of injury or illness, or by a 'hysterical anesthesia' or by a schizophrenic self-mutilation without pain.[5]

INCREASED INTEREST IN THE BODY

The word 'increased' is not used to represent the observer's opinion that the patient has a more intense reaction to a bodily event than he ought to (as if the observer said, '. . . it does not hurt *that* much!'). Rather, it denotes the measure of the ego's interest—perhaps even to the exclusion of all other interests—in its body or in certain parts of it.[6] Although this meaning too cannot dispense with the observer's estimation of what goes on, his estimate should refer to the ego orientation and not simply to the subject's affect or sensation. The theoretical importance of this distinction is evident. Practically, such a distinction should be helpful in eliminating the observer's personal point of view about what types or degrees of affects are normal or appropriate. The orientation of the ego to the body is a more abstract notion and its accurate assessment will undoubtedly arouse much less emotion in the observer than do the affects themselves.

The best examples of feelings indicative of increased interest

[5] In the foregoing, we speak of affects (feelings) and of the ego's interest in the body as conscious phenomena (*Cf.* Fenichel [7]).

[6] See, for example, Brunswick's description of the Wolf-man's state of mind when he first consulted her: 'He was in a state of despair. Having been told that nothing could be done for his nose because nothing was wrong with it, he felt unable to go on living in what he considered his irreparably multilated state. . . . He neglected his daily life and work because he was engrossed, to the exclusion of all else, in the state of his nose. On the street he looked at himself in every shopwindow; he carried a pocket mirror which he took out to look at every few minutes. First he would powder his nose; a moment later he would inspect it and remove the powder. He would then examine the pores, to see if they were enlarging, to catch the hole, as it were, in its moment of growth and development. Then he would again powder his nose, put away the mirror, and a moment later begin the process anew. His life was centered on the little mirror in his pocket, and his fate depended on what it revealed or was about to reveal' (5, pp. 439-440).

in the body we find among so-called hypochondriacs. Here interest in the body tends to blot out all other interests. We must, however, abandon traditional nosology, for hypochondriasis is usually spoken of only in the absence of an 'organic' illness *(16)*, whereas we find a similar preoccupation in some persons who do have an injury or 'organic' disease. To speak of a 'neurotic superstructure' or 'psychogenic overlay' of an organic disease does not add to our insight into this matter. The crux of the situation is whether or not the ego orientation is predominantly to the body or to other objects and pursuits as well. The ego may focus attention on the body whether or not physical changes have occurred in it. And conversely, in the physically injured or ill the ego may or may not remain focused on objects other than the body. We know that even in severe chronic diseases, only a small portion of the ego's interest is turned toward the body, and that most of its attention may be directed toward interactions with other persons and toward sublimated pursuits. (Bodily disease may, of course, even help the ego to do so, but this is a matter with which we are not concerned in this study.)

Besides the general category of hypochondriacal symptoms, we include in this group the diverse feeling states associated with increased interest in the body found in patients with schizophrenic and depressive psychoses. These phenomena are adequately described in the psychiatric literature *(4, 8, 16)*. A famous literary example of this type of bodily feeling (now usually thought of as characteristic of a schizophrenic state) is to be found in Kafka's Metamorphosis *(19)*. Finally, the following familiar clinical occurrences, which cannot be fitted into any nosological group, belong also to the category under consideration: 1, persistent or recurrent pains (the 'pain syndrome' [*36*]); 2, phantom body parts and phantom pain *(33)*; 3, itching *(23)*; and 4, excessive interest in the æsthetic or cosmetic qualities of the body or of certain parts of it (concern, for example, with weight and dieting, or rhinoplasties [*17, 20*]).

The specific psychological meaning of a particular bodily feeling depends upon a number of factors, most important among

which are the life history of the individual (including his vocabulary, skills, and culture) and whether or not the body as an object is being used to re-enact and work out a conflict. If it is so used, the meaning of the feelings will be further determined by the nature and status of this process.

In spite of this complexity, a few generalizations can be made. Feelings associated with an increased bodily interest often have the meaning of a signal which calls attention to the body or a part of the body. This can be paraphrased as follows: 'Look here —or touch here—examine and find out what is going on . . .'. This is often part of the meaning and function of pain and particularly of itching *(23)*. These feelings also reaffirm the presence of the affected part of the body, and they may be regarded as a primitive, somatically enacted defense against a fantasied loss, according to the following pattern: 'My head [or tooth or stomach] hurts—it cannot be that I have lost it . . .' *(33)*. We are familiar with our tendency to poke an area or lesion that was painful and has ceased to hurt.

Regardless of the organ involved and the specificity of the bodily feeling, there is an important parallel between these phenomena and the psychological structure and function of paranoid ideas and strong religious preoccupations. In a paranoid delusion of persecution, the persecutor functions as the chief object of the ego, around which the ego organizes its experiences. The ego maintains such integrity as it has by its relationship with an overvalued object of fantasy. The fact that the affects associated with this object, such as fear of being persecuted, are largely unpleasant no longer misleads us as to the nature of this psychological phenomenon. The 'benign paranoia' of religion substitutes 'protection' for 'persecution'. The same conflicts of childish helplessness and fears of being damaged and victimized, and the primitive defenses of the ego against them by alliance with magical powers or by high pitched preparedness and vigilance are embodied in the phenomena of increased bodily feelings: in these the dangers and fears, as well as the preparations for protection, are all aimed and oriented toward the body (in-

stead of toward the self and other people, as in paranoia).[7] This theoretical view of these bodily feelings is consistent with, and strongly supported by, the well-established clinical fact that paranoid delusions and hypochondriasis invariably coexist, and that hypochondriasis is often the beginning of paranoid delusions *(23, 26, 37, 41)*.

DECREASED INTEREST IN THE BODY

Decreased bodily feelings denote a state in which the ego has little interest (cathexis, attention) in the body or in certain parts of it. Just as increased bodily feelings may be compared to paranoid ideas or delusions, decreased bodily feelings are sometimes homologous to the withdrawal from, and loss of interest in, human objects, a condition characteristic of catatonic and hebephrenic forms or phases of schizophrenia. Decreased bodily feelings, however, are not being equated with a psychotic mechanism or state. A loss of interest in the body by the ego may be motivated by various factors. The following are common examples of decreased bodily feelings.

The behavior of the stoical person is familiar, although such conduct is less common among us than it was in such past ages

[7] The psychic equivalence for the ego of the body and of other people is well illustrated by the following experience. A patient of mine sought treatment for, among other problems, severe hypochondriacal preoccupations particularly involving pains in various joints and fears of arthritis. In the course of our work, he obtained great relief from these symptoms; he 'lost' most of his diverse bodily preoccupations. One day, however, when we were contemplating the termination of treatment, the patient expressed the thought that after the analysis his 'joint symptoms' would surely return. This belief seemed to express the conviction, based on his childhood relationship with his father, that he is 'safe' only when in contact with an object that makes him feel helpless and endangered. All children are 'helpless' yet 'safe' in their relationship to their parents. This is the model upon which later feelings of helplessness vis-à-vis the body (to the point of being persecuted by the discomforts which it inflicts upon the ego) may be based. The essential unity of the notions of helplessness and danger on the one hand, and of protection and safety on the other, as these may be embodied in some types of bodily preoccupations, is the chief consideration that I want to emphasize in this connection.

as the days of ancient Sparta. The behavior of the stoic strikes us as unusual in that he does not complain of, or seem even to notice, illnesses and afflictions which we regard, by identification with him, as painful or extremely unpleasant. On closer analysis we often conclude that he has turned away from his own body; his attitude is truly 'counterhypochondriacal'. He denies the unpleasant affects of dangers to his body and often exposes himself repetitively to them—a conduct similar to that of the counterphobic person with respect to his concept of himself (rather than of his body). The 'counterhypochondriacal' mechanism is probably not uncommon. It represents an attempt at mastery of an intense unconscious dread of preoccupations with damage or mutilation of the body. Like the counterphobic attitude, this orientation often parades in the guise of 'normality', and may even command social admiration and praise. It has therefore remained more obscure than other so-called psychopathological states.

Another example of a feeling state associated with decreased interest in the body is seen in the painless loss of an extremity in the soldier in the heat of battle. The soldier's attention is all directed to some specific task in order to insure survival in an acutely dangerous situation. The ego is completely absorbed by this task and the body remains uncathected. Even if injury occurs, no signals indicate it. Later, as the ego shifts back its attention to a variety of objects, including the body, pain is experienced.

Hypnotic ablation of pain (whether the pain is 'organic' or 'psychogenic') lends itself to a similar interpretation. The hypnotized subject's ego is absorbed in the person of the hypnotist, who imposes himself upon the subject as his sole object of legitimate interest. The ego is, in effect, commanded to abandon its investment, at least for the time being, in all other objects and to focus attention exclusively on the hypnotist. As the ego relinquishes its interest in the body, affects pertaining to this orientation do not arise.

In so-called 'hysterical anesthesia' also, the lack of feeling

signifies a lack of orientation (possibly as a result of denial or repression) of the ego toward the affected part of the body. The mechanism in these cases is usually repression of the part of the body—for example, the genital organ—as in the hypnotic ablation of pain, except that the command to pay no attention, so to speak, to the body comes from the superego rather than from the hypnotist. Moreover, this command often originates from, or is ascribed to, the prototype of the hypnotist, the parent.

Various forms of hypesthesia and anesthesia occur commonly in schizophrenia. These patients also state, or sometimes complain, that various parts of the body feel dead, numb, strange, or alienated. This state seems to reflect one of two basic experiences in the schizophrenic ego's dealings with its world. First, the body may be in part a transference object, as in the clinical example cited, and signify in a concretive 'body-language' the catastrophe of object loss. This may be paraphrased as follows: 'My body [or my head, or other part] is dead; I cannot feel it. My child [or mother] is dead—that is, removed from me: I have lost all that I need. My world is dead. . . .' The 'dead body' and loss of bodily feelings is thus interpreted as a homologue of the fantasies of world destruction *(Weltuntergang)* of the schizophrenic; the former occurs in so far as the ego is oriented to the body, while the latter relates to the ego's orientation to the outer world (not the body). Second, loss of bodily feelings may also signify the ego's experience of its essential dissolution, as does the fantasy of *Weltuntergang.* The unrelatedness to the body in these instances does not signify a recent, actual loss of object (and does not serve as a possibly inadequate attempt at its mastery), but expresses simply the inner experience of personal dissolution at the periphery with a tendency to retrenchment and survival in progressively narrower areas of ego and object.[8] This takes us to a corollary of this process, the actual attempts to alter the body.

If we wish to change our body there are two basic avenues open to us: we can induce someone else, a surgeon for example,

[8] For a fuller discussion of bodily feelings in schizophrenia, see ref. *37.*

to make alterations or we can do it ourselves. People are often successful in inducing doctors to change their physical appearance or to remove organs. We may look upon this phenomenon as an attempt by the ego to 'bring the body up to date' so that it will conform more to the ego's image of what it is or should be like than it did before the surgical intervention. When the bodily alteration is socially sanctioned, as it is in plastic operations, its psychological meaning and impact is less striking since the patient's idea of what his body should look like tends to coincide with that of the observer (the physician or society).

The most striking lack of agreement between patient and observer as to what the body should look like occurs in psychoses. Sometimes psychotic patients attempt with their own hands to bring about the changes in the body that they consider necessary. Their self-mutilations, such as pushing out an eyeball or cutting off the penis or testes, are painless. The act often takes place during a period of excitement and tension which subsides after the successful completion of the bodily alteration. The psychosis is said to 'remit' after the self-mutilation. This suggests that the part of the body involved was 'lost' before or during the psychosis; that is to say, as far as the ego was concerned this part of the body was lost, just as a human object may be lost for the ego without the object being necessarily lost for other egos (or without its actual death). Thus, while the body or body part, as observed by the physician, may be present, it is gone for the patient. Perceptions calling attention to its presence are now clearly unwanted: the ego, in its attempt to reintegrate, alters the world (in this case, the body) to fit it more closely to its own image, and thus satisfies its need to maintain this image. Since the part of the body involved in the self-mutilation was already lost to the experiencing ego, its removal is unaccompanied by pain. On the contrary, successful self-mutilation leads to a sense of 'work well done': '. . . in all cases the event was accompanied by a feeling of relief and tranquility and there were no regrets' *(15)*.[9]

[9] I believe we may regard self-mutilations as at least partially analogous to the socially much admired work of censorship. The work of the censor, after all, is

PERTINENT PSYCHIATRIC STUDIES

The psychiatric literature abounds with descriptions of diverse bodily feelings associated with various 'psychopathological states' *(8, 10, 27, 28, 38)*. I restrict my comments to a few contributions of interest for their theoretical position toward the phenomena.

Bleuler's classical treatise on schizophrenia is a rich source of clinical examples of increased bodily feelings. No concise theoretical position is taken regarding the psychological nature of these phenomena, but Bleuler clearly stated the importance of bodily preoccupations in schizophrenia.

> Characteristic of the schizophrenic hallucinations is the preference for the auditory sphere and for the sphere of body sensations. Almost every schizophrenic who is hospitalized hears 'voices', occasionally or continually. Almost equally as frequent are the delusions and illusions which are related to the different body organs *(4,* p. 95*)*.
>
> The hallucinations of bodily sensations present such kaleidoscopic multiplicity that no description could possibly do justice to them. Any organ can be the seat of most severe pain *(4,* pp. 100-101*)*.

The terms 'sensation' and 'hallucination' tend to prejudge and obscure this matter. 'Sensation' implies something 'objective', a hypothetical normal response to a 'stimulus', whereas 'hallucination' implies that the patient 'imagines' the experience in contrast to a normal reaction to a 'real' experience *(6)*. I believe that in such a frame of reference the observer intrudes too much into the observed phenomena; his subjective judgment is then all too readily viewed as an 'explanation'.

The difficulty to which the observer's intrusion into the observed may lead is well illustrated by this comment by Bleuler:

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to so modify the information reaching the audience that the image of the world that it receives will coincide closely with the audience's preformed, and therefore preferred images of it. Or, perhaps, the self-mutilation of the psychotic should be compared to the burning of books, by which society tries to ablate unwanted 'knowledge', or to the burning or persecution of individuals who are too noisy in proclaiming unwanted impressions.

'When the physical complaints constitute the first symptoms they can be related to the psychosis only after the psychosis has become overt' *(4,* p. 254*)*. This statement reflects the physician's inner doubt about whether or not the patient is right in his complaint about the body: perhaps some physical derangement has occurred and it is of this that the patient complains. This way of looking at patients' complaints we find also in the current general medical and psychiatric approach to these matters. An assessment of the patient's ego involvement—for example, his conviction of disease or his compulsive wish for certain procedures—makes it unnecessary for the physician to assume an omniscient role in his judgment of the physical functioning of the body, of whether or not there is 'physical' disease. This issue becomes subsidiary, but not unimportant, to an accurate assessment of the patient's integration of ego and body, which becomes the psychiatrist's chief concern.

Our thesis regarding the homology between increased interest in the body and paranoia is consistent with Bleuler's observations: 'Most incurable hypochondriacs are schizophrenics whose delusions are primarily concerned with their own bodies. . . . Some genuine paranoiacs may perhaps also be hypochondriacs with delusions concerning their health' *(4,* p. 288*)*. Bodily feelings occupy an ambiguous position in psychoanalytic theory. Macalpine has called attention to the fact that '. . . psychoanalysis has been built up on and for the psychoneuroses and has little to contribute directly to somatic symptoms, either in theory or practice, other than the hysterical' *(22,* p. 25*)*.

Elsewhere I have tried to show that considerations of the body, and of affects pertaining to it, have been in a sense excluded from the basic conceptual model of psychoanalysis *(35)*. Much of this difficulty rests on the traditional philosophical dichotomy between body and mind and a tacit acceptance of this by the founders of psychoanalytic theory. Philosophical preconceptions are of greatest importance in this matter. The notion that some sensations are caused by bodily disease—and its converse, namely, that others are not—underlay all Freud's comments on problems

pertaining to bodily feelings. He considered hypochondriasis in greatest detail in his paper, On Narcissism: An Introduction (1914):

> Hypochondria, like organic disease, manifests itself in distressing and painful bodily sensations and also concurs with organic disease in its effect upon the distribution of the libido. The hypochondriac withdraws both interest and libido—the latter specially markedly—from the objects of the outer world and concentrates both upon the organ which engages his attention. A difference between hypochondria and organic disease now becomes evident: in the latter, the distressing sensations are based upon demonstrable organic changes; in the former, this is not so. But it would be entirely in keeping with our general conception of the processes of neurosis if we decided to say that hypochondria must be right; *organic changes cannot be absent in it either.* Now in what could such changes consist? *(11,* p. 40. Italics added.)

Freud then compares hypochondriasis to neurasthenia and anxiety neurosis and suggests that all three are 'actual neuroses'. He postulates an increase in the erotogenicity of the affected organ in hypochondriasis, and concludes with the comment: 'It is not within the scope of a purely psychological inquiry to penetrate so far behind the frontiers of physiological research' *(11,* p. 41*).*[10]

Fenichel's views on the subject reflect the influences of the same philosophical preconceptions:

> Hypochondriasis is an organ neurosis whose physiological factor is still unknown. It may be assumed that certain psychogenic factors, namely, a state of being dammed up and a nar-

[10] For a critical evaluation of these concepts, see Macalpine and Hunter, who stated: 'Jones (in a personal communication to the authors) regretted that Freud could not be persuaded to take up the problem of actual neuroses again from where he had left it in 1895. As it stands today the concept is unacceptable and useless, the theory of damming up of libido in one organ has not led to deeper insight but merely to a barrage of terms such as organ neurosis, pregenital conversion, and erotization of organs. The toxic effect of undischarged libido is an outmoded concept, however hard it seems to die' *(25,* p. 381*).*

> cissistic withdrawal, or rather a readiness to react to a state of being dammed up with narcissistic withdrawal, create *organic changes* which then in turn give rise to hypochondriacal sensations *(8,* p. 261. Italics added.).

How strenuously is a purely psychological approach to bodily feelings avoided in these and most other analytic writings! Yet we know so well that the greatest strength of psychoanalysis lay —and must continue to lie—in the steadfast application of a purely psychological frame of reference, and an idiom appropriate to it, to various phenomena of human experience. Elsewhere Fenichel *(8,* pp. 418-419*)* speaks of the relationship between hypochondriasis and schizophrenia and in this connection actually interprets the symptoms of hypochondriasis in a purely psychological manner, in terms of variations in the cathexes and countercathexes of organs.

R. D. Gillespie's little book, Hypochondria *(14),* accurately describes this 'syndrome' and its differentiation from other types of ego orientation. Gillespie noted that the hypochondriac has a conviction of a bodily disorder and not a fear of it.[11] He wrote:

> The affect in hypochondriacal preoccupation is better described as a type of interest, not of a fearful kind. . . . Closely connected with the affective attitude is the reality value for the patient of his hypochondriacal notions. It may be said of the merely anxious patient that he fears but does not believe that he suffers from the malady which he professes to apprehend, and that in fact he chooses something to worry about, which he knows in his heart to be a perfectly safe topic upon which he can always get dogmatic reassurance. On the other hand, for the hypochondriac that fancied ailment is real. He has a conviction and not a fear, of disease—it may be simply a malfunction, or it may be a morbid structural alteration *(14,* pp. 41-42*).*

The hypochondriac's conviction of the reality of his notion about his body is crucial: it touches on the ego's incapacity to deal with symbols (abstractions or 'possibilities') which is such

[11] Note the homology with the difference between a paranoid delusion of persecution and a phobia.

an important feature of the mental state of the child and of the schizophrenic, as contrasted with that of the 'normal neurotic' adult *(32)*.

Macalpine's recent studies on skin disorders *(22)* and pruritus ani *(23)* and her reanalysis, with Hunter, of Schreber's psychotic symptoms *(25, 26)* are valuable references in connection with the theme of this paper. Her approach in these studies is organized in terms of the ego's orientation to the body and illustrates the fruitfulness of this approach. Pruritus ani, for example, is shown to be related to childhood, nongenital procreation fantasies ('theories'):

> Pruritus ani, although it presents as the only symptom, never occurs alone, but is associated with bizarre gastrointestinal symptoms and sexual disorders. Depressive and paranoid trends are common. It is the leading symptom in a syndrome. This syndrome exists in its own right. No distinct personality type could be established; it was found to occur without personality disorder, in psychoneurotic and prepsychotic personalities, and in frank psychoses. Its origin can be traced to a reactivation in adult life of infantile (unconscious) fantasies about procreation centering around the anal function, which precede genital interest and knowledge of sex. These 'cloacal' fantasies are revived in their original primitive mode, as bodily sensations rather than ideas; the symptom thus represents the fantasy. They appear as distressing somatic symptoms because such archaic fantasies are incompatible with reality. A breakthrough into consciousness is thus prevented and psychotic delusions avoided *(23,* p. 507*)*.

Macalpine makes no comment about the specific symptom of itching. Itching may be regarded as the signal of an interaction between ego and body. Its apparent meaning is to call attention to, and specifically to stimulate manual exploration of, the affected part of the body, as if to attempt to dispel the ego's doubts about its image of that part. Such a view of itching is very much in harmony with Macalpine's basic thesis. Her interpretation of Schreber's 'hypochondriacal delusions' as archaic ambisexual procreation fantasies is particularly germane to our

discussion of the psychological nature of increased bodily feelings.[1] [2]

In his recent scholarly work on schizophrenia, Arieti *(1)* comments on 'perceptual alterations' in schizophrenics (pp. 372-378). He notes, for example, the loss of pain and temperature sense, states that it is difficult to understand this phenomenon (p. 377), and suggests an entirely nonpsychological explanation for it. ('We have interpreted this phenomenon as a consequence of some possible psychosomatic dysfunction of the parietal cortex' [p. 431]).

For references regarding self-mutilation in psychoses, the reader's attention is again called to Bleuler *(4)* and to Hemphill *(15)*. The following lines from Hemphill's paper are of particular interest to us from the point of view (which regards the body as an object of the ego) proposed in this essay:

> The tendency to hold organs of the body responsible for ethical failure and to get rid of them so that the individual can pass blameless into another existence occurs in some cultures, and has been described in parable in the injunction: 'If thy right hand offend thee, cut it off and cast it from thee; for it is profitable for thee that one of thy members should perish, and not that thy whole body should be cast into hell'. . . . Martyrs are reported to have burnt off a hand that has signed a recantation, but in modern times it would appear that the genitals alone amongst the organs are the object of mutilation, and there are no instances in the literature of hands or other organs being cut off for these special reasons. As in many authenticated martyrdoms, physical destruction of the organ caused no pain at all at the time, having been performed in a state of ecstasy; and afterwards, as in all cases, the event was accompanied by a feeling of relief and tranquility and there were no regrets *(15,* p. 294*)*.

The introduction of the notion of 'ecstasy' tends to obscure what really happens in such instances. In this paper, Hemphill also gives a review and brief summary of previous cases of self-

[12] Macalpine's work has been a valuable stimulus to my views on this subject.

mutilation reported in the literature. He believes that 'most of the recorded cases have been depressives, with some doubtful cases of schizophrenia' *(15,* p. 295*)*. Apparently all had hypochondriacal symptoms and from our point of view they would be interpreted as predominantly schizophrenic.

SUMMARY AND CONCLUSIONS

The philosophical dualism of body and mind, and the assumption that there is a mutual cause and effect relationship between them, is of crucial significance in the psychoanalytic theory of bodily feelings. This paper attempts to present a psychologically consistent approach to these problems which is devoid of abstractions belonging to other frames of reference such as anatomy or physiology.

Illustrative observations from the experiences of a schizophrenic woman are cited and certain theoretical inferences are offered. The ego has three sorts of relationship to the body: 1, The silent feeling of well-being. This consists of a preconscious awareness of the body, which is, so to speak, taken for granted. 2, Feelings associated with increased interest in the body, including an almost limitless diversity of affects, for example, pain, itching, paresthesias, anesthesias, and feelings of bodily estrangement. The common quality in these diverse feelings is an increased interest or cathexis of the ego toward the body. 3, Feelings associated with decreased interest in the body. Under this term we similarly categorize many diverse affective states which have in common a relative diminution or complete lack of interest in the body on the part of the ego. This notion is analogous to the loss of interest in human objects, familiar to us from the theory of schizophrenia. Clinical examples are cited to illustrate the theoretical concepts described, and the pertinent psychiatric literature is reviewed.

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River Symbolism

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RIVER SYMBOLISM

Part II

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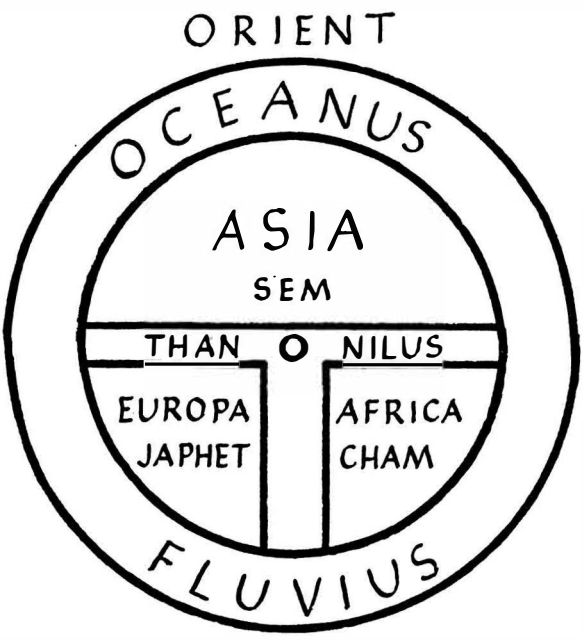
Let us briefly examine the age of discovery, certain features of which are of interest to the psychoanalyst as well as to the historian and geographer. As will be seen presently, the history of discovery is linked with a variety of myths, conscious and unconscious strivings, haunting anxieties, superstitious beliefs, and —among other elements—with early cartography, the last providing a sort of documentary backdrop against which the fantastic story of geographic exploration unfolds, almost like a dream on a dark or foggy dream screen.

It may be well to remember, in this connection, that a transposition of ideas into visual experience is not limited to the dream alone. Picture language is as old as symbol language, and is equally primitive. Map-making, in particular, seems to be common to all peoples who in the primitive stages use sand, wood, fibres, stones, and later more refined materials for this purpose. Geographic maps have 'so ancient a history that it is not possible to ascertain their first beginning' *(71)*. Starting from the premise that geography, as the name implies, is the study of Gæa, the *Urmutter,* and that the great questions of geographic research—'where', 'wherefrom', the relentless investigation and exploration of the earth—resemble and in a sense repeat the libidinal questions of every human, I soon came upon a mass of virtually untapped, early data, the analytic evaluation of which appeared well justified. To the psychoanalyst studying historical and cartographic documents of the periods prior to and during the age of discovery, the special nature of geographic exploration becomes easily apparent. The documents examined by me consist mainly of medieval maps and writings dated between 500 and 1500 A.D. They are filled with various pictorializations and explanatory texts which the analytic observer can perhaps best

characterize as pictorial, descriptive aggregates of œdipal and preœdipal fantasies projected on areas of the world which, if still unknown today, would presumably appear as blanks on our maps. Freud's dictum *(28)* about 'thirst for knowledge [being] inseparable from sexual curiosity' seems here directly applicable. The abundance of illustrations on many of these early maps is remarkable. Mystery and dreaded secrets became perhaps less frightening when given some sort of pseudoperceptual expression, and the accompanying texts equally concretize certain fantasies and superstitions included in the conception of the world at that time. To understand them, a brief survey of some historic and geographic data of the past appears necessary.

The oldest known map is a clay tablet from Babylonia, possibly dating to the period of King Sargon (c. 2300 B.C.) which depicts a part of lower Babylonia surrounded by a 'salt water river'. Little is known, and hardly anything is preserved, of the charts used by the ancient Phoenicians, Greeks, and Romans. One reason for this apparently is the utter secrecy in which such charts were kept by the ancient mariners. There is a story about a geographic map ordered to be prepared for Julius Caesar, but completed only in the reign of Augustus. Augustus is said to have placed a copy of the map engraved in marble in the portico of his sister Octavia's house (7 B.C.). It is possible that a later copy of this map of the Empire was used by Claudius Ptolemy (c. 150 A.D.) in his famous work on geography. Ptolemy seems to have abandoned the idea of a world encompassed by a circumfluent stream of water; apparently, however, he left the question open for further investigation. He also originated the practice of orienting maps so that the north is at the top and the east at the right.

The first medieval maps date to Isidore of Seville (570-636 A.D.), who wrote a manuscript called *Origines,* a kind of medieval cyclopedia left incomplete by its author. The codex of Isidore, preserved in the library of the Abbey of St. Gallen, contains the earliest Christian mappamundi. In this oldest known map of the Middle Ages the world is surrounded by the ocean,



MEDIEVAL T–MAP

The ocean was thought to be a river encircling the earth (*Oceanus Fluvius*). The vertical limb of the T represents the Mediterranean; the horizontal limb, the borders of Asia, presumed to extend along the rivers Thanais (Don) and Nile. This schema forms the basis of the T–maps. The city of Jerusalem is in the center. The codex of Isidorus shows *Paludes* near the center.

a circumfluent river. The map shows the distribution of the earth—according to Biblical precepts—among the sons of Noah, Sem, Cham, and Japhet; the Nile and Don rivers; the Mediterranean; and an area called the *Paludes,* or swamps. The Orient, as in most medieval maps, is at the top (see figure).

Similar circular or wheel maps became popular later in the Middle Ages, especially under the name 'T-maps', the basic diagram of which the medieval Italian author Leonardo Dati described in his poem, *La Sphera,* as

un T dentro a uno O mostra il disegno . . .

[a T within an O shows the design . . .]

One of the so-called Beatus maps, drawn by the Spanish monk Beatus in the eighth or ninth century, shows *Oceanus Fluvius* surrounding the earth, Adam and Eve at the top, covering their genitals with their hands, with the serpent close to Eve. Human figures holding Æolian bags who represent the windblowers often complete the pictures on these early charts. Figures of the windblowers were popular on maps as late as the seventeenth and eighteenth centuries.

From about the eleventh century, the mappaemundi become more elaborate. Paradise, with its four rivers, is in the east as usual. The ocean remains a circumfluent river, but the inscriptions and pictures become more numerous. The city of Jerusalem is at the center of the earth, as the *umbilicus terrae*. On some maps, Paradise appears as an island separated from the earth and protected by a fiery wall against adventurous intruders; on others, it is a part of the mainland, surrounded by inaccessible mountains. It is mostly referred to as Garden of Eden or as Garden of Delights. It was generally felt that the secrets of the sea belonged to God and were not to be explored by mortals. It does not require great analytic acumen to recognize in this idea an expression of the fantasy that the water and its secrets (mother) are the domain of father (God), who is sternly opposed to filial intrusion.

Idrisi's[1] map of the twelfth century, engraved on a silver plate for Roger II, made history for at least two hundred years. It showed the Nile with an arm branching off the mainstream in Nubia. This imaginary branch of the Nile is shown flowing westward across all northern Africa and emptying into the Atlantic. It was this branch, later also called the river of gold, that the Portuguese explorers in the service of Prince Henry the Navigator tried to discover. A century after Idrisi, another Arab geographer, Ibn Said, warned against exploring the sea because 'whirlpools always destroy any adventurer'. Arab legislators of

1 Abu Abdallah Muhammed ibn-Idrisi or Edrisi (1099-1154), was a Moorish geographer at the court of Roger II, the learned Norman King of Sicily and southern Italy at the time of the First Crusade.

that period suggested that a man bold enough to embark on exploration of the sea should be deprived of civil rights. At any rate, such a man would soon be lost in a world of 'mist, fog, and vapor'.

Many medieval maps between the twelfth and fifteenth centuries show an area in the West called *mare tenebrosum,* or 'sea of darkness'. Some authors name it the 'green sea of darkness', or 'sea of pitchy darkness'. On a fifteenth century map, one legend, indicating its author's conceptualization, covers the whole southern region: *Brumae* (fogs). It is worthy of note how often in the lore of the sea, rivers, and wells, a beautiful woman emerges from or disappears into the fog. On scores of maps from different countries and centuries one reads *zona torrida, zona inhabitabilis et impermeabilis,* or similar legends. Medieval authors describe this zone as the one 'where elements melt with fervent heat'. He who dares to enter has 'to bathe in fiery floods'. Some commentators compare this *zona torrida* to the flaming sword that barred access to Paradise after the Fall. A legend on a twelfth century map reads *humanus oculus non videt* reminiscent of Freud's interpretation of the *caput Medusæ.* The ocean-river is populated by sea demons, dragons, serpents, and man-devouring whirlpool monsters. The prevalence of dangerous animals in fantasies about crossing rivers and access to the opposite shore has been observed clinically by Friedman *(30)* in a patient 'who suffered from a true gephyrophobia'. The patient described this as a fear 'that he would cross into an unknown dangerous country, where he might be ripped apart by prehistoric animals'. Friedman points to the oral connotations of the fantasy which, in his view, may be an underlying motivation of neurotic bridge phobia. Fraiberg *(23),* in her analysis of a treasure-hunting, seven-year-old boy, found that his fantasies of fierce animals near the longed-for treasure chest represented 'the child's conception of the female genitalia in which the vagina is given the attributes of a fierce mouth which bites off the male organ in coitus'.

One of the most famous maps of the later Middle Ages is the

Hereford Mappamundi, drawn in the Cathedral of Hereford, at the end of the thirteenth century. This map, which is partly in color, with the rivers and lakes in blue, is circular in form, has Jerusalem in its center, and shows the ocean stream flowing around the earth. At the top is the Last Judgment, below which Paradise is represented as a circular island, with Adam and Eve, the four rivers, and other Biblical sites. Among the creatures depicted on this and other charts are monoculi; people without noses and tongues; men with one leg, sitting in the sun and holding their single foot over their heads as a sort of umbrella; acephalic people, described as *gens ista habet caput et os in pectore*[2]; dog-headed people, *androphagi humanas carnes edunt;* and a tribe called Philli who *pudicitiam uxorum probant obiectu noviter natorum serpentibus.* Another British map belonging to the same period, the Higden Mappamundi from Cambridge, has among its legends: *Hic habitant homines patrocidae.*

There are, on these maps, all kinds of weird animals such as dragons, white lions, gold-digging ants, griffons, phoenixes, and other fabulous creatures. Among them, *Linx videt per muros et mingit lapidem nigrum,* the latter possibly an allusion to *lyncurion,* an ancient name for amber which at one time was thought to originate in the urine of the lynx. In the north, the Hereford Map shows the *Sinus Germanicus in quo septem viri iacere feruntur, incertum est quot tempore* (the German gulf where seven men are reported to lie sleeping for an indefinite period of time). This undoubtedly refers to the *Siebenschläfer* legend mentioned also by Adam von Bremen as *in quadam spelunca oceani iacere septem viri dormientes,* which has been studied by Dr. Marcel Heiman in his recent analysis of the Rip van Winkle story. It deals with the relationship of such legends to fantasies about birth and rebirth, to orality, and primal scene experiences.

These are only a few of the numerous texts and strange sites

[2] Shakespeare, in Othello, mentions them as 'men whose heads do grow beneath their shoulders. . . '.

appearing on the old charts. A detailed description would easily fill a volume, and any reader interested in these matters is referred to the geographic literature indicated in the bibliography. From an analytic point of view, two legends on the Hereford Map seem worth noting. First, amidst the unknown regions and waters inhabited by dragons, monsters, and people without heads, legs, etc., the Hereford Mappamundi shows an island near Ethiopia with the legend, *Hic sirenae habundant.* The analytic connotation here suggests: seductive females in the midst of dragons, devouring whirlpools, castrated men, and all the other fantastic terrors of the deep constitute a sexual geography par excellence. Second, among the islands on the Hereford Map, there is a group of six named *Fortunatae Insulae,* the Isles of Bliss. These islands can also be found on many other maps of that epoch, in varying numbers, often in pairs. Because of their special nature and obvious psychological implications, they warrant some further discussion.

The story of these islands can be traced, if not to Plato's famous remark about Atlantis, at least to Strabo (c. 65 B.C. to 20 A.D.), who speaks of 'the golden apples of the Hesperides, the Islands of the Blessed'. In Euripides' account of the Garden of Hesperides, situated at the western edge of the world, 'immortal springs flow by the bridal couches of the halls of Zeus' *(60).* One of the early Beatus maps bears the inscription *Insulae Fortunatae* where the Canary Islands are located. A reference to them can also be found in Idrisi's annotation: 'The Fortunate Islands are two in number and are in the Sea of Darkness'. The Hereford Map carries the inscription, *Fortunatae Insulae sex sunt* and locates them also at the site of the Canary Islands. However, the Dulcert Map of 1339, drawn by the Mallorcan, Angelinus Dulcert, as well as the map of the brothers Pizigani of 1367, shows several islands corresponding to the Madeira group as the 'Isles of the Blessed'. The legend of the Dulcert Map at this site is difficult to read, but has been reconstructed by Babcock *(5)* as *Insulle San Brandani sive puellam* (or *puellarum*). On the Pizigani Map, these islands are inscribed *Ysole dictur sommare*

—Islands called of slumber. The juxtaposition of sleep, bliss, females, and legendary islands in the ocean becomes still more significant through the inclusion, at the same site and on the same map, of a stern warning against any attempt to sail the ocean around the general area of the Madeira Islands.

Freud, in his Introductory Lectures, tells us something about the name Madeira: '. . . in the Atlantic Ocean, there is an island named Madeira, and this name was given to it by the Portuguese when they discovered it, because at that time it was covered with dense forests; for in Portuguese, the word for wood is *madeira.* But you cannot fail to notice that this *madeira* is merely a modified form of the Latin *materia,* which again signifies material in general. Now *materia* is derived from *mater* = mother, and the material out of which anything is made may be conceived of as giving birth to it. So, in the symbolic use of wood to represent woman or mother, we have a survival of this old idea.'

To return to the 'Isles of the Blessed', sometimes also called *Insulae San Brandani,* the historians tell us that the latter name refers to a legendary Irish or Scottish monk, Brendan (also Brandon or Brandan), who in the sixth century undertook a voyage in search of Paradise and after a number of stirring adventures arrived at an island of great beauty and fertility. To him it was Paradise, and later it was designated St. Brendan's Island. On fifteenth century maps it usually is associated with Madeira. On the famous Behaim Globe[8] of 1492, it appears at the site of the Canary group. A mermaid and a merman are shown south of the islands. On later maps it is moved to the area west of Ireland, then to the area of the Delaware River, and for a while becomes located in the West Indies. It still exists on charts as late as 1759. For more than two centuries, Portuguese expeditions tried to reach it until it was finally established that it was a fantasy and that moving it from one position to another did not remedy this condition.

There were two more phantom islands located off the Irish

[8] The original German name of the Behaim Globe made in Nuremburg was *Erdapfel.* The oral connotation (apple being equivalent to breast) is obvious.

coast, named *Daculi* and *Bra.* They appear, situated as sister islands close together, on fourteenth and fifteenth century maps. Babcock *(5)* thinks that the name Daculi is derived from the Italian *culla,* cradle, and interprets the name as Cradle Island. Pareto's map of 1455 carries a somewhat obscure inscription about Daculi and Bra: *Item est altra insulla nomina Bra in qua femine que in insulla ipsa non pariuntur sed quando est eorum tempus pariendi feruntur foras insulla et ibi pariuntur secundum tempus.* In other words, being transferred to the outer island, Daculi, helped pregnant women who had difficulties in giving birth on the inner island of Bra. Jones *(43)* in his study on Ireland has emphasized 'the geographical fact of insularity' which in the unconscious tends to become attached to 'ideas of woman, virgin, mother, and womb' and ultimately to one's own birthplace.

Another pair of such islands is shown on the Behaim Globe in the area of the Indian Ocean. They are named Masculina and Feminea. The legend here reads: 'In the year 1285 after the birth of Christ, one of these islands is inhabited by men only, the other by women only, who meet once a year. They are Christians.' No source is given for this statement nor for its specific date. One aspect of these phantom islands with their connotations of womb, birth, and bliss is that they appear so often in pairs as sister islands. Freud observed that 'sisters' in dreams represent mother's breasts; the connection with Lewin's observations on the oral triad and the infant's blissful sleep at the maternal breast is obvious. St. Ambrose, Bishop of Milan at the time of Theodosius, spoke of these islands as a refuge for those 'who wished to find an asylum from the delights of unruly pleasures . . . upon the beaches of these happy isles'.

Another feature of the age of exploration was the incessant search for the Kingdom of Prester John. This was a mythical Christian ruler, priest-king or emperor, who in some medieval chronicles is also called Presbiter Johannes. He reigned over a kingdom of great power and wealth, first located in Asia and later shifted to Africa. As with the phantom islands, we see here

the moving of another mythical site from place to place. This is another example of the persistence of such fantasies: when the mythical character of a region is exposed by exploration, the fantasy itself is not abandoned; only its legendary location is shifted to another imagined position.

The story of Prester John has been linked to a forged letter of unknown origin, in three copies, allegedly sent to Pope Alexander III, Emperor Frederic Barbarossa of the Holy Roman Empire, and Emperor Manuel Comnenus of Byzantium, in 1165. The alleged letter from Prester John not only extolled the immense power of the ruler (' . . . I surpass all the kings of the earth in riches, mercy, and omnipotence . . . '), but also stated that in his kingdom no war, no private property, and no poverty existed. For several centuries the existence of Prester John was universally believed in Europe, and played a role in all early explorations. Even Columbus thought for a while that he had discovered Prester John's country in Cuba. Most leaders of the expeditionary forces in the later Middle Ages, especially those organized by Portugal, were under orders to locate both the kingdom of Prester John and the river of gold in Africa, with Idrisi's imaginary western Nile as the geographic landmark on their maps. While these Portuguese expeditions were searching for Prester John in Africa, Martin Behaim's globe showed his kingdom still located in the area of the Hwang Ho River with the legend: 'In this country resides the mighty emperor known as Master John'.

Although the weight that should be assigned to such factors in influencing the course of history may be variously appraised, there can be little doubt that these and other fantasies were among the forces shaping the age of discovery. To venture a highly tentative formulation of the unconscious factors involved, I should say that it was perhaps because of its strong libidinal connotations that the search for the Isles of Bliss and the secrets of the sea went hand in hand with the quest for Prester John, the benevolent yet powerful Christian father. Perhaps the situation can be explained as compromise-formation or as the result of denial, as if the early explorer, repudiating part of his original

aims, declared: 'I am really not imbued with any forbidden desires for the mother and her secrets; rather, as a good Christian I am mainly interested in finding the good priest-king John'. The fear of punishment and divine retribution was enormous. According to the historian Beazley *(8, 9),* it was the prevailing idea throughout the age of discovery that any Christian who passed Cape Bojador would infallibly be changed into a 'black' and would carry to his end this mark of God's vengeance for his insolent prying.

A well-known example of renaming amounting to denial also occurred when Bartolomeu Diaz, searching for the kingdom of Prester John, finally succeeded in reaching the southernmost point of Africa. He appropriately named it *Cabo tormentoso,* Cape of Storms. On his return to Portugal in 1488, he reported the discovery to King João II who promptly rechristened it Cape of Good Hope.

The two towering personalities of the age of exploration were Prince Henry of Portugal and Christopher Columbus, one of the most enigmatic men of that epoch. Prince Henry, called The Navigator, probably never sailed beyond sight of land and yet did more than any other individual of his time to promote exploration and geographic discovery.[4] Columbus, a man so unknown that even his exact name is not known to us (Colombo, Colon, Colomo, or Colôbo) has left us among his official reports one that is truly extraordinary. It is a report on his fantasies of having discovered the terrestrial paradise.

On his third voyage in 1498, which brought him to the American mainland, Columbus named the strait between Trinidad and present-day Venezuela in the Gulf of Paria *Boca de la Sierpe,* The Serpent's Mouth; and another strait in the same gulf *Boca del Dragon,* The Dragon's Mouth. At that time, he

[4] A nineteenth century biographer, Richard Henry Major *(53),* remarks about Prince Henry, a lifelong bachelor, that 'He never married, but took for his bride "knowledge of the earth" '. Another biographer, Azurara, states: 'Above all, this Prince was bound to attempt the discovery of things which were hidden from other men, and secret'.

found himself in the area where the Orinoco River empties into the ocean from several estuaries with stupendous force. It was here that Columbus for the first time realized, however dimly, that he had discovered an *'otro mundo'*, another world.[5] At least this is the term he uses. It was also here, perhaps under the impact of this sudden awareness, that Columbus entered upon a series of 'imaginative speculations', as one biographer has it *(39)*, and arrived at the 'weird conclusions', as another biographer puts it *(55)*, of having found 'the original abode of our first parents, the primitive seat of human innocence and bliss, The Garden of Eden. . . '. These ideas, which he detailed at considerable length, Columbus communicated in a letter to the Castilian sovereigns. He further stated that his conclusions, in view of the large body of fresh water 'flowing from the fountain of Paradise' into the Gulf of Paria, were that the earth

> 'is not round in the form they [Ptolemy and others] describe it, but is . . . in the shape of a pear which is round everywhere but where the stalk is, for there it is higher; or it is like a very round ball, on one part of which is placed something like a woman's breast and this nipple part is the highest and closest to heaven. . . .'

Suffice it here to point briefly to the sequence of events. Throughout the first half of August 1498, Columbus was preoccupied with a mixture of correct observations and disturbing feelings which found their expression in the naming of the straits, part recognition, part repudiation of the idea of a new continent, and in his brooding speculations about Paradise, finally culminating in fantasies about the breast shape of the earth, (*'come una teta de muger allí puesta'*, he writes),[6] and about his

[5] Nonetheless, Columbus never relinquished his conviction that he had been in the Indies.

[6] It is interesting to note that Columbus openly speaks of a woman's breast and nipple (in Spanish, *pezon*), while his later biographers generally avoid the expression 'nipple' modifying it to 'stalk' and other terms. Ironically, the famous Waldseemüller Map of 1507, employing for the first time the name America, shows the top of the earth shaped as a nipple as postulated by Columbus. Thus the very document which erroneously immortalized Amerigo as discoverer of the new world, contains Columbus's view about the shape of the earth.

being in the vicinity of Paradise. At this point he fell sick. He ordered anchors lifted and made a hasty return to Hispaniola. The nature of this illness has hardly been considered by his biographers who have contented themselves with ascribing it to 'eyestrain' caused by Columbus's untiring captainship, overwork, and constant watch on deck. The explorer himself, however, explains his hurried departure from the Gulf of Paria in his letter to the Spanish rulers much more specifically: '. . . I was in a hurry . . . to restore myself, for I was ill, with my eyes sore for lack of sleep; for though during the voyage in which I discovered the mainland, I was thirty-three days without sleeping and blind for so long, I did not suffer so much from my eyes nor did they hurt and bleed as they have done now' *(56)*. It is obvious that Columbus understood more about his illness than his biographers. He did not attribute it to overwork but to lack of sleep and to the need for restoring himself. In view of his ideas about the current folklore, with its oral and genital connotations, it seems justified to assume that the appearance of his illness at that particular time had to do with phobic anxieties (names of the straits, sudden departure) and a state of depression (insomnia, fantasies about woman's breasts) accompanied by physical symptoms. The assumption of a psychological cause for the ocular symptomatology seems at least as justified as the assumption of physical strain alone.

There is still another detail to consider which is included in Las Casas' description of the events during that voyage. Las Casas records Columbus's brooding preoccupation, prior to and during the Orinoco episode, with a particular passage in a book by Glanville which the explorer read and re-read during that time. This quotation from Glanville, also called Bartholomeus Anglicus, is based on earlier writings by St. Basile and St. Ambrose about certain features these authors attributed to Paradise. The passage reads: *'Paradisus autem in oriente, in altissimo monte, de cujas cacumine caductes aquae, maximum faciunt lacum que in suo casu tantum faciunt strepitum et fragorem, quod omnes incolae, juxta praedictum lacum, nascuntur*

surdi . . .'. According to this opinion, the waters of the fountain located in the Garden of Eden fall into a very great lake with such enormous power and noise that the inhabitants living in its vicinity are born deaf. Whether this refers to a primal scene fantasy or, on the basis of the water symbolism expressed in the Latin text with particular forcefulness, to the group of perinatal phenomena discussed earlier in this paper (Part I. This QUARTERLY, XXV, 1956, pp. 480, ff.) is difficult to decide. At any rate, Columbus's sudden illness and precipitous departure, his fantasies about the breast and nipple, his anxieties with their gephyrophobic or vagina dentata connotations, finally his depressive mood and insomnia, appear to be suggestive of a breakthrough of such unconscious forces in the explorer's mind at that time.

The unconscious impulses influencing exploration are described in Kipling's poem, Explorer, with rare insight:

> Something hidden. Go and find it. Go and look
> Behind the Ranges—
> Something lost behind the Ranges. Lost and
> Waiting for you. Go!

Ancient texts contain many references to the consistency of water and its perils. Dreams and fantasies about 'dirty water', 'foul', 'smelly', or 'frozen' gutters, or change of clear water into muddy sewage are clinically known to have urethral as well as anal connotations.[7] They are often related to the infantile cloacal theory of female anatomy, vagina dentata fantasies, and sexual anxieties connected with them. In the English epic poem, Beowulf, which dates from the eighth century, the hero, after having killed the vicious monster Grendel, is irresistibly swept by a strong current of water into the slimy retreat of Grendel's mother. There she clutches him fast and deprives him of his sword. He has great difficulty in freeing himself from her deadly

[7] The latter have been clinically studied in a number of cases by Dr. Mortimer Ostow (J. Amer. Psa. Assn., III, 1955, No. 4).

grasp, but finally succeeds. His sword, however, gets overheated, melts in the bloody water (from the fiery blood of the she-monster), and nothing but the hilt of the sword remains. The dramatic fight between Beowulf and the monstrous female is described in psychoanalytically unmistakable terms: '. . . away to her den the wolf-slut dragged Beowulf the bold, o'er the bottom ooze. Swimming monsters swarmed about him, dented his mail with dreadful tusks. . . . Now that goodly sword began to melt with the gore of the monster; in bloody drippings it dwindled away. . . . The blade had melted. Its metal had vanished, so venemous hot was the blood of the demon-brute. . . .'

Antoninus of Placentia, a Christian pilgrim to Palestine in the time of the Emperor Justinian, reports that nothing can float in the Dead Sea because 'it is instantly swallowed up', and that the Jordan 'stands up in a heap every year at Epiphany'. Medieval literature abounds with accounts of the 'slimy sea', filled with all sorts of jellies, impenetrable weeds, and sucking swamps. A chart of the Atlantic issued by Andrea Bianca in 1436 has a section called *Mar de Baga,* the Sea of Berries. The belief in the existence of a 'coagulated sea', in which adventurous sailing craft would get stuck and never return, dominated the history of navigation from antiquity almost up to the present time. This idea drew support from Aristotle who had taught that the heat of the tropical sun must condense water into a jelly so that no ship could pass. The heat would first kill the captains and their crews and then set their ships afire. Konrad Gesner, in his 1560 edition of *Nomenclatur Aquatilium Animantium (32)* describes a thick and slimy *Lebermeer* (liver sea) from which no ship, once having entered, can free itself. In the same book the gruesome whirlpool monster, Physeter, is also depicted. It is described as *Meerteufel* and its appearance in a river near Rome, in 1523, is reported.

The universality of such fantasies as those related in the Beowulf saga and the story of the whirlpool monster is strikingly shown in the so-called *Florentine Codex,* the sixteenth century version of Sahagun's *Historia general de las cosas de Neuva*

España. It tells of the highest gods worshipped by the natives of ancient Mexico. Among the deities named is the *Jade-skirted Chalchiultli ycue* who was goddess of the waters and is described: '. . . Her likeness was that of a woman. It was said that she belonged among the rain-gods, as their elder sister. Hence she was esteemed, feared, and held in awe; hence she terrified men. She killed men in water, she plunged them in water as it foamed, swelled, and formed whirlpools among them; she made the water swirl; she carried men to the depths. She upset the canoe, she emptied it; she lifted it, tossed it up, and plunged it in the water. And sometimes she sank men in the water; she drowned them. The water was restless: the waves roared. . . . When it calmed, when it quieted, it heaved to and fro. . . . They offered her offerings, and the fire priests came out to receive her. They strewed aromatic herbs before her. . . . They remembered that because of her we live. . . .'

The notion of the Sargasso Sea, a well-defined area in the Atlantic with much seaweed and of no particular danger, became a focal point for fantasies of horror, decay, and destruction. Here, according to the graphic description of two contemporary authors *(14),* ships of all epochs 'slowly rot in the slimy but unbreakable grip of a . . . floating continent of seaweed, sometimes heaving with the terrible life of enormous crabs and gigantic cuttlefish. Nothing caught there can escape again, unless it can fly like the birds . . . here time loses its meaning where there is nothing but silence and haze and heat and the stench of rotting seaweed. . . . ' Thus, the Sargasso Sea 'of fiction', the authors add, 'and the Sargasso Sea of fact have really nothing to do with each other except that both concern seaweed'. How deeply ingrained, however, are the horrifying fantasies concerning the Sargasso Sea today was forcefully brought to my attention when I showed the manuscript of this study to an enlightened and scholarly educator. 'But the dangers of the Sargasso Sea are real, not imaginary', he exclaimed and hurried to consult the nearest encyclopedia. He was astonished when he found none of the perils he had imagined listed there.

As mentioned earlier, rivers provided relatively easy avenues for exploration. This can be understood as another factor in the unconscious equation of river and sister. A sister, as a more available and usually less prohibitive mother surrogate, is often the first object of the boy's desired sexual experimentation, in fantasy and—sometimes—also in fact. When a river is an object of exploration, efforts are usually concentrated on determining its source. Possibly the best known example of such a quest is what has been called 'the romance' of the exploration of the Nile *(6)*. Perhaps no other geographic exploration has exercised a more lasting influence upon the imagination of man than the search for the origin of the Nile. Efforts to find its sources continued for well over two thousand years. They came to a close less than a century ago, between 1858 and 1863. Through many centuries the Nile was sought and found in widely separated areas. Until the beginning of the nineteenth century the conviction prevailed that there was a secret connection between the Nile and the Niger. It was thought that the river issued from the Indian Ocean. Another belief was that the Senegal estuary was really the mouth of the western branch of the Nile, which also formed the river of gold and reached the Atlantic on the west coast of Africa. The persistence of such legends for so many centuries is difficult to account for. The common basis may have been the unconscious wish to have this great stream of fertility and abundance, this perennial source of food, wealth, and strength—Egypt was known as the 'gift of the Nile'—as accessible as possible. In the Judaeo-Christian tradition, the Nile had always been associated with one of the four rivers flowing through Paradise. To have the Nile within reach meant owning, as it were, a piece of Paradise. This ideal presented some difficulties. The site of the Garden of Eden was generally supposed to be in Asia, somewhere near the land of the twin rivers. It was therefore thought that the Nile, on coming out of Paradise, vanished and descended beneath the earth where it plunged 'through huge chasms and subterranean channels inaccessible to men' *(per praecipitia hominibus inaccessa)*. The river was then swallowed

up in valleys so exceedingly deep that 'it [was] received in the very bowels of the earth and absorbed in its abysses'. After that, it reappeared in Africa and, passing the cataracts, flowed with many meanderings *(multiplici gyro)* emptying into the sea, the river's mazedness 'rivaling that of the Daedalus labyrinth'. This is how a seventeenth century scholar, the Jesuit Athanasius Kircher *(46)*, described the course of the Nile. According to Leonardo da Vinci, 'all the sea and the rivers have passed through the mouth of the Nile an infinite number of times', and the movements of water in the earth are equivalent to the movements of blood in the human body.

Some of the ambivalent qualities of the river symbol are here manifest: it is visible, yet hidden; near, yet far; familiar, yet mysterious; close, yet inaccessible. To these can be added other manifestations of ambivalence: fruitful—barren; creative—destructive; pure—dirty; healthful—dangerous; calm—turbulent.

From Biblical times, the Nile has been associated with Pharaoh's famous dream about the seven kine, 'fat fleshed and well favored', which were devoured by 'seven other kine . . . ill favored and lean . . .' (Genesis 41, 1-8). Though this dream is briefly mentioned by Freud *(26)*, it has never been analyzed. The following observations are based solely on its manifest content and on the circumstances recorded in the text: It is a river dream (Pharaoh 'stood at the bank of the river'). It is a dream of birth (animals 'came up out of the river'). It is an oral cannibalistic dream in which the older, fat-fleshed cows (mothers) are eaten up by the lean, young ones later born (children). And it is a dream in which the greatest oral danger threatening the child's and, historically seen, mankind's existence—starvation—is successfully averted by its correct, although magic type of interpretation. The dream assures plenty instead of famine; abundance instead of destruction. Its interpreter, Joseph, is an alien, destitute slave-prisoner, who is forthwith made viceroy of the country.

About the sources of the Nile, a tale ascribed to Herodotus has it that there was only one person who knew anything about the origin of the Nile, a certain scribe in the city of Sais. This scribe

related that 'between Syene and Elephantine there are two hills with conical tops; the name of the one is Crophi, and the name of the other is Mophi. Midway between these two, there are the fountains of the Nile, fountains which it is impossible to fathom. . . .' This story, which goes back to the fifth century B.C. can be supplemented by a report written in the nineteenth century by Sir Samuel White Baker *(7)*, one of the discoverers of the sources of the Nile: '. . . I looked down from the steep granite cliff upon these welcome waters, upon that vast reservoir which nourished Egypt and brought fertility where all was wilderness . . . that source of bounty and blessings to millions of human beings, and as one of the greatest objects in nature, I determined to honor it with a great name. As an imperishable memorial of one loved and mourned by our gracious Queen . . . I called this great lake "The Albert Nyanza". The Victoria and the Albert Lakes are the two sources of the Nile.'

After this sketchy survey of fantasies accepted for centuries as historic and geographic facts, let us briefly examine the question: what do these ancient texts and maps show? Most historians and geographers, unaware of the unconscious implications of this material, have either dismissed as meaningless or attributed to earlier authors, like Pliny, Pomponius Mela, Solinus, and later Mandeville, the occurrence of mythological data in medieval geography. 'As for the maps of the Middle Ages', writes Hendrick van Loon *(72)*, 'maps became mere funny pictures, full of headless monsters and snorting unicorns and spouting whales and kraken and mermaids and griffons and all the other denizens of a world bewildered by fear and superstition'. Newton *(57)* finds it 'hardly worthwhile to devote much space to Columbus's geographical fictions . . .' ;and to Lloyd A. Brown *(12)*, a contemporary authority on the history of maps, it seems 'impossible to trace in them [the maps of the Middle Ages] a developmental process, a progression of thought . . . or to grade them according to accuracy and utility'. Some of these authors inveigh especially against Solinus and Mandeville ('an utterly shameless spinner of

tall tales', says Brown of Solinus) and attribute many of the errors of medieval cartographers to the 'fanciful' descriptions and 'gruesome' ideas of those ancient writers.

Why, specifically, medieval geography became 'a distillate of folklore, religious cosmography, and an assortment of statistics transcribed with all the errors from ancient itineraries' *(12)* has no simple answer. Apart from the known aspects of medieval thinking with its emphasis on faith, dogmatic notions of paradise and beatitude, religious concepts of sainthood, miracles, sin, malefaction, and damnation, an analytic approach to exploration and cartography may offer at least some clue to this problem. Fraiberg *(23)* has recently shown that the quest for unknown places and hidden treasures so frequently observed in children's play is really 'an anatomical search'. The map, in such a setting, represents 'the acquisition of a magical device' through which the hero, that is, the explorer, 'achieves the means of obtaining the inaccessible woman'. In Fraiberg's study the map reveals 'the place where something is hidden . . . the treasure' which, on analysis, turns out to be 'the Queen', that is, the mother. These findings are not new, of course. Freud, in his analysis of Dora's second dream, had already spoken of 'a sexual geography of sex'. Kanzer *(44)*, in his study of Robert Louis Stevenson's Treasure Island, has presented ample material which demonstrates that 'the sea, the ships, the hidden treasures . . . mark the haunting lineaments of the feminine form'. This close connection between anatomical and geographic exploration has long been recognized by poets and artists. The poetic literature of the seventeenth and eighteenth centuries contains many allusions to the hidden charms of the female body expressed in geographic terms. An eighteenth century German map shows the *Reich der Liebe* replete with details of female sexual anatomy, hemispheres, rivers of love and longing. The English poet John Donne (1573-1631) describes his voyage of discovery to the secret charms of his mistress' body in these words:

'. . . licence my roving hands, and let them go,
Before, behind, betweens, above, below.
O my America! My new-found-land,
My kingdome, safeliest when with one man man'd,
My Myne of precious stones, My Empire,
How blest am I in this discovering thee!

. . . . .

There in a Creek where chosen pearls do swell,
The Remora, her cleaving tongue doeth dwell.
These, and the glorious promontory, her Chin
Ore past; and the straight Hellespont betweene
The Sestos and Abydos of her Breasts . . .
Succeeds a boundless sea . . .
And sailing toward her India, in that way
Shall at her fair Atlantic Navell stay . . . '.

As shown on Greek vases and engraved stones, the first sailors who navigated on slow-flowing rivers or crossed sea distances between islands used small boats made of inflated skins. The Latin name of these ancient craft was *utricularia* (from *utriculus,* diminutive form of *uter* [bag]) and the mariners who sailed them were called *utriculares.* They were the forerunners of today's frogmen. The inner experience of these modern *utriculares,* engaged in underwater exploration, has been compared by one of them, the learned French *plongeur,* Philippe Diolé, with 'the dream that memory distorts . . . a glamor which nothing else can equal'. In another passage he quotes Charles Maurois: 'Life in the bosom of the waters remains linked with the memory of lost happiness'.

How then is the lost happiness regained and the unreachable mother found? In certain cases, I submit, this is done via the river, that is, via the sister and an attempt to explore her. It is true that the river is an object of exploration per se, but at the same time the river is also an avenue *for* exploration which leads to the mysterious abode from whence come both brother and sister, mother's inside. One factor in the unconscious river-sister equation certainly is that the exploratory desires of the little

boy, ultimately aimed at the mother, can be more easily gratified, in fantasy at least, with the more readily available sister. Another aspect of the river symbol, based on the unconscious meaning of water, is birth. The patient who dreamed about the Hudson River and its smaller tributary[8] described in a later session the great impact of such an event, when his mother gave birth to the younger sister at home. With intense emotional participation he told of streams of water and blood, wild cries, soaked linen, wet floors, and various women surrounding the bed on which his mother lay weeping. Amidst all the excitement, he related, one of the women caught sight of him as he was crawling in terror toward the maternal bed. The woman, perhaps the midwife, raised her hand and shouted at him: 'Get out!' He quickly ran or crawled out of the room. Whether this was an actual experience or a fantasy, could not be fully determined in analysis. At any rate, the patient dated his lifelong resentment toward the mother from this event and the double maternal expulsion, as he termed it—the arrival of the sister and the imperative command addressed to him, 'get out'. It is likely that behind all this lay also an expulsion fantasy concerning his own birth.

The mappaemundi, with their rich pictorializations and strange legends, can be understood as magic revelations of the site of the mother by indicating the location of paradise, isles of bliss, and other places of happiness, as well as the stark perils threatening the explorer who daringly sets out to win this 'treasure of treasures'. It is essential to note that there exists, in addition to those described, another set of medieval charts not yet mentioned, the so-called *portolani*. These were more realistic maps which throughout the Middle Ages coexisted with the mappaemundi, and in contrast to them showed rather accurate outlines of the seacoasts, countries, and trade routes. The *portolani* were used by seamen as practical guides for navigation. The simultaneous existence of two sets of maps, one filled with fantasied and the other with factual geographic data, appears to

[8] See Part I of this paper. This QUARTERLY, XXV, 1956, pp. 483-485.

correspond to a split in the approach to geographic problems[9] comparable to the primary and secondary processes. In other words, in one case it is geography we deal with; in the other it is anatomy under the guise of geography.

In fact, the whole idea of the *alter orbis* as a place of unmentionable doings, unheard-of terrors, and indescribable experiences of bliss probably represents such a primary process fantasy on a gigantic scale. It seems to me that we are witnessing today a revival of the idea of the *alter orbis*—with the only difference that the *mare tenebrosum* has been projected into the dark spaces outside the earth, with spaceships taking the place of caravels and interplanetary travels substituting for journeys to Paradise and Isles of Bliss. The mother has moved from her earthly dwellings. Now she hovers in the outer spaces[10]—or, in the case of underwater exploration, in the hidden deep—where she is as eagerly sought today as she was in the days of old, across the seas. In the mythology of the twentieth century, it is true, the legendary river woman who comes out of the water and vanishes into it, has been partly superseded by 'flying saucers' which mysteriously appear and disappear in the sky, and similar fantasies. The aquatic realm has expanded into a celestial one where the elusive female continues to reign, as alluring as ever and, in the words of the great explorer, 'closest and nearest to heaven'.

[9] Tooley *(71)*, who divides medieval maps into 'symbolic-theoretical' (mappaemundi) and 'practical-nautical' (*portolani*), correctly observes: 'It is unwise to assume that medieval scholars were as ignorant as their maps would imply . . . '.

[10] The sexual meaning of space exploration was expressed by a woman patient who, coming to her analytic hour from a gynecological examination, referred to the gynecologist's manual exploration of her genitals as 'a journey into space'.

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THE PSYCHOANALYTIC DIAGNOSTIC INTERVIEW

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Psychoanalytic treatment is much more than a process of repeated sessions of free association and interpretation. It is less analogous to such a hydrotherapeutic procedure as daily immersion of a limb for a certain period in water of a certain temperature and swirling at a certain rate, than it is to major surgery in which the pathology must be thoroughly understood and skilfully corrected without damage. As Freud said, it is 'after-education of the neurotic; it can correct blunders for which his parental education was to blame' *(10,* p. 67*)*. Psychoanalytic treatment cannot be carried out intelligently and with full comprehension unless the analyst first penetrates diagnostically to the main issues, the major parental blunders, and other major traumatic influences, and the main effects of these. If he does not succeed in discerning the main issues, the central emotional forces that need correction, preferably in the very first interview, or in the first few interviews, he may find himself beginning an analysis without knowing exactly what he is trying to correct,—a situation as potentially dangerous as that of a surgeon not knowing clearly what he is doing. To master the psychoanalytic technique and achieve results rationally and scientifically, the analyst must first be able to diagnose the central dynamic structure of the problem, what is wrong, and what he seeks to correct.

In the earlier days of psychoanalysis, it seems, relatively little attention was paid to the initial history and to rapid diagnostic penetration to the central dynamics. In certain instances there

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was quick initial determination only of whether the patient seemed to have a neurotic problem, was not psychotic, and was suitable for a trial psychoanalysis. Very often a psychiatrist without any psychoanalytic training actually learned much more about the patient in one hour than did an analyst in many weeks. Even today there is need for increasing appreciation of the necessity for thorough and accurate psychodynamic understanding of every patient in the first diagnostic hours—instinctually, structurally, and in relation to the strength and functioning of the ego, and to the entire life of the patient. Some systematizations have already appeared in print *(12)*. This paper contains certain points that I believe have not been discussed before.

It is convenient to divide into three parts the written history, which is intended to give understanding of the central dynamics of the patient's character in a single interview, if possible. Depending upon the kind of patient, the purpose of the interview and the circumstances, more time may be necessary or advisable. The three parts of the history are A, anamnestic data; B, conscious emotional attitudes; C, unconscious associative data. These parts are not sharply differentiated; the division is for convenience. Sometimes, perhaps, it is simpler to consider the history in only two aspects—the anamnestic and the associative. Supplementary information may also prove useful.

The interviewer is attempting throughout the interview to 'read' the material and penetrate to the essential underlying motivations as rapidly and surely as possible. He seeks insight into the core of the dynamic forces and the historic connections. He must penetrate to the major current motivations and must understand these in terms of the early conditionings. The most effective therapy will depend upon seeing how the patient's life is dominated by disordered patterns of childhood, for this is the essence of neurosis. A bird's-eye view, a clear perspective of the causal forces should be gained in the very first interview. It is usually exceedingly difficult to obtain once treatment is under way, and may not emerge sharply until after the end of the analysis.

I. *Data obtained from interviewing the patient.*

A. Anamnestic data. This includes the patient's description of the main facts of his life, past and present.

1. We examine the patient's reasons for seeking help, his current life, his chief interests, and his libidinal investments. The interviewer tries to construct a picture of the patient's current behavior, motivations, and emotions.

The patient lives in a real world. A thorough grasp of each patient's current real situation is usually vital for understanding the patient's basic dynamics and his present emotional problem as these interact with his environment. Each patient's situation is in part a result of the ways in which his personality functions and a source of pressures and stimuli to which the patient reacts in accordance with his character. Is it a middle-aged woman with two small children and a sadistic elderly husband who refuses divorce? Is it a person of great wealth? Or one in dire poverty? Or someone struggling under an unshiftable load? Is there a physical handicap? How are his immediate emotional problems and the structure of his character related to such realities and,—for later in the history taking,—what are his external and internal resources and flexibilities and other potentialities for handling these realities of his life?

Are his human relationships good, bad, few, many, close, gratifying, frustrating; of what sort are these relationships with men, women, peers, older or younger persons? 'For all practical purposes in judging human character, a man's actions and conscious expression of thought are in most cases sufficient' *(6,* p. 570*)*.

The history must determine how much of his problem is internal and how much reactive to his environment, even though he may be largely responsible for creating this environment or finding himself in it. The basic principle is to recognize that the patient can only be understood as an individual human being, with his total personality, id, ego, and superego operating and interacting with his environment *(5,* pp. 1-3*)*. That is, he must be understood in terms of all his motivations, of his total psychodynamics. And the interviewer must value him and feel for him mature responsible interest as a person; he is not a depersonalized psyche and may well be superior in many ways to the interviewer to whom he

comes for help. He comes as a patient, but as A. A. Brill often said, 'We are all patients'.

2. The patient's habits, which are part of his current life, should be reviewed; usually it is well to try to get a picture of a typical day of twenty-four hours.

3. The analyst is next, of course, interested in the development of the patient's complaints and symptoms, the circumstances of their onset, and their course, and why he comes to the psychiatrist at precisely this time. The circumstances of onset are usually best discovered without directly asking the patient, who rarely can describe them and, if asked about them, often tends not to divulge them. It is usually more effective to question him about the date and manner of the onset of the symptoms and then later, without reference to this, find out as part of the history what was going on in his emotional life at that time. The circumstances surrounding the onset of symptoms may reveal the specific emotional vulnerabilities which, under pressure, led to the emotional problem *(15)*.

4. The interviewer can then trace back the patient's history to his emotional relationships within his family in earliest childhood; or else, as is usually more convenient, jump back to these and then trace his history from childhood to the present. The relationships are conveniently divided into those of the very earliest years, from birth until three, four, or five (for by five the basic personality is established); then from about five until ten, the latency period; and thereafter, during adolescence and maturity. Naturally, it is most difficult to learn the outstanding relationships prior to about five, the most important period, for this is usually before development of continuous memory. Yet something can usually be learned by asking about the patient's 'feeling' or 'sense' or guess as to what the major emotions were in the family, especially in relation to himself during this period. It is usually well to ask for the specific feelings of each person of the family toward the patient and of the patient to each of them during these earliest years.

In all relationships one must watch for the elements of identification and object relationship. For example, a child may identify itself with its father and unconsciously behave like him; and may also be dependent upon him.

It is well also to learn as much as possible about the emotional and physical conditions of the patient's parents during the period from just before his conception to birth, even though we do not as yet know much about how to choose and use this information precisely.

During the first five years of life the basic pattern of our emotional reactions, the core of our motivations, is formed. Therefore we must know something of the emotions in and about the child during that time if we would understand the central features of its character, its strength and weaknesses, and if we would plan treatment and offer a prognosis. If the patient had no satisfactory relationships during childhood he is not likely to be able to see the analyst or others as good imagoes and the prognosis is not good; for the analyst, instead of beginning as a good imago and analyzing out the bad features, must build a good imago almost from nothing. Hence an evaluation of the patient's imagoes is of great significance for prognosis.

The effects of the early emotional influences depend upon their intensity, consistency, duration, relation to age (usually the earlier, the greater the effect), and relation to vulnerable points in the libidinal development. The central symptoms may be a guide to the degree of development; disturbances of sexual function, for example, in an otherwise healthy personality suggest adequate development to the œdipal period, while schizophrenic symptoms strongly suggest traumatic influences much earlier in life.

The patient's attitudes in describing the earliest years, his 'feeling' about the period he cannot even remember, are a guide to whether that time was pleasant or unpleasant.

5. A medical history is necessary and revealing. Enough is now known about many symptoms, both physical and psychological, for a symptom itself to be suggestive of some aspect of the character. A thorough medical history is also a safeguard for the psychiatrist and is essential for every patient.

B. The conscious attitudes are learned by careful questioning; the analyst, instead of passively waiting while the patient plunges into free association, can learn many essentials of attitude and feelings by simply asking.

1. We are interested in his feelings about others, especially individuals important for him emotionally, and about himself, now and during his early years. An ounce of feeling is worth many pounds of historic facts.

2. It is especially important to ask the patient for his opinion and understanding of himself and his complaints. Even the least self-observant person can tell the interviewer valuable observations about himself.

3. Also illuminating is the patient's view of the future, his expectations, ambitions, fears, and the like.

4. The usual examination of the mental status employed with psychotic or near-psychotic patients is not practicable with most of the patients seen in the office or clinic, who are likely to be neurotic. Nevertheless, it is well always to have it in mind and to adapt it as needed.

5. Since the analyst works with the major motivational forces in the patient, it is important to include these in the history. This must be done with care, skill, consideration, and tact. The patient will be fully aware of certain of these emotional forces and of their operation. Of others he will have but a glimmering awareness; and of still others, and of the processes connected with them, he will be unconscious. The therapist should form an idea of all this during the taking of the history and not wait many hours to learn what the patient could have told in the first interview.

In reviewing these major forces one may follow Freud's original 'horizontal' description of libidinal levels, or one may think of these forces as Freud did later when he wrote that they 'persist side by side with, and behind, later organizations and obtain permanent representation in the economy of the libido and in the character of the individual' *(9,* p. 137*)*. Such a presentation of the major forces in the mind has been attempted by a systematic evaluation of the major dynamic mechanisms of each of a series of analysands over a period of ten years *(15)*. The forces so observed correspond with the libidinal levels but, following Freud's statement, are presented 'side by side', the presence of one drive not excluding another. It is probably a matter of personal choice which method

is used when the history is taken. The important thing is to cover each major motivation explicitly:

a. A sexual history has no doubt been taken by every analyst since Freud made his first observation of the importance of sexuality.

b. One great force which underlies neurosis is dependence; and it is to the long years of dependence upon the parents that Freud repeatedly attributed the human propensity to emotional disorders *(10,* pp. 16, 85, 88*)*. Hence the history should cover as explicitly as seems indicated the interplay between the forces toward dependence and those toward independence.

c. The same applies to the patient's needs for love and to his receptivity and demands, as opposed to his capacity for giving energy, love, interest, and sympathetic understanding to others.

d. Also vital are feelings of inferiority and their sources, and egotism, narcissism, and competitiveness toward parents and siblings and their representatives.

e. The superego can also usually be tactfully explored: the kind of training and how the patient adapted himself to it, the state of shame and guilt, and the kinds of imagoes the patient has. This is of immeasurable importance for the prediction of the course of the transference and the success of treatment.

f. That the hostile motivations are as important as the libidinal was recognized by Freud in his later publications *(8)*. The history of hostility is as indispensable as the various aspects of the libidinal history. Asking the patient about his temper, his anger, his resentments from earliest childhood to the present time, usually brings out highly significant information. Freud's classification of drives and impulses as erotic and destructive is eminently useful in taking histories and in evaluating clinical data.

g. Mechanisms of flight, including regressive trends, should be explored. Hostility is one direction, flight the other, of one of the basic biological reactions for meeting life, the fight-flight response. Psychological flight takes many forms, the best known analytically being regression to earlier, more or less 'fixated' patterns. (This inquiry will overlap somewhat with others.)

h. For neurotic symptoms to be present, the nuclear emotional pattern must have been warped to some extent by injuri-

ous influences during childhood. We seek the nature of these traumatic influences and their effects upon the core of the patient's personality. For the success of analytic treatment will depend very largely upon understanding these injurious influences and their effects, since the essence of psychoanalytic treatment lies, as expressed by Freud, in this: 'If the patient puts the analyst in the place of his father (or mother), he is also giving him the power which his superego exercises over his ego, since his parents were, as we know, the origin of his superego. The new superego now has an opportunity for a sort of *after-education* of the neurotic; it can correct blunders for which his parental education was to blame' *(10,* p. 67*)*.

Alexander has called this after-education the 'corrective emotional experience'. It is actually a matter of 'deconditioning and reconditioning'. The treatment cannot be accurately aimed and conducted unless the early traumatic influences and their effects are understood, in the first interview if possible, and so far as feasible discussed with the patient.

The motivational forces listed above, which are to be examined in the history, are not all on the same level, as was pointed out, and are not discrete, nor even all strictly comparable; but they are empirically derived and include it seems the major motivations of the personality. How closely each can be examined in these first hours depends on the patient and on the skill, judgment, and tact of the interviewer. But they should be in his mind and not neglected in taking the initial history. Nor is it correct to suppose that all will have become known by the hundredth or two hundredth hour. The perspective obtainable in the first interview, if once missed, is never again as clearly attainable, once the patient and the analyst are involved in treatment and are reacting to it.

i. Throughout the taking of the history the interviewer does well to notice explicitly the ego functions, the relation of the ego to the forces of id and superego, its sensitivity, its most prominent defense mechanisms, its grasp of reality, its æsthetic and intellectual capacities, and its judgment, will, and strength.

6. Favorable characteristics of the patient are important. Psychoanalysis developed, as Freud stated, from a study of symptoms. It has progressed from study of the repressed to understanding

also of the repressing forces; through study of the pathological, it has begun to learn the nature of the healthy *(15)*. If we are to establish a prognosis and goals and methods of treatment, we must understand the patient's favorable characteristics as well as his weaknesses. Such understanding may, for example, convince us that we shall do best to subject an artist to limited analysis only and to leave untouched those forces that do not interfere with his art but rather are the well-springs of it. Moreover, some analysts are a little condescending in tone with their patients; this attitude, which ignores the patient's good qualities, can only impair analytic understanding and treatment. Dostoievski, an epileptic and gambler, with a disordered family life, had superior potentialities *(7)*. No matter how deep the analyst may go in understanding and treatment, he will not do a proper job if he does not evaluate quickly and accurately the ego in all its functions, the total personality,—its resources as well as its problems,—as it interacts with other persons and with the environment.

C. In collecting the *unconscious associative* material, we make use of much that has been learned before, including everything that can provide us with insight. It also includes at least the following:

1. Memories.
   a. Earliest memories, the very first and one or more others if possible. These are most revealing since the adult personality retains just those that fit it, distorting them if need be *(16)*.
   b. The earliest content of continuous memory.

2. Dreams *(17)*.
   a. The first and other dreams of early childhood.
   b. Repetitive dreams in childhood and later.
   c. Dreams that have occurred often in the past and today.
   d. Some recent dreams.
   e. The dreams of the night before the interview and of the night after the appointment was made are usually revelatory of the patient's whole attitude toward his illness and toward treatment and the therapist.

3. Conscious fantasies and daydreams—in childhood and today —and repetitive ones.

Of course, it is not always possible to get these data in the first interview and some of them, such as fantasies, the patient may be wary of revealing at once. Success frequently rewards gentle persistence and repetition of the request later in the interview.

4. The patient's facial expression, voice, mode of dress, posture, carriage, mannerisms, and the like, are nonverbal clues which should not be missed by the analyst when taking the history.

5. Transference. In the data supplied by the patient we listen for indications of how the transference will develop and of the patient's attitudes, conscious and unconscious, toward the analyst from the very beginning of the interview; these clues help us to understand his current motivations. For example, one patient evidently uses the first diagnostic interview as a confessional and plea for relief from his feelings of guilt; another, with very strong dependent needs, makes termination of the interview difficult because of his intense wish to prolong it. Each patient reacts characteristically.

6. Everything the patient says can also be reviewed as though it were produced like free associations. Of course, it is not adequate associative material because it is not 'free' but comes in response to specific questions by the interviewer. Nevertheless, the answers are in part associations to the questions and often contain passages which, treated as associations, are revealing. It is therefore well to watch for indications for letting the patient ramble a bit at times during the interview.

7. The countertransference is usually an excellent guide in understanding the patient. For example, the analyst may sense within himself feelings which he considers to be inappropriately strong and this reaction is a clue to the motivations in the patient that evoke them. Things may look well but the analyst may feel anxious; or they may look alarming but the analyst feels easy about them. These are all useful accessory guides.

II. *Noninterview material; supplementary data.*

Supplementary data not gathered from the interviews is becoming increasingly important as analysts undertake the treatment of more seriously disturbed patients,—patients who twenty

years ago would have been promptly sent to institutions. We must understand such a patient's relation to his environment. Two special sources are available to us when we are concerned with these disturbed patients or with certain other types.

A. The center of attention in analytic therapy is rightly the patient himself, but there is in some cases great advantage in meeting the patient's relatives. Seeing the patient's spouse often does not hinder treatment but is useful; it is often especially necessary to consider the relatives when treating children and adolescents and postadolescents such as college students. Young people of this age are not usually earning money and cannot pay for treatment. Moreover, their parents still have a strong interest in them as children and the students are in reality not yet living independently. It is sometimes beneficial to such a person for the analyst to meet one or both parents. The parents then do not feel that they are being pushed out, that their child is now confiding only in the psychiatrist while the parent merely pays the bills. This may also help to relieve anxiety, guilt, and shame in the patient for being in treatment.

B. Data supplied by social case workers can be very useful.

C. Psychological tests such as the Rorschach and Thematic Apperception Test are used for supplementary insight by many analysts. The patient's degree of intelligence is usually evident from the history, but special tests of intelligence, ability to read, or other functions may be indicated.

This guide for the psychoanalytic diagnostic interview is chiefly useful in helping the interviewer to keep clearly in mind the essential points to be covered. How it is used is a matter of the analyst's knowledge, experience, skill, and art, and is also a matter of tact. If the patient is antagonized or does not have confidence in the psychoanalyst, the task of understanding the patient rapidly becomes very difficult. The art of interviewing lies in making the interview not frightening to the patient, in making him feel that he is not forced to reveal anything, in not

offending him but rather in giving him a sense of the therapist's sympathy, accurate understanding, and potential helpfulness. Only if the physician actually has these feelings and capacities can he convey them to the patient. What the data he obtains mean to the interviewer, what use he can make of them, depends upon his capacity for penetrating, precise, professional understanding.

The great goal is to try to understand the essential dynamics of the personality in one single interview, if possible *(1)*; or if not in one interview then in as few as possible. In the author's experience of twenty-five years, the dynamics as understood in the first or first few interviews are usually borne out by the long analysis. In the full analysis, many more facts appear, new light is shed on many areas, and quantitative differences in emphasis and in strength of various emotional forces may appear. It is rewarding to make these initial formulations in every case, then to repeat them after perhaps six months of analytic work and again a year or more after treatment has ended. At these times the reformulation can usually be done in discussion with the patient.

The better the patient is understood at the outset, the more does the analyst, and the patient too, work in the light and with a perspective hard to achieve once the conflicts of the transference develop. Moreover the first interview usually unfolds like a powerful short story as the various clues accumulate and develop to a climactic revelation of the essential motivations of the personality and of the emotional problem. This burst of insight is usually highly therapeutic for the patient and confirmatory of the analyst's impression; it establishes the interest in analytic treatment; and it provides a kind of illumination and understanding probably attainable in no other way.

SUMMARY

Freud pointed out that psychoanalysis is 'a sort of after-education' able to 'correct blunders for which the parental education

was to blame'. It is intelligible as 'deconditioning' and 'reconditioning' to reopen the emotional development. To master the analytic technique and achieve therapeutic results which are rational and scientifically based, the analyst must be able first to penetrate diagnostically to the major traumatic influences and the effects of these so that he may know from the outset what is wrong and what he purposes to correct. Psychoanalysis is analogous to major surgery.

OUTLINE

A form for taking the psychoanalytic history can be a valuable guide for penetrating quickly (in the first interview, if possible) and surely to the essentials in each patient—his personality with its problems and assets as he functions in his environment. The following points should be included.

I. *Information from the interview.*

A. Anamnestic data.

1. Chief complaints, current life, and emotional involvements.
2. Habits, routine, a typical day.
3. Onset and course of complaints and symptoms.
4. Significant interrelationships at various ages in childhood; history of period from conception to birth.
5. Medical history including symptoms, psychological and physical.

B. Conscious attitudes.

1. Toward others, past (especially during earliest years), and present.
2. Patient's attitudes toward and understanding of himself, his symptoms, and his problems.
3. View of the future; his expectations and ambitions.
4. Conventional examination of mental status, if indicated modified as advisable.
5. Major forces in the personality.
   a. Psychosexual.
   b. Dependence and independence.
   c. Needs for love and object interest.

d. Feelings of inferiority, egotism, narcissism, competitiveness toward members of family and toward representatives of parents and other relatives.

e. Superego imagoes; shame and guilt.

f. Hostility.

g. Mechanisms of flight, including regressive trends.

h. The nuclear emotions, the childhood motivational pattern at the core of the personality (a fundamental which the interviewer is trying to understand).

i. Ego functions and interrelations with id and superego, grasp of reality, prominent defense mechanisms, æsthetic and intellectual capacities, judgment, will, and strength.

6. Favorable characteristics: an understanding of the patient's assets, capacities, talents, and potentialities.

C. Unconscious associative material.

1. Memories.

a. Earliest.

b. First part of continuous memory.

2. Dreams.

a. From earliest childhood.

b. Repetitive, in childhood and later.

c. Common types of dreams throughout life and currently.

d. Some current dreams.

e. Dreams of the night preceding the interview and of the night just after the appointment was made.

3. Conscious fantasies and day dreams,—past, present, and long-continued ones.

4. Nonverbal, such as facial expression, mode of dress, and mannerisms.

5. Transference.

6. Tendency and themes of interview (treated as if it were free association).

7. Countertransference.

II. *Information from other sources (as required and if not contra-indicated).*

A. Interviews with relatives and others.

B. Information from social caseworkers.

C. Psychological tests.

The analyst will find it rewarding to make formulations of the most essential dynamics in writing, after the first interviews, and to do so again at intervals of about six months or a year while treatment continues, and again about two years after treatment.

The better the patient is understood at the outset, the more is his wish for analytic therapy strengthened and the more rational is the treatment.

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A NOTE ON THE SIGNIFICANCE OF NAMES

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The names of individuals play an important role in the organization of their ego defense patterns and are cathected and utilized from the point of view of ego defenses in a manner similar to an organ or body part. As a person becomes conscious of his or her name as a part of the self between one and two years of age, the fantasies and *Gestalten* formed around a name and its variations throughout the years will always tend to be intimately bound up with the vicissitudes in the development of the ego. With some, the name may become a part of the core of a severe neurosis. The degree of pathological disturbance varies from exaggerated pride or exaggerated shame over one's name, commonly encountered among adolescents, to extremes of psychotic proportions.

Freud *(6)* was well aware of the importance of names and discussed mechanisms and causes of forgetting names, which consciously or unconsciously have unpleasant or other associations, and the distortion or falsification of names. In Totem and Taboo *(7)* he mentions that compulsive-obsessional and other neurotics, like savages, 'show a high degree of "complexive sensitiveness" in regard to uttering or hearing particular words and names; and their attitude toward their own names imposes numerous and often serious inhibitions upon them'. He notes that 'in the view of primitive man one of the most important parts of a person is his name'. Freud was inclined to believe that, unlike primitive man, we regard names 'indifferently'. Ernest Jones *(8)* has also discussed the significance of forgetting names which have unpleasant associations. In a discussion of the development of the love life of the individual, J. C. Flugel *(5)*

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states that 'names are apt to play an important but subtle part and one that is very liable to be overlooked or, where observed, ascribed to coincidences rather than (as it more often should be) to the operation of unconscious mental factors'. He cites a number of examples of people who repeatedly fell in love with others because of their names. Oberndorf *(10)* cites many interesting examples of the unconscious factors influencing a change of names, and illustrates an author's use of substitute names to evade the problem of recognition which plagued Stekel *(12)* when he wrote a lengthy paper on the influence of names on their bearers. According to Jones *(9)* Stekel's study did not appeal to Freud whose relations with Stekel at the time were somewhat strained. Abraham *(1)* has also discussed the influence of names upon the destiny of an individual in relation to the choice of his career. Silberer *(11)* has also touched on this subject. Oberndorf *(10)* also concerned himself with the 'unconscious feelings on the part of the individual bearing a name that in some way reveals an inherent weakness in personality which the individual wishes to conceal'. Ingeborg Flugel *(4)* has called attention to the possible unconscious influence of names on conduct, character, choice of profession, and choice of love object, and cited many examples from history and literature where apparently the love object was chosen repeatedly on the basis of a name.

There are many facets to a person's name which deserve to be mentioned and each has its own set of problems. One can focus on the given name, the middle given name or names, and the surname. Those with more than one middle name or no middle name may have their own special problems. In any case, conscious attitudes and unconscious fantasies connected with all or any part of one's name are many. Then there are nicknames which are frequently of great historical import. These may be derived from either the first, the middle, or the family name. The unwanted middle name is a common problem, contrasting with the individual who uses his second or middle name preceded by the initial of his first given name. Many names so

omitted are regarded by their bearers as 'queer' with any of the various implications of this word. Persons with three or more given names have a greater choice of selective emphasis or omission. The preference for the 'hidden' maiden name of the mother may assume great unconscious importance. The retention of the husband's name or the preference for keeping the maiden name should be assessed clinically among women who have professions or are divorced. The choice of adopting the name of a stepfather following the loss of the father is often charged with conflict. The overdetermination of aliases and noms de plume must be considered as instances in which the name serves as a focus of fixation to a narcissistic ideal.

This is a report of the reaction of patients either in analysis or in 'sector therapy' *(2, 3)* to their names. Many of the instances were reported to me by colleagues over a period of ten years. The family names and some of the given names used as examples are altered to illustrate the clinical material without disclosing the identity of the persons.

The given or first name is of primary importance and as a rule is recognized as a part of oneself long before the family name is known. It is the name most subject to abbreviation, condensation, or distortion as nicknames. Multiple nicknames may lead to confusion and perplexity in acting out various identifications. A simple example is expressed in a nursery rhyme: Mother calls me William;/ Auntie calls me Will;/ Sister calls me Willie,/ But Dad calls me Bill!

The preference for identification with the father is here implicit. This is, however, not always the rule. A nineteen-year-old Jewish college student named Bernard was called Bernie by a cold and aggressive, financier father, and Ben by his doting, artistic mother who was somewhat anti-Semitic, and who ultimately persuaded the father to change the family name from one that was obviously Jewish to one the patient jokingly referred to as 'synthetic Scotch'. Throughout his life and his career, which included elements of both art and engineering, he wavered between the choice of one of these nicknames as he

wavered in his identification with, and allegiance to each of his parents. Throughout his analysis, this patient suffered from obsessive indecision over which name he should use. Bernie appeared to him to be a better 'balance' to the 'short, Scotch' name, but was too Jewish. Ben 'fitted' the Jewish name better but sounded 'dishonest'. A dishonest person was one who was 'weak' and 'queer' and succumbed easily to temptations. In either case he longed to restore 'harmony' to the household by uniting the Jewish father and the pseudo-Gentile, dishonest mother, but found that he enjoyed playing one off against the other, with great feelings of guilt which were, for the most part, unconscious.

As stated, a second given name may be discarded, adopted, or changed permanently to an initial. When the first name of a child is the same as that of the parent, the middle name may be used to emphasize his individuality. A twenty-six-year-old medical student, following the death of his father, Charles Paul Smith, changed his name from C. Phillip Smith to Charles P. Smith. This act was followed by increasing depression and difficulty with his studies, which culminated in a spell of severe anxiety about getting his degree. As might be expected, the associative material revolved about phallic competitive and aggressive feelings between him and his father. A twenty-eight-year-old nurse, whom I shall call Ella Johnson McCoy, was irritated by anyone who addressed her as Ella for, according to her, she was from a southern state and accustomed to being addressed as Ella-Johnson. This trifle owed its importance to the fact that her father's name was John and this was of significance in her need for therapy which devolved upon her sense of inadequacy in relation to her brother—not being John's son. A college student from Maine, who was treated for an inability to study and a facial tic, always combined his middle name with his family name because the former was the name of a famous old Yankee family in his dead mother's ancestry. None of the current generation of three brothers, the father, nor the patient himself had much to brag about in the way of attainment. He depended

upon the magic of his middle name to open all doors for him as an adult, just as he had depended upon his mother to dress him until the age of six, and he was always amazed and furious when this magic symbol failed. It is of interest that during treatment he dropped the use of his mother's maiden name before he became conscious of its import. In this instance the name served somewhat the function of a transitional object and allowed him to retain a relationship with his mother and deny her loss, as well as protect his narcissistic needs.

The use of the name as an indicator of changing concepts of the self is common. I am indebted to a colleague for the following example. A female physician, whose maiden name was Florence Smith, was at the time of her marriage an unattractive woman who used no cosmetics, wore shoes with flat heels, black cotton stockings, and poorly tailored suits. After her marriage she added her husband's name and became Florence Smith Harvey. She then began to wear gay, feminine clothes, high heels, and 'make-up', and became F. Smith Harvey. Ten years later she was 'super-feminine' with platform soles and ankle straps on her shoes, bouffant skirts, and bedecked with jewelry including rhinestones in her 'bobby pins'.

The hidden name or maiden name of the mother can be a strong influence in the fantasies of a patient. An analysand, whose mother's maiden name was White, fell in love with a girl name Wyatt at the time they were introduced, and he was inconsolable when she rejected him. He completely repressed any recognition of the similarity between the two names until early in his analysis, which he entered with the chief complaints of masturbation and depression. His penis, it transpired, served as a narcissistic phallic representation of, and substitute for the mother. As a child he masturbated using cold cream, with the fantasy this would make his penis so 'white' and clean that a beautiful girl would fall in love with him (or it) at first sight. Another college student, whom I shall call Swift, changed his name to Jones when he failed in Latin in high school, and back to Swift when he entered college. Swift was the name of his

doctor-father who died just before the patient's birth. In one of the patient's fantasies, Dr. Swift was a famous and beloved medical genius, adored by his mother, a graduate of high school at fourteen who took prizes in Latin and Greek. Jones was the name of his stepfather, an ordinary high school teacher, who was mean to his mother and considered the boy a 'spoiled brat'. The boy's failure in Latin and changing his name marked the onset of a flight into an appendectomy, the renunciation of the goal of being a medical genius like father, and an attempt to ingratiate himself with the stepfather. His unexpected acceptance by a university of renown enabled him to resume his ambition and the fantasies associated with his father's name.

Individual reactions to family names are in some ways the most interesting of all. Some names are inferentially a part of the initial complaints of a patient. These could be classified as symptomatic, descriptive names. McCold was affected by a blanching and coldness of his extremities diagnosed as a mild form of a spastic vasomotor disturbance, which became associated with depressive feelings and difficulty in establishing 'warm', personal relationships. This sympton developed when he returned from army service overseas and began to live with a wife whom he had married when he was about to go abroad. He was proud of his powers of detachment which enabled him to keep 'calm, cool, and collected'. A 'cold', aloof, and studied ego ideal was a façade for a passionate hatred of his father's indifference and a longing for a 'warm' and intimate relationship with him. Words expressive of degrees of temperature were of surprising frequency in his recorded interviews, and his medical record was replete with colds. A patient, Paine, suffered from neuralgic pains and aches over a number of years, beginning at puberty and culminating in a severe sciatica of undetermined etiology at twenty-eight. He complained also of joint and head pains, and eventually of beatings by a cruel stepmother. Both patients were quite sensitive to the implications of their names, the former in a positive sense, the latter in a negative one. The patient may at first regard these significances as a play on words

by the therapist. Investigation shows that these significances are frequently complex.

A more directly revealing case is that of a young college man whose name was Stankey. He complained that axillary sweating was responsible for his many social difficulties. An associative anamnesis revealed a lifetime sensitivity to odors, a grammar school nickname of 'Stinky', and the presence of many compulsive and obsessional traits of character, including complex toilet rituals. When he was a child, his schoolmates mocked his name by holding their noses. His name not only served to augment and become interwoven with compulsive character traits but led to his developing a rigid aloofness from his friends in the latency period, and seriously affected his family relationships. The mother and father were both compulsive and phobic in their attitudes toward odors of any kind. The mother persistently belittled the father's name. She carried a large supply of paper tissues in her handbag as she was phobic about public toilets and door knobs. The father was continually preoccupied with odors in the home, the freshness of food in the icebox, and sin on Sundays. The patient and a younger brother used laxatives frequently; a sister alternated between constipation and diarrhea with shifting abdominal pains that had once been diagnosed as chronic mucous colitis. A most vivid memory from his ninth year was of passing flatus while playing chess with his father who reacted with 'black rage', slapped the boy's face and made him remain in the toilet for fifteen minutes. The interesting thing about this case was that the initial denial of the implications of his name was later implemented by facts showing plainly that the effects of what in therapy he called his 'cursed name' were considerable. From the point of view of ego defense mechanisms, he used his name in a manner similar to patients who use racial or religious background to defend themselves against guilt and anxiety over certain aggressive and sexual strivings. Outstanding among these in this case at first was blaming his mother for her 'ridiculous concern' about the family name, and for his toilet habit of anal masturbation 'to break up the fecal masses' and

accomplish a quick evacuation. As might be expected, the central problem in this case was the anally depreciated parental images and the patient's body image. Eventually, by making the father responsible for his name and bad odor, he spared the 'good mother' and himself at the expense of an inability to cope with the bad mother and his own 'bad', anal and passive feminine cravings.

Reaction-formation to a name in an attempt to master its disagreeable significance is frequently accompanied by a suppression or repression of its associative implications. Attitudes of this sort may be either positive or negative; thus, patients Trembly and Shy were aggressive and pugnacious, whereas Queery and Feery were passively oriented. Personal conflict about such names in these cases was only slightly suppressed, but Gurl and Sweet were semiprofessional athletes who vehemently denied any recognition of distasteful memories in association to their names other than occasional fights about them in the early grades of grammar school. Their masculine protests had ostensibly been so vigorous that not only they but their acquaintances had come to attribute no derogatory import to their names.

Apparent good humor and passive acceptance were manifested by some alcoholics with names suggestive of alcoholism, such as Beers and Drinksick, the second being an alcoholic clergyman; however, the associative material revealed deep-seated, oral fears and fantasies of being destined to a malignant fate, the names in these cases representing bad father introjects. Beers drank mostly beer, reacting to his name almost as a command. Drinksick drunkenly defied himself, as well as his overly religious, teetotal mother who, he felt, had despised his father. His maternal identifications were quite apparent and were avoided by his belief that he was like his father who had died shortly after his birth. In a fantasy taken directly from the family name, the father was an alcoholic through the fault of the mother, even though there was admittedly no basis for this assumption.

Two patients who were chronic dipsomaniacs, Boosier and

Mellow, found in their names an excuse for their behavior, which oddly enough was an assumption readily accepted by female members of their households. Unconsciously they equated their names with a defective father-son relationship which, as in the cases previously mentioned, served for a rationalization for a tragic and unalterable destiny. The second of the two in his adolescent days had associated his name with 'fruit' which had for him worse connotations than alcoholism. In these cases it would appear that the name fell within the orbit of the sick ego. Thus, Mellow in his teens feared he was 'fruity' (homosexual), and later a 'weak alcoholic'. He remembered that as a small boy his companions would chase him crying, 'Mellow is yellow'. He first laughed at himself when relating these anecdotes. It was when later he discussed his father as a weak, yellow, passive man who depended upon his wife for a livelihood that he had memories laden with affect. The father stopped drinking when he quit his job and remained at home while mother went out to work when the patient was ten. Before this period father had been a sexually promiscuous alcoholic who flaunted his relations with other women in the presence of the mother and the boy. In the boy's fantasy he competed with these women. In becoming an alcoholic the patient strove unsuccessfully in drinking relationships with men to dispel the threat of passive submission by imitating the masculine, drinking father.

Feelings of inferiority among males are commonly connected with names such as Small, Little, Short, Bent, and examples of similar names are common in out-patient clinics. Patient Bent was worried about his name which was a reproachful reminder of his adolescent masturbatory practices and adult infidelities. From eleven to fourteen he had tried to curb his masturbation by wearing an athletic supporter while sleeping. This had failed to stop his erections but had the result that his erect penis bent downward which was of tremendous concern to him during military service overseas, and was connected with a mild degree of psychosexual impotence. In this case the anxiety was reenforced by a nickname, 'Dinkey', which had been used by his

parents in a 'joking' manner to discourage his infantile masturbation in his nursery school and kindergarten days.

A masturbatory conflict with much guilt was reported by a WAC corporal named Fiddler, who complained of transient episodes of amnesia and great difficulty in remembering names. Underneath her manifest anxiety over the size of her clitoris, which she felt had become hypertrophied and deformed by masturbation, lay her feelings of penis envy and jealousy of her younger brother who could do no wrong in the eyes of their mother. She had repeatedly witnessed her mother cleaning her brother's foreskin and had conceived the idea that this kind of 'fiddling' was responsible for her brother's superior development in practically all spheres. Another WAC, a private named Hogg, with a syndrome diagnosed by an internist as early anorexia nervosa, reacted to her name as an agent of the superego as well as a displacement of genital libido onto eating. During therapy this patient related a joke showing her reaction to her name: a colored man who is being worked to death allows his penis to hang out of his pants and replies to the boss's complaint, 'If I'm gonna be worked like a hoss, I'll act like a hoss!' The patient was an only child. When she was one month old, her mother had developed painful, cracked nipples, and the child was found to be 'allergic' to practically everything except 'milk made from soy beans'. From the ages two to four she had been a feeding problem and had suffered from an exudative dermatosis of the perineum and the inside of her thighs which was prevented from healing by her continual scratching and rubbing. From four to five her feeding difficulties and her skin disorder ceased, and she became an overweight child who rejected her mother and clung to her father who was hypersensitive and overweight. She had been his 'buddy' in spite of the mother's complaint that she looked 'like a pig' up until the age of twelve. By this time the attention of the father could not make up for the loss of her mother and social pressures in school. Her sensitivity to her name at this point was so severe that when she was called 'Miss Hogg' by a teacher who normally called her by her

first name she burst into tears. Shortly after that she went on a diet, became slender, and after a period of good adjustment at home and in school, which lasted until she was fifteen, she then became anorexic and alarmed over her scanty and irregular menses for which she and her mother made numerous visits to a doctor. At seventeen, after her mother had undergone a hysterectomy for multiple tumors, she attempted to join the WAC and was rejected because she was underweight. In one year she gained thirty pounds, enlisted, and made an excellent adjustment for approximately eighteen months when she fell in love with a rather passive boy. Following a courtship consisting mainly of walks and drinking milk shakes together, she 'offered' herself to him sexually only to be rejected as 'too nice for that'. Following this she again became anorexic and developed spells of vomiting which led to her discharge from the service with a diagnosis of conversion hysteria. The sexualized aspects of eating as a defense against chronic depression were apparent.

Appleby jokingly referred to himself as having once been the apple of his mother's eye and he was now the bad apple in the barrel. Querschnitt had a fear existing since grammar school days that someone would pronounce his name 'queer shit'. Drumhell was proud of his name, as to him it belied a reputation he had acquired in his home town for shyness and passivity. A patient, Redman, reported to me by a colleague, was excessively sensitive to the political connotations of his name. This compulsive and mildly paranoid patient when introduced paid great attention to the pronunciation of his name. In addition to the social implications of his name was an interesting anamnestic datum in connection with a former erythrophobia; although no connection was found between them, the name appeared to be associated in both instances with threatening phallic aggression.

Some names, by contrast, are definitely syntonic with the ideal ego. A colleague, Dr. Avery Weisman, has kindly allowed me to use his name as an example. During his life people frequently have called him 'a very wise man'. Patients Braverman and Manley talked calmly and convincingly of their superior will power

and made a show of their imperturbability despite underlying feelings that they could never live up to their reputed qualities. Both patients were proud of their names, delighted in meeting new people and hearing themselves introduced, and used their last names as forms of address for reassurance. Five of six patients with names prefaced by 'Saint' were inclined to feelings of guilt, depression, and unworthiness. An exception, a St. George, was chronically hypomanic, and had as one of his earliest memories an identification with the knight who slew the dragon in Spenser's Faerie Queen.

A common reaction to an embarrassing name is to change its pronunciation. A patient named Hoey carefully accented the first syllable of his name. To himself, he pronounced it as the derogatory slang, 'hooey', a hidden upstart in œdipal rivalry with his father. Frigate pronounced his name with accent on the second syllable as to him his name was a constant reminder of masturbatory, phallic aggressive fantasies.[1] He was not at all conscious of his reason for this pronunciation, and he was teased by a sister to whom the name meant nothing. Patient Doome called himself 'dome' and revealed marked retaliatory fears over the death of a baby sister when he was three years old. In the second year of grammar school, a sensitive teacher continually called a patient Rape, 'rap-pee'. He gradually adopted this pronunciation following the death of his mother two years later and was so insistent about it that his two younger brothers followed his example. A married woman who had phobias about aggression directed against a mother who had never told her about 'sex', and a husband who was 'careless', had four children in the same number of years. She evolved from the first letter of each of their names the word 'luck' (Lucy, Una, Clyde, and Kevin). Behind the manifest feeling, 'I am lucky to have such a fine family', was the doubt, 'What bad luck to be always pregnant'; and behind this there was a great anxiety over her competitive and aggressive relationship with her mother who had had nine children.

[1] 'Frig', an obsolete and dialectic verb meaning 'to wiggle', has become in this country a vulgar expression in slang for sexual intercourse.

The entire family structure was 'loose' in the sense that she believed no one cared for anyone else. Relating the names of her children also served as a magic way of uniting her family. A highly intelligent but psychopathic white college girl came to an out-patient clinic because the college authorities learned that she was having a homosexual affair with an older colored girl. She gave a history of numerous affairs of this type since puberty. The only connecting link in these affairs was the 'queerness' of the patient's first name, her mother's name, and the names of her homosexual partners. The similarity of the oddity of these names was quite as unconscious to her as the nature of her relationship to her mother.

The difficulties of individuals whose names are identical with their fathers' names are in a class of their own. I am indebted to Dr. Joseph Michaels for an illustration from the life of Henry James.[2]

> Throughout his life, Henry volubly protested against the parental failure to let him have a *distinctive* name and (by the same token) an *identity* of his own. He pleaded always with vehemence against the conferring of *juniorhood* upon a 'helpless babe'. He pleaded with brother to cut short the family confusion—William naming his son William, Jr.
>
> He had agreed that the name given to a child 'can affect his whole life', and he could not 'but feel sorry' that William was embarking upon that 'unfortunate *mere* junior'. 'I have a right to speak of that appendage—I carried it about for forty years . . . disliking it all the while, and with my dislike never in the least understood or my state pitied . . .'. The 'interminable career of the tiresome and graceless *Juniors*' clearly could not be arrested in the James family.
>
> As late as 1882, the year of the elder Henry's death, the father and son were being taken for one another since they both wrote and published and on occasions appeared in the same table of contents of the Atlantic Monthly.
>
> Some sons are proud to bear their father's given name and

[2] Edel, Lena: *Henry James, The Untried Years: 1843-1870.* Philadelphia: J. B. Lippincott & Co., 1953, p. 56.

Henry was protesting through no lack of filial devotion. Deeply emotional reasons, as well as practical ones, are reflected in the acute feelings he conveyed in his various appeals. Foremost among these was his struggle in that family of *competing egos,* to find his own *identity.* Henry *alone* had a shared name within the family circle. The very word 'junior' had a diminishing sound, at least to the novelist. His dislike of the 'appendage' is clearly evident in the signature he evolved up to the time of his father's death. Use of the 'Jr.' often caused him to curtail the first name to an initial. At first the 'Jr.' was quite legible and in early days even written out in full. As the years passed, it was finally reduced to an unreadable flourish, over which floated a seemingly inexplicable dot—sole evidence that he intended the small letter j to be there.

The dot and the flourish were dropped upon the death of Henry Sr. and the novelist thereafter wrote his name in full, large letters.

The motives of people who change their names are often extremely complex. Simple names may become elaborate and vice versa; or the new name may be similar to the old. In his communication, Oberndorf *(10)* was particularly concerned with the difficulty of bearing a German name during World War I. A forty-one-year-old single patient signalized relinquishment of his 'hope of marriage' and masculine success by a desire to change his name of Bojuk to 'Ogneg'. He rationalized this by saying Bojuk was too much like 'bohunk', in slang a common term of opprobrium. It developed that Ogneg was a corruption of 'egg nog' which was strongly associated with fantasies of his mother's care of him. Just as the vicissitudes of names parallel those of their owners, so does the usage of aliases and noms de plume reveal the unconscious fantasies of those using them. A young author predominantly phallic and narcissistic, used the pen name, Henry Hunter. He had applied the first name to his genital during his late adolescence as a pet name. The second was a combination of his own last name and that of a lifelong friend with whom he had once developed an ambivalent homosexual relationship. Following the death of this man, he had attempted

to revive him by writing stories whose heroes were an idealized version of this friend. A lack of success in this field plunged him into a deep depression, associated with marked castration anxiety phobically focused on the same disease which had caused his friend's death. This led him to abandon his writing and the nom de plume to which much of the anxiety was attached.

First names appear to be closely associated with the ego and become highly cathected during the preœdipal period. Family names develop importance during the formation of the superego, especially during the œdipal period. Fantasies associated with family names during this period are commonly repressed with other facets of the œdipus complex. They reappear during puberty when adolescent social relationships revive the œdipus and family rivalries. Marriage may arouse problems concerning the use and the forgetting of names especially among women who have surrendered their names. The choice made by divorcees of resuming their maiden names or retaining their former husbands' names is often worthy of note. The birth of children sometimes has the effect of evoking conflicts concerning the choice of names.

SUMMARY

The significance of names in the organization of the ego defense patterns is discussed and illustrated. Given names, surnames, nicknames, and assumed names have numerous important significances in the development of individuals, and often give clues to their attitudes toward themselves and others with whom they have been closely associated. In some instances they appear to have an initially pathogenic influence.

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Susanna S. Haigh 1893–1956

Phyllis Greenacre

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SUSANNA S. HAIGH

1893-1956

The death of Dr. Susanna Haigh Hardy on November 7th brought intense sadness to all who knew her. It occurred three days after an attack of coronary thrombosis from which it was hoped she was recovering, and at a time in her life when she seemed to be on the brink of a renewal of her life and interests. There was a relief, however, in the knowledge that death came suddenly, for she had suffered deeply through the prolonged illness, which in April 1954 caused the death of her husband, Dr. Le Grand H. Hardy, one of our leading ophthalmologists. During the last four years her own health had been less certain and she had restricted her activities in an attempt to conserve her energies. It had been the hope of her friends that this care would carry her through the coming years and still permit her the fulfilment of some of the plans she had cherished for a long time, but had been able to realize only incompletely.

Sue Hardy loved life and appreciated its textures in a richness and a range of interests beyond those of most of us. As an analyst she showed a rare sensitivity and skill, great fidelity to her patients, unswerving integrity in her principles, and both courage and clearheadedness in her work in The New York Psychoanalytic Institute. Soft spoken and rather retiring, she possessed also determination and a capacity for deep conviction.

The wealth of her reading and of her knowledge, especially of history and literature of our own and many other countries, gave a depth and variety, as well as great charm, to discussions with her. Then there were unexpected enthusiasms,—for fine needlework, for dogs, for gardening, for the theater. She possessed a rare gift for travel, and could re-create former times with extraordinary vividness. She was a person of fastidious and varied tastes and infinite patience in pursuit of that which caught her interest. In my last conversation with her she was planning a trip to Peru. It was a great loss that she wrote so little and that

in recent years she had withdrawn so much from active teaching.

She had a wide circle of friends in connection with her many interests. She enjoyed having people around her, and devoted much thought to those whom she liked. Yet the number of really intimate friends was small, and there was always evident a lurking shyness. She was ever generously responsive to the needs of others and her interest was quickly engaged in anyone whom she considered interesting and genuine.

Susanna Haigh was born in December 1893 in Bergen Point, New Jersey, the oldest child of a Southern father and a Dutch New York mother. She attended schools in New Jersey and then entered Vassar College, graduating in the class of 1915. Two years later she entered the College of Physicians and Surgeons of Columbia University and received her M.D. in 1921. During an internship at Bellevue Hospital, she became interested in psychiatry, then just beginning to develop as a clinical field outside hospital work in which it had been bound so long. After a period of training at Manhattan State Hospital, she began the study of psychoanalysis. She became one of the early members of the New York Psychoanalytic Society, even before the organization of the Institute in 1931. She was an instructor from the beginning of the Institute and for many years was active in the various parts of the training program.

For those who were close to her, it is very hard to grasp that she is gone. She was a person with whom one enjoyed a joke, or discussed clinical problems, or heard of the latest theater or exhibit. In so many ways she was enormously comforting in her discrimination, her rigorous candor, and her extraordinary good sense. She made of life's struggle something of gentle dignity, grace and friendliness. The one phrase which I have heard most often is 'She was a great lady'.

She is survived by two sisters, Mrs. A. V. R. Blomshield and Mrs. J. Clawson Roop, and a brother, Mr. T. D. Haigh.

PHYLLIS GREENACRE, M.D.

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Lincoln Rahman 1904–1956

David Brunswick

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LINCOLN RAHMAN

1904-1956

Lincoln Rahman, M.D., a member of the Los Angeles Psychoanalytic Society, died on August 11, 1956, the victim of a tragic automobile collision in which the driver of another car drove through a red traffic light because of misdirected attention. The life thus extinguished was one of great value to his family, his friends, his colleagues, his patients, and his students, and one that through his varied activities and relationships gave high satisfactions to himself.

At the time of his death, Dr. Rahman was a Trustee of the Los Angeles Institute for Psychoanalysis, Vice-President of the Los Angeles Psychoanalytic Society, Secretary of the Southern California Psychiatric Society, and Associate Professor of Psychiatry in the Medical School of the University of Southern California. He had been for four years Director of the Clinic of the Los Angeles Institute for Psychoanalysis and he was about to be nominated President-Elect of the Southern California Psychiatric Society.

Lincoln Rahman had attained these positions not because he was ambitious—he was essentially a modest man—but because he loved constructive activity and service. He repeatedly served on committees to frame or revise by-laws of the Psychoanalytic Society and Institute, and he had just completed compiling and publishing for the Southern California Psychiatric Society a most useful Directory of Psychiatrists and Clinical Psychiatric Facilities in Southern California. Warm friendliness and devoted activity were keynotes in his character.

He was born in New York City on February 12th, 1904, and grew up in Ossining, New York, the eighth in a family of thirteen children. His father was an architect of German descent; his mother was of French and Belgian extraction. He graduated from high school at fifteen, winning a four-year scholarship to Cornell University. There his plan to major in chemistry was

thwarted by the burning down of the chemistry building at the start of his first year, and he majored instead in economics and political science. After graduation from college, he became an editor with the Condé Nast Publications, working on the magazine Vanity Fair for three years, with regular promotions. He decided however to study medicine, returning to Cornell for his premedical studies and a master's degree. He then entered Cornell Medical School in 1928, graduating in 1932. After a two-year internship at Roosevelt Hospital in New York, he became a resident in the Phipps Psychiatric Clinic at Johns Hopkins for two years (1934-1936) and went on to residencies at the Payne Whitney Psychiatric Clinic in New York until 1941, where he was chief resident during the last part of his service. He then went into the private practice of psychiatry and psychoanalysis in New York City until 1943 when he was called into military service. In the meantime he had received his psychoanalytic training at the New York Psychoanalytic Institute.

Rahman's war service was in the United States Public Health Service, and he was sent to California in April 1944 to take charge of the Merchant Marine Rest Center at Pacific Palisades near Los Angeles, later being transferred to San Francisco. In June 1946 he resumed private practice in Southern California. He was a charter member of the Los Angeles Psychoanalytic Society and served as its Secretary-Treasurer from 1951 to 1953 and Vice-President 1953-1955 and again in 1956. He began teaching as an Instructor in Psychiatry at Cornell Medical School 1936-1944, and in more recent years he was Associate Professor of Psychiatry in the University of Southern California Medical School and lecturer in the Los Angeles Institute for Psychoanalysis.

He was married on July 4th, 1940 to Ruth Jaeger, M.D., who is also a psychiatrist and psychoanalyst. Their daughter, Emilie, was born on December 11th, 1943. The family bond was a particularly close one, but his devotion to his wife and his daughter did not exclude his close friendship with many of his colleagues and others.

Outside his profession he was particularly interested in music and the arts. During his adolescence he was dissuaded from becoming a concert pianist but he remained a good pianist and retained a passionate and discriminating interest in music. He was skilled in the electronics of radio and phonograph, built his own radio-phonograph, and collected a choice selection of recordings. Photography was a hobby in which he was skilled and active. He was unusually well read in the humanities and general sciences, in addition to the literature of his profession. Political and economic questions were also among his serious interests. These broad interests added substantially to his fitness for psychoanalysis, which was enhanced by his sensitive and friendly nature.

All who knew Lincoln Rahman, the quiet, friendly, active, and devoted man, mourn him and know that he is irreplaceable.

DAVID BRUNSWICK, PH.D.

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Alexander Bromley

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BOOK REVIEWS

FINAL CONTRIBUTIONS TO THE PROBLEMS AND METHODS OF PSYCHOANALYSIS. The Selected Papers of Sandor Ferenczi, M.D. Volume III. Edited by Michael Balint, M.D. New York: Basic Books, Inc., 1955. 447 pp.

Some thirty years ago, on December 28, 1926, Sandor Ferenczi delivered a paper before the Midwinter Meeting of the American Psychoanalytic Association, on Present-Day Problems in Psychoanalysis. He began as follows: 'Perhaps one of the chief handicaps which may prevent the American members of our movement from contributing to psychoanalytic knowledge and research through their own original works, is due in great measure to the fact that only after considerable time are they able to acquaint themselves with European literature in translated form'.

This quotation not only gives historical perspective to the contents of this volume; it also brings into the foreground the fundamental changes which have taken place, making English the accepted medium for discussion and scientific communication. Ferenczi's important works have long been available in English. In Final Contributions to the Problems and Methods of Psychoanalysis, the task of the editor, Dr. Michael Balint, has been to round off the presentation of Ferenczi's Selected Papers by assembling in one volume contributions hitherto scattered through various scientific publications and by making available in competent translation relevant material from the *Bausteine zur Psychoanalyse,* till now accessible only in German.

The material has been divided into three groups: 1, Papers written after the publication of Further Contributions to the Theory and Technique of Psychoanalysis, covering the period 1926-1933. 2, Posthumous papers: earlier notes and fragments (1909-1932). 3, Miscellaneous papers (1908-1922), omitted from the earlier volumes of collected papers, but which the editor felt merited inclusion. Each group is arranged chronologically and a bibliography is included of Ferenczi's works published in English, with carefully detailed references. This method has the advantage of allowing the reader to follow the development of the author's thought and to position it against the general growth of psychoanalytic knowledge, especially of Freud's work.

The second and third sections leave a feeling of *déjà vu,* perhaps because they largely retread the period covered by First Contributions and Further Contributions. There are numerous short communications, some of only a few lines, some notes of a scrap-book type, jottings of ideas as they occurred.

The first, and principal section, covering the controversial period 1926-1933, consists of thirteen articles. They include the paper on Gulliver Fantasies, delivered in New York before the Society for Clinical Psychiatry in 1926, and the paper referred to above, read before the Midwinter Meeting the same year. Again the chronological presentation has an advantage, as it gives poignancy to the references in both these papers to Rank's theory of Birth Trauma, and his defection from psychoanalysis, juxtaposed against the mounting crescendo in Ferenczi's own development. His search for a means of making the process of analysis shorter and more effective had originally been stimulated by Freud's general formulation that analysis under certain conditions (which he well and precisely defined), had to be carried out in a state of abstinence and frustration. The Development of Psychoanalysis (1925), written by Ferenczi in collaboration with Otto Rank, was the first systematic exposition of 'active' technique published. It was written before the publication of Freud's Ego and the Id, and though the ego aspects were discernible, its approach was libidinal, and the technique was divided into three contrived stages. The vicissitudes of the subsequent developments of Ferenczi's 'active' technique are well known, with its commands and prohibitions, later referred to as 'positive' and 'negative' suggestions, and finally the complete *volte-face* in his attempt to provide his patients with the love they missed and longed for in their early lives. The therapy he evolved, led Ferenczi to abandon psychoanalytic technique in favor of what might be described as rapport therapy. The seven papers, from The Adaptation of the Family to the Child (1927), culminating in Confusion of Tongues Between Adults and the Child (1933), cover the final period of this development.

It is no part of the purpose of this review to reopen the debates and resuscitate the polemics which Ferenczi's theories evoked. They are part of psychoanalytic history. The riddle of the man who possessed such a comprehensive and profound understanding of the development and theory of psychoanalysis, who has contributed so richly to our knowledge, and who was so dedicated to the psychoana-

lytic movement, will have to be answered by the future biographer. Some of the material of the volume appears dated; much has become an accepted part of our knowledge, but one is constantly struck anew by the wealth of clinical experience, its wide range and scope. In all he had to say, Ferenczi showed a sensitive and subtle imagination, an intuitive acumen and a rare gift of psychological insight and exposition. Many of the questions which he posed have yet to be fully explored and adequately answered.

ALEXANDER BROMLEY (NEW YORK)

SCHOOLS OF PSYCHOANALYTIC THOUGHT. An Exposition, Critique, and Attempt at Integration. By Ruth L. Munroe. New York: The Dryden Press, Publishers, 1955. 670 pp.

Almost fifty years have passed since the first schisms took place in psychoanalysis. When Adler and Jung broke with Freud, psychoanalysis as a school of thought was in its very beginning. The term 'psychoanalysis' itself had only recently been coined and much of what is now fundamental to psychoanalytic theory and knowledge was yet to be discovered. The succeeding years, especially the late thirties and forties, witnessed further controversies. Although the departure of Rank, Horney, Fromm, and Sullivan from the basic tenets of psychoanalytic theory may not have been as dramatic as that of their predecessors, it was, for a time at least, quite clamorous and bitter. In the meantime, the contributions of psychoanalysis to art, medicine, psychotherapy, and science had attained wide recognition. It commanded a growing public acknowledgement, confused by the spectacle of rival groups of psychoanalysts—each purporting to be the representative of this new body of science. For patients contemplating analysis, for doctors considering training in psychotherapy, and for students of psychological theory, this confusion has very practical implications.

Little elucidation of this confusion came from many of the expositions of psychoanalytic critique, most of which were written in a rather partisan spirit. Most articulate and polemic have been the spokesmen for the 'dissident' groups. Karen Horney, for example, took scientific issues to the general public in a series of popular books. The need for a comprehensive, definitive presentation of the issues has long been appreciated, and this need is exactly what Ruth Munroe has attempted to fill by Schools of Psychoanalytic Thought.

There is no book in this field which approaches this one in completeness and in its genuine effort to be objective and fair-minded. Dr. Munroe, a clinical psychologist and teacher, has had close professional relations with representatives of the different viewpoints which she describes. By virtue of training, discipline, and detachment, the psychologist rather than the psychoanalyst, according to Dr. Munroe, is qualified to undertake such a comparative study. She is probably correct in this view but this will not negate the validity of certain reservations which some psychoanalysts may voice.

This book is described as an 'exposition, critique, and attempt at integration.' The title and plan of organization are perhaps the clearest indicators of the author's orientation. The core of the book is divided into three main sections: 1. Freud and the freudians—who are especially distinguished by adhering to the libido theory; 2. Adler, Horney, Fromm, and Sullivan—who reject the libido theory, emphasizing the adaptation of the total personality to life situations; 3. Jung and Rank. The major accent of the book falls on the element of critique and in order to facilitate the comparative presentations of this element, each of the main sections listed above is subdivided under five headings: terms of the organism; terms of the milieu; the genetic process; the dynamics of the functioning personality; pathology and treatment.

The fallacy in this organizational plan is the implication that each of the authors mentioned represents a 'school', i.e., a consistent set of hypotheses encompassing in an all-embracing fashion both normal and pathological mental functioning. This is hardly the case in regard to Adler, Fromm, Horney, and Rank. Consequently, reading their contributions under the five different headings, one is left with an impression of thinness and repetitiousness. The meagerness of what they have to offer becomes patently evident. Bertram D. Lewin once remarked, in this connection, that Adler has found a place in history primarily because of the fact that he broke with Freud.

Since the question has been raised whether certain 'schools of psychoanalytic thought' actually constitute schools, the question may also be raised whether they constitute, properly speaking, psychoanalysis. In an earlier review of this book Knight[1] indicated that both Jung and Adler definitely dissociated themselves from psychoanalysis and chose new names by which to identify their theories. Why should they and the followers of Horney, whom Wittels aptly

[1] Knight, Robert: In: Scientific American, May 1956

called the 'neo-Adlerians', continue to be associated with psychoanalysis? The author anticipated this question and in answer wrote, 'Four basic concepts are accepted by all schools of psychoanalysis: psychological determinism, "the unconscious", goal directedness, a genetic approach'. In this respect she follows the criteria emphasized by Freud with the very striking omission of the etiological significance of childhood sexuality in the mental life of man, an element which Freud appended to the criteria already mentioned. It is not the hypothesis of the libido theory alone that the 'dissidents' repudiate, but the fact of childhood sexuality as well.

The discovery of infantile sexuality followed inexorably once Freud applied the principle of strict psychological determinism to his probings of the unconscious and the genetic process. This is especially true of the œdipus complex which certain schools characteristically underplay or repudiate. The fundamental issue is how far back in the genetic process and how deep in the unconscious are problems to be traced. Put another way, the question reads: How seriously should one take the principle of psychological determinism? This fundamental concept was at the bottom of Freud's therapeutic procedures, namely, free association, dream analysis, the neutral position of the analyst, and so on. Those groups which have abandoned these techniques are, in effect, giving no more than lip service to the principle of psychological determinism. They may be practicing effective psychotherapy but it is not psychoanalysis.

Dr. Munroe's attitude in these matters is obviously more liberal and eclectic. In keeping with this spirit she has surveyed and organized a vast literature into a highly readable and lucid volume. To this she has appended her own evaluations and the record of her many years of reflection on psychoanalysis. There is a wealth of data and observation in this book from which every reader will derive immense profit.

JACOB A. ARLOW (NEW YORK)

THE ANNUAL SURVEY OF PSYCHOANALYSIS, VOLUME III, 1952. Edited by John Frosch, M.D., in collaboration with Nathaniel Ross, M.D., Sidney Tarachow, M.D., and Jacob A. Arlow, M.D. New York: International Universities Press, Inc., 1956. 682 pp.

The surge of activity and productivity in the field of psychoanalysis proper has in recent years made it increasingly difficult for the

practicing analyst to keep abreast of developments. When, to this is added the necessity of maintaining at least a nodding acquaintance with collateral fields such as anthropology, sociology, æsthetics, art and literature, neurophysiology, religion, intramural psychiatry, criminology, and education, the task becomes well-nigh impossible. Inevitably, if a confusion of tongues was not to eventuate, certain measures had to be taken to cope with this situation. The Annual Survey of Psychoanalysis has been hailed as one such measure.

The present volume, the third in the series, encompasses the psychoanalytic literature of 1952. There has been a lag of four years in its appearance since the editors chose to place thoroughness ahead of timeliness in its preparation. A fair sampling of the contents of the volume makes it evident that the editors and their co-workers have retained their original enthusiasm and industriousness. It is the product of very painstaking work. Some idea of the scope of the enterprise can be conveyed by stating that between the covers of the book one finds surveyed no fewer than two hundred sixty-three items —individual papers, symposia, panel discussions—culled from at least eighteen journals, in addition to comprehensive reviews of nine books. The reader who is interested in a special field of inquiry is aided by classification of the material under the headings, Critque and Methodology, Ego Psychology and Instinct Studies, Clinical Studies, Dream Studies, Psychoanalytic Child Psychiatry, Psychoanalytic Studies in Psychiatry, Psychoanalytic Studies in Psychosomatic Medicine, Psychoanalytic Therapy, Applied Psychoanalysis. A brief note at the end of each section indicates the general trend of contributions during the year or some shift in emphasis as compared with those of previous years. As for the main text, however, the obvious goal of the editors has been to present factually, without predilection and without critical assessment, the content of each paper, whatever the source and whoever the author. Reading is facilitated by the high level of the reporting, which is clear, trim, and competent throughout. Whoever wishes to explore what in a paraphrase of John Gunther may be called 'Inside Psychoanalysis—1952' should find this volume a serviceable guide.

WILLIAM NEEDLES (NEW YORK)

SIGMUND FREUD. FOUR CENTENARY ADDRESSES. By Ernest Jones, M.D. New York: Basic Books, Inc., 1956. 150 pp.

This absorbing little volume contains the four Freud Centenary lectures addressed by Ernest Jones to the profession as well as to the enlightened lay public. Three of these lectures were delivered in the United States and one in Great Britain, all on the occasion of the hundredth anniversary of Freud's birth. In their directness of approach, clarity of formulation, compactness of style and thought, these addresses are not only a tribute to the greatness of the master in whose honor they were made, but also attest to the loyalty and fecundity of the disciple, biographer, and pioneer of analytic thinking who delivered them.

The first lecture, delivered as the 1956 Freud Anniversary Lecture before the New York Psychoanalytic Society and Institute, is entitled The Nature of Genius. Starting from the premise that attempts to define genius have not proved helpful, on the whole, Jones sets out to survey in broad outline some of the psychic factors operative in 'certain forms of productive thinking'. Among these, he briefly discusses the elements of intellectual surprise, spontaneity of production, periodicity of creativeness, originality of thought, power of concentration, love of truth; and transcending all these that the genius possesses is, according to Jones, a remarkable capacity 'for perceiving with somnambulic sureness what is absolutely and universally true', a capacity which he sees often combined with a certain naïveté and 'curious credulity'. Most of these elements which were prominent features of Freud's personality, Jones also finds, in varying degrees, in Copernicus, Newton, Faraday, Darwin, and other men of genius.

The second lecture, Our Attitude Toward Greatness, was delivered before the annual meeting of the American Psychoanalytic Association in Chicago, in April 1956. After describing the courage, loneliness, and revolutionary originality of Freud's achievement, Jones turns to the 'varying degrees of ambivalence' with which the medical profession and the world at large received this achievement. He recalls the hostile outpourings of 'German neurologists and psychiatrists. . . for at least twenty years', and the almost universal condemnation of Freud's work by that particular generation of psychiatrists. In passing, he notes the current manifestations of ambivalence, in America and elsewhere, from overt abuse to the subtler forms ('Freud was a great genius, but unfortunately all his ideas were

mistaken'); from extreme reactions of anger and condemnation to certain types of misunderstanding and misrepresentation. Among the latter, Jones wittily discusses some frequent errors of the 'Freud legend' and quotes a few amusing examples from the reviews of his Biography: that Freud's discoveries were 'borrowed' from Janet; that Freud was a stern father; that he was intolerant; that he was a quarrelsome person. . . tyrannical, difficult to live with, opinionated, and irascible. 'I never knew a man more averse to quarrelling or who would do more to avoid it', states Jones simply and unequivocally.

In the third lecture which was delivered before a joint meeting of the American Psychiatric Association and the American Psychoanalytic Association, the author deals with the status of psychiatry before and after Freud. He reviews the broadened scope of contemporary psychiatry which it largely owes to Freud's *Lebenswerk*. He concludes: 'Freud, through his life's work, bestowed inestimable gifts on psychiatry, which have resulted in widening its scope, in enhancing its dignity and in raising its social prestige'.

The fourth lecture is a radio address entitled Sigmund Freud: The Man and His Achievements, which was delivered over the facilities of the British Broadcasting Corporation in London on the day of Freud's hundredth birthday, May 6, 1956.

This handsome, forthright, and highly readable volume includes, as an appendix, Jones's moving eulogy, Sigmund Freud 1856-1939, reprinted in part from the International Journal of Psychoanalysis, Volume XXI, 1940. In his eulogy Jones records what seems to me like a particularly appropriate memento on the occasion of Freud's hundredth birthday. The philosopher Ludwig Klages was once asked in Jones's presence whose writings he would suggest reading in order to understand Freud's teachings. Klages, Jones reports, answered simply: 'His own'.

WILLIAM G. NIEDERLAND (NEW YORK)

LES THÉORIES PSYCHOSOMATIQUES. ORIGINES PSYCHANALYTIQUES—IMPORTANCE PSYCHOLOGIQUE (Psychosomatic Theories. Psychoanalytic Origins—Psychological Significance). By Jean-Paul Valabrega. Introduction by Dr. Henry Ey. Paris: Presses Universitaires de France, 1954. 192 pp.

The value of this book lies in the attempt to locate the place of psychosomatic medicine somewhere at the crossroads of psychoanalysis,

psychology, and somatic medicine, the latter especially expressed in the syndrome of stress, adaptation, and endocrinological response. The author defends, with good reasons, the monistic viewpoint that psychosomatic medicine is not a liaison science, but that the central importance of psychosomatics is to be found in the organism itself.

In the first chapter, Valabrega describes the relationship between psychosomatics and psychoanalytic evolution. He opposes the critical attitude of Marie Bonaparte, who tries to keep certain analytical concepts as clearly as possible separated from the general psychosomatic approach. On the other hand, the description of the work of Sacha Nacht clarifies the relationship between psychoanalysis and psychosomatics. Extremely illuminating is the comparison between *Explication Specifique* (specific explanation) and *Explication Plaquée* (schematic explanation). He acknowledges the corrective self-criticism of the psychosomatic school as represented by Alexander, Weiss, English, and Dunbar, and discusses extensively the shortcomings of psychosomatic treatment outside psychoanalysis. The work of Margolin is regarded as an outstanding experimental model of investigation in the psychosomatic field.

Much space is given to the future psychoanalytic training of physicians in which the author gets lost in wishful thinking. As nobody else has offered anything better, Valabrega at least does justice to each theoretical approach of the didactic psychoanalytic problem. In the chapter about the psychosomatic conception of illness versus psychosomatic disease, he points out the importance of opposing theories, and tends to accept Alexander's viewpoint on etiological overdetermination.

After a historical exposition of monistic and dualistic conceptions of pathology, the author reviews the monistic hypothesis of Parcheminey following the theory of Alexander. Very important in this respect is the attention drawn to Bonaparte's original idea about the relationship of the organic unconscious to the mental unconscious. He compares at length the monistic viewpoint of conversion hysteria and psychosomatic dualism. Alexander's well-known conceptions are clearly and extensively demonstrated. Valabrega here points out that all theoretical differences of opinion have little clinical importance; so far no technical therapeutic changes have evolved.

An interesting chapter is devoted to the observations of F. Pasche concerning the psychological reactions and psychosomatic interactions in a case of tuberculosis. Progress of the analysis resulted in ag-

gravation of the pulmonary disease; amelioration of the organic symptoms was accompanied by a decrease of neurotic symptoms. Valabrega correctly states that in this field everything is still in state of observation without satisfactory explanation. He outlines the role of the analyst in psychosomatic consultation as somebody who gives psychoanalytic interpretations in small dosages to his most astonished and surprised patient, but who after the next consultation surprises the analyst by his improved accessibility.

The whole procedure should be practiced by a group of psychoanalytically trained physicians in a hospital environment. The monistic psychosomatic approach is contradicted 'by the dualism of a group of physicians' *(dualisme doctrinale* and *dualisme operatoire);* Nacht therefore recommends treatment by one physician only. How a short period of psychotherapy helps some 'psychosomatic patients', a well-established fact, is unknown. Note is made of Melanie Klein's conception of good and bad objects in relation to the success or failure of medication. Physician and medicine are ambivalent objects to patients.

In the last chapter the author discusses as a special psychosomatic illness the syndrome of stress among combatants, particularly during the last war. He concludes that the pathological stress was a result of essential inaptitude of the subjects for the tasks to which they were assigned.

The endocrinological section, mainly the work of Selye, is a schematic outline about which the author states that nothing is known of the interaction of hormones on psychological changes (including the action of ACTH and cortisone). Because the importance of hormonal action in connection with the psychoanalytic approach was anticipated by Freud, it is an undeniable part of psychoanalysis.

Altogether, the book is an excellent critique of different modern trends in psychosomatic medicine written, to this reader's great surprise, by an author who is not a physician. This accounts for a rather philosophical, but very objective approach to the subject.

SIMON WEYL (NEW YORK)

ENERGY AND STRUCTURE IN PSYCHOANALYSIS. By Kenneth Mark Colby, M.D. New York: The Ronald Press Co., 1955. 154 pp.

Metapsychology, Colby points out, uses Freud's tripartite structural model of id, ego, and superego and no fresh structural system has

been proposed. While admitting its clinical usefulness, he points out that the tripartite model 'lacks the complexity and refinement so endearing to the pure theoretician'. In this book the author is concerned only with the theoretical aspects of psychoanalysis.

In Colby's consideration of the postulate of psychic energy, he notes that Breuer and Freud offered no definition of psychic energy in a psychological language; they borrowed their concepts from electrophysics, and thought of psychic energy in terms of electric currents. But, says Colby, 'energy' is not mechanical, thermal, chemical, or electrical. Indeed, he says, it is possible that we have no right to speak of energy at all. Today's physicist is cautious in saying what it is. Because the earlier analysts thought in terms of the physics of their time the psychic apparatus was thought of in terms of a hydraulic metaphor: a series of pipes and passageways, a vast conduit system through which instinctual energies underwent various vicissitudes but remained the same except for their location.

Qualified by his knowledge of modern physics Colby makes a provocative attempt to revise these two postulates in the light of modern scientific conceptions. Instead of the tripartite model he proposes a 'cyclic circular structural model' which 'represents the scientific ideas and images of our time'. This hypothetical cyclic model, he emphasizes, has a convenience and usefulness not for all psychoanalytic theory 'but only for the logical and metapsychological interrelating of basic postulates of psychic energy and structure'.

The text of this highly compressed treatise contains many illustrations having to do with his 'cyclic circular structural model' which in their complexity are as much in advance of the old tripartite model as the engine of today's car is in advance of the old T model Ford. The reader—and we will assume that he is a work-a-day analyst little schooled in Einstein's theories—will naturally ask, where will this get me? Clinically, I did not do so badly with my old tripartite model, though I admit its shortcomings; must I now trade it in for this new 'cyclic model'? At this point Colby lets us down. He admits that his model might have certain implications for therapy, 'but they must await further theoretical developments'. Instead of the last phrase I would suggest 'clinical application'.

This book is the work of one primarily interested in pure theory and who is exceptionally knowledgeable about modern physics. Unless the reader is equipped with a similar background of knowledge —and how many are?—it is not only uncommonly difficult to under-

stand this book, it is still more difficult to pass judgment on it. Colby may be, to use his phrase, 'a bold and graceless innovator', but unless he can elucidate his theories in simpler language the world will never know it!

WILLIAM N. EVANS (NEW YORK)

DER TRAUM UND SEINE BE-DEUTUNG (The Dream and Its Significance). By Werner Kemper. Hamburg: Rowohlt Taschenbuch Verlag, 1955. 220 pp.

This little book appeared as part of a large series on psychology published in the collection called Rowohlt's German Encyclopedia. The author, since 1948 a training analyst in Rio de Janeiro, was a staunch proponent of psychoanalysis in Germany. He deserves special credit and recognition for defending psychoanalysis against the assaults of Nazism and for maintaining throughout the political and social vicissitudes of German life the Berlin Psychoanalytic Clinic. He is fortunate in having at last succeeded in establishing it as the first popular clinic of its kind in connection with the Berlin Insurance Institute as The Central Institute for Psychogenic Diseases.

The book offers an impressive wealth of information presented in a lively, clear way, not too technical and yet not without scientific precision. The essence of Freud's work on the dream is sufficiently complete; the pre-freudian and post-freudian literature is also given serious consideration. Examples of dream analysis are clear and useful. Some are dreams of the author. Various modifications, additions, and deviations from freudian dream analysis are presented critically and yet with full recognition of their possible value.

GUSTAV BYCHOWSKI (NEW YORK)

A CLASS FOR DISTURBED CHILDREN. By Leonard Kornberg. New York: Bureau of Publications, Teachers College, Columbia University, 1955. 157 pp.

Mr. Kornberg reports on his work as a teacher in the school that is a part of the Hawthorne residential treatment center, administered by the Jewish Board of Guardians. The greater part of the book is an account of his work with a group of boys of ages thirteen to sixteen. Kornberg provides many excellent ideas for teachers of severely

emotionally disturbed children. Some of his suggestions are not only original, they are outright courageous as he cuts across the conventional division between traditional and progressive education. He is aware that his boys, although quite unable to take the pressure of an average school, nevertheless want the normality of school. 'The ironic thing (and bewildering problem) was that they were as suspicious of something that differed from school, as they were repelled by school.'

Mr. Kornberg found various ways to solve this dilemma, principally by organizing the classroom in a very definite and even rigid way and daily meticulously resetting the original design. '. . . I was always aware of my action and goal as conveying respect and care for them. This constant, unreproachful cleaning-up, I believe, was more proof of my interest in them, and more definition of purpose of this room, than many words and exhortations.' As each boy entered the classroom, he found materials for his work and daily personal instructions waiting for him at his seat. But there also was a radio frequently playing popular music. Mr. Kornberg realizes that a quiet room may serve 'as a stimulus to impulsive behavior, almost as if my boys needed loudness and excitement to conceal from themselves their inner disturbances'.

Providing for his boys 'the satisfaction of doing what other children do in school' included a good deal of simple rote activity (arithmetic computations, for instance). Such activities may give also 'a welcome escape from social meanings'.

The teacher was available one or two mornings a week for individual children, believing that teachers of such deeply disturbed children need 'planned opportunities for individual contact with their children'.

To summarize the outstanding qualities of this report, we have to compare it with other reports from schools for deviant children. All teachers of such children have nowadays a basic orientation toward progressive education. Quite a few realize that these methods do not fill their children's needs and thus some educators practice and propagate a 'middle of the road' course which is, in all fields of human enterprise, a good solution for those who lack know-how, imagination, and courage. Mr. Kornberg, knowing the specific needs of his children, selects those matters in which he is lenient and others in which he is quite strict and rigid. He protects his children from

the seductions of a disorganized room as well as from the social pressures of their own classmates.

The theoretical part of the book left this reviewer completely dissatisfied. It is a mixture of professional lingo and vague mystical writing. Here the author at times makes up his own definitions, for instance: 'The theoretical differences between therapy [psychiatric therapy] and education are empty or confusing, unless they clearly refer to a two-person contact or a group situation'. This would put individual tutoring into the area of therapy and group treatment into the field of teaching! And although Mr. Kornberg is aware of this, he sticks to his definition.

An appendix contains psychological reports on the fourteen boys, giving many interpretations, many details, yet leaving out some basic data of the boys' history and of their present life. We do not learn whether a boy has younger or older sisters or brothers, although the structure of his family may make his behavior toward classmates more understandable. Very little is said about the boys' present contacts with their parents or parent substitutes, nothing about their other teachers at Hawthorne. Mr. Kornberg had the boys five afternoons a week from one to four o'clock. We agree wholeheartedly with his statement: 'I believe that the teachers should have as much knowledge about the child as does the therapist, and that this must include etiological and diagnostic facts, and information about treatment developments, what happens to the child on home visits, and what his experience is elsewhere in Hawthorne. This idea, of course, impinges directly on the question of how the educator's job is related to the therapist's.'

LILI PELLER (NEW YORK)

FAMILY, SOCIALIZATION AND INTERACTION PROCESS. By Talcott Parsons and Robert F. Bales. With the collaboration of James Olds, Phillip Slater, and Morris Zelditch, Jr. Glencoe, Illinois: The Free Press, 1955. 422 pp.

For those familiar with the previous works[1] of Parsons and his co-

[1] *Cf.* Parsons, Talcott: *The Social System*. Glencoe, Illinois: The Free Press, 1951. *Essays in Sociological Theory* (Revised Edition). Glencoe, Illinois: The Free Press, 1954. (Reviewed in This QUARTERLY, XXIV, 1955, pp. 306-307.) Parsons, Talcott; Bales, Robert F., and Shils, Edward A.: *Working Papers in the Theory of Action*. Glencoe, Illinois: The Free Press, 1953.

workers, this volume—chiefly the work of Parsons—is a challenging, detailed extension of their theory into the process of the child's early social development. Some psychoanalytic concepts, cultural data (Zelditch), and studies of differentiation of roles in small groups outside the family (Bales and Slater), support the authors' analysis of the phenomena of ego differentiation and development and of the 'interpenetration' of personality and family 'systems of action' with the culture in which the child lives.

This is not an attempt to translate psychoanalytic findings into sociological term (a compulsive occupation in certain academic circles), nor to validate psychoanalytic concepts by nonpsychoanalytic methods (a more ubiquitous compulsion). In fact, Parsons is sufficiently acquainted with such fundamental psychoanalytic concepts as the phases of psychosexual development and narcissism, that he uses them to test his sociological hypotheses. He is not, however, uncritically accepting of psychoanalysis, and most psychoanalysts will take exception to certain points, particularly to his minimization of biological factors, and especially to his avoidance of the unconscious as an explicit entity. I would here remind the authors, as well as the psychoanalytic reader, that (as in the case of masochism and the death instinct) the psychoanalytic theory of ego development is not dependent on Freud's biological reconstructions. Even with such differences, Parsons' contribution in enriching our knowledge of the interaction of parent and child and in integrating sociology and psychoanalysis is impressive.

Major questions regarding Parsons' thesis have to do with its tendency to neglect content in favor of emphasis on process and structure. He finds that 'the broad structural outlines of the American nuclear family' are determined not by the specific culture, 'but are of generic significance with respect to the structure and functions of the family in all societies'. This will surprise no psychoanalyst; but what constitutes the real differences among societies? Doesn't it matter what, specifically, is communicated in the generic process of interaction? The authors can reply that they are concerned only with exploring and testing their thesis; and it is true that they are not offering a definitive 'sociology'. But they explicitly and, more frequently, implicitly make judgments of value which stem from content unwittingly smuggled into their thesis. For example, Parsons is optimistic about the 'stability' of the American family in opposi-

tion to those who think it is becoming 'disorganized'. Stability for what? For the transmission, internalization, and integration of 'systems' fostering maximal ego development and productiveness, or for conformity, repression, and regressive displacement as the 'norm'? There is a recurrent implication that, if the system works (if the 'lines of interaction' remain open), the system is all right. Surely this is not the authors' intention, to judge from their other works and their statements in this book. I am suggesting that judgments of content and value (based on demonstrable psychological and sociological criteria) be more explicitly considered in the further testing of their valuable thesis.

H. ROBERT BLANK (WHITE PLAINS, NEW YORK)

MIGRATION AND MENTAL DISEASE. A Study of First Admissions To Hospitals For Mental Disease, New York, 1939-1941. By Benjamin Malzberg and Everett S. Lee. New York: Social Science Research Council, 1956. 142 pp.

This investigation compares the incidence of the major mental disorders among native-born residents of New York State with those who have migrated into New York from other states and from other countries. The authors conclude that the rate of first admissions to hospitals for mental disease was much higher for migrants than for natives, and that the differential in some instances was as high as three hundred percent. This relationship held true for all forms of psychosis, including organic brain disease, as well as all age groups.

The book describes the method and the data on which these conclusions are based. In addition it contains a critical summary of similar investigations conducted elsewhere, and an analysis of the methodological difficulties involved in such studies.

Unfortunately the theoretical implication of these data is far from clear, convincing though the factual conclusions may be. However, as these data may shed some light on epidemiology of mental illness, they are worthy of consideration.

LOUIS LINN (NEW YORK)

THE NEUROSES IN CLINICAL PRACTICE. By Henry P. Laughlin, M.D. Philadelphia: W. B. Saunders Co., 1956. 802 pp.

The method of presentation in this volume is based largely on the long experience of the author in teaching medical students; the substance has been derived from his private practice as a psychoanalyst. The interpretation and discussions, therefore, are essentially analytic. Some of the chapter headings are: Nature and Origin of Anxiety; The Anxiety Reactions; Intrapsychic Mechanisms of Defense; The Phobic Reactions; Depression; Overconcern With Health; The Neuroses Following Trauma.

The chapters in general start with a definition and sometimes a historical note, followed by a systematic analysis of the important points. There are two hundred sixteen brief case histories—some of them tantalizingly brief—and thirty-two tables. The principal emphasis is on symptoms and dynamics, with references to treatment remaining rather general. A very convenient and comprehensive glossary of psychiatric terms is included.

The book is comprehensive and readable. Its particular value is for students and for physicians in general practice who may be interested in learning more about the psychodynamics of a large segment of their practice.

WINFRED OVERHOLSER (WASHINGTON, D. C.)

THE PRACTICE OF PSYCHIATRY IN GENERAL HOSPITALS. Edited by A. E. Bennett, M.D., Eugene A. Hargrove, M.D., and Bernice Engle. Berkeley: University of California Press, 1956. 178 pp.

The establishment of psychiatric facilities in general hospitals, looked upon with suspicion only a half century ago, is now widely accepted as desirable and necessary; in new hospitals, indeed it is the rule. Doctor Bennett, the senior editor of this volume, was an early worker in this field. He has gathered about him experts in various aspects of hospital administration—clinical, nursing, psychological, social service, architectural, occupational therapy, legal—and has produced a comprehensive volume which should be read by all who are interested in the practical operation of general hospitals.

Dr. Daniel Blain in the Foreword and Dr. Karl M. Bowman in the Introduction emphasize the importance of psychiatric facilities in bringing psychiatry into closer touch with general medicine, as regards both the practitioner and the general public.

Doctor Bennett reports that a questionnaire study showed that three hundred twenty-nine general hospitals had psychiatric beds, although the total number of patients cared for was less than one percent of the total of the hospitalized mentally ill!

There are sound chapters on staffing the unit and on training programs. The one on administration, by the lay administrator of the Herrick Hospital at Berkeley, points out that a minimum of fifteen beds is necessary for economical operation, that eighty percent of all patients recover at least socially, and that most psychiatric units are not only self-sustaining but show a profit. Guttersen contributes an excellent chapter on architecture, based on his wide experience with the Public Health Service and the Architectural Project of the American Psychiatric Association.

A chapter on Psychiatric Referral points out some public misconceptions of mental illness and treatment, and ways to overcome them. Dr. Ewen Cameron discusses the Day Hospital, in the establishment of which type of facility he has been a pioneer. There are other chapters on medicolegal aspects, voluntary health insurance, and special treatments.

The volume is a valuable expansion and development of Ebaugh's significant publication (1940) on the same topic.

WINFRED OVERHOLSER (WASHINGTON, D. C.)

THE PSYCHOLOGY OF ECONOMICS. By Walter A. Weisskopf. Chicago: University of Chicago Press, 1955. 266 pp.

To the analyst, one of the most important aspects of human relations is the way in which the common wealth of a community is allocated to each of the community members. Such allocation reveals the masochism, the morality, the hostility, and the independence of those concerned, as any analyst will tell who has discussed the matter of fee with an analysand. The student of matters such as monetary rewards, the economist, thinks of his subject not in these terms but according to theories of the determination of value of quality or labor and of price.

In this book the author reveals how economic theories from Adam Smith to Alfred Marshall, though apparently constructed by the pure glimmering of reason alone, actually were concocted by fears and desires old as mankind and hidden in the unconscious. Convincingly the author correlates the interaction of the worker with the

raw material of his labor, essentially the land, with the œdipal situation, and reveals how the various rationalizations of man's economic relations are solutions of the family conflict as much as actual representations of the current state of affairs. Finally he points out that in an economy of abundance a new factor influences the price of a commodity, the consumer's reactions to it, and the extent to which these satisfy his whims and fancies. The modern existence of competing means of production has brought about an economy in which, to quote Rothschild, 'The oligopoly-theorist's classical literature can neither be Newton and Darwin, nor can it be Freud; we would have to turn to Clausewitz's Principles of War'.

The author's point of view is represented by the following excerpts.

> Our discussion of psychodynamic factors which have influenced economic thought does not imply the sexual, erotic, and biopsychological factors are prime causes and ultimate determinants of thought and behavior. They interact with social and cultural and intellectual factors as parts of a total situation. Earlier we emphasized the role of other than biopsychological factors; in this section we are concerned with the latter as determinants of the labor theory of value . . . the entire system of interpretation forms an inseparable whole. The male-female antinomy is only one manifestation of the deep conflicts which confront human existence in general and social thought in particular. As long as man belongs to different realms, physical and spiritual, conscious and unconscious, as long as culture imposes on him restrictions which suppress some of his natural traits, such conflicts will arise and will be reflected in thought.

Speaking of Marshall's thought as a manifestation of economic rationalism, he says:

> Reason perceives, orders, and classifies the results of perception in a logical way; but there is also intuition, the direct, lightninglike comprehension of the essence of things, which is different from logical, discursive, and analytical understanding. The latter operates in an active way; but there is also the mood of passive, silent, intuitive receptivity as an instrument of acquiring knowledge. But reason is an instrument for dealing with, and for adapting one's self to, the social and cultural conditions of life.

In this book the analyst who delves into the unconscious will find new vistas of the world around him and a new understanding of concepts he has taken for granted. For instance, the author points out that

> The very mode of intercourse may be influenced by cultural attitudes toward activism. Thus in our civilization the 'active' one is the male and not the female. . . . All this leads to the conclusion that we are projecting our social

> and cultural value attitudes into our interpretation of sex differences. We evaluate highly the active and the masculine; that is why Freud and others have equated them. . . . The use of money as a unit of accounting; the acquisitive attitude with its precise profit and loss calculation; the use of double entry bookkeeping as a methd which makes the rational, systematic pursuit of economic gains possible; the capitalist form of enterprise, which distinguishes itself from previous kinds of enterprise by the use of this type of accounting—all these phenomena merged together and simultaneously with rationalism, science, and technology, as characteristics of modern western civilization.

In conclusion the author stresses the unmapped impulses of the id rather than the orderly operations of the ego. 'A picture of the individual, the economy, and the universe emerges full of uncertainties, without ethical guideposts, relativistic, probabilistic, and appropriate to the precarious situation of mankind in mid-twentieth century.' The interest and stimulation this book provides more than compensate for the labor and difficulty of reading it.

GERALDINE PEDERSON-KRAG (NEW YORK)

EMOTIONAL PROBLEMS OF LIVING. Avoiding the Neurotic Pattern. By O. Spurgeon English, M.D. and Gerald H. J. Pearson, M.D. Revised and Enlarged Edition. New York: W. W. Norton & Co., Inc., 1955. 592 pp.

In this edition of their book the authors have kept unchanged the basic organization of material and much of the text of the first edition published ten years earlier. The section on mental illness and old age has been expanded and the diagnostic categories changed to conform with current psychiatric standards.

This book remains one of the best popular surveys of dynamic psychiatry, adequate for intellectual grasp of fundamentals for the novice or dilettante among medical students, clergymen, teachers, nurses, and the laity. It is simple, lucid, informative, and accurate. With a few exceptions, such as statements to the effect that juveniles who are delinquent because of lack of love should be placed in institutions where a select staff able to love them will do so, and that in maturity one should have at least four friends, the authors avoid oversimplification, complication, optimism, or pessimism. There is, however, an over-all promise of ready solutions implicit in the mental hygiene attitude, which does not accord with psychoanalytic experience.

The case histories are too few in number, too condensed, and do not come alive.

RICHARD BURNETT (NEW YORK)

THE OBJECT RELATIONS TECHNIQUE. (Book and Test Cards). By Herbert Phillipson, M.A. Glencoe, Illinois: The Free Press, 1956. 224 pp.

This is the presentation of a new projective technique for psychological testing. The method combines certain diagnostic characteristics of the Rorschach and the Thematic Apperception Tests.

The Object Relations Technique consists of thirteen cards, nine by eleven and a half inches. Twelve contain pictures of human forms and other objects. These are drawn in varying degrees of clarity, allowing scope for the projections of the subject's own perceptions into this unstructured material. This permits psychological interpretations to be drawn regarding the individual's personality structure, his anxieties, defenses, etc. The thirteenth card is blank. The subject is asked to tell a story in response to each card.

The pictures, being less specific than those in the Thematic Apperception Test, require greater projection from the subject to identify and clarify the material. The unstructured quality provides some of the advantages of the Rorschach plates, but in the reviewer's clinical practice this test has been found useful as a supplementary rather than as a substitute technique.

The basis of this procedure is the psychoanalytic concept of unconscious object relations. The perceptual processes of the subject, and their effect upon the dynamic structure of his interpersonal relationships, are the points of study, as reflected in his projections.

This is a valuable contribution to the field of psychological testing; it offers a method of studying unconscious processes which effectively complements existing techniques.

MYRON W. HARRIS (NEW YORK)

ESSAYS ON THE SOCIOLOGY OF CULTURE. By Karl Mannheim. New York: Oxford University Press, Inc., 1956. 253 pp.

The three essays contained in this volume were written during the last years of Karl Mannheim's life in Germany (before 1933). They extend, elaborate, and attempt a new departure from 'Ideology and

Utopia', his principal study in the field of the sociology of knowledge. He incorporates the disillusionment over the excessive claims of German idealism into a sociological theory of thought. He criticizes the overestimation of the role of ideas in human affairs, and he assumes that concepts which emerge in various periods of history evolve from one another in logical continuum. Ideas are functions of social involvement. Once the image of an autonomous evolution of ideas has been abandoned, the exploration of the relationship between thought and its social milieu becomes feasible.

As may be expected, Karl Mannheim is more concerned in relating his conceptual structures to Hegel, Marx, and Max Weber than to Sigmund Freud.

The editors (Ernest Manheim and Paul Kecskemeti) had to rethink the original text and succeed in doing so without distortion of the author's intentions. They have succeeded in the even more difficult task of making the meaning and import of Karl Mannheim's Essays comprehensible in another idiom than the one in which it was written, and understandable to the readers of a different generation, raised in a different national tradition.

MARTIN GROTJAHN (BEVERLY HILLS)

ALCOHOLISM. Its Psychology and Cure. By Frederick B. Rea. New York: Philosophical Library, Inc., 1956. 143 pp.

The book contains much information about the types that become addicted to alcohol, the physiology and metabolism of alcohol, and the cardinal signs and symptoms of the progress of the disease, alcoholism. The various treatments by creation of aversion are discussed.

Some psychiatrists have been interested in those relatives of their alcoholic patients who suddenly stopped drinking without medical treatment in the years before Alcoholics Anonymous. Such cures always have included a revolutionary change, a sudden growth in the personality, something akin to a religious conversion. The author stresses the significance of religious conversion and reviews the familiar steps of participation in Alcoholics Anonymous. The movement is an interesting and powerful antibody in society against self-destructive drives of those addicted to the 'sweet poison'. Most patients suffering from alcoholism who come under psychiatric care in mental hospitals have tried Alcoholics Anonymous. All are en-

couraged to join again during the last few weeks of hospital treatment and to be active in the organization after leaving the hospital. Many refuse, but the workers in the field are most coöperative and unselfish when called upon to help. The dynamic forces of the groups and the willingness to help others are factors impressive to psychiatrists by the good results they produce in those who can grow, change, and endure. The vast number who do not respond to all our efforts continue to be a challenge.

JAMES H. WALL (WHITE PLAINS)

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Journal of the American Psychoanalytic Association. II, 1954.

Irvin Galin, Jay Shorr, Herbert Aldendorff & Milton Gray

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ABSTRACTS

Journal of the American Psychoanalytic Association. II, 1954.

Dreams and Perception. Charles Fisher. Pp. 389-445.

In a carefully documented paper, the author describes his repetition and extension of Poetzl's classical experiment on preconscious perception and the formation of dreams. He was able to confirm Poetzl's essential findings. In general, those portions of the pictures shown by tachistoscope that were excluded from conscious perception made up the manifest content of the subsequent dream. A remarkable process of preconscious perception is employed, characterized by extreme accuracy of registration and great distortion of the percepts. In some instances the preconsciously perceived visual percepts retain the meaning of the object denoted in the dream while in others the percept is treated as a concrete object. This is also true of preconsciously perceived words. The preconscious visual percepts were not available to free association but could be recaptured by confrontation.

The role of suggestion and of transference in the experiments is discussed. The preconscious visual process here is related to similar perceptual processes found in visual agnosias, eidetic images, and alcoholic hallucinosis. Concepts of 'primary' and 'secondary' perception are discussed; primary perception is under the influence of the unconscious wish, the drives, and the primary process, and it plays an important role in normal dream formation and in certain pathological states. It is believed that the process of dream distortion may take place at the same time, or nearly the same time, as the moment of perception, and may involve the first as well as the second stage of the dream process. Evidence supports the theory that perception develops in levels or stages. Probably the dream cannot create a new visual structure any more than it can a new speech. Memory pictures from the past do not appear in dreams unless screened by a recent visual percept. Evidence indicates that a recent visual percept retains a capacity for hallucinatory revival for not longer than several days.

IRVIN GALIN

Day Residue in Dream and Myth. Martin Wangh. Pp. 446-452.

The author presents a patient's dreams in which the imagery is reminiscent of the myths of the 'little people', such as gnomes and elves. In the formation of this dream, the day residues that formed the preconscious stimulus were intruding external figures (children and squirrels). The unconscious cathexis was derived from ambivalent feelings toward dead and living rivals. These figures were felt as threats, primarily to oral gratification. The dreamwork, by denial and transformation, changed these malevolent figures into helpful, beneficent ones. The author postulates that in the creation of various myths of 'little people' the food supplies of poor people, among whom such myths prevailed, were threatened by external intruders (rodents and children), which formed the preconscious stimulus. When this was re-enforced by the unconscious cathexis of ambivalent feelings toward past ancestry and future generations, the myth could be formed. As in the dream, so in the myth; anxiety is allayed by turning the malevolent into the beneficent.

Color in Dreams. Victor Calef. Pp. 453-461.

From a segment of a patient's analysis the author deduces some theories on the metapsychology of color in dreams. Color in dreams partakes of the resistance and regression inherent in the sensory image of a dream. Color, usually removed by the repressing forces of censorship, may appear when there is danger of a return of the repressed; it represents further regression. Scoptophilic and exhibitionistic impulses form the basis of the latent content of color in dreams; the surprise, fascination, and mystification with which the patient reacts when color in a dream is brought to his attention is directly connected with scoptophilic impulses. Many color dreams are concerned with the primal scene. Perception of color and exploratory impulses probably develop at the same time in the child. Certain problems of color in dreams demand investigation.

Color in Dreams. Louis Linn. Pp. 462-465.

Psychoanalytic literature neglects this subject. Freud believed that colors in dreams are repetitions of those actually seen. Linn contests Dr. Isakower's view that auditory experiences are primary in formation of the superego, pointing out the importance of visual experiences in this function. Moreover it is untrue that expression of the superego in dreams is almost entirely verbal, for color in dreams is also an evidence of function of the superego and, at times, representative of id strivings. It is useful to ask the patient about the shades of colors in a dream and for associations to these colors, which are likely to be numerous.

JAY SHORR

The Convertible as a Symbol in Dreams. Alexander Grinstein. Pp. 446-472.

Grinstein briefly reviews the meanings of the automobile in the manifest dream, then reports five dreams from the analyses of four male patients. In these dreams, the 'convertible' automobile was chosen to express the idea that the patient could be converted into a woman. This is an example of 'plastic word representation'. The automobile serves as a bisexual symbol. All the patients had strong passive tendencies with intense anxiety. Passivity was used as a defense against aggressive impulses.

The Written Dream. Louis S. Lipschutz. Pp. 473-478.

A twenty-three-year-old single man began toward the end of his first year in analysis to write down his dreams and carry them with him in his wallet. When the analyst learned that the patient had not consulted his notes since he had written them, he encouraged him to continue with his associations and then, for comparison, to read the written dream. Four such dreams that occurred during the following two weeks are described. The written dreams were more disguised, sometimes to the point of contradicting the oral report of the dream. The author concludes that the written dream is invariably a transference dream. In the written dream greater distortion is possible, because genetically writing is a later ego function than talking. The written dream is an expression of resistance and

should be analyzed. It can signify the gift of feces to the mother, a wish to have an anal baby with the analyst as father, and a defense against castration anxiety by producing and retaining an anal penis.

HERBERT ALDENDORFF

A Note on Morning Depressions. Samuel A. Guttman. Pp. 479-483.

After brief reference to the various theories of depressed states and the phenomena of sleep, Guttman suggests that in morning depression the affect, 'at least in good measure, is the product of the preceding dreams forgotten or remembered'.

Primitive Genital Mutilations in a Neurotic's Dream. George Devereux. Pp. 484-493.

In this interesting paper, Devereux discusses the complementary relationship between anthropology and psychoanalysis. 'For better or for worse anthropology and psychoanalysis have the same subject matter.' Excerpts from the analysis of a dream of phallic mutilation show how anthropological understanding can be of practical value to a psychoanalyst.

Extramural Psychoanalytic Treatment of a Case of Narcotic Addiction. Robert A. Savitt. Pp. 494-502.

Savitt discusses the difficulties and opportunities that acting out presents to the analysis of a drug addict not in a hospital. Such patients must be carefully selected.

An Episode of Sleepwalking. Don D. Jackson. Pp. 503-508.

Analysis of a patient who had a brief overt psychotic episode preceded by the occurrence of sleepwalking showed that 'the somnambulistic episode and the psychosis have certain features in common regarding the forbidden impulses and the defenses against them'. Jackson reviews psychoanalytic studies of sleepwalking and its connection with enuresis.

Enuresis and Bisexual Identification. Martin A. Berezin. Pp. 509-513.

Analysis of a severe hysterical character neurosis showed that a bisexual identification was 'utilized with striking similarity in enuresis, in masturbation, and in intercourse. . . . It is possible that the enuresis itself may represent a prototypical sexual experience . . . that later . . . acted as a determinant in the fantasies connected with masturbation and sexual intercourse.'

Regressive Reaction to the Interpretation of a Dream. Lawrence J. Friedman. Pp. 514-518.

A patient's regressive reaction to interpretation of a dream raised the technical problem of persistently interpreting not only the evidences of regression but also

at the same time the defensive purpose of the regression. No matter how deep such regression, elements of the œdipus complex are recognizable in it. Persistent interpretation of the defensive nature of the regression will finally result in the giving up of this pathological defense.

MILTON GRAY

The **Psychoanalytic Review.** XLII, 1955.

Empathy, Common Ground of Ethics and of Personality Theory. David A. Stewart. Pp. 131-141.

The goal of treatment is freedom, and good will is the means to that goal. The therapist is best able to reduce his aggressiveness toward the patient when able to identify himself with the patient, and such deliberate self-identification is a precursor to true empathy. It is through empathy that the therapist can cultivate in his patient 'the freedom to choose one way or the other' (Freud). The ethical implications of the concept of freedom and of the limiting of aggression are explored. Empathy is the common ground of ethics and theory of personality. Communication, the *sine qua non* of personality theory, can be fostered in the empathic process in which a person identifies himself with another while developing insight into himself. Control of patient by therapist is incompatible with the therapeutic goal of enabling the patient to be free, to stand on his own feet. It is necessary for this control to be self-control. Then personal freedom is enhanced for both individuals participating in the empathic process.

JOSEPH LANDER

Toward a Theory of the Ego. Stanley Rosenman. Pp. 142-159.

This paper integrates phenomenological and sociological approaches with the more orthodox psychoanalytic ideas in an attempt to resolve some of the present inconsistencies in ego psychology. The ego as agent is conceptually equivalent to the ego as object; behavior is designed to realize one's self-representations. However, the representation of the self derives its meaning from the representation of the other person and the relation of the self with him. Indeed, the self-representation frequently acts merely as a qualifier for behavior that is ascribed, often unconsciously, to an introjected other person. Therefore the ego is finally defined as the resultant of various schemata of self in relation to other. This idea of a multiple structure of the ego is further discussed, and it is applied to problems of character structure, defenses, and emotions.

AUTHOR'S ABSTRACT

Unconscious Mechanisms in 'Writer's Block'. Edmund Bergler. Pp. 160-167.

All artistically creative people have undergone oral masochistic regression, and they employ mechanisms peculiar to them. Creative writing is an episodic temporary sublimation, preceded by a painful and depressive struggle; it is unlike other forms of successful sublimation. 'The creative writer is a perpetual defendant

standing trial before the tribunal of his superego', accused of voyeurism and of wanting to be refused by the image of the precœdipal mother. Creative writing is an unconscious denial of these 'accusations', the work expressing not the unconscious wishes but rather the defenses against them.

Hybris—A Reaction to Positive Transference. Alfred J. Siegman. Pp. 172-179.

Fenichel and Nunberg, among others, have stressed that one of the greatest sources of an interfering countertransference is the analyst's narcissistic need. It is here suggested, however, that interfering countertransference comes from guilt arising in an almost primitive form from apparent gratification during the positive transference. This situation is compared with that of Greek tragedy: 'the original sin of the Greek tragic hero is *hybris,* believing that one is godlike'. When the positive transference elevates the analyst, without any choice on his part, to Olympian heights, he is in the role of the Greek tragic hero. This concept is applied to a study of the handling of the transference and countertransference.

Psychotherapy of Aged Persons. IV. Alvin I. Goldfarb. Pp. 180-187.

Pre-existent psychological problems merely increase the helplessness and disabilities of the aged. Nevertheless, even the very old and disabled continuously struggle to maintain a manipulative mastering contact with the world. This is the basis for effective therapy. The aged tend to show little evidence of guilt, but do have fear of retaliation. The absence of true depression seems to be related to a decreased capacity for affectionate relationships.

Emotions as a Cause of Cancer, Eighteenth and Nineteenth Century Contributions. Samuel J. Kowal. Pp. 217-227.

Medical literature from the eighteenth century to the twentieth is quoted in support of the suggestion that emotional disturbances, especially despair, can produce cancer.

Early Phases of Ego Structure Adumbrated in the Regressive Ego States of Schizophrenic Psychosis, and Elucidated in Intensive Psychotherapy. David W. Abse. Pp. 228-238.

Glover has described the primitive ego as composed of many 'nuclei': an oral 'nucleus' has a positive relation to the nipple, and also a negative (biting) relation. Other erotogenic zones or levels of organization also constitute nuclei. Glover stated also that 'the decomposition products of schizophrenia' represent primitive ego nuclei. This paper postulates that although primitive ego nuclei normally operate during the early course of individual development, these early phases of development are much more intensive and persistent in those people who later develop schizophrenia.

Left-Handed Writing, A Study in the Psychoanalysis of Language. Theodore Thass-Thienemann. Pp. 239-261.

In contradiction of the generally accepted view that left-handedness is congenitally determined, evidence is adduced that all children are congenitally ambidextrous, and left-handedness develops on the basis of unconscious motivation. That writing has come to symbolize coitus is suggested by a considerable mass of philological and other data. Because the connotations of 'left' as opposed to right are those of wrong, sinister, evil, to write with the left hand is to perform coitus in illicit fashion. Because writing is symbolically 'to plow the fields', writing illicitly is sowing 'into the holy field of the mother'; early man's fantasies, preserved in the words we use, dealt much more with agricultural terms than do ours today. This is reflected also in the farmer's supposition that a castrate is meek, good, and tame. The accused, the evil, the unchaste is the left-handed; his illicit œdipal impulses have led him to select left-handedness, thereby acting out both the forbidden impulse and the punishment therefor, of being classed as a pariah.

The Illusions of Work. Harold Feldman. Pp. 262-270.

Because feelings and ideas related to incest are displaced onto work, man has ambivalent feelings toward his work: it is a source of sublimated gratification, and a punishment for such gratification. As technological advances reduce man's enslavement to work, his unstable solution of his œdipal conflict becomes even more precarious. Etymological evidence indicates that the father is seen as an ideal nursing mother, a substitute for the animal preœdipal mother. Everyday language shows many connections between the ideas of deception and of weaving (the prototype of work in general). This is attributed to man's need to maintain his illusions concerning the complex relationships between work, incest, and the role of the father.

On the Superego in Adolescence. Rudolph Wittenberg. Pp. 271-279.

The estrangement of the ego from the superego in adolescence has several causes, such as the increase in instinctual demands and the activation of infantile wishes. Through identification the ego strives to combat regressive tendencies. This identification can interfere with reality testing and growth of the ego and can complicate treatment; there may ensue a less flexible adaptation. A strong identification with the therapist can, however, be used to enable the patient to test reality better, rather than be used in a frontal assault on the infantile wishes. Such ego strengthening is often necessary in the treatment of the adolescent.

Concerning the Biological Aspects of the Œdipus Complex. G. M. Davidson. Pp. 280-283.

The turning of the child to the parent of the opposite sex is linked to a dynamic force stemming from the X-chromosomes of which the boy receives only one from the mother whereas the girl receives one from each parent. The evolu-

tion of this biological impulse is strongly re-enforced by the psychological influences of early development.

Incest as Revenge Against the Precœdipal Mother. Lillian Gordon. Pp. 284-292.

The use of one id impulse as defense against another is illustrated clinically. Manifest œdipal behavior is not merely an acting out of œdipal impulses. Of greater significance is its use to punish the rejecting mother and as defense and denial of masochistic dependence on her.

The Second Book and the Second Play. Edmund Bergler. Pp. 293-297.

It is a major hurdle for the writer of a successful first work to produce a second success. The good and the inferior writer have great difficulty with this second creation. This difficulty is here attributed to the writer's need to prevent and devaluate his own success, which constitutes an attack on himself by his superego.

Paroxysmal Tachycardia. Maria F. Fleischl. Pp. 298-303.

The working through of phobias and transference problems in a thirty-eight-year-old woman led to a drastic reduction in frequency of attacks of paroxysmal tachycardia. This confirms the belief general among doctors that emotion is a major cause of these symptoms.

Modesty as a Quasi-Moral Resistance. Theodore Branfman. Pp. 304-306.

In a case of masochism and impotence, the resistant patient used certain childhood precepts to justify his pseudo-aggressive sexual withholding. His 'sexual miserliness' concealed a wish to be refused, for by identification he had put himself into the role of his wife. His rationalization of this withholding was that he gave, but in modest amounts. Cure of this behavior was effected by destruction of quasi-moral resistance.

JOSEPH LANDER

Bulletin of the Menninger Clinic. XX, 1956.

Chlorpromazine, Depersonalization, and Visual Hallucinosis. Donald J. Watterson. Pp. 20-24.

Recalling a report of Winkelman's that a number of patients on chlorpromazine experienced increased frequency and intensity of dreaming, Watterson became interested in a patient receiving chlorpromazine who had feelings of estrangement, disorientation in space, continuous dreaming, and haunting visual imagery as prominent symptoms of a borderline psychotic process originally precipitated by an operation on the hip. The symptoms continued for two and a half months but began to abate when the patient was admitted to a state hospital and the medication stopped. The chlorpromazine seems to have sustained the symptoms

without making them worse. Watterson postulates that the lessened psychomotor activity brought about by chlorpromazine may be correlative to the promotion or sustainment of visual imagery.

A Controlled, Blind Study of Effects of Thorazine on Psychotic Behavior. P. E. Feldman, B. S. Lacy, A. E. Walker, and N. J. Garrez. Pp. 25-47.

Enthusiasm, suggestion, alteration of accustomed routine, and other factors have caused overoptimistic reports on new drugs. The authors selected twenty-two patients from a male ward for a test of thorazine, carefully controlled to eliminate these factors. Of the eleven given thorazine, nine showed some improvement, moderate or marked in eight. The two who failed to improve were a forty-eight-year-old paretic, psychotic for eighteen years, and an eighteen-year-old catatonic who had been ill and hospitalized for one year. The patient with only slight improvement had been ill for twenty-five years and had undergone lobotomy. The average duration of illness in the improved cases was eighteen and a half years (range, five to twenty-eight years). Of the eleven controls receiving placebos identical in appearance with the thorazine, seven showed no change or became worse. Four showed improvement, but of these two were paranoid schizophrenics who had been ill less than a year, and a third was a mixed manic with alternations of mood for forty-three years.

The authors conclude that thorazine is useful in converting acutely disturbed psychotics into tractable, accessible patients better able to participate in the hospital program of rehabilitation. Brief accounts of all twenty-two cases are included.

LINCOLN RAHMAN

Psychosomatic Medicine. XVII, 1955.

Idiopathic Sexual Precocity in the Male: Management; Report of a Case. J. Money and J. G. Hampson. Pp. 1-15.

Idiopathic Sexual Precocity in the Female: Report of Three Cases. J. G. Hampson and J. Money. Pp. 16-35.

In these two papers, Money and Hampson review sixteen cases of idiopathic sexual precocity, illustrating their findings with detailed reports of one male and three females. Their principal conclusion is that the sexual precocity does not in itself predispose to any psychological maladjustment or gross psychosexual disorder. Overcoming baffling and difficult problems of life caused the important conflicts of these patients. The unusually severe psychological problems of one girl were related not to her precocious development but rather to her life with a psychotic father. No unusual erotic activity was encountered. The authors state '. . . learned information and experience are extremely significant in the genesis of sexual dreams, thoughts, inclinations, and orientation: unlearned biological processes establish only the magnitude of libido; for instance, the intensity and frequency of autonomous genital organ sensations and functions and perhaps of

activities to promote close tactile stimulation of one human body to another'. The importance of providing early and adequate sexual information to these children (especially the girls) is stressed.

Psychophysiological Correlations in Ulcerative Colitis. A. Karush, R. B. Hiatt, and G. E. Daniels. Pp. 36-56.

Six patients with chronic ulcerative colitis were observed during psychotherapeutic interviews, and the physiological activity of the colon was simultaneously recorded in an attempt to correlate segmental colonic motility with emotional responses. The principal emotional reaction producing such colonic activity proved to be fear, usually aroused by forbidden or otherwise conflicting sexual wishes or 'by intense rage at a frustrating "parentified" authority whose protection and love was desired for security purposes'. 'Activation of the colon' may serve as an outlet for increasing autonomic excitation and can be initiated by a variety of physiological disturbances as well as by 'an infantile fantasy of defecation as a means of expression of the suppressed rage at the frustrating "parentified" figure'. These patients looked to a magical, omnipotent authority for cure of their illness and resolution of their conflicts about aggressive rage. Their characters resembled those of paranoid schizophrenics.

Study of Correlations Between Electroencephalographic and Psychological Patterns in Emotionally Disturbed Children. J. H. Taterka and J. Katz. Pp. 62-72.

Electroencephalograms and psychological test findings in one hundred ninety-five emotionally disturbed children were compared with those of a group of comparable children without significant psychological defects. Of the disturbed children, 81.6 percent had abnormal electroencephalograms, about three times as many as in the control group. In the psychological tests the disturbed children showed marked distortions in visual-motor functions, body image, and perceptual functions. These findings support Schilder's thesis that organic damage to the brain leads to a confused body image which in turn plays a significant role in the behavior of such children.

Studies in Itching: (I) Contributions Toward an Understanding of the Physiology of Masochism. J. G. Kepecs and M. Robin. Pp. 87-95.

Tickle, itch, and cutaneous pain are all sensations mediated by the pain-perceptive system and they share many anatomical, physiological, and psychological properties. Itching is 'an intolerable intermingling of approximately equal pain and algedonic pleasure sensations. . .'. Scratching may represent an attempt to relieve this 'intolerable middle ground' by increasing the painful component of the sensory experience. Frequently an ordinarily painful stimulus is felt as pleasurable when the skin is masochistically erotized. The precise basis of this masochistic erotization of the skin is not clear but probably derives from the intensity and nature of the stimulus ('masochistic pleasure is experienced only within

certain levels of intensity of stimulation') and the state of cutaneous excitement (which depends on local factors such as dermatitis, central factors such as the emotional state of the individual, and regional factors such as the comparative excitability of different areas of the body).

Emotional Factors in Graves' Disease. N. M. Mandelbrote and E. D. Wittkower. Pp. 109-123.

Twenty-five cases of thyrotoxicosis were compared to twenty-five controls. The incidence of 'neuroticism' in the thyrotoxic group was significantly higher than in the control group. 'Personality defenses rendered these patients vulnerable to thyrotoxicosis. However, no specificity can be claimed.' The thyrotoxicosis is a form of maladaptation, but no real information is available to explain why the thyroid is affected. Disease of the thyroid may be a symbolic expression of fantasies of oral impregnation, a symbolic expression of introjection of an ambivalently regarded mother or mother's breast, or a nonspecific affective concomitant of regressively released anxiety. In some cases the thyrotoxicosis appeared to be the equivalent of a depressive reaction. The findings in this series of thyrotoxic patients differ in many ways from other reported series, an indication that we must be wary of conclusions drawn from small groups of patients.

Dr. Kinsey and the Medical Profession. Lawrence S. Kubie. Pp. 172-184.

Kubie reviews some of the mutual criticisms expressed by Kinsey and the medical profession. He grants the validity of both sets of charges. Kubie is particularly concerned with the gynecologists' and urologists' ignorance of the sexual lives of their patients, and he points to some of the psychological problems that interfere with the gathering of such information. The principal defect in Kinsey's work is his neglect of unconscious determinants in human sexual behavior. Kinsey blamed all sexual difficulties on the repressive effects of Victorian morality, ignoring the fact that frequently such problems arise in a free and permissive atmosphere. Furthermore, Kinsey insisted on considering sexual behavior as an isolated aspect of an individual's life and failed to recognize that certain sexual patterns and practices are symptoms of an underlying disorder of personality. Using Kinsey's work as an example, Kubie argues for the need of some kind of psychotherapeutic preparation for those who would investigate human behavior in order to clarify their motivations and diminish their emotional blind spots. Kubie concludes his essay with the hope that Kinsey's valuable research can be continued, but with broader scope and with greater psychoanalytic sophistication.

Cutaneous Vascular Reactions in Raynaud's Disease and in States of Hostility, Anxiety, and Depression. D. T. Graham. Pp. 200-207.

Vascular changes in the skin in nineteen patients with a variety of diseases were observed in conjunction with experimentally induced emotional disturbances. Constriction of the arterioles and increased tone of the minute vessels were associated with expression of hostility. Such changes invariably accompanied attacks of

Raynaud's disease in the four cases studied. Similar changes in the skin vessels were noted in those experimental situations where anxiety was demonstrated. When depression was produced, the vascular changes consisted of arteriolar constriction but a decrease in tone of the minute vessels.

Nocturnal Gastric Secretions of Ulcer and Nonulcer Patients Under Stress. P. Wolff and J. Levine. Pp. 218-226.

The nocturnal gastric secretions of five patients with duodenal ulcer and an equal number of controls were studied before and after the induction of emotional stress. Under stress, the patients without ulcers showed greater production of acid than the patients with ulcers. The reverse was true when the subjects were not under stress. The difference occurs because the patients with ulcer are already in a state of chronic anxiety and therefore respond less sensitively to a small additional stress.

Sudden Death from Asthma. D. Leigh. Pp. 232-239.

A forty-year-old woman with chronic bronchial asthma died shortly after a psychotherapeutic interview. Leigh suggests that her sudden death occurred because the emotional reactions associated with the psychotherapy stimulated excessive vagal discharge which produced a heavy flow of intrabronchial mucous; asphyxia resulted. Leigh suggests that atropine be administered before interviews when excessive emotional discharge is expected.

EDWARD WEINSHEL

Archives of Neurology and Psychiatry. LXXII, 1954.

A Neural Fractionating and Combining System. Richard M. Brickner. Pp. 1-10.

The type of verbalization manifested under the influence of amobarbital suggests that a specific and definable portion of brain organization operates during narcosis. This portion is designated the C-organization. The definable and reproducible mental activity that occurs under anesthesia indicates certain inherent properties of the neural organization rather than simply a superimposed pathological process caused by the drug. The verbalizations of narcotized patients suggest the concepts of 'fractionation' (separation of complicated intellectual units into smaller parts) and 'recombining' (of words and concepts), which are the principal modes of the C-organization. The C-organization provides new combinations of fractionated material for such intellectual functions as memory and constantly forms comparisons and categories.

By the innate processes of neurophysiological functioning, fractions are always being formed and comparisons always being made; these comparisons may generate conflict and hostility. 'It might help to make behavior more objective if people knew that the comparisons they were acting on often had only slight founda-

tion in external reality and were mainly based on a neurophysiological need to find something to compare.'

According to these concepts, the unconscious is regarded as one aspect of the C-organization, which forms the underlying physioanatomical groundwork. Although Brickner does not explicitly say so, the hypothesis of a C-organization appears to be an effort to establish a neural basis for primary process mentation as observed in narcosis.

Appetitive Behavior and Sign Stimuli in Human Life. Richard M. Brickner. Pp. 92-107.

In introducing a theory of behavior and consequent therapeutic applications, the author states that customary evaluations of instincts 'do not seem to consider the huge component of the human personality comprised by instincts. . . . Man's relation to the rest of the animal group is not regarded as a primary, dynamic force underlying his behavior. It is seen as something the human organism tries to get away from; the animal components of man must be repressed and escaped from for man to fit into society. Instincts . . . are considered more as nuisances than as essential parts of man and as the intrinsic foundation of his individual and social behavior.'

Behavior is the expression of those 'survival functions' that have enabled the species to survive in the evolutionary struggle. Survival functions and instincts are similar concepts, but survival functions may employ many of the instincts. Examples of such survival functions are the functioning of the individual as an entity, the self-importance of the organism causing it to satisfy needs such as eating, and the ways of responding to other entities. The human brain takes over and elaborates the expression of survival functions by means of inherited and acquired telencephalizations. 'The cortex is thus not an organ for repressing primitive processes in the interests of group living; one of its main functions is the expression of these very processes of survival functions. . . . Various cultures differ in the way they teach of telencephalizing survival functions.'

By means of purposive and plastic 'appetitive behavior', specific 'sign stimuli' are sought in order to consummate survival functions (or instincts). In man, adequate telencephalization of the survival functions enables appropriate appetitive behavior to find those sign stimuli that afford satisfaction of the impelling survival function. Thus a particular mode of behavior, such as work, is the consequence of the appetitive search for a learned stimulus to satisfy a survival function. Significant past frustration of such a function could lead to a continual unsatisfying search for consummation. If learned sign stimuli do not coincide with inherited ones, the survival function is given only distorted, unconsummated expression. The effort to achieve consummation may then be manifested by repetitive unsatisfying behavior. Other types of interferences are described, and their relation to diseases explained.

By means of a procedure using narcosis and the reading of appropriate scripts therapeutic results were achieved. It is suggested that the procedure split off learned sign stimuli from instincts with consequent alteration in the instinctual manifestation or its relation to sign stimuli. Four cases are cited.

MAIMON LEAVITT

Psychological Review. LXII, 1955.

The Descent of Instinct. Frank A. Beach. Pp. 401-410.

The concept of instinct served practical purposes in secular and sacred philosophies. It provided a rationalization for elevating man above other creatures. As a result of the Darwinian revolution, the concept gained scientific attention. 'Proponents of the evolutionary theory accepted uncritically the assumption that all behavior must be governed by instinct or by reasoning. Their aim was to demonstrate that animals can reason and that men possess instincts. The same dichotomy has persisted in experimental psychology. Attempts to eliminate the instinct concept were unsuccessful because those who made the attempt accepted the idea that all behavior is either acquired or inherited. No such classification can ever be satisfactory. It rests upon exclusively negative definitions of one side of the dichotomy. The analysis that is needed involves two types of approach. One rests upon determination of the relationships existing between genes and behavior. The other consists of studying the development of various behavior patterns in the individual, and determining the number and kinds of factors that normally control the final form of the response.' The author expects the concept of instinct to be replaced by one that will yield more fruitful explanations of behavior.

PHILIP S. HOLZMAN

Helliniki Iatriki. XXIV, 1955.

Melampus's Treatment by Psychocatharsis of the 'Childlessness' of Iphicles. D. Kouretas and G. Tsoukantos. Pp. 1025-1029.

This interesting paper shows that the ancient Greeks possessed knowledge of the unconscious and of the role of traumatic events in sexual life. In pre-Homeric times, Melampus, diviner and healer, attributed the sexual impotence of Iphicles, King of Thessaly, to castration anxiety strengthened by a traumatic event in childhood caused by his father. Suggestion and disclosure of the old trauma cured Iphicles of his impotence and enabled him to have two sons.

GEORGE ZAVITZIANOS

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Meetings of the New York Psychoanalytic Society

Merl M. Jackel

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NOTES

THE TWENTIETH INTERNATIONAL PSYCHOANALYTIC CONGRESS will be held in Paris, from Sunday, July 28th through Thursday, August 1, 1957.

All psychoanalysts listed in the 1956 International Psychoanalytic Association's roster need only complete the registration forms which have been mailed to the membership and send them with the Congress admission fee to Dr. S. Nacht, President of Committee on Organization, 187 rue St. Jacques, Paris 5, France.

Students of accredited psychoanalytic institutes or training centers should have their registration forms countersigned by the secretary of their institute (or training center).

Admittance will be granted to a limited number of guests who can claim prolonged and serious scientific contact with and interest in psychoanalysis—provided they are recommended by a recognized local (or national) psychoanalytic society and approved by the Central Executive of the International Psychoanalytic Association. Such applicants should obtain letters of recommendation from two members of an affiliate society of the American Psychoanalytic Association and submit these letters with their registration forms to the secretary of that society. The endorsed registration form and letters of recommendation should then be forwarded for countersignature to the President, Dr. Heinz Hartmann, 1150 Fifth Ave., New York 28, N. Y., or to the Hon. Secretary, Ruth S. Eissler, M.D., 285 Central Park West, New York 24, N. Y., of the International Psychoanalytic Association.

The Annual Meeting of the AMERICAN PSYCHOANALYTIC ASSOCIATION is to be held in Chicago at the Morrison Hotel from the ninth through the twelfth of May, 1957.

Scientific papers, not requiring more than forty minutes to read, and brief communications of five or six pages are solicited for this meeting.

The Executive Council of the Association has approved the recommendation that papers presented to the Association become the property of the Journal of the American Psychoanalytic Association, but that a liberal policy be pursued in releasing such papers upon the author's request.

Manuscripts and inquiries should be addressed to the Chairman, Program Committee, The American Psychoanalytic Association, 36 West 44th Street, New York 36, N. Y.

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

January 17, 1956. THE RELEASE OF INTERNAL IMAGES. Gustav Bychowski, M.D.

This paper is the fourth in a series of studies under the general heading of The Ego and the Introjects. In following the vicissitudes of these introjects, the author has found that in certain types of patients and under certain conditions, there is a tendency to 'externalize' the introjected image. This process he calls 'release of the introjects'. Under this heading he discusses clinical phenomena which we have been accustomed in the past to include under the term 'projection'.

Externalization is a process leading to the creation of objects or part objects, whereas in projection what is projected are certain drives or certain instinctual drives. This phenomenon is particularly likely to occur in individuals whose attitude toward their parents at an early age was characterized by deep ambivalence. Incorporation, in such cases, results in a split in the ego along the lines of the 'bipolar' cathexis, love and hate. Whereas previous papers dealt with this problem in male homosexuals and schizophrenics, the present paper applies to latent schizophrenics.

As an example of externalization of introjects without active participation of the ego, the author presents a case. A college student in the course of his analysis repeated the process of externalization in everyday life and in the transference. He reacted with intense ambivalence to individuals whose image became fused with projected internal images. He would want to attack them and smash their skulls. At the same time he felt drawn to them and would want to make love to them if they were women or submit sexually to them if they were men. At night he would be haunted by invisible and frightening 'presences'. He anticipated their immediate materialization and looked for them under the bed and behind doors. Sometimes his parents came back in the form of floating olfactory hallucinations: mother was represented by perfume or menstrual odors; father by the smell of tobacco or perspiration.

The author found that the early incorporative mechanisms have a most concrete character and are preserved in their original freshness. The release of these introjects is accompanied by an eerie feeling and partakes of the uncanny.

The release of the internal images represents a reversal of the original process of incorporation. Under certain special conditions the ego feels the need to reexperience the object as lying outside the boundaries of the ego. In explanation, the author supposes that because of powerful instinctual forces, the original introjection was accomplished with difficulty so that at certain critical points in instinctual and ego development they were released and then reintrojected, i.e., during transition from oral to anal phase, or anal to phallic phase, various stages of the œdipal conflict, the climacterium, and the analytic situation. Important aspects are intense ambivalence and an oscillation between activity and passivity. The split segments are maintained in the ego by countercathexis. Weakening of this would create a condition favorable to release of the introjects.

The author describes two ways in which the analytic situation can bring this about. In working through, the ego is forced to give up parts of the countercathexis by which the introject is kept deeply buried with or without symptom formation. Second, the transference situation forces the ego to send out considerable quanta of libido, which apparently are taken away from the investment in the archaic introjects.

The author applies his theory to religious experiences, to the uncanny character of the early schizophrenic hallucinatory experiences, to some aspects of art, and to intoxication by mescaline.

Dr. Rudolf Loewenstein felt that the concepts of projection, introjects, memories, and fantasies were not clearly enough distinguished in the paper. He warned against too ready acceptance of the patient's descriptive terms, which might lead

to a kind of demonology and 'exorcism'. This discussant felt 'release' had been used in three different senses, which should be separated: 1, projection, as in psychosis; 2, transference; 3, certain processes occurring in analysis which lead to separation of past from present and inner reality from outer reality.

Dr. Jacob Arlow was of the opinion that studies such as this might shed light on the psychology of demonology. He criticized what he felt was a lack of precision in the use of the term 'ego'. He also pointed out that not all that is projected necessarily represents an externalization of an introject, and that 'release' resulted from a shift in the equilibrium between the cathexis and countercathexis of the introject. He mentioned the following possible advantages of release of introjects: freedom from conflict resulting from ambivalence; transforming an intrapsychic problem into an interpersonal one; freedom from symptoms; preservation of object relationship; recouping the lost sense of omnipotence. He maintained that release of the introjects was not a cure.

Dr. Ludwig Eidelberg stressed the importance of repressed infantile libido. He objected to the term 'release' since it implies one can get rid of narcissistic libido. Release of an object should not be regarded as therapeutic.

Dr. I. Peter Glauber stressed the frequency of part-object representations in this type of patient. Clinically, these patients come to consider growth as repetitive processes of birth. At such points they frequently act out; furthermore, the analyst is apt to misunderstand the release of an introject as an attempt at true object relationship and thus be misled. Theoretically, he finds Dr. Bychowski's approach important in that it studies the ego from the standpoint of various cathexes as well as structure.

In his closing remarks Dr. Bychowski pointed out that this approach might be helpful in understanding the transformation of ego libido to object libido. As to why in these patients changes in the ego cathexis led to externalization rather than, for instance, to symptom formation, this, he believed, was peculiar to the ego structure of these individuals.

MERL M. JACKEL

February 14, 1956. PHOBIC AND COUNTERPHOBIC ATTITUDES IN A RESEARCH SCIENTIST. Robert A. Savitt, M.D.

This is a report of an analysis, still in process, of a research scientist, with particular attention paid to phobic and counterphobic mechanisms. The patient, a man in his thirties, had as his main presenting symptom a severe and acute syphilophobia, which followed a visit to a prostitute.

The patient had a phobic and irascible father, and a rather cold rejecting mother who expected the patient to excel intellectually and to make reparation to her for her difficult pregnancy and labor. As a child he was frequently threatened for minor infractions and developed intense feelings of guilt. His early development was precocious. Significantly he had repressed the memory of his mother's second pregnancy when he was four. His aggressive fantasies toward mother were turned into overpoliteness; his sadistic fantasies were sublimated in his research which involved the killing of laboratory animals. Although he observed his sister's anatomy, he managed to scotomize the lack of a penis in women

until the age of eighteen. His castration conflict was represented by a temporary period of fetishism and transvestitism during adolescence. His concept of the vagina was that of a dangerous castrating cavity, but he managed, with the aid of counterphobic mechanisms, to associate with girls. Strong scoptophilic impulses are related by the author to the investigative curiosity of his later scientific research.

At thirteen he built a cannon. As an adult he built a scientific apparatus of great merit and usefulness which was nicknamed 'penis' by his co-workers.

He derived considerable gratification from his work. His research dealt with a search for healing factors as a reaction against his sadistic wishes and fantasies which included preoccupation with poisons and thoughts of mass murder. Some of his aggressive impulses were gratified by killing laboratory animals, while reactions to these impulses were countered by rituals like hand washing, which not only served to undo guilt over masturbation but also cleansed his hands of the blood he had shed. He developed new phobias as old ones were analyzed. The author describes him as a 'character in search of a phobia'. He compulsively avoided pleasure and approached intercourse as a prescribed duty, fearing that it might kill him.

The author believes that his career as a researcher offered him an opportunity to meet the requirements made upon him by his parents. He was able to demonstrate his brilliance and to daydream omnipotent fantasies about gaining international recognition. While this fed his narcissism, his symptoms served to expiate his guilt. His research became a partial means of transferring his unconscious sadism to acceptable aims. Another factor motivating him was his need to disprove his unreasonably authoritative father, whom he feared. The content of his experiments dealt essentially with the problem of symbolic restitution of the penis as reassurance against his fear of castration. His voracious acquisition of knowledge from childhood on is viewed as a counterphobic mechanism in the process of sublimation. This patient illustrates a type of sublimation easily disturbed by the breaking through of anxiety and by the sexualization of his work. At such periods his productivity would decline, although never cease entirely. The author raises the question: why was this very disturbed man able to be so productive? The case illustrates the use of sublimation in work (research) as a way of mastering castration anxiety, acting out bisexual fantasies, and channeling aggressive and libidinal drives. It contains gratification and expiation and atonement.

Dr. Kubie welcomed this contribution to the study of interweaving of neurotic mechanisms and scientific creativity, and likened it to the problem of the choice of the neurosis. He declined to differentiate dynamically between sublimation and symptom formation. He emphasized the neurotic malignant quality of the patient's scientific interest and wondered if his scientific contributions cannot be considered a symptom. Why did this man not become a paranoid schizophrenic? With analysis, what might be expected of his scientific work? Dr. Tarachow suggested a further investigation into the relationship between sublimated scientific interest and scientific curiosity which stops at the stage of an obsession. There must be some critical factors which impel movement from pure symptom

to sublimation. He also raised doubts about the possible diagnosis of schizophrenia in this patient. He was particularly impressed with the object relations which the patient maintained in spite of his anxiety. Dr. Sperling proposed the accumulation of a series of case histories of scientists for purposes of research into motivations of scientific work. Dr. Ostow emphasized the masochistic side of the patient's personality and felt that the 'penis machine' which the patient constructed could very well also represent a uterus. Dr. V. Rosen deplored the lack of material relative to the transference in this paper, and Dr. Brodsky questioned the use of the term counterphobic for much of this patient's behavior and called for a greater discrimination between the various types of defense which make up sublimation.

HENRY F. MARASSE

February 28, 1956. TRAUMA, DEPENDENCY, AND TRANSFERENCE. Max M. Stern, M.D.

Transference is studied by Stern as an ego function in the service of self-preservation. It is regarded as similar to the conditioned reflex which results from a physically traumatic situation. Transference is defined as a fixation to a previous situation displaced onto a substitute object which symbolizes the previous experience. It is an attempt at reparative mastery of the infantile sexual trauma. Trauma is defined as any occurrence resulting in a more or less lasting damage to the function of self-preservation. Primary trauma is a physiological condition characterized by a failure of internal homeostatic regulation in a situation of stress. Psychic trauma is any experience which elicits anticipatory repetition of previous primary traumata. Any threat of such repetition automatically produces a physiological homeostatic effect which is called primary defense. Primary defenses seem to be the precursors of psychic defenses. Infantile traumata are instrumental in creating transference by forcing a libidinal dependence and premature development of the mental apparatus, especially of symbolic thinking. Libidinal gratification is associated with protection against trauma. Stern feels that formation of the ego, relation to objects, and transference are simultaneous processes developing under the impact of trauma in a circular way, one re-enforcing the other. The fixation in transference is to the protective anxiety-reducing effect of libidinal dependence in situations of stress.

Fixation persists after danger is past because of later traumata, particularly those associated with pavor nocturnus. Stern ascribes far-reaching traumatic impact to such nightmares. He feels that the nightmare is not only an expression of psychopathology, but in itself produces psychopathology. Premature sexual stimulation contributes to the traumatization because of physiological immaturity. The trauma of the primal scene is attributed to its elaboration in nightmares rather than to the scene itself. The degree to which it is able to integrate the traumata is determined by how strong and reliable are a child's object relationships. Examples are given from four patients in whom the analytic transference induced repetition of traumatic nightmares of childhood.

In the discussion, Dr. Greenacre noted that the fantasied trauma is the nucleus of the neurotic disturbance, but that realistic traumata may have an organizing

effect on the fantasy and produce a state of shock which may also initiate a new psychic trauma. While agreeing that pavor nocturnus is possibly a traumatizing force, she called attention to the restitutive and protective function of the dream, even in nightmares. She emphasized that basic transference originates in the body warmth of the mother holding the child in the first year of life, and preferred to regard traumata as increasing transference demands rather than as creating transference. Dr. M. Sperling agreed with Dr. Stern's emphasis on pavor nocturnus, and classified three types of nightmare: psychotic, traumatic, and neurotic. Dr. Ostow noted three points: 1. Stern's concept that the displaceability of libidinal cathexis can be founded on the organic disposition to respond by conditioned reflex must be limited. 2. The idea that pavor nocturnus is both an expression of neurosis and a contributor to neurosis has parallels in organic medicine, and deserves further study. 3. That transference is a re-establishment of an object-libidinal relationship in response to a current trauma which revives early infantile traumata tacitly assumes the repetition compulsion while attempting to replace it. Dr. Mahler maintained that pavor nocturnus is much more frequently observed by general practitioners and pediatricians than by psychoanalysts.

SAMUEL R. LEHRMAN

April 10, 1956. THE STRUCTURE OF THE *Déjà Vu* EXPERIENCE. Jacob A. Arlow, M.D.

The *déjà vu* is common in normal and in pathological states. Freud noted that *déjà vu* corresponds to the memory of an unconscious fantasy; Oberndorf, that it constitutes a defense against a future danger as well as anxiety associated with the memory of an undefined, unsolved experience of the past; Marcovitz, that it represents the illusory fulfilment of a wish that one might make the outcome accord better with the desire.

Dr. Arlow cited in detail two *déjà vu* experiences that occurred in the analysis of a thirty-three-year-old male patient. In the first, the analogy to dreams was emphasized; i.e., each manifest element in the *déjà vu* phenomenon was richly determined by its latent connections. The entire reaction, like a dream, was interposed in the patient's psychic life against the genetic development of his conflict. Both the affective tone and the accompanying misjudgment of perceptions could be understood in the same manner as the manifest content of a dream; i.e., they represent condensed expressions of many latent trains of thought, subject to defensive distortions and displacement, capable of representing the expression of wish fulfilment. A second example from the same analysis was cited to demonstrate the overdetermined defensive structure of *déjà vu*.

Dr. Arlow then postulated theoretical formulations for the phenomenon. The *déjà vu* constitutes a defense against overwhelming anxiety. It represents the result of a combination of several defensive activities of the ego in a situation which both symbolizes and stimulates the revival of an anxiety-producing memory, wish or fantasy. The memory, wish or fantasy which threatens to emerge is minimized as being unreal, dreamlike or already past. The inner source of anxiety is suppressed by projection or external displacement. The current situation is offered as a substitute for the original memory or fantasy in an effort to keep the

memory or fantasy repressed. This is dynamically similar to the function of screen memories as substitutes in the aid of repression. This provides the consoling feeling, 'Don't worry you have been in this kind of dangerous situation before and emerged safe and alive. The same will happen now.'

The wish is not from the id but from the ego, and is not a compromise formation. It is a transitory, circumscribed disturbance of a specific ego function. The associated affect similar to that experienced in typical 'examination dreams' or 'missing train dreams' serves to fortify the feeling of consolation. The precise relationship between the *déjà vu* encountered in organic brain conditions and the defensive response of the ego remains to be clarified. The difference between *déjà vu* and hallucinations was then noted. The former is related to an illusion, the latter is associated with falsification of perception and disturbances in reality testing. *Déjà vu* differs from delusions by the ready amenability to discriminatory judgment of the true nature of the perceptions received. However, delusions may incorporate into their structure the unsuccessful reassurance of *déjà vu*.

In the discussion, Dr. Louis Linn cited his experiences in a hospital neurologic service, noting the similarity of his findings to Dr. Arlow's. In every *déjà vu*, three elements can be distinguished: a psychologically traumatic external reality; a withdrawal of cathexis from the presenting traumatic reality; the hypercathexis of a previous trauma, affectively linked to the present one, but which has been successfully mastered. Dr. Ernst Kris noted that one must assume the operation of a historic factor to account for the use by the ego of an extremely primitive device, namely the renunciation of some of its functions particularly in the visual sphere. He noted the continued stimulation of this patient from early childhood. What is archaic in his responses may have been due to symptomatic and regressive factors devolving upon these experiences. He also pointed to the absence of a sharply demarcated latency period. Dr. Bertram D. Lewin related the *déjà vu* both to dreams and to nursing. Dr. Ludwig Eidelberg differentiated guilt from remorse stating that the neurotic feels remorse when he should feel guilt; the *déjà vu* then acting as an undoing: 'It is not true that I am peeking at my mother; I am looking only at a completely harmless garden'. Dr. Meyer cited several instances of *déjà vu* in surgical patients where the defense was used to deny alterations in body image. Dr. Judith Kestenberg discussed the problem in terms of the infant who uses recognition as a method of warding off anxiety and obtaining pleasure. Dr. Ostow discussed *déjà vu* in terms of brain function, noting that the *déjà vu* not only expresses ego wishes, but also id wishes. Dr. Rosen postulated that the *déjà vu* has to find a compromise between two anxieties, and settles upon a familiar scene. Separation anxiety must also be considered. Dr. Heinz Hartmann raised the question whether the 'uncanny' is not also an affect similar to guilt or anxiety.

Dr. Arlow, in closing, noted the importance of reviewing the *deja vu* in the light of each patient's analysis. In his case each of the experiences had the structure of one particular fantasy: castration anxiety. Although separation anxiety and the other dynamics mentioned by the discussants did exist, they were not directly related to the *déjà vu* experiences of the patient. Dr. Arlow emphasized Dr. Kris's statement that visual function was enlisted not only in the service of

libidinal gratification but also for mastering anxiety. The role of identification with the mother in the specific task of reassurance against anxiety played an important part. The oral factors were noted but again were not part of the recorded symptom.

HARRY JOSEPH

June 12, 1956. A STUDY OF 'THE PRELIMINARY STAGES OF THE CONSTRUCTION OF DREAMS AND IMAGES'. By Charles Fisher, M.D.

The experiments reported are extensions of Fisher's previous work on preconscious perception, utilizing Poetzl's method of tachistoscopic exposure of pictures and the examination of subsequent dream material for derivatives of these stimuli. In this study pictures were tachistoscopically exposed to the subject below recognition thresholds. Immediately following a tachistoscopic exposure, the subjects were requested to close their eyes and to report and make drawings of any images that had developed. This is described as a process of 'free imagery' analogous to free association. Following the period of the 'free imagery', the subject was requested to make comparisons between the drawings of his images and the number, words, or pictures that had been exposed upon the screen. In a combined dream-imagery experiment, the re-exposure of the picture was postponed until the next day, and instead the subject was given a suggestion to have a dream that night. Drawings of the manifest dream images (if any) were obtained. Protocols of sixteen positive results are reported with graphic illustrations. These suggest very strikingly that memory images of preconscious percepts derived from the tachistoscopically exposed picture appear in the images that develop during the period of 'free imagery' and in subsequent dreams. The images which developed during the imagery experiment may be photographic or distorted representations of the preconscious percept, resulting from the tachistoscopic exposure. These images are constructed in precisely the same manner as the manifest images of dreams. According to Fisher, manifest dream images may in part be reactivations of such images.

Fisher suggests several implications for the theory of perception, including a revision of Freud's model for the construction of the manifest dream content. It is demonstrated that perception cannot be simply equated with consciousness, as in the familiar freudian model. A more comprehensive model is suggested by Fisher, which takes into account the greater complexity of image formation indicated by his experimental results, particularly in regard to the preconscious registration of day residues. In this description the necessity for making a distinction between a 'progressive' or 'regressive' course of the dream impulse is obviated. In conclusion, Fisher stresses the thesis that there are no 'new' constructions in the manifest dream content, and that each manifest element in the dream can be shown to be derived from the fusion of infantile memory-pictures associating the unconscious wish with recent sensory material, especially preconscious visual percepts.

Dr. George S. Klein in his (invited) discussion, pointed out that psychoanalysis has had generally too little to say about the detailed workings of cognitive proc-

esses. He felt that one reason for this gap has been the need for laboratory assistance in such a study, since the tools of the consulting room are more adequate to the task of studying adaptive results of processes than their determining drives. The laboratory enhances the opportunity for such a study, although it imposes grave limitations on the study of motivation. Dr. Klein felt that in the union of clinical and laboratory studies lies the possibility that psychoanalysis will indeed become the comprehensive general psychology which Freud envisioned. Dr. Fisher, according to Klein, has made a long stride in this direction. He has demonstrated experimentally the extraordinary efficiency of perceptual registration without awareness. Second, he has highlighted the complex motivational web into which 'incidental' perceptions or registrations can be drawn. Third, his work implies that perception outside of awareness actually acquires distinctive qualities from the very fact that it is unaccompanied by awareness. Fourth, Klein feels that Fisher has taken experimentation to the point where it may now be possible to investigate the role of perception in inventive and creative thinking, and last, not the least of the merits of his work has been the demonstration of the usefulness of laboratory experiments for a general psychoanalytic theory of thought processes. Dr. Klein's criticisms of Fisher's experimental methods were first, that its emphasis was too heavily laid upon demonstration rather than upon variation of conditions; second, the heavy reliance upon an *ad hoc* plausible rationale at the expense of controlled variation of conditions; third, 'an unfortunate tendency to by-pass instances where the effects do not occur'. Dr. Klein hoped that future studies would clarify the issue: 'that if there is such wholesale co-ordination between motives outside awareness and peripheral or incidental percepts outside of awareness, and if these affect the thought product, both in the waking state and in various stages of consciousness, isn't it remarkable that perception can nevertheless be so efficient and so well co-ordinated with reality under most conditions of perceiving?'

Dr. Mortimer Ostow felt that some of the difficulty in understanding what goes on in perception arises from the difficulty in terminology. He believes that we may clarify our thinking if we restrict the term 'perception' to the process of registering a percept within the central nervous system and use the term 'apperception' to denote the process by which the percept is given meaning and is integrated into central nervous system processes. He feels that the tachistoscope introduces an artifact. Dr. Ostow wonders, for example, how different Dr. Fisher's results would have been had he used exactly the same technique without a tachistoscope. He asks whether 'free imagery' and dream imagery would not then proceed in an entirely similar fashion. Ostow suggests that the fusion of some percepts with an unconscious memory may be an alternative reason for their being rejected from consciousness. Dr. Max Stern asked whether the test situation, which inevitably involves a failure to recognize a presented stimulus, might activate previous traumatic failures and contribute this unconscious meaning to the resultant images and dreams.

Dr. Jan Frank suggested that Dr. Fisher's methodology may be one approach to the measurement of the elusive ego quality of 'ego weakness' or 'ego strength'. Dr. Rudolph Loewenstein noted that Dr. Fisher's results explained the dissatisfaction that we often feel in dream analysis in fully understanding the provoking

stimuli. He felt, unlike Dr. Klein, that demonstrations of the phenomena being studied were still important and that Dr. Fisher should continue with the tachistoscopic method until he had fully exploited it. Dr. Loewenstein also disagreed with Dr. Ostow's criticism of terminology. The question of the connecting links between the preconscious percept and its state in the manifest dream content is another question still to be studied and should not be confused with the phenomenon that Fisher has demonstrated.

Dr. Max Schur reported the registration of subliminal auditory phenomena in a patient with partial deafness as an example of a method of implementing Dr. Klein's suggestion for studying phenomena other than visual tachistoscopic ones.

Dr. Samuel Atkin called attention to the special attributes of the tachistoscopic test situation. He was impressed by the fact that out of the welter of stimuli to which the subject is exposed during the day, those of the test situation still largely dominate the subsequent dream material. Dr. Atkin noted that the analyst's consultation room is also a laboratory and that particularly in the transference situation, the patient is exposed to subliminal tachistoscopic impressions. Atkin suggests that the highly charged experimental situation is analogous to the analytic transference and may account for the curious dominance of the experimental subliminal impressions over those arising from other sources.

Dr. Ernst Kris predicted, in regard to questions raised concerning the difference between the tachistoscopic and nontachistoscopic exposure (in dreams and imagery), that this would be apparent in the longer time interval necessary for the nontachistoscopic exposure to be utilized by the primary process. In other words, the greater the ambiguity of the percept, the more immediate its usefulness for the dream work. Dr. Kris noted that many of Dr. Fisher's graphic examples were reminiscent of the end phases of the work of certain modern artists in which the decomposition of the percept is consciously utilized as an artistic technique. The similarity of this process of decomposition and the preconscious percept in the experimental situation is a function of their proximity to the id, whether they arise from an unconscious psychic process or as part of a designed, creative act.

In his summary, Dr. Fisher agreed with Dr. Klein that other lines of work were indicated, and that his present efforts had been largely on a level of demonstration. He noted that it was not altogether true that negative results had been bypassed, having pointed out in some instances, for example, that this was based upon the subject's inability to draw or a blocking of the process of free fantasy. Nor is it entirely true that he has remained too attached to the tachistoscope, other types of experimental situations having been cited in his earlier works. The failure to study individual differences, also noted in Dr. Klein's discussion, was explained as part of an initial attempt to study first the universal aspects of the phenomenon. Future plans include the study of defenses against preconscious percepts, experiments with hypnosis, with drugs such as LSD and mescaline, and also patients with injuries of the brain. Dr. Fisher did not agree with Dr. Ostow that the term 'perception' should be confined to conscious registration and another term such as 'apperception' reserved for preconscious perception. The best we can do, he believes, is to agree that there are prestages leading up to conscious perception, which may take place at unconscious or preconscious levels. In regard to Dr. Schur's remark, Dr. Fisher noted that he also had some evidence in his

own work that auditory percepts are handled in the same way as visual ones and probably also the same holds true for other sensory modalities.

VICTOR H. ROSEN

THE PSYCHOANALYTIC SOCIETY OF PARIS celebrated the centenary of the birth of Sigmund Freud in November 1956 at the Congress of Romance Language Psychoanalysts which includes the Belgian, Italian, and Swiss Psychoanalytic Societies.

To commemorate Freud's sojourn in Paris in 1886 in the service of Charcot at the Salpêtrière, a plaque was dedicated in the amphitheater which bears a memorial to Charcot, recalling Freud's association with him.

Attending this ceremony were Monsieur André Le Trocquer, President of the National Assembly, and Professor Lajouanine, head of the Clinic of Nervous Diseases.

Addresses were made by Dr. Ernest Jones, Madame Marie Bonaparte, Dr. M. Bouvet, President of the Paris Psychoanalytic Society, and by Dr. S. Nacht of the Paris Institute of Psychoanalysis.

Professor Freud's family was represented by his son, Ernst Freud, in the absence of Anna Freud who was indisposed.

Monsieur Lechat spoke for the Belgian Society, and Dr. de Saussure for the Swiss Society, following which Dr. Francis Pasche paid homage to Professor Freud, the man and his works. In the discussion which followed, several participants emphasized the harmonious integration of his achievement with the humanistic sciences.

Dr. Michael Balint, formerly Director of the Budapest Institute for Psychoanalysis, has been appointed Visiting Professor of Psychiatry in the UNIVERSITY OF CINCINNATI MEDICAL SCHOOL. Dr. Balint will spend a month of each academic year in residence in Cincinnati, participating in the training program for psychiatric residents. At present he is in practice in London, is a member of the faculty of the London Institute for Psychoanalysis, and a consultant at the Tavistock Clinic.

Mrs. Enid Balint has been appointed to the faculty as Visiting Associate Professor of Research in the Behavioral Sciences and will collaborate with her husband in the teaching program.