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G. Stanley Hall

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SIGMUND FREUD AND G. STANLEY HALL: EXCHANGE OF LETTERS

We seldom see so free and frank an exchange of ideas between major figures in intellectual history as appears in the final correspondence between the American psychologist, Granville Stanley Hall (1844-1924), and the founder of psychoanalysis, Sigmund Freud (1856-1939). Hall and Freud were eminent in different ways. Hall as an editor, teacher, and college administrator contributed greatly to the development of the disciplines of psychology and education in the United States; moreover, a large, educated audience heard and read his interpretations of contemporaneous social developments. The courage of the two men in their willingness to review their relationship and to discuss fundamental problems gives to this exchange of letters more than ordinary interest.

Stanley Hall was the older of the two men and died a few months after writing his letter. Born in rural New England, he expected to become a clergyman. As a result of two trips to European universities he turned away from the ministry and, after studying under William James, received the first Ph.D. awarded in psychology in the United States. He founded the psychological laboratory at Johns Hopkins University and started the first psychological periodical to be published in this country, The American Journal of Psychology. As interested in pedagogy as in psychology, he was the founder of genetic psychology as a discipline. In 1888 he became the first president of Clark University, a post that he held until retirement and that seemed to bring him little but grief. Hall was an impresario of ideas; his biographer characterized him as 'The Playboy of Western Scholarship' *(15)*.

These letters, in the Harvard University Health Services Library, Cambridge, Massachusetts, have been annotated by John Chynoweth Burnham, Ph.D., a post-doctoral fellow of the Foundations' Fund for Research in Psychiatry at the Austen Riggs Center. Dr. Robert L. Nelson coöperated generously in preparing them for publication. The letter by Freud is published with the permission of Mr. Ernst L. Freud; the one by Hall is published with the permission of Dr. Robert G. Hall.

In the first decade of this century Hall spoke and wrote about Freud's work more than almost anyone else in America, including physicians who specialized in nervous diseases. 'Who could have known', Freud wrote to Oskar Pfister, 'that over there in America, only an hour away from Boston, there was a respectable old gentleman waiting impatiently for the next number of the *Jahrbuch* . . . ?' *(12,* p. 57*)*. Hall, by his publications, his editing of several journals, and his teaching, brought the name and some of the ideas of Sigmund Freud to the attention of both psychologists and educated people in general. Within academic psychology, Hall was still the chief publicizer of psychoanalysis when he died in 1924.

In 1908 Hall had invited Freud to be one of the chief speakers and to receive an honorary degree at the twentieth anniversary celebration of Clark University. Freud accepted gladly *(12,* p. 54*)*. The occasion was not only the formal introduction of psychoanalysis into the United States but in Freud's mind a crucial event in his scientific life. As he recalled, '. . . my short visit to the new world encouraged my self-respect in every way. In Europe I felt as though I were despised; but over there I found myself received by the foremost men as an equal. As I stepped on to the platform at Worcester to deliver my Five Lectures upon Psychoanalysis it seemed like the realization of some incredible daydream . . .' *(2)*. Freud had good reason, therefore, to have a special concern for Hall's interest in psychoanalysis.

Yet Hall was not a freudian nor in any sense a convert to psychoanalysis, and the nature of his interest requires explanation.[1]

Hall was a representative of the American eclecticism that so annoyed Freud in his later years. He believed in a thorough-

[1] In Hall's autobiography *(6,* p. 449*)* there appears this single sentence: 'I began to psychoanalyze myself but, finding the task too hard, called in an expert to finish the work, with results which nothing would ever tempt me to tell'. This analysis seems not to have affected Hall's understanding of psychoanalysis one way or the other. His own characterization of himself *(6,* pp. 573, ff.*)* suggests that he explored only the surface of his own life. As for the theory, he always held strong reservations, for example, about the usefulness of dream interpretation and about the universality of the œdipus complex *(6,* pp. 410-411*)*.

going evolutionary interpretation of all life phenomena, but otherwise his views were not necessarily consistent. That he employed certain psychoanalytic concepts meant only that he found them convenient to make particular points. For example, he utilized the idea of sublimation for the purpose of showing how unacceptable impulses might be used in the service of righteousness, but at the same time he protested against what he interpreted as Freud's pansexualism. On one page Hall would praise Freud; on the next he would praise Durkheim or Janet or Kraepelin for a view that was—had he thought about it—antithetic to psychoanalysis.

Nevertheless, as these letters show, Hall thought that he was greatly influenced by Freud even though he used only parts of Freud's teachings. Hall was generous in his interpretation of influence; he even believed that a citation from Adler or Jung was a sign of freudian influence, since the ideas of those men grew out of Freud's work. Freud, on the other hand, believed that he truly influenced only those who could accept psychoanalysis in its pure form and who did not turn to other interpretations when the application of psychoanalysis became difficult or disturbing *(2)*.

This correspondence is especially valuable, then, because Freud and Hall confront each other with the two main points that have created misunderstanding throughout the history of the absorption of psychoanalysis into American thinking *(*see, for example, *16)*. Hall, for his part, could not understand why Freud was so intolerant of those who adopted only choice morsels out of psychoanalytic theory. Indeed, the very occasion of this exchange was a letter of Hall's introducing Edward J. Kempf, an American psychiatrist who had proposed a psychology largely inspired by psychoanalysis but for which he provided a physiological basis. Hall hoped that Freud might be persuaded, by a personal discussion, that Kempf's synthesis of Cannon, Sherrington, Pavlov, and Freud contained much of value and merited the attention of Freud and his colleagues.

On the other hand, Freud questioned how Hall was able to advocate simultaneously his ideas and those of Adler and Kempf.

He said frankly that he did not understand how Hall could embrace such mutually exclusive points of view. Thus was the issue joined between what Hall regarded as Freud's intolerance and what Freud regarded as Hall's inconsistency. It is a tribute to both men that they could exchange blunt criticism without rancor, each showing for the other the esteem due him.

JOHN CHYNOWETH BURNHAM (STOCKBRIDGE, MASS.)

Prof. Dr. Freud

Lavarone Trentino
Wien IX. Berggasse 19
28 Aug 1923

Hochgeehrter Herr President

Dr Kempf den Sie mir empfohlen haben hat mich in meiner Einsamkeit auf einem jetzt italienischen Hochplateau besucht und mir einen sehr vorteilhaften Eindruck von seiner Persönlichkeit hinterlassen. In der Schätzung seiner wissenschaftlichen Arbeiten stört mich der Umstand dass er nicht ganz Analytiker ist sondern einen anatomischen Nebenweg eingeschlagen hat, der ihn nach meinem Urteil zu nichts führen wird. Für seine Einführung in meinen Wiener Kreis konnte ich nichts thun da um die Mitte August alle von Wien abwesend waren.

Ich war sehr erfreut zu hören dass Sie sich voller Gesundheit erfreuen und erst kürzlich einen Beweis Ihrer Geistesfrische durch eine bedeutsame Publikation gegeben haben. Man hatte mir früher erzält dass Sie es beklagen von mir und den meinigen nie eine Antwort auf Ihre Zuschriften erhalten zu haben. Allein ich kann Ihnen versichern dass seit dem Krieg keine Zeile von Ihnen zu mir gelangt ist.

Mit hocher Befriedigung las ich in Ihrem Brief dass Ihre Schätzung meines Beitrags zur Psychopathologie unverändert geblieben ist. Ich hatte dies nicht erwartet denn Sie haben in sehr entschiedener Weise für Alf. Adler Partei genommen, und es kann Ihnen doch nicht entgangen sein, dass die volle Verleugnung der Psychoanalyse zum wesentlichen Inhalt seiner Lehren gehört. Auch heute weiss ich diese zwei Seiten Ihrer Äusser-

ungen nicht zu vereinigen. Wären Ihnen die wirklichen Vorgänge besser bekannt so würden Sie wahrscheinlich nicht geurteilt haben es liege wiederum ein Fall vor, dass ein Vater seine Söhne nicht aufkommen lassen will, sondern hätten gesehen dass die Söhne ihren Vater beseitigen wollten—wie in Urzeiten.

Mit ergebenen Grüssen und aufrichtigen Wünschen für Ihr Wohlbefinden

Ihr

FREUD

[Translation]

My dear Mr. President:

Dr. Kempf,[2] whom you sent to me, visited me in my solitude on this now Italian plateau and left me with a very favorable impression of his personality.

My appreciation of his scientific studies is marred by the fact that he is not altogether an analyst, but rather has taken the by-way of anatomy which, in my judgment, will lead him nowhere.[3] I could do nothing about introducing him to my Viennese circle, since they were all absent from Vienna by the middle of August.

I was very much pleased to hear that you are enjoying good health and have just recently given proof of your intellectual vitality with a significant publication [*8*]. I had been told earlier that you complained about not having heard from me and my friends in answer to your communications. But I can assure you that since the war not a line from you has reached me.

I read in your letter with great satisfaction that your estimate of my contribution to psychopathology has remained unchanged.

[2] In a personal conversation, Dr. Kempf told the annotator that he is preparing an account of his visit with Freud. He also said that both of them enjoyed the visit but that neither changed his opinions as a result of it. This, of course, is confirmed by the letter.

[3] Dr. Kempf stated that in 1923 Freud threw up his hands and said that it would not be possible to correlate mental events with physiological events for hundreds of years. Freud's reaction should not be surprising since he himself in 1895 *(4)* had failed to find a neurological explanation for what he had observed in neuroses. Freud's use of the term anatomy in his letter is curious because Kempf's work was distinctly physiological *(13, 14)*.

I had not expected this, for you have taken a very definite stand in favor of Alf. Adler, although it cannot possibly have escaped you that a complete rejection of psychoanalysis is an essential part of his teachings.[4] Even today I do not know how to reconcile these two stands that you have taken. If you were more familiar with what really happened, you would probably not have judged that here was another case in which a father would not let his sons come into their own; rather, you would have seen that the sons wanted to get rid of their father, just as at the dawn of time.

With sincere greetings and wholehearted wishes for your well-being,[5]

Yours,

FREUD

156, Woodland Street
Worcester, Mass.
September 24th, 1923.

Professor Dr. Freud,
Wien IX.
Berggasse, 19,
Austria.

My dear Professor Freud,

I am very glad you made sympathetic personal touch with Kempf. Although he is not so exactly a follower of your views as Brill,[6] he has been profoundly influenced by them, more I think than he knows, and has influenced others in that direction.

[4] In 1914 Hall had published an article *(9)* in which he made conspicuous use of Adler's ideas. That same year Freud wrote to Ernest Jones *(12,* p. 58*)* that he was distressed by the news that Hall had become an Adlerian. In spite of Hall's interest in Adler's thinking, particularly his idea of compensation, Hall was even less of an Adlerian than he was a freudian if one judges, for example, from the frequency of the citations of the two men in Hall's later works. (See Hall's letter and fn. 7.) Expositors of Adler's teachings were rare indeed in the United States while Hall was alive, and even Smith Ely Jelliffe *(11)* cited Hall's treatment of *Minderwertigkeit.* Hall, for his part, undoubtedly enjoyed his position as the man who introduced Adler into the United States, just as he had Freud earlier.

[5] Translated by Erik H. Erikson and David Rapaport, edited by Suzette H. Annin, all of the Austen Riggs Center.

[6] A. A. Brill was the first to translate Freud's works into English.

As to your kind and frank comments about me, it is quite true that I have found real help in my own thinking from Adler's ideas of compensation and *Minderwertigkeit,* and that I had a brief correspondence with him some years ago and would have liked to have brought him to this country to give a few lectures.[7]

I have also found much that helped me in Jung, mystical and unintelligible as much of his writing is to me.[8]

I think the world knows that both these men owe their entire impulsion to you, and I also think that both illustrate the revolt against the father which you have so well explained. I do not know that psychoanalysis tells us what is the instinctive, or what ought to be, the attitude of the father toward his revolting sons. Wundt[9] had the same feelings against his own pupils who developed the methods of introspection. In my own small sphere I, too, have had painful experiences with those whose model seemed to be *periunt illi qui nostra ante nos dixerunt.*[10] I think the impulse to wish the death of those who said our things before we did is pretty strong, and it is most exasperating to those who suffer from it.

But your own achievements are far and away beyond those of any psychologist of modern times; in fact history will show that you have done for us a service which you are not at all extravagant in comparing with that of Darwin for biology. It seems to me you can well afford to be magnanimous toward these revolting children.

[7] The only surviving document from the Hall-Adler correspondence is a letter from Adler to Hall, May 6, 1914, in the Hall Papers at Clark University. Dr. Kurt A. Adler has informed the annotator that there are no Hall letters among his father's papers.

[8] There is an unenlightening letter from Jung to Hall, December 5, 1917, in the Hall Papers at Clark University.

[9] Wilhelm Wundt, the founder of experimental psychology. Hall *(7)* had made the same analogy in 1920: 'We cannot forbear to express the hope that Freud will not repeat Wundt's error in making too abrupt a break with his more advanced pupils like Adler or the Zurich group'. In Life and Confessions *(6,* pp. 204-207*),* Hall described his relationship to Wundt and the animosities that embittered Wundt's old age.

[10] Thomas Benfield Harbottle *(10)* gives this quotation as *'Pereant qui ante nos nostra dixerunt',* from St. Jerome, Commentary on Ecclesiastes. He translates it as 'Perish those who said our good things before we did'.

I know far too little of clinical or pathological psychology, and have had far too little clinical experience, to judge the severer scientific aspects of psychoanalysis, although I realize that it is just here where lies the crux of everything; but I am amazed to see how many members of our American Psychological Association who, (before in their publications slighted or condemned psychoanalysis, and on the program of the meetings of which it very rarely occurred,) are now being subtly and profoundly influenced by it, and also to see how very often its themes are the leading motives in dramas, historical studies and novels (e.g. Elsa Barker's 'Fielding Sargent' which I have just finished.)[11]

For me, your work has been the chief inspiration of most that I have done for the last fifteen years. It has given me a totally new view of psychic life, and I owe to you more than to anyone else living or dead. I think I am the only American Psychologist of the normal who has given through all these years a special course upon this subject.[12] To my mind the psychology of the normal in this country lives in a pre-evolutionary age. Until you came genetic considerations of things psychic were unknown or taboo. I think I have read about everything you have ever written, although in my limitations, there is much that I did not understand, and a little which, if I did understand it aright I have to question. Nevertheless, I owe to you almost a new birth

[11] This novel *(1)* presents psychoanalysis in a diluted and distorted form indeed, and for that reason illustrates well how Hall found the influence of Freud in writings that departed materially from Freud's own teachings. The narrative concerns a businessman who becomes 'nervous', retires, and believes that he is losing his mind. He is sent to a psychoanalyst, and the plot deals mostly with the progress that the protagonist makes in insight in the course (seventeen days!) of his analysis and how he comes to see that the heroine is his adult love object. A very large part of the novel consists of quotations—put into the mouths of characters who evidently have unusual memories—from any number of technical and popular works, many of them loosely psychoanalytic. Miss Barker's psychology was eclectic; references to 'the racial unconscious' and the like give the impression that she leaned heavily toward Jung, like Constance Long and Beatrice Hinkle, two contemporaneous analysts whom she quoted.

[12] Hall noted *(6,* p. 410*)* that he had offered 'courses on various aspects of [psychoanalysis] annually since 1908'. The Clark University Register and Official Announcement reveals that from 1908-1909 to 1911-1912 Hall resumed his former course on abnormal and borderline psychology. How much of this course was

of intellectual interest in psychology, as is perhaps best shown in my Jesus book, which, without this, would not have been written.[13]

Please pardon the length of this letter, and accept my most

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devoted to psychoanalysis is problematical; the course description was unspecific except in 1911-1912, when 'With Special Reference to the Freud School' was added to the title. From 1909-1910 through 1911-1912 Hall also offered a course on the psychology of sex that included special attention to the 'theories of Freud, Moll, Ellis, etc.' In 1912-1913 there was a new course, given for only one year, on 'The Unconscious or Subconscious', and the description specifically mentioned Janet, Freud, and Jung. In 1920-1921, and in that year only, Hall offered a course on 'Psychoanalysis', which included 'Freud, Janet, Jung, Adler, and others. The mechanisms are considered less in their applications to sex than to fear, anger, and other emotions. The psychoanalysis of great men. Dreams, hypnotism, multiple personality, somnambulism, and the more common forms of neuroses and psychoses, the psychology of everyday life.' Although this was the last year that Hall taught at Clark, he noted that this course would probably take two or three years to complete. It is not known whether Hall's lecture notes have been preserved.

[13] It is illuminating to compare this touching statement of indebtedness to psychoanalysis with the introduction to the book itself (*5*, I, p. xviii): 'My study of adolescence laid some of the foundations of this work, because Jesus' spirit was in a sense the consummation of that of adolescence. Some of it is based on conceptions derived from the conditioned reflex studies of the school of Pawlow, which open up the whole field of the transference of incitations and of psychokinetic equivalents. I have also made use of some of the most important of the so-called Freudian mechanisms, especially *Uebertragung* and *Verschiebung*, and the doctrine of surrogates, projection, *Objektwahl*, and inwardization, or extro- and intro-version; ambivalence, or the doctrine of opposition and antitheses of affectivities, compensation (in Adler's sense); and retreat from reality; some of the psychology of symbolism. All these apply as well to fear, rage, hunger, and other original impulsive powers of man, as they do to the erotic impulsions, as I have elsewhere tried to show [Hall here cites his relevant writings]. I of course owe much to Frazer's great work, and something to Bergson, Semon, the Vaihinger type of pragmatism, and perhaps most of all to a psychogenetic perspective or attitude of mind which my long interest in paidology has made almost a diathesis. . . .'

Two comments should be made. First, the Jesus book could easily have been written—with the exception of only a few passages—without Hall's having read any psychoanalytic literature at all. Second, Hall occasionally speaks as if he had discovered something new in the application of freudian mechanisms to fear, rage, etc. Freud, too, believed that all primary processes and not just those pertaining to libidinal instinctual drives were expressed through the mechanisms (*3*).

heart-felt wish that you may continue for many, many years the great work you have already established in the world.

Most sincerely yours,

G. STANLEY HALL

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Observations on Research Regarding the 'Symbiotic Syndrome' of Infantile Psychosis

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OBSERVATIONS ON RESEARCH REGARDING THE 'SYMBIOTIC SYNDROME' OF INFANTILE PSYCHOSIS

BY MARGARET SCHOENBERGER MAHLER, M.D. AND MANUEL FURER, M.D. (NEW YORK)

Our previous work has resulted in the hypotheses that children pass through a 'normal-autistic', a symbiotic, and a 'separation-individuation' phase of development. We postulate that in the normal autistic phase, the infant has not yet become aware of anything beyond his own body. In the symbiotic phase, the infant seems to become vaguely aware of need-satisfaction from the outside, but the mother is still a part of his own self-representation: the infant's mental image is fused with that of his mother. In the third phase, the infant gradually becomes aware of his separateness; first, the separateness of his body, then gradually the identity of his self. He subsequently establishes the boundaries of his self.[1] We have postulated in previous papers that the primarily autistic-psychotic child has never developed beyond the autistic phase, whereas the symbiotic-psychotic child has regressed from the challenge of separate functioning at the onset or during the separation-individuation phase into a symbiotic-parasitic, panic-ridden state. As states of panic are unbearable for any organism, the child's very survival requires further defensive regression. We therefore find that many, if not all, primarily symbiotic children secondarily resort to autistic mechanisms.

Our first therapeutic endeavor in both types of infantile psychosis is to engage the child in a 'corrective symbiotic ex-

Presented at the Pan American Medical Congress, Section on Child Psychiatry, Mexico City, Mexico, in May 1960.

This research is supported by a grant from the United States Public Health Service and is conducted at the Masters Children's Center, New York City.

[1] In another research project, supported by a grant from the Field Foundation, we are engaged in studying the individuation phase of normal twelve- to thirty-six-month-old infants in the presence of their mothers.

perience'.[2] This most essential step requires a long period of time to achieve and to consolidate, and a still longer interval elapses before the higher levels of personality development, beginning with the separation-individuation phase, are attained.

To achieve this goal we had at our disposal, and at first could not help but use, the existing methods of approach to the treatment of psychotic children within conventional institutions, all of which routinely entail exposure of the preschool psychotic child to group situations. Our experience with these facilities convinced us that premature efforts to expose such children to group situations which interfered with or diluted the corrective symbiotic experience by subjecting them to any kind of social situations, even in the most carefully planned therapeutic nursery, were harmful. Not only was progress impeded but in many instances there were detrimental traumatic effects.

One boy, for example, who was referred for private treatment at the age of four and a half as a case of infantile psychosis, promptly developed a symbiotic attachment to the therapist. This child, S, was given a thorough preliminary examination as an inpatient in an academic center. During the psychological testing it was readily observed that he responded best to bodily affection. In fact, in the course of treatment his need for bodily contact, which he could provide for himself either only very passively or very violently, was continually in evidence. Before referral the psychologist noted: 'It may be of interest that S's highest level of success occurred when he was being caressed by patting or stroking on the head and shoulders; he was given this demonstration of affection because he seemed to be entirely impervious to vocal expressions of praise and encouragement'. His selective awareness of emotional situations was demonstrated

[2] 'Corrective' is not used by us to indicate a manipulative kind of intervention. By promoting the re-experiencing of early stages of development, the child should be enabled to reach a higher level of object relationship. We arrived at calling this approach 'corrective symbiotic experience' by comparing it with Dr. Augusta Alpert's research on 'corrective object relationship', conducted at the Child Development Center.

by his correctly noting in a picture of the test that a child depicted with his mother was crying.

S responded rather unspecifically but very well to any exclusive relationship with an adult. In fact he loved to have two or more adults concentrate on him simultaneously. However, he clearly showed anger or proneness to tantrums if the adults excluded him by talking with each other. When his mother talked on the telephone, he would deliberately take apart one of his toys and yell, 'Fix it, fix it!'. He was fascinated by his baby cousin and imitated the baby talk, thus showing us the way he wanted to be treated.

This child's mother was, unfortunately, a very rigid and proper lady who, though loving her child very much in her own way and consciously ready to make any sacrifice for him, could not provide the warmth he needed. The child's father had abandoned them on S's first birthday. The mother could not tolerate her child's bizarre behavior, particularly in public. She talked with him almost exclusively on a rather adult level, despite her awareness that what she said had very limited meaning for him. She could not give him any tender physical affection. She was probably not capable of it. Gravely deficient in adequate self-esteem herself, the child was for her a conspicuous proof of her worthlessness and social inacceptability.

After a few months of treatment it became apparent that four hours weekly therapy in the office was not adequate for the child or the mother. The concentrated, partly symbiotic-parasitic, partly autistic atmosphere of an exclusive living arrangement of mother and child in a small furnished room needed to be counterbalanced; furthermore, the mother felt keenly that some more formal learning situation with other children should be provided for her child. We succeeded in having S accepted in a small nursery school. He behaved there as we had expected; not as a participant in the group but as a tangential appendage. Even this was possible only because his mother remained passively by and the school staff was most patient and helpfully understanding. He did not profit either socially or intellectually during the months he was patiently tolerated there, despite the

fact that in the therapeutic relationship he made definite progress.

At the end of the school year the teacher's report stated: 'S does not participate in most of the activities of the class. He seldom talks to children or adults, but frequently communicates by sound and action rather than words. When he does talk, and this is when *one* teacher has time to be with him, he shows particular interest in trains and book illustrations, etc.'

S grew especially tall for his age and as it was impossible to keep him in the nursery, he was transferred to a kindergarten when he was five-and-a-half-years old. In kindergarten his panic and tantrums instantly recurred. He had catastrophic reactions to the situation, especially as his mother was not permitted to remain with him. She was asked within a few days to withdraw him. This failure upset her more than all the other signs and proofs which should have made her aware of the gravity of the child's mental illness.

A few weeks later special tutoring was provided for S. Again, in this exclusive one-to-one relationship he made progress in a characteristic, peculiarly unspecific symbiotic experience, just as he had in the therapeutic relationship. With the help of the tutor and of the therapist, his tendency to autistic withdrawal diminished. His courage to test reality increased, as did his vocabulary and his perception of the outside world. For the first time in his life this child displayed fondness for such soft, transitional objects as pillows and toy animals. These now served—as they had not before—to allay his anxieties and tensions. He surrounded himself with these transitional objects, particularly at night, and relived early stages of babyhood in a more normal way.

Again we made the mistake of enrolling him in a group, this time in our pilot project, in what we thought was a particularly sheltered learning situation in a special therapeutic nursery group. S was bewildered but made, we thought, an initial adaptation because he shared the teacher with only one other child. His distress soon became apparent when a few more children joined the group. We were still inclined to attribute a rapid

regression in his speech and in other areas of his functioning to measles he had contracted near the end of the school year. But when after a fairly good summer at the seashore he rejoined the group, his ego threatened rapidly to disintegrate. In uncontrollable panic and rage he violently attacked his mother and teachers. His speech became unintelligible, and he seemed to hallucinate.

This much of S's case is presented to demonstrate that in all situations this child desperately craved and violently demanded exclusive symbiotic possession of an adult. He repeatedly retreated after severe tantrums into lethargic states of hallucinatory withdrawal whenever he could not be given the exclusive attention of an adult to the extent that his fragmented ego craved and needed.

The last of numerous similar experiences which led us to abandon the therapeutic nursery design for psychotic preschool children was the case of a four-year-old psychotic child who had been placed in a smoothly organized group of five disturbed but not psychotic children with two teachers. When P arrived at the therapeutic nursery school, she appeared to be a serenely beautiful child. She quickly became extremely restless, sought constantly to find her mother, and then roamed through the building, followed by the teacher who had to leave the other children and go after her. The teacher learned that by rocking her and other devices she could induce P to remain in the room with the other children, to whom the child paid absolutely no attention. In her relationship to the adult, for P there were only two alternatives: either in a phase of autistic withdrawal she used the teacher as an extension of her own body in order to control the environment with this executive external ego, or there was a clinging, burrowing type of behavior during which the teacher had to focus her attention completely on P, lest she have a panic-tantrum. It became apparent that to keep the child at this higher level of relationship, the teacher had to abandon her duties to the other children. The child's behavior demanded an exclusive relationship with the teacher; any demand

for the teacher's attention by the group was increasingly deleterious to her.

For a while we continued to believe that the deleterious effect of the group on P was due primarily to the fact that she was a case of early infantile autism, particularly vulnerable as she began to attain a symbiotic relationship. When we saw the process occurring with still another, a symbiotic-psychotic child, we realized that a revised research had to be designed for all cases of infantile psychosis. Our hypotheses about psychosis had already indicated this from a theoretical point of view.

That there was a conflict in P's mind about her growing attachment to the teacher and her relationship to her mother was apparent, for example, whenever she was hurt. She would run to and from the door leading to her mother, and then back to the teacher until finally she rubbed the injured part against the teacher's body. What was most amazing was that as the child's conflict mounted and she ran to seek her mother, the mother was increasingly difficult to find in the building. The mother was, in fact, almost consciously trying to avoid her child as the child became more demanding and expressive. These changes in P made the mother so anxious that she became angry with the child's therapist.

From this case we recognized another important factor in revising therapy and research. The revised design would not involve the child with other children in a group situation before he is ready for it. The two cases described and many others like them made it clear that to provide the psychotic child's need for protection within the corrective symbiotic experience must be the basis for treatment. The child's development from autistic withdrawal toward primitive, unspecific clinging to the therapist as well as to the mother gave us another significant clue for the revision of our research design. We had repeatedly observed that the presence of the mother within the therapeutic situation was not only very well tolerated but that it was a sign of progress when a mother was sought by her psychotic child. The mother's presence proved, furthermore, to be most helpful to

our understanding of the child's 'signal communications' throughout treatment. In our experience, even though the mothers were not able to fulfil these children's needs, they understood their own child's nonverbal communications to a surprising degree.

It was evident that these considerations were not only of theoretical importance but that they indicated the direction which must be taken for the immediate treatment and for optimal future planning for the psychotic child's mental health. We evolved from this a method of research in which the mother, the child, and the worker are present in the room during the sessions, which extend from two to three hours, the mother and worker collaborating in the rehabilitation of the psychotic child.

The advantages of this design are manifold. Our initial understanding of the child comes not only through observations but also through information and explanations given by the mother. By this method there can be mutual exchanges of information and understanding between the child's therapist, the supervising psychiatrist, and the mother, as the child's behavior is being observed by all three. The mother is first gratified by our interest, and then heartened by the feeling she gradually acquires that someone believes her child can be helped. There also appears to be a great sense of relief produced by the understanding, initially intellectual, which the mother gains. She may, and often does use it defensively, but it gives her the feeling that some possible control can be exerted over what previously had been to her a desperate, hopeless, and uncontrollable problem.

The information the mother gives us enables the therapist to institute those procedures which seem to foster the development of the need-satisfying symbiotic relationship between the child and the worker. In the beginning, for example, a signal type of communication has to be fostered between the child and the worker, which can later be used by the worker in a corrective manner.

A four-year-old boy, M, frequently rolled a toy car to and fro.

The mother explained to us that this indicated he had to urinate. We had discovered from our observations that he also meant by this action that there was something wrong with the car; that it was broken. We learned, moreover, that this activity, which we took as a signal of his bodily need, occurred after many hours of withholding his urine, to the point where he was in pain and probably afraid that he could no longer withhold. We then understood these signals to mean that he was afraid of being overwhelmed by these inner bodily stimuli. Our therapeutic procedure was to respond to this signal as a mother would to an infant, that is, as an auxiliary ego which we hope the child can add to his own ego, thereby overcoming otherwise overwhelming anxieties. Instead, therefore, of interpreting the displacement and anxiety, the therapist tells the boy that he will feel very good when he goes to the toilet and that she will help him. She takes him with her to the toilet, encouraging him to urinate, and expressing her pleasure and admiration when he does. In this way we believe we have begun to liberate the child from the feeling of being the passive victim of bodily discomforts and discharges, and with this help he may proceed to independently active functioning.

In general the new design allows for the development of a more and more specific relationship with the therapist without interference from other children. The development of the child's relationship to the worker, which always brings with it changes in the relationship with the mother, can be observed directly, and the frequently occurring defeatist attitudes of the family counteracted. With the emergence from autism, and the achievement of a higher level of behavior, the patience of these children's families is often greatly taxed. The endlessly repetitive banging of doors, throwing of objects, switching off and on of lights often generate uncontrollable hostility within the family, and sometimes lead to ill-considered placement of the child away from home.

After M became better able to comply when he was encouraged to urinate, he began to spit in an uncontrollable way. He first spat at his therapist, and soon at his mother. His mother

reprimanded him for it, and he withdrew into his autistic shell. We had learned that the child's disturbance of urinary functioning had occurred as a consequence of the mother's disgust at finding that he urinated into the bathtub instead of the toilet. Had the spitting happened at home as an extension of the child's behavior in the therapeutic situation, this mother might well have reacted, as had P's mother, with hostility. But M's mother had been made a member of the 'therapeutic alliance', and the simple explanation she was given of the beneficial value of M's transient regressive behavior made sense to her. She had, in fact, previously reported in the course of the therapy that M had begun at home to invite her to exchange babbling and cooing sounds with him. The mother spontaneously expressed her opinion that he seemed belatedly to be permitting himself indulgences of babyhood which—in contrast to his brothers—he had missed completely. Observing the way the therapist handled the situation gave the mother a security of feeling, a way of understanding, a model for helping her child.

Such experiences with the example and help of the child's therapist, the supervising psychiatrist, and the social worker become assimilated in time if the mother herself is capable of learning and of providing the additional and essential corrective symbiotic experience for the child. Why the spitting developed in the case of M could be directly explained to the boy's mother by the worker, by the psychiatrist, and subsequently more fully gone into by the social worker. Whatever deeper fears and defenses might be involved in her reaction, the mother's immediate response to the child—and this is always partly dictated by unconscious forces—is opposed by her conscious determination, aided by her understanding and the example given to her by the team. This kind of therapeutic help for the mother of the psychotic child is consistent with our theory that the treatment of the child must extend over many years of the child's life and that his development must be re-experienced and relived, not only with the therapist but with the primary love object. The mother, therefore, must be trained

to assume and maintain the corrective symbiotic experience developed by the therapist. This emotional-intellectual learning is stabilized by the mother's individual sessions with the supervising psychiatrist and the social worker.

In this method we believe we have evolved a mother-child-therapist unit, supervised by a male child psychiatrist, which can result in the development of the personality instead of in fixation at the stage of the psychosis. It is interesting and disquieting that it took us so many years to arrive at these inevitable conclusions and to apply their logical requirements in therapeutic research. They were inherent from the start in our theoretical hypotheses of autistic and symbiotic psychosis. Gradually, tardily, and retrospectively we came to these conclusions from clinical data which abundantly demonstrated that failures ensued whenever the corrective symbiotic relationship was threatened by disruption—as it too frequently was when we adhered to traditional methods.

The crucial therapeutic problem in psychosis remains the same. The psychotic child must be kept from retreating into the autistic defensive position. He must be enticed into and be encouraged to relive a more fully gratifying—albeit still regressive —, exclusively symbiotic-parasitic relationship with a substitute mother. This relationship is made liberally available to the child for whom it becomes a buffer in the process of dissolution of the vicious cycle of the distorted relationship with the mother. Gradually and cautiously the child is then helped to develop some autonomous substitutes for the pathological primitive regressive demands exacted from the pathologically defensive and ambivalent mother. In this manner the child is led to discover the boundaries of his self, and to experience a sense of himself as a separate entity in his environment.

In the treatment of primarily symbiotic or primarily autistic children, a contradiction sometimes confuses workers in the field. Although these infants seem insatiable in their need for the passively available symbiotic partner, their symbiotic claim is at first not at all specific. Several adults are well tolerated and often simultaneously enjoyed. But at first, and for a long time,

they are utterly intolerant of any type of group relationship involving other children, even the most carefully devised ones. Only the most important symbiotic partner who seals herself off as completely as possible with the child can form for him that insulating layer against the give-and-take aspects of social group situations for which he has no capacity or tolerance during the period described. Only after a prolonged period of corrective symbiotic experience should the psychotic child be given carefully graduated dosages of rhythmic play—preferably to the accompaniment of soothing music—in which the symbiotic partner is right at the side of the child. In the course of the therapeutic research, we carefully watch the preferences of these children as they slowly evolve interest and reach out for association with the other children treated at the Center. They show us unmistakably when they are ready for such social learning; also how much of it they can take.

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SCREEN MEMORIES IN HOMICIDAL ACTING OUT

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The influence of the past on the present remains a fundamental problem for psychoanalysis. Is the pressure of the past exerted steadily or does it only manifest itself at times of stress and in areas of conflict? Does the ego become passively subject to these influences, or is it perhaps its basic function to strive persistently to overcome them? We know that certain traumatic events in the past are particularly subject to being represented by screen memories. Freud observed that the primal scene is a universal experience and provides the content of some of the earliest memories uncovered by analysis. Kanzer points out that Freud's statement carries with it the inference that the primal scene, therefore, 'constitutes an irremovable filter through which the past is subsequently admitted to consciousness' *(22)*.

Freud ascribed the universality of the primal scene to phylogenesis. More recently, following Selye's investigations of the biological reactions to stress, it has been suggested that initially the primal scene floods the organism with overwhelming sexual excitations during sleep or half sleep *(37, 38)*. This flooding of the infantile ego, as yet unable either to abreact or associatively to absorb the excitation, has been defined as the essence of trauma *(29)*. It is one of the tasks of adaptation to attain reparative mastery of the basic infantile trauma, the primal scene. Many of the manifestations of neurosis, for example the shock sensations of pavor nocturnus, as well as religion, art, and ritual, have been viewed as repetitive attempts in the service of this task *(37, 38)*.

The pervasive importance of the primal scene has been well recognized since the publication of Freud's paper on the Wolf-

Presented under the title of Scanning and Screening in an Acute Aggressive Episode, before the Psychoanalytic Association of New York in March, 1959, and at the Annual Meeting of The American Psychoanalytic Association in Philadelphia, in April, 1959.

man. Five years before its publication, he wrote that 'the hysterical fit is an equivalent of coitus' and that, through multiple identification, the patient undertakes the parts played by both persons in the fantasy *(11)*. The following year Abraham noted the connection between orgasm and hypnoid, twilight states followed by amnesia and catatonic attacks *(1)*. A few years later he reported the case of a nine-year-old child whose observation of parental intercourse precipitated a severe anxiety dream of mother being murdered which was followed by a twilight state and amnesia *(2)*. Melanie Klein cites many examples of the importance of primal scene fantasies in play therapy, especially in the form of violent outbursts of rage following insistent questioning related to the primal scene *(23)*. In 1927 she observed that certain crimes of dismemberment and cannibalism correspond to fantasies in the analyses of some small children *(24)*. She reported the case of a twelve-year-old boy who assaulted little girls in the way an older sister had assaulted him, and as he felt his father had assaulted the mother in intercourse. The boy had shared his parents' bedroom throughout his childhood. In 1932 Lewin reported the content of a hypomanic attack based on an identification with both parents in coitus *(27)*. In 1950 he cited other cases of depression and elation from the literature in which the primal scene was symbolically represented *(26,* p. 118*)*. Other authors, from Reich in 1929 *(33)* through Fraiberg in 1952 *(9)*, have cautioned that the primal scene does not produce neurosis directly; it depends on the strength of the ego and on preceding experiences, especially sadomasochistic impulses and fantasies. Kanzer has suggested that the differences between the symptoms of paranoia and manic-depressive psychosis depend on the different ways of reacting to the primal scene *(22)*.

The primal scene, then, the nucleus of the œdipus complex, is subjected particularly to the screening functions of the ego. Freud first noted the significance of screen memories in 1899 *(12)*. In 1925 he suggested the existence of some kind of scrutinizing process: 'It is as though the unconscious stretches out feelers, through the medium of the system Pcpt.-Cs., toward the

external world and hastily withdraws them as soon as they have sampled the excitations coming from it' *(13)*. In 1927 and 1928 Fenichel wrote that the ego scans its store of memories and new perceptions from a need to select screen memories to aid repression *(5, 6)*. The following year Glover observed that, in addition to the apparently innocuous screen memory, the traumatic memory itself was ideally suited for the screening and should be carefully scrutinized to determine what repressed material it might be covering *(18)*. Anna Freud, more recently, has noted that hundreds of traumatic memories may be telescoped in one screen memory *(10)*. Greenacre has shown that little girls may instigate traumata which repeat with great specificity and thus screen the main disturbances of the precœdipal period *(20)*.

In the seventh chapter of The Interpretation of Dreams, Freud showed that unconscious ideas may transfer the intensity of their cathexis onto particular percepts and by so doing become 'covered' by the percepts and thus be admitted into the dream *(14,* p. 562*)*. He felt that this selectiveness of available percepts and the choice of some to 'cover' or screen unconscious ideas was part of the dream work. Pötzl in his experiments in 1917 showed that this selecting of percepts takes place at the very time of the original perception, within one one-hundredth of a second at the utmost, thus setting the origin of the dream at the time of the perception *(32)*. More recently Fisher has repeated such experiments and confirmed Pötzl's conclusion *(7, 8)*. Further light has been thrown on the selective process of the ego as it relates to perception by Kragh, as quoted by Faergeman *(25)*. An experimentally isolated perception is found to recapitulate, in a totally condensed temporal form, the phylogenesis as well as the individual development. By the study of tachistoscopic after-images, Kragh determines the pre-stages of perception, then investigates the contents of the perceptual pre-stages by use of TAT, line drawings, and other similar stimuli, and he finds that they exactly parallel ontogenesis. He points out the striking likeness between his concept of perception and Schilder's concept of the process of thought. In 1920

Schilder said: 'Every thought is the product of a process of development . . . every thought recapitulates the phylogenesis and ontogenesis of thinking' *(35)*.

Reider has demonstrated the possibility of the existence of a whole hierarchy, from the simplest screen memories to symptoms, *déjà vu,* hysterical acting out, *pseudologia fantastica,* and even character structure *(34)*. Linn has suggested a neurophysiological model of the selective function of the ego in brain-injured patients, where past and present are merged in contaminated responses and the timelessness of the primary process is apparent *(28)*. Finally we may cite the dramatic case of Bonaparte where the analysis of a screen memory led to the uncovering of a primal scene experience which was then strikingly confirmed by subsequent external evidence *(3)*.

Late one Fourth of July eve, a search party approached an abandoned gravel pit. A man, about thirty, came stumbling toward them, apparently dazed, half-dressed and bloodstained. Nearby was found the beaten and raped body of a three-year-old girl, missing for several hours after she had wandered away from her parents at a roadside tavern. The man was taken into custody and charged with murder. He pleaded innocent and claimed absolute amnesia for all the events of that evening following the time he left a local military base at the end of the day.

The man was interviewed during the course of one morning. He appeared to be of dull normal intelligence, seemed rather apathetic, but genuinely perplexed as to why and how he had come to the gravel pit. He had been in charge of some military recruits. At the end of the day he had unlawfully released one of them from disciplinary restrictions and together they had gone out drinking. He was going to kill time in this way until his wife, a waitress, got off from work at midnight. At first this was all he could recall. But a few days after being taken into custody he struck his head in his cell and was thereupon able to 'recall' something further. He and his buddy had been drinking heavily. He had been looking at a girl in tight slacks. He had

driven his buddy back to the barracks. A strange man and a girl came up to him as he stood by his car at the side of the road; the man kicked him in the genitals and hit him in the stomach. He had vomited, then fainted, and when he regained consciousness was lying on the ground without his clothes. He could not understand how he got to the gravel pit and why he was undressed.

He spoke bitterly of his brutal father who beat him black and blue for throwing corncobs at the chickens. He tried to run away from home that night but was caught and put back to bed. A particularly vivid memory from age nine was of seeing his father beat a horse to death for stepping on a pig: 'He kept beating that horse on the head till he hardly had a head left'. He lived in fear that his father would kill him and had recurrent nightmares of being chased by him. The father abandoned the family while the patient was an adolescent. He was later said to have been killed in a fight. Little is known of the prisoner's relationship to his mother.

At age ten he was forced to attempt intercourse with a female cousin of about the same age. A group of boys stood around and jeered at his impotence. The cousin struck him on the head with a rock and had the older boys throw him into a swimming hole. He could not swim and almost drowned. This, and the memory of his father beating the horse to death, were clear and compelling memories, recounted with vividness and affect. The girl cousin abused and tormented him in other ways, such as taking away his food and belongings. He observed her having intercourse with older boys. She continued to attempt to taunt him into having intercourse with her. He began having nightmares, about twice weekly, of a black cloud coming down on his head and suffocating him.

He recalled two homosexual experiences at age six and twelve involving fellatio and masturbation with an older boy. From thirteen to sixteen, a few times a week he would use chickens to masturbate. On one occasion he had intercourse with a calf. He continued masturbating regularly into his adult years and throughout his marriages. He suffered from enuresis

until age sixteen. He used to take pleasure in setting fire to anthills.

He was frequently truant from school, repeated the sixth grade, ran away from home five or six times, and left school after the eighth grade. At sixteen he was involved with a group of boys who broke into a store and stole cigarettes. Thereafter it seemed to him that people looked at him as if he were going to steal. He went regularly to church and wrote poems on religious themes. One of his poems began: 'Like father like son, like horse like cart . . .'.

At eighteen he impulsively married a girl of his age. During the one month that the marriage lasted, he was frequently unable to have an erection. This was followed by a period during which he and a girl made dates with his mother and her male friend. In photographs from this period it is difficult to tell which woman is his mother. When his mother remarried, he enlisted in military service and, as a tail-gunner, is said to have earned the Bronze Star medal. Having attained the rank of sergeant, he took leave without permission and was demoted.

When he returned from overseas the childhood nightmares of suffocation recurred. He would wake up in a cold sweat screaming. There were compressive headaches which sometimes assumed the character of migraine with a strange taste in the mouth associated with vomiting. For a period of six months he sneaked into his mother's home at night and had intercourse with his step-father's sister. He then decided he did not want to live near his mother any longer. In moving away, he gleefully cheated his girl friend out of her car.

During the next several years he had many jobs. His relations with women were chaotic; the women often became pregnant by some other man; there would be fights followed by reconciliations. One relationship, however, lasted six years. He married a second time and the following day re-enlisted in military service.

He never had a close friend. He was shy, passive, and seclusive, never really trusting anyone. He was afraid of being hurt and avoided fights. He had a fear of guns and knives. He had

difficulty concentrating, would become depressed, and wander off 'in a daze'. He drank heavily week ends and subsequently had difficulty recalling events. He suffered increasingly from headaches and would dip his head in cold water to seek relief.

There was no gross evidence of psychosis. His intelligence rated dull normal. Responses to various tests indicated poor control of strong emotions, impulsiveness, and marked inner conflict, with fear of being injured. Some responses suggested distortion of reality. None of these tests were considered normal. Physical examination and an electroencephalogram were within normal limits.[1]

On the basis of the foregoing material a hypothesis was formulated. If this man had committed the rape and murder, it represented an acting out of a series of screen memories of such passively experienced incidents as seeing his father beat a horse to death, being beaten by his father, being seduced by his cousin, then struck on the head and almost drowned. The innocent victim of the rape and murder represented the girl cousin, his childhood tormentor. An amytal interview was then conducted by that member of the psychiatric staff who was the most sceptical of this formulation.

When the amobarbital sodium injection began to take effect, the prisoner was taken back to the evening of July third when he was sitting in the bar drinking beer with his buddy. He related that he saw a little boy and little girl there, that it was growing late, and, knowing that he had to pick up his wife at one A.M., he drove his buddy back to the barracks. He then spoke with a sense of urgency about driving off alone to meet his wife, but he stopped again at the bar. At this point in the interview, he suddenly became disturbed, sat up, and looked around, frightened. The interviewer soothed him and he whispered with wonderment: 'Now I see . . . now I see . . . the same

[1] Acknowledgment is made of contributions to the psychologic and psychiatric examination of the patient made by Dr. Raymond Brown, Major William Doidge, and Dr. Louis West. Dr. Jan Frank and Dr. Melitta Sperling have suggested, and I concur, that despite the negative neurological and EEG findings this man may well be considered an epileptic with psychic equivalent attacks.

cars are there as when I left. . . . Well, I walked around to the juke box and played a song, you know, and stood looking over the place. Then I started outside, and here's this little girl . . . so the little girl wanted to go for a ride, you know. I figured no harm in that . . . I love children . . . .' He continued, 'I am always impulsive and get times that are right—you know what I mean?'. He said that he drove off with the child, not knowing about 'that place up there but the girl did'. After telling how he got the child 'up there', he suddenly stopped and said, 'I—don't know!'. He again sat up, looked around with terror, perspiring profusely, and clapped both hands tightly over his mouth. He became acutely agitated, thrashed about wildly, sobbed, and screamed: 'Hey, hey, let me out of here! Please let me out!'. Then, trembling violently, he said: 'It was that girl back home . . . and I beat her until she was a pulp and I was glad!'. When asked which girl back home, he went on heatedly to say it was the one who treated him so meanly, always taking things from him, food especially; the one who hit him on the head with a rock and almost had him drowned. Then without interruption he groaned: 'My father. My father! I'm telling you he was the most rotten, the most deceiving man there ever was'; and weeping, 'I hated his guts, absolutely hated his guts . . . whip a horse to death with a chain because it stepped on a little pig. . . . He beat me, do you know, Joe?. . . . He beat me with a lariat rope . . . a lariat rope!'.

With a little difficulty he recalled the girl cousin's name, B, and stated that she had been killed in an accident some years before. The amytal was beginning to wear off. He asked for more, and as he received it, said: 'I'm here to coöperate, you know. . . . I never was afraid of the needle before but that's quite a needle. . . . You sure I'm getting it, doc? . . . Hey, it's those blood veins right there. Hm, hm . . . private property . . . can I have a cigarette?'.

He was again taken back to the evening in question and said that when he returned to the bar the little girl stood by his car and threw stones 'at my windshield and at my body'. He told her to stop and she refused in the same tone of voice that B had

used. 'I don't know what got hold of me at that time. I just don't realize how in the world I could do such a thing as I did. . . . I slapped the little girl down . . . .' He put the child in his car and drove off. 'I thought it might feel better to do something like that. . . . I didn't have anything on my mind at that time . . . but then later on an evil came up over me . . . and even more of an evil.' He spoke of his headaches, saying that they could drive one to anything.

He was taken over the material repeatedly and further details were elicited. He disliked his cousin 'because she is past, but she is still coming up on me. She is still grasping me, trying to take things away from me like she always did.' While drinking that afternoon he had heard God's voice telling him 'to find B and destroy her . . . because she was from the Devil and was going to take all my things away from me again . . . everything I have!'. Each time he spoke of B, his next associations would be to his father. 'I had a fight with God one time . . . he beat me, you know, and kept on beating me . . . all over . . . all over my head. . . . My father beat a horse with a chain and he died . . . on the head . . . he might beat me on the head with a chain. . . . I was so scared he would catch me and beat me. . . . I would have got even if I ever had the chance. . . . I would have beat him . . . just like he did that poor horse. . . . Well, I got B. . . . I hated them both . . . they were no good . . . they were evil.' When he was told that it was not B whom he had killed he reacted very strongly, said that he would have to pray, that she looked just like B because she was throwing stones, and her voice was the same, but that now he would have to be punished. 'But B was evil!', he insisted, 'Nobody would send me to the electric chair for her'.

The discussion of this case will focus on the structure of the defenses against screen memories of a postulated primal scene. A study of the identifications within the primal scene suggest that they recapitulate the patient's psychosexual development which, in turn, is recapitulated in the events of the murder. The emphasis is on this constant recapitulation in varying time

frameworks, of various levels, each of which cover deeper levels. The failure of this process in an ego perhaps constitutionally weak, and further weakened by repeated unassimilated traumata, when confronted with a particular configuration of events and while intoxicated, led by regression to psychotic acting out.

The man's neurotic symptoms are estimated to be symbolic condensations, repetitive defenses against threats and fantasies of injury and death. Among his neurotic symptoms, his sexual impotence and marked passivity, compulsive masturbation, enuresis, and bestiality are all, in part, defenses against castration. The symptoms of migraine, poor concentration, and dazed spells represent the conflict in repressing memories and fantasies of being beaten around the head—that is, a displacement of castration fears to the head. Monsour has given a number of clinical examples which illustrate the dynamics of migraine to be a feminine identification in the primal scene with an unconscious equating of head and female genitals *(30)*. A number of other reports in the literature support this thesis *(17, 19, 21, 31, 36, 39)*.

The nightmares of smothering, the excessive drinking, and the attempts to cure headaches by dunking the head in water may screen the memory of almost drowning after being impotent with B, and also may represent castration threats displaced to the head. Lewin has mentioned that sinking and smothering sensations, along with the losing of consciousness, are included in fantasies of being devoured *(26,* p. 107*)*. Stern has noted the connection between the frequent oral sadistic trends in the dreams accompanying pavor nocturnus and the castration complex *(37, 38)*.

The psychotic episode, the actual murder, may be regarded as another level of defense. The amytal interview confirmed the initial hypothesis that the crime represented a reliving in active form of traumata passively experienced at the hands of his cousin and his father. In the murder there is evidence of a double identification. He was first identified with the aggressor. He beat the child on the head, raped and killed her, and threw her into the gravel pit, as B had assaulted him sexually, hit him

on the head, and had him thrown into the swimming hole where he almost drowned; also, as father killed the horse by beating it 'till it hardly had a head left', and as father had so beaten the son that he lived in fear that father would kill him. He was also identified with the victim. He had stumbled away from the scene of the crime in a daze, causing himself to be cut and bruised by the brush and rocks, looking as if he had been beaten, and he was impotent during the crime, just as he had been with B (castrated).

It will be recalled that a few days after his apprehension by the police he struck his head in his cell and thereupon felt that he could 'recall' something of what had happened. The content of this 'recall' was a confabulation. It is significant that it was ushered in by a blow to the head, just as the psychotic episode had been engendered by blows to the body of his car. In a study of organic confabulations it was found that in each of fifteen cases, no matter how bizarre or unusual the content of the confabulation, it was possible to show that at some time or other in the course of the patient's life such an experience had occurred, and that it was never a complete fiction *(40)*. This man's confabulation, too, was accurate to the extent that it recapitulated successive levels of screen memories. In the confabulation, he has himself hit on the head and genitals by a man, knocked out, and stripped; here he identified with the murder victim. This confabulation also recapitulates and screens the assaults by B and his father when he himself was the child-victim. Being beaten on the head includes the memory of the horse that was a victim of his father. From this is reconstructed a primal scene memory or fantasy: he looks at a girl in slacks (himself as a woman); he gets rid of his male companion (the masculine part of himself); he sees a man and a woman together (father and himself identified with mother); he is attacked by a man who hits him in the genitals (as mother is attacked by father); he is knocked out (mother is murdered by father in the primal scene).

A cruel and sadistic father on the one hand and a sexual initiation with a cruelly sadistic female from which he emerged

emasculated were later traumatic determinants. It is conjectured that his lifelong neurotic adaptation was based predominantly on masochistic identifications with both parents in the primal scene, and that the psychotic episode was based on an eruption of repressed sadistic identifications with both parents in the primal scene.

Fenichel wrote: 'Certain neurotics give the impression that they labor in vain throughout life belatedly to master the impressions of a primal scene. A sadistically perceived primal scene may change the character of the world for a person in such a way that he vacillates between fearfully expecting the repetition of this trauma and actually performing it' *(4)*. This man's lifelong neurotic adaptation was based on just such fearful expectations. Schematically his repressed sadism was directed toward the parents (perhaps orally toward the mother and anally toward the father). There was no possibility of sexual identification with either, and the neurotic symptoms were designed to defend against fantasies of injury and death by castration. As he was consistently cheated and exploited by the women in his life, an identification with the father meant being eaten, castrated, and destroyed. Identification with the anal, masochistic mother meant being castrated and killed by the father. He was often exploited by other men.

What is usually stressed is that in the primal scene the mother is seen as being passively subjected to the father's sadistic attack; yet it may be that the primal scene as a mutual attack is of more than incidental significance. In the case of the Wolf-man *(15)* Freud stressed the father's role which he attributed to phylogenesis. But what was new in that primal scene was not the possibility of castration—which the Wolf-man knew from his knowledge of sexual differences—but that his mother, in addition to being castrated, appeared to be castrating his father. He saw his mother's look of pleasure, heard father's heavy breathing, saw the penis disappear and felt compassion for father. This remobilized the memory that he had heard all the hints and threats of castration from women—his sister, Nanya, and Grusha. The Wolf-man defended himself by turning against women with

hostility, turning to father for love, having intercourse only with debased women with whom he felt superior (safer?), and then only from behind (defense against fear of being devoured by the open thighs?), and by identification with women (identification with the aggressor?).

Just as the identifications within the primal scene recapitulate psychosexual development, so in the case reported do the events of the day of the murder. The day begins with a situation of frustration in which he is alone on duty on a holiday eve. His wife, a waitress, is feeding others. He turns to heavy drinking. He projects the oral wishes in the form of auditory hallucinations which tell him that B is returning 'to steal everything' from him. He protects himself from this threat by identifying himself with the (feminine) aggressor. This involves the wish to be loved (beaten, exploited) by a man. Under the pressure of this wish he breaks military regulations, frees a male prisoner who has been left in his custody, and satisfies latent homoerotic, oral wishes by drinking with him. This homoerotic choice must in turn be repressed and covered with the passive wish to be beaten by mother (B).[2] He leaves the prisoner and returns to a bar to look at a little girl. She strikes the body of his car with a stone, as B had struck him, and speaks to him in the same tone of voice that B had used. His masochism initially stimulated, there is a countersurge of repressed sadism projected in the form of auditory hallucinations to the effect that God (father) wishes him to destroy this girl. Identification with the anal-sadistic father releases the sadism that had been bound in by the superego (now dissolved in alcohol) and results in a psychotic outbreak of aggression. The active sadistic aim against mother is retained under cover of passive obedience to father (God), as in the Schreber case. The sadism, vented in murder, subsides and there is a return to the habitual passive masochistic position. He stumbled back into the arms of the law, looking severely beaten. Under amytal he expresses his passive homoerotic orientation: 'That's quite a needle . . . you sure I'm get-

[2] *Cf.* Ref. 16.

ting it . . . it's those veins right there. Hm, hm . . . private property . . . can I have a cigarette?'.

What determines the abrupt change from the one state to the other? Freud's intersystemic explanation referred to a pathological reduction in the censorship (here, especially due to alcohol), or such a pathological intensification of the unconscious excitations that the censorship is overpowered, actions and speech correspondingly altered, or hallucinatory regression forcibly brought about *(14,* p. 568*)*.

To examine the matter from the standpoint of the ego we may refer to an impairment of neutralization and long-circuiting. This may be the same as partial failure of screening. In either case, secondary process thinking is disrupted and the way is prepared for psychotic acting out. If, as in this case, the ego is constitutionally weak (possibly epileptic) and has been further impaired by intense, unassimilated traumata and alcohol, when it is confronted with circumstances which 'resonate' with those traumata, an impairment of neutralization, long-circuiting, and screening functions which lie at the base of secondary process thinking is a result. The screening is not abolished. The psychotic acting out which erupts is itself an archaic attempt at screening and mastering the very traumata which it screens.

At the beginning of this paper the question was raised: how persistently does the ego strive to overcome past conflicts? On the basis of our findings, and in the light of some of the perception experiments cited, it appears that the ego ceaselessly screens the chief nodal points of psychosexual development, in wakefulness as well as in the dream, and in varying time frameworks—the momentary percept, structured symptom, patterned episode, lifetime style. Such a basic function may well have an intimate connection with organic neutralization processes.

SUMMARY

From the story of the murderer of a three-year-old girl, a hypothesis was formulated that the crime represented the reenactment of consciously remembered, severely traumatic events

in the man's childhood. An amytal interview conducted by an independent observer confirmed this hypothesis. From the data, the probability that the primal scene was also re-enacted is reconstructed, and the psychic functions involved are discussed.

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PSYCHOANALYSIS AND EXISTENTIAL ANALYSIS

BY FRITZ SCHMIDL (SEATTLE)

During the period immediately following World War II, 'existentialism' became a well-known but, by and large, not well understood concept. 'Existential analysis' *(Daseinsanalyse)* differs from existentialism but is related to it. A small number of books and articles on it in the fields of psychiatry and psychoanalysis has appeared, and a recent collection of essays entitled, Existence: A New Dimension in Psychiatry and Psychology *(13)*, has aroused some curiosity. Alexander's report on the discussions of existential thought at the Fourth International Congress of Psychotherapy in 1958 *(1)* and the discussion of psychiatry and existentialism at the meeting of the American Psychiatric Association in 1959 *(2)* have increased the interest in this topic.

As far as the American professional public is concerned it can be assumed that any curiosity about existentialism is tinged with a certain amount of scepticism. There is an aura of metaphysics about existentialism and existential analysis which does not accord with the American philosophical tradition of pragmatism and realism; yet this is insufficient reason to ignore something that is new. The theorist is curious to find out what existentialism means, and whether it may help to understand and aid human beings. The practitioner will be interested in the fact that some authors, e.g., Van Dusen *(18)*, stated that the new theory which originated in continental Europe is sufficiently developed to be introduced to this country. It has been reported (1959) that two organizations for this purpose have been founded in the United States. Existential analysis is based upon existentialism. Existentialism is defined in the dictionary as 'an introspective humanism or theory of man which expresses the individual's intense awareness of his contingency and freedom'. Rollo May has stated (1958): 'Existentialism, in short, is the endeavor to understand man by cutting below the cleavage

between subject and object which has bedeviled Western thought and science since shortly after the Renaissance' *(13)*. But to Walter Kaufmann 'existentialism is not a philosophy but a label for several widely different revolts against traditional philosophy' *(11)*. Existentialism is therefore by no means a clear-cut concept, and there are great differences among philosophers who are classified as existentialists. Historically, existentialism is based on the distinction between 'essentia' and 'existentia' made by some medieval philosophers. By essentia is meant what things have in common with each other. It is essential for the triangle to have three sides; for a human being to be mortal. Essentia, then, is correlated to a class of things. The word 'existentia' stands for one unique thing, or for that matter, for one unique person, irrespective of belonging to a class of things or persons. Science endeavors to establish general laws. 'Science', complains Rollo May, 'gets identified with methods of isolating factors'. 'Subjectivity', says Jean-Paul Sartre, 'must be the starting point' *(15)*. The existentialist is an extreme individualist who does not want to be understood as man or woman, Englishman or American, but only as a self: his own human existence.

Existentialists rely largely on intuition rather than on the methods of science. Henri Bergson, a forerunner of present-day existentialists, described intuition as 'the power of attuning oneself to things, following them in their subtlest movements, and vibrating in sympathy with them' *(14)*. The existentialist is opposed to any form of determinism. From the existentialist point of view man's will is free; through making appropriate decisions he can shape his life as he wills. The existentialist has an affinity for ethical philosophy, for religion and art. Some existentialists contend that they can verify their propositions, but existentialists do not use methods of verification which are basic to science. They try to convince by the sheer power of their word. Since they make a constant effort to demonstrate the basic difference between their way of thinking and that of the scientist, they tend to coin new words rather than to use the scientist's terminology. Such neologisms, particularly in the

language of Martin Heidegger, one of the foremost existentialists, frequently make existentialism sound like mysticism. This is probably the main reason why Heidegger's writings are essentially untranslatable. According to Heinemann, Heidegger has protested against being called an existentialist; nevertheless 'not only all the writers on existentialism but also the compilers of textbooks register him as an existentialist even to the extent of making him the leader of the whole movement' *(10)*.

The existentialist is critical of any kind of conformity or mechanization. He deplores the 'alienation' and the 'estrangement' of man in our time in which 'truth' means something scientifically established and verified, rather than 'truth in the face of God'.

While existentialism is a philosophy, or a revolt against traditional philosophy, existential analysis is a method of understanding human beings based upon existentialism and on phenomenology. The latter attempts a direct and immediate understanding of human behavior, rather than an understanding through reduction to underlying forces as, for instance, instincts. Ludwig Binswanger defines existential analysis as a 'psychiatric-phenomenologic method of research' which 'has its basis in the new conception that man is no longer understood in terms of some theory—be it a mechanistic, biologic, or psychological one—but in terms of a purely phenomenologic elucidation of the total structure or total articulation of existence as being-in-the-world' *(4)*. This well demonstrates the difficulty the existential analyst encounters when he tries to explain his method. It seems that 'a purely phenomenological elucidation of the total structure or total articulation of existence as being-in-the-world' implies a theory, even a rather complicated one; yet the existential analyst has committed himself to understanding man 'no longer in terms of some theory'! Heinemann, in discussing some of Heidegger's ideas, states that here and there an attempt is made 'to jump over one's own shadow' *(10)*. This could as well be applied to Binswanger's definition of existential analysis.

Unfortunately existential analysis, which is based upon

Heidegger's philosophy, avails itself of the obscure language of this philosopher. We learn, for instance, that the various psychoses and neuroses are to be understood and described as 'specific deviations of the a priori or the transcendental structure of man's humanity, of the *condition humaine,* as the French say. . . . The structure of existence as being-in-the-world . . .' is investigated. 'Existential "dimensions", i.e., height, depth, and width, thingness and resistance, lighting and coloring of the world, fullness or emptiness of existence . . .' are being studied *(4)*.

The thinking of existential analysis may be illustrated by reference to a few of Binswanger's case analyses *(13)*. He reports 'the case of a young girl who at the age of five experienced a puzzling attack of anxiety and fainting when her heel got stuck in her skate and separated from her shoe. Ever since, the girl—now twenty-one years of age—suffered spells of irresistible anxiety whenever the heel of one of her shoes appeared to loosen or when someone touched the heel of her shoe.' According to Binswanger, '. . . psychoanalysis proved clearly and convincingly that hidden behind the fear of a loose heel were birth fantasies, both about being born and therefore separated from mother and about giving birth to a child of her own'. Binswanger does not deny the value of psychoanalytic interpretations, but says that they are incomplete. He continues the discussion on this patient as follows: 'What serves as a clue to the world-design of our little patient is the category of continuity, of continuous connection and containment'. Such a key to the understanding of a human being is considered as being neither conscious nor unconscious, but 'outside the contrast of these opposites'. In a case of 'pseudoneurotic syndrome of polymorphous schizophrenia', Binswanger states that 'the temporality of this world was one of urgency, its spatiality therefore one of horribly crowded narrowness and closeness, pressing upon "body and soul" of the existence'. In a third case, this time of a person suffering from 'severe hallucinatory delusions of persecution, preceded by a pronounced phobic phase', existential analysis arrived at the conclusion that the patient's 'world-design [was]

one reduced to the categories of familiarity and strangeness'. These brief quotations, of course, omit Binswanger's lengthy elaborations; yet they are samples of the trends in Binswanger's existential analytic thinking.

Boss, one of Binswanger's prominent followers, criticizes Binswanger for not making a sufficiently radical use of the philosophy of Heidegger. Boss makes the following statement: 'Existential analysis *(Daseinsanalytik)*[1] offers the psychoanalytic practitioner practically no new words, concepts, or phrases but "only" a very silent, but the more deeply founded and knowing, attitude toward a sick human being and toward the act of treatment' *(8)*.[2]

Binswanger asks that man be 'no longer understood in terms of some theory'. Boss apparently goes further, saying that existential analysis in the sense of Heidegger offers 'practically no new words, concepts, or phrases'. The writings of Binswanger as well as of Boss are nevertheless full of expressions such as 'being-in-the-world', 'world-design', or 'modes of human existence'. Henry Lowenfeld correctly speaks about a 'jungle of words' *(12)*. It is difficult to find an explanation for the discrepancy between the existential analysts' desire to refrain from new theories, concepts, and words, and the fact that they express themselves in so many new words, concepts, and phrases. In all likelihood the creators of existential analysis have developed such an intense identification with Heidegger's philosophy that they may not even be aware of the fact that their language can hardly be understood by anyone except a Heidegger follower!

For the reader who refuses to leave the basis of scientific thinking in favor of existentialist philosophy, there is only one message of significance in the writings of the existential analysts; their emphatic protest against seeing a patient 'as a sum

[1] In German Binswanger's *Daseinsanalyse* is differentiated from Heidegger's *Daseinsanalytik*. It seems that no translation into English could be found which would allow for this subtle distinction.

[2] Translation of this sentence and of the following quotations from Medard Boss, Ludwig Binswanger, and H. Thomae were made by the author of this paper.

total of single symptoms of different kind and different significance which fail to show an inner connection' *(8)*. Boss acknowledges that Freud, in spite of his scientific and systematic bent, never lost sight of the patient as a unique personality. Thomae, in his review of Boss's book, points out that according to Boss 'Freud in his psychoanalytic practice was an existential analyst without being aware of it' *(17)*.[3] The holistic approach of the existential analysts is not something new; it is new only in regard to their rejection of a scientific understanding and the claim that the existential aspect should be the main basis of psychotherapy.

Kaufmann's opinion that existentialism is not a philosophy but 'a marked dissatisfaction with traditional philosophy as superficial, academic, and remote from life' *(11)* can be extended to existential analysis. The existential analyst doubts the value of the scientific concepts developed by psychoanalysis. His feeling that a merely scientific attitude toward a patient may be insufficient is so overwhelming that he avoids any conscious attempt to think in terms of psychoanalytic theory. The existential analyst glorifies psychoanalysis as an art, but rejects it as a science.

Regarding the practice of existential analysis as a psychotherapy Thomae *(17)* states that there are significant differences among the therapists. However this may be, by and large, Freud's technical rules are observed. The patient lies on a couch, he is expected to associate freely, there seems to be about the same frequency of interviews. Boss has stated definitely that Freud's technical rules are applicable *(7)*. Binswanger has said that Freud, in inventing the procedure of psychoanalysis, 'has

[3] It is interesting to note that H. M. Tiebout, Jr., a professor of philosophy, arrived at a similar idea, apparently without any knowledge of Boss's writings. In a paper on Freud and Existentialism (J. of Nervous and Mental Disease, CXXVI, April 1958), Tiebout said: '. . . Freud was more than a product of his times. . . . By virtue of his creative genius and his radical openness to experience he was able to transcend his inherited mechanistic framework and . . . not only his empirical observations but also his metapsychological concepts are quite compatible with the current existentialist approach to man.'

deepened the empirical basis of understanding through systematic rather than sporadic observation in a way never before attempted' *(3)*.

The existential analyst does not deny the occurrence of transference, but it is overshadowed for him by the existential idea of 'being together in actual presence'. 'Existential psychotherapy', says Ellenberger, 'prefers to the use of psychoanalytic transference the use of another interpersonal experience, "encounter" '. He defines encounter as 'the decisive inner experience resulting from the meeting of two individuals' *(13)*. The existential analyst, like his predecessor the phenomenological psychiatrist, focuses his interest on the phenomenon itself, for instance the manifest dream, and rejects any notion of looking for what lies behind it. 'In psychology as well as in psychiatry', says Boss, 'existential analysis basically will show only the immediately given concrete phenomena of the human body and of human life, within which existence as an original understanding of being happens' *(8)*.

From the case histories published by therapists of this group it is difficult to learn what kind of interpretation is given. In many of them the emphasis is on a theoretical understanding of a patient rather than on therapy. We assume that the existential analyst must convey an understanding of the patient's life in terms of the philosophy of Heidegger and Binswanger. The existential analyst apparently does not limit himself to interpretation.

Boss *(8)* presents a case of a severely obsessive patient who remained unimproved after two periods of psychoanalytic treatment. The existential therapist was the third one who attempted to help the patient. In the beginning of this period of treatment the patient complained that psychology always resulted in a vicious circle with no way out. Thereupon the therapist suggested to 'try it without psychology'. During the first half year of this treatment period the patient produced a great number of anal dreams. Thomae, in his critical discussion of Boss's book, says that the breaking through of anal instinctual tendencies and the regression of the patient are phenomena which had

to be expected from psychoanalytic theory *(17)*. After some time in treatment, the patient developed a serious psychotic episode. He heard voices, had olfactory hallucinations, broke objects in the therapist's office, finally lapsed into a catatonic state. Boss reports: 'His psychoanalyst did not give up. He sat with the patient for the full days and half of the nights, fed him, and insisted upon taking care of the patient with his own hands like a baby's nurse. After forty-eight hours the patient embraced the physician vehemently in the way an infant might cling to his nurse, and exclaimed a hundred times, "Mama, Mama". A few weeks later the patient had improved so much that the therapist could return to the classical couch technique of psychoanalysis.' The patient finally became well, able to work, married, and had children. A follow-up after five years showed that the improvement had become stabilized.

Boss attributes this success to the use of a technique based upon existential analysis. This claim is unjustified. When and under which conditions a technique of completely taking over a mother role can help is certainly a relevant problem; but it can be assumed that successes in such cases are independent of the theoretical or philosophical ideas of the therapist. Technical measures, similar to the one mentioned by Boss, have been used by therapists who do not belong to the existential analysis school, and have been reported in the literature.

As far as existentialism as a philosophy of life is concerned, its acceptance or rejection is more a personal problem than a problem of a psychoanalyst as a professional person. From Freud's reaction to Binswanger's address on the occasion of his eightieth birthday, particularly his letter to Binswanger *(5, 16)*, we can safely assume that Freud would have rejected existentialism.

The psychoanalyst might try to explain existentialism as a sign of psychopathology. For example, in the life history of Kierkegaard, the adopted 'patron saint' of existentialism, it is easy to identify a great deal of pathology and to relate this pathology to Kierkegaard's ideas. It seems, however, that such an approach is not fruitful. In recent years psychoanalysts have

been particularly interested in studying the problems of genius and creativity. We know that in the history of mankind some of the greatest and most influential ideas have been developed by persons who, measured with the yardstick of the psychiatrist, seem to have been suffering from extreme pathology. This does not cause us to disregard or devaluate their ideas for that reason.

A more worthwhile approach seems to lie in profiting from some of the psychological insights which are to be found in the writings of many of the existentialists as a by-product of their philosophy. Freud repeatedly noted that the poets and philosophers anticipated many of the discoveries of psychoanalysis, but they had been unable to organize and present them in a systematic way. Kierkegaard's writings are a source of extremely interesting and deep insights into the unconscious. In 1847 Kierkegaard wrote, for example, an essay entitled, Does a Human Being Have a Right to Let Himself be Killed for the Sake of Truth? This essay is full of deep insights into the psychology of masochism. That these insights are presented within a framework of religious thinking does not make them less significant. While the writings of authors such as Kierkegaard or Bergson certainly do not contain any direct contributions to psychoanalysis as a science, they clarify many facts about the unconscious.

In general, it may be said that from the point of view of psychoanalysis as a science and an art no decision about the value of existentialism as a philosophy can be made. As far as existential analysis as a basis for psychotherapy is concerned, two claims of its followers should be examined: that existential analysis offers a 'new dimension' in psychotherapy, and that it avoids the 'errors' of psychoanalysis as a science.

Boss has stated that 'Freud in his practical work never ceased to see his patients as whole human beings' *(8)*. This statement is in line with a number of similar statements made by Binswanger. Since it is assumed that this holistic approach is the one significant element in existential analysis, the claim made by the editors of the anthology, Existence, that it offers a 'new dimension' is unfounded. Where the existential analysts claim

that their method is better than psychoanalysis, unfortunately they generalize philosophically and fail to indicate in what kind of cases they had therapeutic successes superior to those achieved by classical psychoanalysis. Although the existential analysts are restrained in their criticism of freudian analysis, it is clear that they consider their method a progress beyond it. The differences between freudian psychoanalysis and existential analysis can be summarized as follows: Psychoanalysis is based upon the psychology of the unconscious; existential analysis is phenomenological. Existential analysis discards transference in favor of something called the 'encounter'. Psychoanalytic interpretation of the unconscious is replaced by interpretation of the patient's 'existence'. In existential analysis no conscious attempt is made to understand the patient in terms of any general laws like those which are the basis of psychoanalytic theory. That the existential analysts are indebted to psychoanalysis for their knowledge of the dynamics established by psychoanalysis is safe to assume.

Most of the innovations of existential analysis are negative. The effort to arrive at an immediate understanding of the patient as a human being might be considered one positive feature of existential therapy if there were no question that this is something new, something alien to psychoanalysis. Beginning with Freud, the practice of psychoanalysis has always aimed at an immediate and direct understanding of the patient as a unique human being; moreover, it goes beyond such understanding in its search for the genesis and the dynamics underlying the patient's difficulties.

The obscure language and terminology of the existential analysts, and their grandiose claims to offer a new dimension, stand in the way of any communication between its adherents and freudian psychoanalysts. The existential analysts seem to be engaged in a type of relationship therapy which may prove successful in certain cases. A psychoanalytic evaluation of existential practice of psychotherapy will not be possible until reports become available which give matter-of-fact descriptions rather than philosophical explanations.

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THE PSYCHIC FUNCTION OF DEPRESSION: A STUDY IN ENERGETICS

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Depression appears from time to time in normal life and also, sooner or later, in almost every mental illness. Pronounced depression occurring apart from mental illness can usually be accounted for as the reaction to objective loss, and there is usually a direct relation between the intensity of the affect and the gravity of the loss. What is lost may be a love object, or more precisely the love of the object, that is, of a person whom one loves. The loss of a love object may come about through death, separation, or disaffection on the part of the love object.

There is a second kind of loss that is actually a particular instance of the first. Everyone reserves a great portion of his love for himself, that is, for his ego ideal *(10,* p. 94*),* and this self-love is secondary narcissism. Self-love can be frustrated by disappointment in oneself much as one's love for another can be disappointed. The second kind of loss is loss of those qualities that form the basis for self-regard. Bibring *(2)* considers loss of self-esteem the basis of all depression, and Rado *(35)* and Fenichel *(8)* too consider it central. Attributes that contribute to self-esteem include, for instance, integrity of body, reputation, intellectual capacity, attractiveness, success, and fortune. In fact, what may appear to be only a loss of object, as when one is jilted by a lover, may also be a serious blow to one's self-regard. Freud *(10,* p. 100*)* noted that self-regard is derived from three sources: a residue of infantile omnipotence, the fulfilment of the ego ideal, and the gratification of object love.

While the loss is usually identifiable in the serious depressions of normal life, mild depressions or depressive moods can often not be accounted for. If the depression is not too severe, the individual may pretend that it does not exist at all. In such instances it may still be apparent to others, who are intimate or observant, as unusual irritability, uncommunicativeness, or the

facies and posture of depression. But in the severe depression of mental illness the loss is usually unknown to the patient, and protracted analysis may be required to ascertain it. In fact a chief criterion by which we distinguish between normal depression and the depression of mental illness is whether the depression can be attributed to an evident loss of commensurate gravity. In general, depression is an affective reaction to a loss of love object or to a diminution in self-esteem.

What are the functions of depression? First, the feeling of depression impels the sufferer to retrieve the lost object. Depression is a form of psychic pain, and it motivates the individual to perform whatever act will relieve the pain most quickly. Therefore in depression if the precipitating frustration or disappointment is known to the individual he will attempt or at least yearn to repair the loss.

When the loss is imposed by circumstances beyond the control of the individual, he cannot repair it. However there is one kind of loss that in a sense is entirely within the individual's own control; it is the loss of object caused by an individual's withdrawal of interest from the object. The object is lost to him because for some reason he has had to forego regarding it as a means of gratification.

The schizophrenic breakdown is typically preceded by a welling up of homosexual libido and then by intensified secondary narcissism. Either because the repressed impulse threatens to break through into consciousness, or because the retreat into secondary narcissism fails as a result of loss of self-esteem, the individual attempts to defend himself against the threatened pain by rejecting both the external world as a source of pleasure and himself as a real person existing in the world. This is an attempt to retreat into the primary narcissism of infancy, which existed before the infant could know of an external world, or of himself as a real object in it. Although the withdrawal is performed for the purpose of averting danger, the loss of the images of the world and of oneself as potential objects of gratification is also a danger, and it is painful. The patient, in this phase of his illness, complains of a dreadful feeling that the world is

being destroyed; it is lifeless and dead. This feeling is essentially the depression that is the reaction to the self-imposed loss. It impels a wish to restore the old images to their places, and, in fact, causes efforts to do so, though these are magical and delusional (for example, projections and fantasies of rebirth).

Depersonalization is another reaction to an abrupt loss, and in this sense resembles depression. If it is the image of himself that the patient rejects, he loses the feeling of reality and familiarity which is normally attached to the self-image. The same distressing loss of reality may pertain to the images of the external world as well. Depression and depersonalization may occur in the case of less overwhelming object losses too. These painful feelings tend to cause the individual to avoid, retard, limit, or undo the turning away from objects; they stimulate a countertendency represented by clinging to the object, which we often see in incipient depression.

Second, Darwin *(5)* suggested that the facial and postural movements and attitudes that characterize each affective state are residua of what were, during an earlier phase of phylogenetic history, instinctual movements. He supposed that these movements became condensed and ritualized and acquired a signaling function. In depression there are telltale facial expressions, postural collapse, weeping, wringing of the hands, and wailing. These indications of depression come about automatically without the individual's conscious effort, indeed they are beyond his control and often without his knowledge. Supposing that Darwin was correct, what is accomplished by one person's signaling to another that he is depressed? In all gregarious species, there exist inherited and perhaps some acquired ritualized movements which, whatever their origin, all serve to coördinate the activities of the members of the group. These include, for example, the young's call for help, the parent's call of alarm, and the mating call of the animal ready for reproduction. The visible physical changes characteristic of the several affects serve to communicate the existence of this affective state to observers. The depressed individual is helpless or at least weakened by his loss. The weakening comes about not only from the loss of the

physical advantages provided by the object, but also as an integral part of the syndrome or reaction of depression. Such a weakened individual requires the support of the other members of the group, both to help him do what he cannot do alone, and to offer themselves to him as substitute objects. When confronted with the visible signs of depression, human beings cannot refrain from offering love, sympathy, assistance, and protection. We may say, then, that the second function of depression is to command for the individual who has sustained a serious loss the comfort and support of others.

Third, depression tends to decrease the libido content of the ego. In the usual depression of normal life, for example that following bereavement, there are loss of interest, relaxation of postural tone, decreased alertness, appetite, and sexual desire, a sense of emptiness and yet heaviness, and manifest inertia and apathy. Freud *(13,* p. 255*)* attributed this syndrome to a loss of psychic energy of the ego; 'normal mourning absorbs all the energies of the ego', and 'the complex of melancholia behaves like an open wound, drawing to itself cathectic energies . . . from all directions, and emptying the ego until it is totally impoverished'. In 1926 Freud *(16,* p. 18*)* wrote of 'the condition of general inhibition which characterizes states of depression, including the gravest of them, melancholia'. Often the ego depletion is appreciated subjectively by the patient. A patient, telling of hearing a catastrophic piece of news, said, 'As I listened, I could feel the steam leaving me'. Another patient, as his depression was developing, dreamed that his pet monkey had cut its hand and, not permitting anyone to approach it, was rapidly bleeding to death. It is as though the man conceived of the ego enervation as the consequence of a 'libidinal hemorrhage'.

Can there be anything useful about such an attenuation of ego libido content? What would happen if, in the face of a grave loss, there were no enervation? The feeling of depression itself motivates wish and effort to retrieve the lost object. But if the object is irretrievable, both the impossibility of securing gratification from the object and the feeling of longing bring

about a rapid increase of activity potential, that is, of ego energy content. This increase will be unrelieved, for no transitive instinctual act can be completed in the absence of an object. Either there will be an attack of anxiety, which is the specific reaction to the threat that the ego will be flooded by energy, or the ego will regress to a more archaic mode of discharge, or both events may occur. If the ego does regress, there will be an excited, disorganized, unrealistic effort to find some means of gratification, an effort which gives direct expression to the fantasies of the ego nucleus, ignoring the realistic requirements of the supplement to the ego *(30)*. Clinically we observe that the immediate reaction to a loss is the affective response, often accompanied by a short-lived effort to deny the loss and perhaps the affective response too, and only after a time does ego enervation follow. It seems that many of the physical signaling changes of depression are brought about by the energy loss. I conclude from these considerations that the attenuation of ego libido serves to decrease the impact of the loss, and to prevent desperate, often destructive, actions and the development of anxiety.

We do not know how this depletion of ego energy occurs. Freud *(13)* states that in mourning the ego is impoverished because all its available energy is absorbed by the work of mourning, and in melancholia impoverishment occurs because the ego's energy is 'bound' by the loss complex. Freud, however, was not satisfied that he had achieved a satisfactory explanation of the mechanism of ego impoverishment. We can only say that the ego seems to have no access to an energy supply otherwise available to it. Perhaps in normal depression and melancholia the libidinal energy of the id is prevented from penetrating into the ego, and, in view of the occasional abrupt depletions that we observe, for example, in the man who could 'feel the steam leaving' him, we may suppose that energy may occasionally be withdrawn from the ego abruptly.

To clarify the ego energy loss, let us consider the two complementary conditions of excessive enervation and inadequate enervation. In excessive enervation, when the libido loss is more profound and protracted than the situation warrants, we see

what is generally called melancholia, characterized by the loss of interest and desire, and by inertia. When there is inadequate energy loss, however, anxiety and desperate acting out, or both, result. Dissociation between intensity of depression and degree of ego enervation is especially common in schizophrenia. We have seen that schizophrenia is precipitated by a rapid and excessive build-up of object-directed or narcissistic libido. The libido is built up in the id, and the ego is rapidly filled with energy from the id. (Perhaps if anxiety had set in earlier in the course of the build-up, and had caused an abandonment of this libidinal position, to be followed by depression and withdrawal of ego energy, the schizophrenic position of complete and cataclysmic withdrawal might never have been reached.) Ego energy increases to even greater heights in the presence either of a promise of gratification or of actual frustration. Either of these may act as a trigger for rejection of oneself as object or of the sexual object; when rejection of either occurs there occurs also rejection of the entire real world as a source of gratification. The ego regresses, as we have noted, to the primary narcissism of the infant who has not yet acquired the concept of people as objects, and for whom the external world is known only as a source of 'sign stimuli', configurations which have the power to influence his feelings and behavior. The response to this self-imposed loss is a prompt and profound feeling of depression, usually expressed in the 'end of the world' fantasy; depersonalization and loss of the feeling of the reality of the world also often appear. Probably in most cases of nascent schizophrenia, the feeling of depression does not bring with it an attenuation of ego energy. The ego then is in the impossible position of being strongly impelled to act, but not knowing of anything or anyone it can act on; indeed not being able to conceive of transitive action.

What happens? Action remains impossible so long as the lost world of objects is not retrieved, yet a resumption of the precipitating state is also impossible. The characteristic schizophrenic solution is to try to rebuild the world and the self as

an object, but with the essential requirement that rebuilt objects consist only of projections of the self in a state of primary narcissism. While the images of the real world serve as targets or carriers for these projections, their actual properties are ignored or distorted so as to make them conform to the projected images. These projected images are components of the psychic structure, the superego, the ego, or the id,—for example, the images of the parents crystallized in the superego, or the superego's idealized image of the self (the ego ideal), or any of the numerous identifications of the ego, or portions of the individual's body (body ego), or one or more of his characteristics such as his name. But these may perhaps be considered secondary projections, for they already have some form or organization. The primary projections are projections of the sensations which constitute the whole of the conscious experience of primary narcissism, the feelings of being happy or sad, full or empty, the subjective experience of looking and being seen, of influencing and being influenced. It is these sensations that seem to pervade the world and carry with them the personality fragments we noted above.

Even the reconstituted image of the self is artificially synthesized. It is not a true image of the self that is reconstructed; it is no more than a synthesis of individual components carrying the feelings of primary narcissism. In that state, the archaic ego cannot yet conceive of either the self or the mother as an independent object existing in a real world. Yet this ego probably experiences sensations of pleasure or pain in its automatic transactions with the mother. It is probably these sensations of the archaic ego in the stage of primary narcissism that are projected into the image of the real self in the restitutive phase of nascent schizophrenia, and that there give rise to feelings of omnipotence and of capacity for magical transactions with other individuals. This process of synthesizing and populating a new world are vividly expressed in schizophrenic delusions and fantasies of rebirth and propagation. (For the original statements of these formulations see Freud [*9*] and Nunberg [*23, 24,*

27, p. 131].) Thus the psychology of schizophrenia illustrates the consequence of inadequate ego enervation in the presence of intense affective depression.

In other cases of nascent schizophrenia, the initial depression does include a significant attenuation of ego libido. Since the object loss which is responsible for the depression is so severe, the enervation cannot be considered excessive no matter how profound it is. In some cases, the prompt draining of ego energy halts the schizophrenic process, and the full clinical picture of schizophrenia does not develop. Instead we see a moderate to severe depression resembling true melancholia, and if the ego enervation is profound and protracted the condition is called schizophrenic melancholia *(3,* pp. 208, ff*)*. The clinical distinction between schizophrenic and nonschizophrenic melancholia is difficult and depends upon a careful history of previous attacks and of the genesis of the current attack. The administration of iproniazid (Marsilid) or beta-phenylisopropylhydrazine (Catron) or a similar energizing drug may differentiate, however; for if the melancholia is part of a schizophrenia the drug may bring to the surface ideas of reference and other delusions, whereas if it is not, the melancholia is usually quickly resolved *(31, 32)*.

A patient had suffered several attacks of depression, at least one of which was probably melancholia, before breaking down into overt paranoid schizophrenia. The psychotic episode was resolved with the aid of a phenothiazine tranquilizer and the patient was then treated by psychoanalysis. After six months, in the presence of a homosexual threat, there was a second mild breakdown, relieved within a few days by small doses of the same drug. Thereafter the patient was maintained on a small daily dose of the drug while analysis continued. After another six months the paranoid tendency reappeared, but under the influence of the drug or of the analysis it failed to advance to the point of psychosis. Instead it was quickly replaced by mild melancholia with a tendency to abandon all objects (see *31,* Case D).

A second schizophrenic patient had been in analysis for about a year after her psychotic episode was resolved by a phenothiazine tranquilizer and had left analysis at her husband's urging, seeming well. Six months later she returned for treatment because she recognized the recurrence of her illness. The illness subsided after a few days of medication, and analysis was resumed while the patient was maintained on a small dose. After two months the patient was again exposed to the situation which had precipitated her second brief breakdown. Her reaction was a resurgence of delusional jealousy, accompanied by a sharp depression without ego enervation. This episode was again quickly resolved by a temporary increase in dose of medication (see *31*, Case A).

These incidents illustrate that in patients subject to schizophrenia, objects or the world of objects are abandoned as a defensive measure and a depression ensues. If the abandonment of the objects relieves the ego of its excess energy by active enervation as in the first case, the pathogenic process will fail to proceed into frank schizophrenia but will be terminated in melancholia. If there is no enervation, the objects will be delusionally restored by projection.

Evidently dearth of ego libido is as painful and dangerous to the ego as is plethora. Both disturb ego function and cause distress. In plethora the uncompromising pursuit of instinctual gratification overrides other ego functions so that the ego becomes disorganized and ineffectual. Ego impoverishment is painful; the patient cannot retain the object or sustain normal ego functions. The ego strives to avoid depletion as vigorously as plethora and employs the anxiety signal in both cases.

Each of three schizophrenic patients (*31*, Cases A, D, E) showed an occasional tendency toward lethargy and excessive sleeping, used as defense against a threatening break-through of schizophrenia. This was a simple motor inertia unaccompanied by depressive affects, depersonalization, guilt, or reversion to primary narcissism and primary self-observation. In some instances it preceded the development of an actual melancholia; in others it followed emergence from it; and in still

others it was temporally unrelated to melancholic depression. This seemed to be a device to contain a threateningly high potential of ego libido by general inhibition of activity rather than by ego enervation, for in patient A, who never showed any melancholic tendency, the administration of prochlorperazine when she was in this state brought about an increase rather than a further decrease in general activity. In other words this seems to be a dynamic defense rather than an energetic one. Perhaps catatonia is a similar general inhibition of activity in a patient whose ego is filled with libidinal energy.

In most cases of depression there is more to the clinical picture than the three elements we have named, the affective feeling, the physical changes, and the ego enervation. The physical changes are in essence no more than manifestations of the other two; but by their signaling function, these changes also serve a second kind of defensive function, that is, a social defense. Some other common features of the depression syndrome, including both primary defenses against object loss and corrective modifications of these defenses, may seem inconsistent with the elements described.[1] Let us examine these other features.

AGGRESSION

Loss of the object is treated by the individual as a frustration and an attack, and it evokes the defensive and predatory activities of the death instincts *(28)*. The patient wishes to retaliate against the disappointing individual and to hold him by overpowering him if he cannot hold him by love. The absence of the object is felt as a loss, a gap, and the consequent feeling of emptiness re-enforces the feeling of need which the ego nucleus appreciates as hunger. In the presence of actual or potential object loss, there is regression in the id to oral instincts. The

[1] Though I have emphasized energetic aspects of depression, this approach is not proposed to replace consideration of genetics, dynamics, and structure. Rather, it is an attempt to suggest a complementary approach. A clinical orientation based on all approaches is more comprehensive and incisive. If this approach should prove useful, it will be necessary to study carefully the detailed relations between energetics on the one hand, and genetics and dynamics on the other.

hunger and the anger coöperate to motivate predatory tendencies, as if the suffering individual wished to hold or to retrieve his object by incorporating it. This fantasy finds its most direct expression in the bulimia that sometimes accompanies incipient depression. Hunger and angry clinging characterize threatening or incipient enervation, or merely affective depression, but once the ego has been deprived of its energy, appetite and interest in the object disappear and are replaced by anorexia, nausea, vomiting, and a seclusive intolerance of others. It is as if, in the absence of energy sufficient to cathect the objects of the external world, the ego responds to the love objects and to food with pain, and strives to avoid both. Conversely, when the ego energy of melancholic patients is restored by the use of one of the energizing hydrazine drugs (iproniazid [Marsilid] or beta-phenylisopropylhydrazine [Catron]), nutritional and erotic appetites return and remain excessive until the patient feels confident of a renewed narcissistic or transitive object relation.

Because the death instinct is triggered or 'released' by the loss, the ego is impelled to hostile clinging and incorporative fantasies and acts, which are belligerent and destructive. Irritability and anger are often the first indications of depression. Some of this energy provided by the aggressive instincts is welcomed by the ego as replacement for the libidinal energy it has lost. A depressed patient who came to her treatment hour in a fury complained, when I showed her that her anger was inappropriate, 'Don't take my anger away from me. It's all I'm going on now. If you take it away from me, I'll collapse.'

A person awakening from sleep or recovering from coma first becomes responsive to noxious stimuli. The response to irritation consists of more or less simple, sometimes purposive, stereotyped movements. If disease prevents full arousal by the painful irritant, violence may appear. As recovery proceeds, the ego recovers its functions of perception, thought, self-control, and anxiety. With full recovery, interest in other individuals as objects of desire and affection appears. In other words, as the ego acquires energy it expresses the tendencies first of the death

instinct, then of the primary and secondary narcissistic components of the erotic instinct, and finally of the tenderness of the object-directed components of the erotic instinct. The opposite sequence occurs in the process of falling asleep or lapsing into unconsciousness. In melancholia the energy of the erotic instincts is excluded from the ego because it has given up its object and can therefore not discharge energy that might be supplied by erotic instincts.

At any rate if it is true that in melancholia the ego cannot support the tendencies of the erotic instincts but can support the tendencies of the death instincts, we see an instance of literal defusion of the two sets of instincts. Freud suggested that normally the death instincts become manifest in derivatives which include also expressions of the erotic instincts; that is, the two are fused so that the death instincts are not permitted to express themselves undiluted. As a consequence of regression, the fusion is undone, and death instinct is permitted direct expression *(15,* p. 57*)*. The description I have proposed for the status of energy in the melancholic patient accounts for ego activities in which death instinct, relatively undiluted by erotic tendencies, appears directly.

Are the self-torture and preoccupation with self that occur in melancholia consistent with a state of deficit of ego libido? We may compare the melancholic's attitude toward his own ego, or toward himself as container and carrier of ego, to the attitude toward a painful limb or organ in the sufferer from causalgia. When the pain first sets in, the individual attends to the lesion, treats it, and protects it. As the pain persists or increases and leaves the sufferer no peace, he becomes angry with his hurting organ and asks to have it removed. The hurting ego of melancholia is treated in this latter way. I do not contend that no last drop of libido remains in melancholia, but I do find it reasonable to suppose that the noisy self-cathexis of melancholia consists largely of the energies of the death instincts.

DENIAL

Denial was defined by Freud *(17,* pp. 199, ff.*)* as the removal

of the preconscious cathexis from an image or idea. In other words, by virtue of some change in its energy the image or idea is prevented from becoming conscious. When one of the lower animals sees an object, orienting and taxic mechanisms compel the animal to attend to the object until the instinct has been satisfied or until a more urgent instinctual need deflects attention elsewhere. In some instances an averting mechanism may overcome the forced fixation when consummation is inappropriate *(22)*. The capacity to withdraw attention from a potential object because of some internal interest alone reflects a great increase in plasticity and probably cannot occur, ontogenetically and phylogenetically, before the ego supplement has appeared *(29, 30)*. Denial has the advantage that the ego nucleus acquires the capacity to select among the external and internal images to which it will attend, independently of a constitutionally provided priority determined by the id, and in accordance with a calculated decision. Denial is also used to defer or attenuate pain by ignoring the threat, the injury, or the pain itself.

During a year of psychoanalysis, a melancholic patient persistently denied that he had been hurt by being jilted by his lover. The incident, he said, had nothing to do with his illness; he retained no interest in the girl. When he began to recover, he revealed that during his entire illness he had kept her photograph on display in his bedroom. When he recovered, he discarded it.

In depression the fact that the object has been lost may be denied, the feeling of depression may be denied, and the incipient enervation may be denied. For this reason depression may be visible to others before the patient becomes aware of it, or it may be masked by complaints of somatic distress. If the injury and the feeling of distress are denied, the ego may be able to retain its normal complement of energy. Thus denial may help to avoid discomfort or pain, but the avoidance is only temporary for three reasons. First, if the pain is severe or persistent enough, it usually overcomes the denial. Second, the reality principle continuously opposes denial. Third, although

denial may cushion the immediate painful impact of the perception of a loss, it creates an even greater loss than it masks. As the result of the original loss, only the image of the lost object becomes unavailable. But what is denied is not the object, for that has been already lost, but the fact of the loss. This denial that any loss has occurred must be supported by abandoning interest in the whole affected area of instinct gratification, and the psyche is considerably more severely crippled by this more extensive injury.

Denial may be considered an act of aggression, driven by the aroused defensive instincts *(15,* p. 185*)*. However what is attacked is not the disappointing object but rather one's own catalogue of potential objects and opportunities for gratification. Therefore denial not only seems to protect one's own sensitivities, but also spares the once loved, now hated object; it does both by means of aggression against the self. The schizophrenic's repudiation of the world of real objects is, in a sense, a general denial of the real world. It illustrates the fact that in denial a specific loss is not acknowledged, that therefore the ego is generally not depleted of its energy, that the act of denial is a hostile one intended for the disappointing real world but injuring only the patient's subjective world, and that the feeling of depression which ultimately results from the denial is more severe than the pain which might have been caused by acknowledging the original, circumscribed loss.

DEPERSONALIZATION

Depersonalization is a frequent component of depression. It sets in soon after the object has been lost or given up, and it often precedes the feeling of depression. It is the response to a defensive process, similar in a sense to denial, in which the fact that the object has been lost is masked by rejection of the disappointing real world or of the disappointing self. Denial in neurosis consists of ignoring a circumscribed area of one's existence, and denial in schizophrenia is a rejection of the entire world. The rejection that brings about depersonalization and loss of the feeling that the world is real applies to one's com-

plete self or to the whole world, as it does in schizophrenia; but it is a more limited rejection, for it does not exclude acknowledgment of the existence of the self or the world. Rather it creates the sense that the images of these are unreal, unfamiliar, and irrelevant to oneself. It is as though a primary process impression of reality, as indicated by the immediacy of sensory experience, is abolished, while a secondary process intellectual judgment of the real world remains intact. It is noteworthy that whereas the recognition of object loss usually induces a feeling of depression, depersonalization (which signals a less complete loss of object) induces anxiety. Because of the promptness and intensity of the anxiety, and because the associations to depersonalization usually suggest castration, Nunberg *(25, 27,* p. 134*)* infers that the experience of depersonalization activates the castration complex, as if the loss of the sense of reality were tantamount to a loss of the genital. The reason for this surprising equivalence may lie in the fact that the feelings of reality and familiarity are psychosocial links essential to an ultimate physical gratification.

In melancholia the patient may say, 'I'm miserable; there is a horrible rawness inside me', giving direct expression to his feelings. In depersonalization, however, the patient reports, 'I have a strange feeling that I cannot understand. It is as if I were not myself or not real.' The patient notices two simultaneous experiences: one is depersonalization, and the second is observation of the first. The first experience may be called primary self-observation, and the second, secondary self-observation. The former, characteristic of primary narcissism, appears in states of dearth of ego energy, and the second, characteristic of secondary narcissism, appears in states of adequate ego energy supply or at least in states in which the ego is not severely depleted *(32)*. Since depersonalization implies secondary self-observation, we encounter it in states of relative ego plethora, such as nascent schizophrenia, in states of adequate supply, such as hysteria and the onset of melancholia, and in melancholia-like depressions in which ego energy depletion has not advanced to the point where secondary self-observation becomes impossible. I doubt

that it is to be found in profound melancholia in which only primary self-observation prevails. Secondary self-observation requires a capacity for detachment from self which cannot be maintained either at the high extreme of supply of ego libido that occurs in mania or incipient schizophrenia, or at the lower extreme that occurs in melancholia.

ANXIETY

Anxiety is an affective response to danger. When the danger is created by external destructive agents, we speak of fear. Anxiety is a term better reserved for the response to danger of intrapsychic origin. This is the danger that the ego may be overwhelmed by the forces of the id, that it may be flooded by instinctual energy and its structure destroyed *(16, 29)*. We speak of 'definitive' anxiety caused by an increase in id pressure which has already come about, and of 'signal' anxiety when something has happened that may be expected to lead to an increase in id pressure. Loss of an object clearly is an adequate signal for anxiety, since it threatens frustration and an accumulation of instinctual pressure. The child who has been left alone becomes anxious or depressed. When is anxiety and when is depression the response to object loss? If, when instinctual pressure has already been built up and an object is needed in order to dissipate a serious increment in libido, the only available object is then lost, the response may be definitive anxiety. The fear of being alone, in a child or a phobic adult, is just that anxiety evoked by the pressure of libidinal desire that is frustrated by the solitude. Neither definitive anxiety nor signal anxiety, however, follows object loss when there is no unusual accumulation of libidinal pressure. The normal response to object loss is depression, not anxiety. Signal anxiety may appear in phobia, when the phobic trigger does not actually increase the libidinal pressure but, because of neurotic fantasies, merely threatens to do so. A man with a phobia of traveling, for example, already under extraordinary libido pressure, finds his anxiety triggered if he has to drive across town. A tie-up of traffic would not really keep him from getting home to his wife or mother, but seems

as if it might do so, and therefore gives rise to signal anxiety. A phobic trigger may also create signal anxiety in the absence of severely abnormal instinctual pressure, as in the small phobias of everyday life.

Von Uexküll *(38)* and Lorenz *(21)* point out that in lower animals an instinctual act is evoked by a specific configuration offered by the object of the act, a social releaser. The releasing or triggering of the subject's act is automatic and involves no subjective cognition or recognition of the object as a member of the species, as an appropriate target, or as a familiar individual. In other words, the object individual does not seem to be represented within the psychic apparatus of the subject. In man, however, we know that not only objects but the entire inanimate environment is represented intrapsychically as a microcosmic reproduction. This intrapsychic microcosm, which in its fully developed form seems to be so characteristically human, exists in what I have called the 'ego supplement', to distinguish it from the phylogenetically archaic nucleus of the human ego *(29, 30)*. This archaic nucleus seems to respond to configurations as does the ego of the lower animal. Between the human mode of object relation and that of the lower animal there are some intermediate forms in the more highly developed birds and in mammals which need not necessarily all be considered to lie in a straight developmental line. For example, some birds, by a process called 'imprinting', acquire the capacity to respond to appropriate instinctual objects or classes of objects. Others learn to recognize individuals and maintain intact families over the entire adult life span. Many mammals, of course, maintain enduring object relations. I do not know of any study of the phylogenetic relation between the capacity to recognize individuals as instinctual objects and the capacity to show signs of depression. Nevertheless there seems to be such a relation; only those animals become depressed that can conceptualize, recognize, and form a relation to an individual instinctual object.

A psychic apparatus that is able to register images of the actual objects of the environment within it and manipulate these

images according to realistic principles, as does man in the 'ego supplement', is obviously much more capable of securing instinctual gratification than an apparatus that responds automatically to innate, or even to acquired releasers. The anxiety reaction (including affect, autonomic changes, and motor responses) is probably phylogenetically archaic; it is released automatically and it issues in a small repertoire of innate or learned, defensive or escape actions. Just as the 'ego supplement' provides for the ego a new and far superior means of gratifying one's needs, so the depression reaction (including all the components we are discussing) greatly surpasses the anxiety reaction as a means of dealing with simple object loss. As contrasted with the anxiety reaction, depression is phylogenetically newer, it is released not by simple sign stimuli but only by the ego's recognition that an image has dropped out of the 'ego supplement' (so that denial is more effective in deferring depression than anxiety), and the only automatic actions in which it issues are weeping and the manifest physical changes noted above. The desire to retrieve the lost object impels more appropriate and precisely calculated activities than those driven by anxiety. However when the depression reaction fails to secure replacement of the lost object, and when the usual ego enervation has not occurred, after the passage of some time anxiety may replace or appear with the depression. I referred briefly above to a woman patient who relied on the energy of the death instinct when she felt her ego relatively depleted of energy. When this woman's mother left town for a trip, the patient became depressed. She denied her depression at first but as time passed the depression became more severe and she acknowledged it. As weeks passed she became gradually more anxious and her anxiety was projected outward onto specific phobic triggers determined by her fantasies of reunion with mother.

When an object that is currently serving to drain off an abnormally high instinctual pressure is lost, the response is not depression but definitive anxiety. When in response to object loss, depression does occur, but without the usual ego depletion, as time goes by without restitution or replacement of the object,

instinctual pressure builds up and anxiety appears alongside the depression. Also signal or definitive anxiety occurs when the depression is accompanied by depersonalization.

One would not expect to encounter anxiety, which is the response to the danger that the ego will be flooded with energy, when the ego is partially depleted of energy. But the fact is that even in melancholia one encounters anxiety although it is true that as the melancholia becomes more profound anxiety tends to disappear. To explain this fact we have to introduce a new concept: not only does the danger that the ego will be flooded with the energy of the erotic instincts provoke anxiety, but the danger that it will be flooded with the energy of the death instinct does the same. In that case any threat of physical or psychic pain may act as trigger for signal anxiety, while an unrelieved exposure to pain may evoke definitive anxiety—the anxiety arising from the possible or actual flooding of the ego with the energies of the defensive death instincts. If this supposition is true and if, as suggested above, in melancholia the pain of object loss and of ego enervation activates defensive death instincts, then we can explain the occurrence of anxiety in melancholia.

A woman had passed from a paranoid schizophrenic state to a state of melancholia either as a result of excessive medication with a phenothiazine tranquilizer (perphenazine—Trilafon) or because I was absent for a short period of time, or for both reasons (*31*, Case D). When I returned I withdrew the perphenazine and when the patient failed to improve I introduced iproniazid which brought her out of melancholia within three weeks. On each of two days in the course of her recovery the following incident occurred. She had had a satisfactory analytic session in which she seemed somewhat better than before, better in fact than she had felt before the session. She met her husband in the waiting room and walked out of my house with him. Within a few moments she insisted upon returning instantly to my office. She seemed anxious, embraced her husband in my presence, and said, 'Let's not leave here'. Previously, when the melancholia had been severe, she had been eager to see me and

tended to cling. However at that time my being with her did not seem to make the profound difference suggested by this later incident, which suggests that at this point enough erotic libido had become available to enable me, by using her transference love for me, to mobilize it and facilitate its passage from id to ego. Leaving me threatened her with the possibility that this small supply of ego libido would be lost again, and this threat by its arousal of the death instinct evoked the signal anxiety and aggressive clinging. It cannot have been the threat that the ego would be overwhelmed by libido upon leaving me that caused her anxiety for, so far as I could judge, she still suffered from a relative inadequacy of ego libido.[2]

AGITATION

The fact that many melancholics become agitated and are continuously restless and moving about seems inconsistent with my thesis that in melancholia the ego does not have its normal supply of available energy. Agitation often appears in moderate degrees of melancholia. If the agitated patient becomes more profoundly depressed, his agitation gives way to inertia. The agitated patient is more likely to kill himself than the inert one. He seems to be trying to work something off in his restless activity. He says that something inside makes him move; he is less uncomfortable moving about. He is unhappy and bitter and can only be hateful to others, even though he loudly confesses his selfishness and guilt.

Bleuler *(4,* p. 475*)* considered agitation in melancholia a manifestation of anxiety. If it is also true that anxiety occurs in melancholia under the pressure of an abnormally high potential of the death instincts triggered by the pain of the depression and ego enervation, the agitation represents an effort to dissipate the pressure of the death instinct by 'working it off' in some way. Pacing, hand-wringing, and wailing are relatively innocent activities compared to what is desired, namely murder of

[2] In a more recent, as yet unpublished paper, The Clinical Estimation of the Energy Content of the Ego, I have discussed the possibility that a threat of losing ego libido may evoke anxiety because of the helplessness that would ensue.

the disappointing object or, under the influence of guilt for that desire, suicide. If the melancholia becomes more severe, the death instincts too are inadequately supplied by energy and they cannot be mobilized even by anxiety, so that agitation disappears. Why agitation is present in some cases and not in others, I cannot guess. It may have something to do with the relative susceptibility of the erotic and death instincts to retardation; that is, when the erotic instincts are attenuated before the death instincts, defusion occurs and with it anxiety and agitation, whereas when erotic and death instincts are attenuated together or almost together a relatively apathetic melancholia ensues.

SUICIDE

Suicide is possible in any kind of depression. But the probability of a fatal outcome, the unconscious intention, and the mode of execution all vary with the nature of the depression. The principal distinction to be made is between the depressed state without ego depletion and the depressed state with ego depletion. When there is ego depletion, suicide is an attempt to relieve one's inner pain by destroying the ego in which the pain exists. When there is no ego depletion, suicide is the expression of anger against the disappointing love object, and often follows a quarrel. Both the death instincts and the erotic instincts fill the ego with energy. Therefore the suicide attempt has erotic components, and is a method of reaching and influencing the disappointing love object. The intention is to repair a broken love relation by compelling the object to return love. This consideration overrides the wish to kill, and these suicide attempts are meant to be impressive, but not necessarily to succeed. In melancholia, however, the death instincts are undiluted. The suicide act is performed in a narcissistic state in which there is no object other than oneself. The self is attacked because it has proved to be a disappointing object, because it hurts, and because there is a powerful need to do something destructive. Suicide attempts in melancholia seldom fail.

In depression without enervation of the ego, the death in-

stincts are triggered by the pain of the object loss, and although the pain is felt within the ego the disappointing object is held responsible. The direct object of the suicide attempt is the self, but the indirect object is the lost, once loved, now hated object. This indirect attack is a defensive substitute for a wish to kill the object. Such a patient may be obsessed with thoughts that others, children, parents, husband, or wife, will be the victims of some catastrophe; that is, he worries lest his wishes come true. Sometimes these obsessions alternate with fear that catastrophe may befall the self. One hysterical woman aimed her car in which her children were riding with her directly at a tree, and swerved aside at the last moment after frightening them. When the ego is depleted of erotic energy, interest in objects is lost and the patient reverts to a single-minded concern with his own feelings, that is, to a state of primary narcissism. The ego is felt as the source and seat of the pain, and a primitive defensive instinct aims to eliminate the pain by extirpating the ego. Also, since the lost object has been introjected, that is, has become part of the ego, it can be attacked only by self-directed aggression.

The man who at the beginning of his melancholia dreamed that his monkey was dying from loss of blood, subsequently became much more depressed. He killed the pet monkey he had dreamed about because 'it was getting on my nerves'. It was as though, to save himself from self-destruction, the patient was trying to eject once more and attack as a separate individual the disappointing love object. The effort failed, for a few days later the patient attempted suicide and was rescued only fortuitously.

IDENTIFICATION

Under the influence of the pain of separation from the lost object, the need for restitution mobilizes an archaic instinctual mechanism, identification. The archaic ego, which in man is most directly represented by the ideal ego of infancy *(29, 30)*, knows no objects as self-contained entities in the real world,

but only sign stimuli. Its transactions with the world consist only of incorporation or ejection. These processes are represented in psychic life as identification and projection respectively. As a result of identification with an object the ego regards itself as possessing the instinctually significant properties of the object.

The individual who is depressed but without ego enervation remains object-oriented and so his identification expresses itself in his behavior toward others; he behaves like the object. Moreover, because the ego is operating under great instinctual pressure it tends to make projections. Hence there may occur simultaneously an identification of oneself with the lost object and a projection of oneself upon other objects.

It often happens that women who are depressed because they can no longer indulge their infantile sensual desires with respect to their mothers recapture the lost mother by identifying themselves with her and projecting themselves upon their children. They behave toward their children as they believe their mothers behaved toward them. The hostility which they direct against their children in fantasy and deed is actually the hatred toward their mothers whom they accuse of deserting and abusing them, but by attributing (projecting) this hatred to the mother, and then by identifying themselves with the hated mother, they can give vent to their anger. They make their children suffer as they suffered in childhood.

In the situation of ego enervation however there is a turning of interest from objects to the self, and if the ego depletion becomes profound the primary narcissism becomes complete, and the concept of an object is lost. Under these circumstances, the only way in which the ego can attempt to satisfy the affective craving for an object is by identification, which permits the ego to retrieve the lost object and still retain its exclusive concern with itself. In profound melancholia the patient sometimes speaks of a creature inside him that is making him suffer.

The man who tried to deflect the suicide drive from himself to his monkey in a previous episode of depression used to say

that his guts were being torn apart by some demon inside him. This was not a delusion, for he knew that there was no real internal creature but only felt as if there were. This was the creature that was making him miserable and that he wished to kill by suicide. Earlier in his depression this man had noticed that his mirror image resembled his father. A schizophrenic woman (*31*, Case D) who had had a number of depressions became depressed again after her mother died, before the patient had any children. Her mother had predicted that the patient would have a child in the fourth year of her marriage, just as the mother had. The patient said that she knew she had become pregnant when one day she looked in the mirror and saw her mother's face. She had, by becoming pregnant, finally succeeded in recapturing her dead mother by identifying herself with her.

The craving for the lost object is to the nucleus of the ego reminiscent of the infant's craving for his mother, which is originally the same as the desire to be fed. Also, the feeling of emptiness which accompanies ego depletion is reminiscent of hunger. Hence the identification that is meant to satisfy the need for the lost object is accomplished by means of a fantasy of consuming or introjecting the object.

Identification serves two purposes. In the state of ego plethora, it serves in place of a lost object relation. In deficiency of ego libido, however, such as in melancholia, not only does identification create the illusion that the object is retained but it also tends to retain the ego libido which would otherwise have been devoted to cathecting the lost object. In other words, identification with the lost object combats the loss of self-esteem, and of ego energy which depends on it, that would otherwise follow object loss (cf. Freud [*19*, p. 107]). One sees this mechanism especially clearly in hysteria: the object is abandoned and object love is replaced by narcissistic cathexis of an organ which functions defectively; but the selection of the organ and of the defect is determined by a need to identify the self with the discarded object. The hysteric seems to feel on the verge of ego depletion and the identification is meant to prevent this catastrophe.

ADDICTION

Addiction is a fairly common component of depressive illness. Those cases of addiction I have seen, which are not a representative group, have been individuals close to melancholic depression. Fenichel *(8)* favors the view that addiction is related to depression, and cites supporting opinions of others. Federn *(7,* p. 276*)* concurs. One addict to sedative and narcotic drugs developed in the course of analysis a full-blown melancholia, from which he recovered after an operation that corrected a physical illness, only to relapse later into his addiction. Another patient developed an addiction to sedatives concurrently with a depression. Iproniazid terminated both the addiction and the depression and analysis kept the patient free from both during the subsequent year *(31,* Case B*)*.

Rado *(35)* has given an excellent clinical description of the role of 'tense depression' in initiating drug addiction. In the cases I have seen, the addiction seemed to be an effort, in the presence of depression, to forestall a threatened depletion of the ego (cf. Fenichel [*8,* p. 380]). In the cases just mentioned, melancholia ensued at some point as if the addiction had failed. Nunberg (personal communication) considers periodic drinking a sign of recurrent depression. Another patient, a woman, became depressed ten years before coming into treatment. During those ten years there were periods when her depression was less severe, but during these periods she was seriously alcoholic *(31,* Case E*)*. Analysis plus daily iproniazid served for a year to keep the ego supplied with its quota of energy, but was not sufficient to prevent her feeling depressed. Despite frequent severe depression the patient felt no inclination to resume drinking, probably because with the drug there was no threat of ego depletion. Recently she has shown clear evidences of schizophrenia, which are obliterated and replaced by melancholia—schizophrenic melancholia—when one of the hydrazine energizers is not given.

If this argument is correct, addiction should have at least one of the following three properties. 1. The addiction may

show some indication of union with the lost object. One form of addiction is the clinging, often with an offensive, nagging quality, that depressed persons exhibit. These are the patients who become addicted to analysis, demanding sessions six and seven times a week. 2. The addiction may create the illusion that some process of innervation or repletion is going on. One of the most common addictions is the bulimia that is used to fight off, and therefore often precedes, a depression. Milk, sweets, clothing, collections of coins, stamps, paintings, or music, and even money itself are used to create the impression of being filled or well supplied. Smoking may sometimes perform the same function. 3. The addiction may facilitate denial of the loss by anesthetizing the ego so that it no longer feels the pain of the depression. This is what is accomplished by alcoholic beverages, barbiturates, opium derivatives, and probably other intoxicants. Beverages containing intoxicants anesthetize the ego and give it the illusion of being nourished.

Addiction may be vigorous while the patient is on the verge of melancholia, but once melancholia actually sets in the addiction is likely to disappear completely and to be replaced by an intolerance of the very things to which the patient had been addicted; this may be called 'negative addiction'. The uniting and repleting processes which the addiction represented are, in melancholia, no longer desired. When medication is given to patients with even mild melancholia, it is accepted with ambivalence. The patient may have fantasies or dreams that he is being poisoned. He dwells on the unpleasant side effects, minimizing the evidence of progress. Whereas during the premelancholic phase the patient may have clung to love objects, in melancholia he avoids them; he may have pursued sexual gratification, retained his feces to the point of constipation, and kept his mouth constantly occupied with food and drink, but when the melancholia comes he finds sexual contact revolting, empties his bowels frequently with vigorous peristaltic action before the intestinal contents have had time to solidify, and replaces appetite by anorexia or even nausea and vomiting. One woman after her analytic sessions during melancholia was aware of a

feeling of perineal dropping or relaxation; as she began to recover, these feelings were replaced by vaginal contractions which seemed to her designed to suck something in. There seems to be a centripetal pull into the body during addiction, and a centrifugal pressure during melancholia. (These simple, direct relations between sphincter function and ego libido are obscured in cases of melancholia of long standing, for example, when protracted failure to eat enough results in constipation.)

How can we explain the patient's intolerance for objects despite his suffering from a lack of objects? Freud *(13,* pp. 249, ff.*)* was inclined to accept Abraham's suggestion *(1,* p. 448*)* that the anorexia of melancholia represents a defense against cannibalistic wishes toward the object. Daily clinical experience demonstrates the correctness of this view.

After five years of analysis, a severely compulsive and seclusive thirty-five-year-old man married and three months later his wife became pregnant. The night after her physician confirmed the pregnancy, the patient could not sleep. A dream indicated his wish to identify with the fœtus. The next morning he was very depressed. He went to see his parents and told them that he wanted to leave his wife and move back to live with them. He had no ambition and no appetite, was nauseated, felt some indescribable abdominal distress, and could scarcely speak loudly enough to be heard. That day his mother, quite alarmed, came with him to see me and the session was spent reassuring her as well as the patient. That night he felt somewhat better, and dreamed:

> I eat some meat, venison. It seemed as if someone offered me a fish—or perhaps a cat. As I eat it, I feel such pain in my throat that I could hardly talk. Someone looked in. A large fishbone was stuck there. They put fingers or an instrument down and pulled it out. It was still painful but I could breathe and talk again.

On the morning after the dream his appetite returned, his distress and nausea disappeared, he felt less depressed and more effective. From the circumstances and the associations it was

clear that the identification with the fœtus, which was a reincarnation of a younger brother born when the patient was two years old, was accomplished by means of a cannibalistic fantasy. During the twenty-four-hour melancholia, the patient's inner pain and nausea and anorexia were unconsciously attributed to the introjected object. My reassuring intervention was experienced as delivery of the introject, which was followed by the patient's recovery.

Another patient *(31,* Case D*)*, on the way down from paranoid excitement into melancholia, complained that she had no appetite and had lost weight. She had awakened at two thirty A.M. and was horrified by fantasies of poisoning her children. Later that morning she dreamed that she was feeding her husband small pieces of something that resembled small penises, as small as her baby's, or perhaps the pills she was taking.

But this dynamic account does not explain the change in symptoms that occurs as the patient passes from the premelancholic, addictive phase to the melancholic aversion or 'negative addiction'. The dynamic account must be complemented by a discussion of the distribution of energy. During the phase of addiction, when the object is given up but ego enervation has not yet occurred, the danger of loss of energy is countered by the clinging to objects or by the addiction that symbolizes it. But in order to cling to objects, either actually or symbolically, the ego must have sufficient energy to cathect their images. When the ego has been enervated, it can no longer cathect the images of objects. The dearth of ego energy is painful. Any object, or food, or superego demand cannot be completely ignored. It calls for a response and an expenditure of ego energy. Therefore in a state of ego depletion objects or superego demands increase the relative dearth of energy and increase the inner pain. Though the approaching object or food is external, the feeling of energy dearth is felt as coming from within the ego. The source of distress is felt to be internal, as though the demanding object could not be perceived in the external world, which has ceased to exist for the patient; in other words, the

object is psychically introjected; it *virtually exists* within the ego. The distress is attributed then to an inner object which the patient tries to expel by various somatic routes—mouth, anus, vagina—and by ignoring or actual turning away.

The patient whose outward and inward vaginal sensations are described above was particularly aware of the relations between her intestinal symptoms and being confronted by objects: when her husband was with her she suffered abdominal cramps and diarrhea, and when her children approached her she retched. Another patient, a man, often suffered cramps and diarrhea during the analytic session and said, 'I feel that I would like you to go away'.

GUILT

In melancholia there is strong preoccupation with guilt. The patient's confession of his guilt for ruining his family and disappointing his friends proves, when analyzed, to be also an accusation against the disappointing lost object that has been introjected; the patient accuses the person he has become. It is as if the superego, which evolves from the faculty of self-observation, were in melancholia changed back so that all self-observation is now critical self-observation. The crimes confessed may be real, as for example in the case of the gambler who has exhausted his own and his family's resources; or they may be merely expressions of the patient's unconscious wishes. In his self-castigation, which his loved ones find so painful to listen to, the patient says, 'Because you failed me when I needed you, I would like to hurt you and reduce you to my state'. When the melancholia is a reaction to being disappointed or deserted by another, there may be overt expressions of resentment. Another evidence of hostility to others is excessive concern for their well-being and fear that harm may come to them. The more profound the melancholia, and the more intense the expression of guilt, the less real interest is there in other persons. The guilt seems to be insincere and does not lead to any effort at rapprochement with another person.

This guilt may have three origins. The first source consists of the wishes associated with loss of the object. For example, the object may have turned away as a result of the patient's extravagant demands. Even when the patient himself is only an innocent victim of circumstances, there is an unconscious wish, no matter how well repressed, that is gratified by the loss, and the patient considers the loss to be evidence of his guilt *(18,* pp. 110, ff.*)*. Again, there are hostile wishes arising from the patient's resentment of his loss and his aggressive desires to recapture the object. Even when the object has been lost by death or some other unavoidable circumstance, the bereaved survivor is angry, but represses his anger. When the precipitating loss is a loss of self-esteem, the self-castigation is clearly appropriate in direction and tone, though exaggerated in intensity.

The second origin of guilt resides in the ego depletion of melancholia. The inability to meet the normal expectations of others, such as children or husband or wife, creates conscious guilt, and so does the fact that these others must care for the patient. Also the melancholic patient tends to project his own illness and suffering upon the others in his immediate environment, and he feels guilty for this projection though he may not be consciously aware of it. For example, a melancholic woman may feel that she is afflicted by some wasting physical illness, and also that her husband is being consumed by the same or a similar disease. Part of her guilt is the consequence of her effort to displace her misery upon him.

The third origin of guilt is an illusory one. Freud *(18)* noted that some individuals and groups—and this is especially characteristic of the Jews—come to believe that personal misfortune is the consequence of being rejected by fate or God or whatever form the projected superego takes. This rejection by the superego is tantamount to a loss of parental love, which loss is the prototype of guilt feeling. Note that here the guilt is not actually caused by condemnation by the superego; rather, the patient merely *feels* as if he were being punished by the superego. Perhaps this explanation can be expanded to a more general

application in the melancholia syndrome. In his paper, On Narcissism *(10,* p. 100*),* Freud notes that self-regard normally proceeds from three sources: from residual infantile omnipotence; from the satisfaction of object libido; and from the fulfilment of the ego ideal. Ego enervation leads to a loss of self-regard and the melancholic patient attributes this loss to failure of each of these three sources. He describes the apparent failure of infantile omnipotence as weakness, ineffectuality, stupidity, and physical illness. The apparent failure of object love he describes as resulting from his being unattractive or even repulsive. The apparent failure to achieve the ego ideal he describes as being unworthy, sinful, and wicked. (Not only does decrease of self-esteem result from ego impoverishment; it is also true that loss of self-esteem may give rise to ego impoverishment. A vicious circle may ensue.)

Although guilt is a presenting and troublesome symptom in melancholia, it does not appear overtly in depression without ego depletion. In states of high ego energy there is little scrutiny of one's feelings, so that the patient is not likely to say, 'I feel guilty'. What indications of guilt do appear? First, there may be obsessive concern lest harm come to the object. Second, there may by reaction-formations be excessive tenderness and generosity, as for example in obsessive-compulsive neurosis and in hysteria. This reactive protectiveness generally betrays its hostile source by making the object suffer, as children do for example when 'overprotected' by their parents. Third, there may be efforts to injure oneself. These efforts may be contrived 'accidents', the exercise of poor professional or business judgment, self-degradation, self-mutilation, or suicide. Fourth, there may be genuine attempts to make restitution and become reconciled with the lost object. This is least common and appears only when the pain of the depression is not too great, for pain itself evokes the assistance of the death instincts which then dominate or at least contaminate attempts to retrieve the object. Nunberg *(26)* distinguished between this true tendency toward affectionate reconciliation, which he believes to be the

consequence of the sense of guilt, and attempts at self-injury which indicate a need for punishment, the erotic instincts determining the former and the death instincts the latter.

SHAME

Shame is an affective reaction against a repressed desire to exhibit oneself to an object, and it motivates a wish to conceal oneself. It operates normally to deter immoderate seductiveness or pursuit of an object, and it especially deters the use of regressive devices in object relations. It also tends to discourage immoderate secondary narcissism and the use of exhibition in the service of such narcissism. The sense of shame is a superego function, comparing current behavior with the standards of the ego ideal. It is affected by the supply of ego libido just as guilt is. In a state of ego plethora the need to consummate an object relation, and in depression the need to retrieve the lost object are so pressing that they override superego protests. The superego is projected outward onto others and the patient complains that others are watching and laughing at him. This projection and the sensitivity to the criticism of others may or may not be delusional. When there is a dearth of ego libido, however, object relations are no longer pressing, and in the extreme case no longer possible. Such a patient's inability to function and fulfil obligations, and his regression to primary narcissism are, by the standards of his superego, shameful. Yet except in relatively mild states of deficiency he is so indifferent to the response of others and to the remonstrances of his superego (which derives its power from love for his parents) that he makes no effort to improve his behavior. He may loudly and annoyingly confess his shame and guilt but he shows no evidence of genuine contrition or desire to make amends. The sense of shame seems to be more verbal than effective.

PROJECTION

When there is a plethora of ego energy there is an erotic orientation toward the object. Even when defense requires narcissistic withdrawal the narcissism is a reflexive relation in

which one takes oneself as object, in contrast to the primary narcissism of depletion of ego energy in which the narcissism is medial, that is, concerned only with one's own feelings. (Retreat into primary narcissism occurs with plethora of ego energy only in schizophrenia and organic brain disease.) Basically the individual wishes to project himself into or onto the object in some way, actively or passively, and by oral, anal, phallic, or genital routes. This tendency to project is expressed psychically as a tendency to superimpose one's own image upon that of the object. While the tendency to project is primarily erotic in purpose, it also serves defensive needs. In schizophrenia, for example, the critical superego images are forced apart from the functioning ego, and are retrieved only by being projected upon the object who becomes in the patient's delusions a critical observer. Other portions of the psyche may be projected: for example, the id may be projected as a tempter or as a scapegoat, or the ego function of self-control may be projected onto some external controlling agent. In these cases, the ego nucleus is trying to rid itself of an internal disturbing influence by creating the impression that the influence is external rather than internal.

When depression occurs in ego plethora, therefore, responsibility for the loss is generally projected upon the object. Attributing responsibility to the object may be wholly or only partly unrealistic. This projection spares the depressed individual guilt and it is also an attempt to retain the object, though substituting a hostile for an affectionate relation. As libido is withdrawn from the ego, the object orientation is replaced by an ego orientation and the preferred mode of object relation changes from projection to introjection. We have already noted however that the pain of the dearth of energy may evoke anxiety as a result of the pressure of the defensive death instincts. We may now ask: Do the mobilized death instincts also lead to external objects and do they therefore encourage projection?

In Beyond the Pleasure Principle *(12,* p. 54*),* Freud suggests that death instincts may be deflected defensively from the self onto an external object, and that this object-seeking may open

the way for subsequent erotic drives to find their way out from the ego to objects. In many cases of melancholia the loss of object, loss of energy, and guilt arising from fantasies of incorporation of the lost object all condense to create the delusion of somatic illness, about which the patient complains. However, he also complains that the love object is ill, in an equally delusional way, and confesses that he, the patient, is responsible. It seems that he attempts to project his fantasied physical defect upon the object. This is an instance of projection along the path of the death instinct. But the object relation is not real, for though the patient confesses to guilt he makes no real effort to become reconciled to the object and worries only that the illness of the love object may add a further burden to himself, the depressed patient. Autoscopic hallucinations and illusions also probably result from an attempt to project the source of pain outside the ego; they represent a purely defensive projection with the charges of the death instinct and seek no libidinal object, in contrast to the paranoid projection *(33)*.

DIURNAL RHYTHM

In melancholia the patient commonly feels most disturbed upon awakening in the morning, and becomes more comfortable as evening approaches. If the melancholic patient suffered primarily from the pain of ego depletion, we might expect that immediately upon awakening from sleep, when there has been some regeneration of energy (cf. Federn [*7*, p. 107]), he would feel least discomfort *(34)*, and that in the evening when whatever energy the ego possesses has been consumed, misery would be greatest. That the opposite is true may be explained by the following facts.

First, the deficiency of ego energy in melancholia is probably not due to insufficient regeneration in the id, but rather to its exclusion from the ego (as in the man who felt the steam leaving him). The relative plethora of energy in the morning is in the id rather than in the ego, and therefore probably not contributory to the phenomena of melancholia. In the few cases I have seen of melancholia induced by phenothiazine tranquil-

izers or reserpine, in which the ego deficiency may have been secondary to a presumed failure of energy regeneration, the diurnal rhythm was similar to that of spontaneous melancholia. The diurnal rhythmicity of melancholia is probably a phenomenon of the ego rather than of the id; in other words, it is the result of ego enervation caused by drugs or by psychodynamic forces.

Second, the energy content of the ego is increased by temptation and by opportunity, and therefore by contact with others. Normally upon awakening in the morning the individual expects gratifications and problems during the day. In melancholia no opportunities for invigorating experiences can be expected, both because there is no interest in the available real world and because the ego does not possess even enough energy to indulge in fantasy. However, as the day brings challenges in the form of actual human contacts, more energy is drawn into the ego: 'the appetite comes with eating'. It is those patients who remain active in their vocations who are most aware of the improvement as the day passes. As the melancholia becomes more severe and the patient avoids contact with others, the diurnal rhythm fades. But as the patient gradually recovers from melancholia, as for example when treated with iproniazid, diurnal variation and responsiveness to love objects increase together, until finally the morning pain disappears.

Third, the degree of discomfort felt by the ego probably reflects the discrepancy between the small amount of ego energy available and the relatively large amount required by the demands of the real world and of the superego. In the morning, supply is least and demands are greatest, whereas in the evening supply is greatest and demands have receded for the day.

Finally, the relative dearth of energy results in a disproportionately greater loss of the energies of the erotic than of the death instincts. Since the total ego energy content is least in the morning, as shown above, the predominance of death impulse over erotic impulse is greatest in the morning and least in the evening.

One sensitive index of melancholia is early morning insom-

nia, which occurs in perhaps two out of three melancholic patients. It may antecede the other indicators of melancholia by days or weeks and it is often the last symptom to recede. Typically the patient awakens with a start, often with a feeling that he is awakening out of a dream, at two or three o'clock in the morning, or in less severe cases at five or six. He lies sleepless, ruminating horrible thoughts and the impossibility of meeting the needs of the coming day. The dreams are usually not remembered. If the primary function of sleep is to permit the regeneration of instinctual energy *(34)*, melancholia appears when the ego rejects the energies of the erotic instincts offered by the id. During sleep the ego is recurrently invaded by the energies of the death instincts, relatively undiluted by eros *(30, 6)*. There result the horrifying dreams of melancholia which may account for the early morning awakening from sleep.

In some cases of drug-induced melancholia, not only is there no insomnia but the patient has difficulty in getting up or being aroused; in others, insomnia occurs in the morning. Moreover, morning torpor occurs in perhaps one out of four patients with spontaneous (as opposed to drug-induced) melancholia. Horrifying dreams occur in patients taking these drugs. I can only surmise that in these cases the energies of the death instincts are retarded less severely than the energies of the erotic instincts. There is reason to believe that various psychically active drugs affect slightly different spectra of instinctual drives. Clearly much remains to be clarified about the relation of sleep to melancholia and other mental illnesses.

MISCELLANEOUS SOMATIC FEATURES

We have already noted that in the struggle to obtain or hold ego energy, or to avoid expenditure of energy, autonomic phenomena are activated in the gut. Before enervation there are bulimia and constipation, but after enervation the ego attempts to rid itself of the internal pain attributed to a virtual introject by anorexia, vomiting, and diarrhea. Automatic somatic phenomena are not limited to the gut or to the genitals. During melancholia there are sensations suggesting a centrifugal force.

The patient may complain of this centrifugal force, or of his struggle against it. In mild form the complaints are of 'drawing sensations', for example in the extremities, or of muscle twitches. When the sensations are more pronounced the patient says, 'Everything is going out of me' or 'Everything is falling away from me'. The man who developed cramps and diarrhea during analytic sessions felt as if his body were being held together by taut ropes. This centrifugal pull upon the painful introject is extended into psychic projection of it upon others, as noted above.

Sighing respiration, which is so common in melancholic depressions, seems to be another mode of expelling an introject. The man mentioned above who complained that his guts were being torn apart by a demon used to try to get momentary relief from his inner misery by blowing out hard through pursed lips. Vocalization is sometimes impaired in melancholia. The patients find it difficult to speak loudly or at all. A patient dreamed he had throat pain because he had swallowed a fishbone (see above). Another patient who became depressed and showed the signs of melancholia stayed in bed because he thought he had laryngitis though his physician found little objective evidence of this condition. Subsequently he observed that when he began to feel depressed his voice became weak. I cannot suggest a convincing psychologic or physiologic mechanism to explain this phenomenon.

The agitation that commonly occurs in melancholia may be regarded as a similar organic manifestation of dearth of energy. In the patient who felt that his body was being held together by taut ropes, agitation was often precipitated by a visit, for example by me or by a member of the family, though it was not limited to these occasions. Some of the phenothiazine tranquilizers, especially perphenazine, prochlorperazine, and trifluoperazine, are likely to cause a restlessness rather similar to the agitation of melancholia; it is perhaps related to the enervating properties of these drugs, or to their relatively more effective blocking of the energies of the erotic instincts than of the death instincts.

As the melancholic patient recovers, he retains food and his diarrhea may give way to constipation. The hydrazine derivatives effective against the syndrome of ego depletion—iproniazid (Marsilid) and beta-phenylisopropylhydrazine (Catron)—which I believe increase the transportation of id energy into the ego, also cause constipation and urinary retention. We cannot yet know whether this is a meaningful or a fortuitous resemblance between the somatic phenomena accompanying recovery from melancholia and the effects of the energy repleting drugs.

At least some of the variables related to psychic function may actually be correlates of ego energy content. For example, Shagass and his associates *(36)* have drawn attention to the fact that the threshold dose of intravenously injected sodium amytal required to attain a physiologically specified effect can reliably distinguish between anxiety states and 'neurotic depression' on the one hand, and 'psychotic depression' on the other. Anxiety states and 'neurotic depression' cannot be differentiated, whereas 'psychotic depression' has a lower threshold whether or not agitation is present. This fact suggests that the ego energy is the relevant variable.

SUMMARY

The depression syndrome is a reaction to a loss, and it governs attempts to retrieve the lost object. It includes the following components. A psychic pain motivates the efforts to retrieve the object. Visible physical changes affect facial expression and posture, communicate the patient's helplessness to others, and thus mobilize the efforts of those who love him to protect him. Inertia and a sense of emptiness and enervation prevent flooding of the ego by instinctual impulses which, in the absence of the lost object, cannot be gratified. These last changes are the manifestations of a depletion of the energy content of the ego.

Enervation does not always occur. When it is absent we see affective depression, accompanied by active and often destructive striving toward objects. When enervation is excessive we see melancholia. Understanding the status of ego energy in depression permits us to explain many characteristics of neurotic

and melancholic depression. Such understanding is vital to proper treatment of depression, whether by psychoanalysis, psychotherapy, or drugs.

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Circumcision and Anti-Semitism

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CIRCUMCISION AND ANTI-SEMITISM

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Freud observed a relationship between circumcision and anti-Semitism in a footnote to the case of Little Hans: 'The castration complex is the deepest unconscious root of anti-Semitism; for even in the nursery little boys hear that a Jew has something cut off his penis . . . and this gives them a right to despise Jews. And there is no stronger unconscious root for the sense of superiority over women. . . . From the standpoint [of the infantile complexes] what is common to Jews and women is their relation to the castration complex' *(4,* p. 36*)*.

The circumcised Jew is often represented as a mutilated person, and this fantasy is repeatedly stated in the literature *(3, 4, 6, 7)*. An uncanny feeling is said to exist in some to whom a Jew is a reminder that one can be castrated *(3, 6)*. The unconscious fantasy develops that a mutilated people desire revenge and want to circumcise (castrate) the non-Jew *(3)*.

Brenner *(2)* and Steel *(10)* suggest that the Jew is regarded also as a powerful masculine circumciser, but present no clinical support for their thesis. Ackerman *(1)* has cited clinical evidence from which one can infer that the Jew is so represented, but he does not draw this conclusion. Loewenstein *(7)* and Ackerman *(1)* observe that œdipal aggression may be partially resolved by displacing hatred onto the Jew. But the fact that Jews are circumcised is not sufficiently demonstrated as a motivation in this defense.

A thirty-year-old Protestant entered analysis because of panic states which prevented him from succeeding in his ambitions for scholastic achievement and for gaining recognition in his father's profession. His hatred of his father was acknowledged, but he could not believe that it had any relation to his sexual attraction to women who consciously reminded him very much of his mother and his sister.

As his œdipal conflict began to emerge from repression, he became involved in a struggle against being explicit about his masturbatory practices. He described instead a series of magical acts designed to reassure himself that he was physically intact. Twisting

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his right wrist assured him that a fracture he had once sustained was healed; looking at a scar on his wrist confirmed that the old wound was healed. He came to the core of the matter by describing the median raphe of his penis as a scar several inches long on the ventral surface of his penis. This he was convinced was the result of circumcision in infancy. It was his fantasy that circumcision was a subincision of the penis without the removal of any tissue—another reassuring denial. He believed that the extent of his 'scar' was a wound that had resulted from a slip of the circumcising doctor's knife. He was totally unaware of the scar of his actual circumcision.

As this was being discussed in terms of his fear of castration, the patient's suppressed anti-Semitism erupted. He was fearful of accepting any of several jobs which might have led to his succeeding as well or better than his father, being deterred, he said, by his hatred of the Jews with whom he would be associated. They would be rich Jews who had made a lot of money dishonestly. A Jew with the same name and same type of 'dirty big car' as his analyst became the subject of his hatred and fear. When he was reminded that Jews are circumcised, he replied that Jews were the 'originators of circumcision'. Reminding himself that his parents had had him circumcised, he thought of biting his father's penis. His father, he said, looked Jewish but he, the patient, did not look as Jewish as his father.

This is the classical œdipus *(5)*, with the father represented here as a castrating Jew—the originator of circumcision. The stereotype of the Jew as the dirty money-maker was his anal, regressive portrayal of the castrating father.

In this connection, Steel *(10)* has suggested that among the complex sources of anti-Semitism, the Hebrew religion being the father of the Christian religion, attacks against Jews are attacks on the father. Ackerman *(1)* cites a patient who appears to have had similar defenses against his œdipus complex. His patient said, 'I can't understand why so many Gentiles are circumcised. That's what the Jews did to America. Their mission is to circumcise every Christian in the country. . . . The Jews try to judeify the Gentiles.'

Another factor in the development of the fantasy of the Jew as a castrator was described by Fenichel *(3)*. It is the belief that a defective person is defective because someone has taken something from him; hence defective people will retaliate by trying to get back what has been taken from them. This fantasy is another in the series

of such projections onto the Jews of the anti-Semite's own feelings and desires. It is not always œdipal in origin, and often has pre-œdipal roots.

A patient felt he had only half a penis by reason of having been born a twin, and that he had been further deprived genitally by having been circumcised. He felt this had made him feminine. By acts of dishonesty, he indirectly attempted to get what he had lost. He was vengeful toward his parents and his twin sister. Being Jewish he nevertheless believed that all Jews were connivers and cheaters (as he was). He attributed this in part to the fact that Jews were circumcised.

A meaning of circumcision noted by Nunberg *(9)* joins these two aspects of the attitude toward the Jew. He observed that circumcision may be considered to have merit as it removes the feminine part (foreskin) of the penis.[1]

The first patient described in this paper envied the Jew whom he regarded as superior, efficiently able to get money, capable of marrying and affording his wife a comfortable home, and of owning a boat—in short, manly. When he was with Jews at school, he added, he felt weak, was fat, and had to wear glasses. He started a session by saying that he wanted an operation on his head to relieve his suffering. He then went on to say that Hitler was not crazy in killing the Jews. He noted in this context that circumcision is hygienic, and that a foreskin causes an odor, 'a musty, dirty, alive smell', both good and bad, like the smell of a belly button or a vagina. Reverting to his need for an operation on his head, he said that his father was about to undergo prostatectomy.

It is apparent that this patient envied the—for him—masculine, circumcised Jew. The fantasy was nevertheless charged with fear of castration as a punishment for his castrating, envious hostility toward his father, from which he retreated into a semicastrated, masochistic state.

Prejudice against a group thus involves the interplay of characteristics of the prejudiced group and the scapegoats *(7)*. The Jew is conceived of as weak, castrated, and feminine; as strong, virile, and manly. Although circumcision is an important characteristic of the Jew that facilitates the development of this double image, another is his general preference for the use of his brain, his wits, his intelligence, over the use of his muscle. For his wisdom he is con-

[1] Nunberg does not discuss this fantasy in relation to anti-Semitism.

sidered manly; through his physical weakness—and as Loewenstein *(7)* suggests, his cowardice—he is considered feminine.

Certain personal characteristics that predispose a person to be subject to prejudice have been described by psychologists and psychoanalysts. As Klineberg *(8)* puts it, such a person must be recognizable, have 'high visibility'. If he has not these characteristics, they will be attributed to him. Another trait necessary for the scapegoat is vulnerability. He must be easily susceptible to attack. He must typify disagreeable traits which the attacker can project onto him. According to Fenichel *(3)* the quality of strangeness in a scapegoat leads to equating him with one's own unconscious which can then be projected.

Making the scapegoat both virile and emasculated facilitates bisexual or homosexual projection. The scapegoat can be hated as father or mother, or as representing the aggressor's own bisexuality. Being overdetermined, the prejudice releases multiple cathexes. As there are many conscious and unconscious, real and imagined prejudicial characteristics ascribed to the bisexual scapegoat, he is a tempting target for projection to a wide variety of people.

SUMMARY

Two clinical instances are cited to illustrate that the anti-Semite may harbor contradictory attitudes toward Jews. Because the Jew is circumcised, he is held to be castrated and effeminate. For the same reason, he is feared and envied as being virile, aggressive, and castrative. In both patients these conflicting prejudices were projections of bisexuality.

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Conceptual and Methodological Problems in Psychoanalysis. By Leopold Beliak, M.D.; Mortimer Ostow, M.D.; E. Pumpian-Mindlin, M.D.; Alfred H. Stanton, M.D.; Thomas S. Szasz, M.D. New York: The Annals of the New York Academy of Sciences, Vol. 76, Article 4, pp. 971-1134 (164 pp.), 1959.

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BOOK REVIEWS

CONCEPTUAL AND METHODOLOGICAL PROBLEMS IN PSYCHOANALYSIS. By Leopold Bellak, M.D.; Mortimer Ostow, M.D.; E. Pumpian-Mindlin, M.D.; Alfred H. Stanton, M.D.; Thomas S. Szasz, M.D. New York: The Annals of the New York Academy of Sciences, Vol. 76, Article 4, pp. 971-1134 (164 pp.), 1959.

This little monograph with a big title demonstrates again that it is good for psychoanalysts to discuss their theories—to extend their daily work at the couch. The protagonists are so evenly matched that it is easy to spot the essential difference between them. That difference is the same now as it was when Freud was alive: the willingness to be as rigorously consistent and systematic with their own contributions as they are being toward Freud's.

The first paper by Thomas Szasz on the libido theory exemplifies this most clearly. The discussant of Szasz's paper, Nevitt Sanford, is almost vulgarly sensible and irrefutable as he disposes of Szasz's objections to Freud's libido theory. But Sanford missed the main flaw: Szasz criticizes several of Freud's familiar concepts as if Freud had presented them as observational data. Yet Szasz, who follows Melanie Klein and Fairbairn, heedlessly uses their basic constructs as if they were data of observation; thus he has a built-in self-verifying technique in his system which like Marxism, paranoia, and African tribal customs is indisputable.

In the second paper on object choices, Stanton concludes that a group of people is more than the sum of its individuals, that there is an interpersonal something which adds to and transcends individual considerations. Sanford, again the discussant, accepts this as a truism. He then poises against each other these two latest schools of psychoanalytic revisionism: Stanton's social science methodology and Szasz's stimulus-response simplification. Sanford is brilliant here, but one is not fully aware of his depth and soundness until page 1095, when he tangles with Bellak (himself a good metaphysician) on another issue entirely. There Sanford comes up with the crucial comment about Stanton's contribution, which the earlier discussion had not yet reached in level and therefore did not deserve. The import of his remarks is that a greater degree of true-or-false decidedness is being demanded of Freud than was ever asked of any of the physical scientists.

Pumpian-Mindlin's paper, Energy and Structure in Psychoanalysis, forces upon Sanford as discussant the need to exercise all his acumen and logic—so much so, in fact, that an unnamed panel member remarked on his inability to recognize Pumpian-Mindlin's major points until Sanford had pointed them out. When Sanford finishes his comments there is really not much more to say. What Sanford does not say explicitly, because he no longer has to, is that Pumpian-Mindlin derives a general psychological theory a priori, and offers it as a model system, on a par at least with Freud's, and says, 'Choose'. As Aldous Huxley with mescaline, so Pumpian-Mindlin takes psychoanalysis and comes up with a new view of man. One can only answer, as Ostow does in effect on page 1057: 'Freud derived his concepts from his experiences with patients; now suppose you take your theory out into the world and test its validity'.

Bellak's paper on the unconscious has the virtue of arousing a good deal of discussion. Here again Sanford's comments were on the main track, but could not be responded to. Bellak is impressed with electronic technology and is in danger (as he well realizes) of testing only those data among which his model can work, so that he will get nothing but verification. If any physical model is useful, it would probably be on the theory of the permeability of membranes which might add to our knowledge of countercathexes.

Ostow's paper, The Structural Model, aroused general unbelief expressed in many ways and a call for more data. At this distance from the paper and the ensuing discussion, one can only say, tentatively, that there is nothing in a record player that resembles the music coming out of it, and nothing in the brain that resembles human psychology.

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PSYCHOANALYSIS OF TODAY. Edited by S. Nacht. (American Adaptation by Ruth Emma Roman.) New York and London: Grune & Stratton, Inc., 1959. 228 pp.

To render a fair account of this book is well-nigh impossible. The translator's note informs us that it is a condensation of the first two volumes of *L'Actualité psychanalytique,* a collection of studies published under the direction of Dr. Nacht by the *Bibliothéque de l'institut de psychanalyse de Paris.* These two volumes contained sixteen chapters of which eight were chosen, condensed, and translated.

How well they reflect the thinking of the original authors is difficult to tell. The book has an overly condensed feeling (telescoped might be the more appropriate term). The first chapter, Indications and Contraindications for Psychoanalysis of Adults, by S. Nacht and S. Lebovici, may serve as an illustration. The entire subject is dealt with in eighteen pages in terse, outlined paragraphs. The reader, it seems from the tone of the text, is expected to know either a great deal about psychoanalysis or nothing at all. It is hard to decide for which audience this book was written. The absence of a preface aggravates this problem.

The book has neither index nor bibliography. In several of the chapters occasional bibliographic references appear as footnotes, but for the most part authors are quoted with no indication of the source of the reference.

The sections, Psychoanalytic Therapy (S. Nacht) and Psychoanalysis and Neurobiology (De Ajuriaguerra, R. Diatkine, and J. Garcia Badaracco), are striking and interesting in their novel approach to fundamental problems in the theory and technique of psychoanalysis. Those who read French fluently may be stimulated to seek out the authors' works in the original; others will hope that a fuller rendition of *L'Actualité psychanalytique* will appear in English. This is much to be desired since Freud, Jones, and others have referred repeatedly to the difficulties which beset the establishment of psychoanalysis in France. Now that French psychoanalysis is fortunately on firm ground, the English-reading psychoanalytic public looks forward with interest to a truly representative expression of the work of our French colleagues.

JACOB A. ARLOW (NEW YORK)

SCIENCE AND PSYCHOANALYSIS, VOLUME II. INDIVIDUAL AND FAMILIAL DYNAMICS. Edited by Jules H. Masserman, M.D. New York: Grune & Stratton, Inc., 1959. 218 pp.

This book comprises the papers and discussions presented before the Academy of Psychoanalysis for the two meetings of December 1957 and May 1958. The former investigated the problem of masochism and the latter reviewed the recent studies of the familial, social, and cultural settings of individual behavior.

Salzman reviews the theory and therapy of masochism. He departs from the classical freudian concept which roots it in an instinctual

drive. He prefers the more recent view where it is described as a means for obtaining love in which pain and discomfort appear as unavoidable obstacles.

Kelman presents the views of the school of Karen Horney. The concept of masochism is denied altogether and the observed clinical phenomena are described in terms of pride, self-hate, alienation, and the defense of self-extinction and self-effacement.

Clara Thompson agrees with Salzman that masochism is the ego's payment for love. However, she emphasizes the role of aggression. She ascribes the genesis of the disorder to parents without affection in whom the child can feel neither trust nor security. She advocates some catering to the patient's need for love and recognition before making interpretations, but insists on the predominant role of interpretation and insight in therapeutic success.

May Romm supports both the classical view of masochism as rooted in an instinctual aim and the more modern one that it is the ego's defensive attempt to insure future pleasure by enduring present pain.

Hoch emphasizes that masochism is not a nosological entity but a common manifestation of humanity which may have different roots. Pathology can only be evaluated within the framework of the personality in which it occurs.

Millet agrees with the concept of masochism as a manifestation of the ego's attempt to deal with persistent maternal rejection. The therapist should play the role of a benign and trustworthy parent. This is more important than the impartation of insight.

Robert Mumford affords a brief digression by pleading for a more scientific attitude which would merge dynamic and traditional psychiatry by becoming aware of multiple intervening variables in process.

Silverberg disagrees with the prevailing attitude of the panel that the therapist be solicitous and kind. He advocates the traditional objectivity. Masserman also favors such objectivity because masochism is a neurotic means of obtaining power and control. Special kindness would therefore only play into the patient's neurosis.

Salzman states that masochism is an adaptive maneuver, not a diagnostic category. It is a device by which one trades present pain for a future gain. The masochist thus develops a feeling of omnipotence and of special privilege which he exploits by making claims on the environment while derogating everything and everyone.

Ackerman stresses the need for an objective study of family relationships as a whole. Freud neglected this in his emphasis on the individual, and on vicissitudes of instinct.

JOSEPH BIERNOFF (SAN FRANCISCO)

GREEK CULTURE AND THE EGO. A Psychoanalytic Survey of an Aspect of Greek Civilization and of Art. By Adrian Stokes. London: Tavistock Publications, Ltd., 1958. 101 pp.

This book of only one hundred one pages is so closely written that to review it adequately would almost necessitate reprinting it.

Applying psychoanalytic concepts to Greek art and religion and the Hellenic origin of science, Adrian Stokes combines Sigmund Freud's concept of projection with Melanie Klein's theory of introjection. He understands Greek art as a projection of the integrated ego structure. The mother's breast is the first part-object, representing the good and the bad. The interchange of introjection and projection starts with the projection of aggressiveness, leading from envy and greed to the introjection of persecutory objects. In the process of integration, the good and bad internal objects are gradually brought closer together. Parts of the ego may be put into external objects or into parts of them, for the purpose of appropriation and control. This happens when the child changes from the paranoid-schizoid stage to the depressive position.

Applying these concepts to matters of culture, Stokes puts forward the hypothesis of an 'ego figure'. It expresses a balance of what is various; it is unlike those cultural images that emphasize the more primitive aspects of the ego. His hypothesis enables the author to give body to the formal qualities of art in general, and in particular to a part of Hellenic civilization from which he develops the birth of science. He has filled out themes in this book that were little more than indicated in a previous study, on Michelangelo.[1]

The Greeks believed that if a man is good he is happy, but also that if he is happy he is good. Human dignity is founded in the pursuit of an integrative balance. The healthy body, to which the Greeks paid unparalleled homage, is an indication of this striving for integration. The Greek gods were not necessarily good, but they

[1] Stokes, Adrian: *Michelangelo: A Study in the Nature of Art*. New York: Philosophical Library, Inc., 1956. Reviewed in This QUARTERLY, Vol. XXVI, 1957, pp. 275-277.

were of incorruptible beauty and unfailing strength. The mad hero of Greek mythology represents a search for seeing integration outside and feeling it inside. In that sense life is an art and not a science. The ego's tendencies to integrate are an expression of the life instinct, whereas the alternating process of disintegration develops out of the death instinct. Works of art are our ideal of integration (yet as such, they stimulate neither taste nor smell, a fact never properly explained in any theory of æsthetics). In art, the mother with her 'oceanic breast' must be re-created through the forms of the integrated ego figure to which she already belongs as the introjected object. Hellenic art projects three principles: the Apollonic principle of 'nothing too much', the philosophical principle of 'know yourself', and the final projection of an integrated ego feeling into a corporal form. In this, Hellenic art has been the model and the despair of all civilization.

The need for integration implies the need to be loved by the internal and external good objects. In other words, there exists a close link between integration and object relations. The fear of disintegration relates to the fear of death. Without constant introjection of an inexhaustible breast, the Greek gods could not remain gods. What ambrosia and nectar do for the gods, classical sculpture does for man: it provides the psyche with amulets and monuments of the integrated ego. All art brings this gift, usually with less confidence after classical times.

The good breast becomes part of the ego, and the infant who was first inside the mother now has the mother inside himself; the ideal breast is the counterpart of the devouring breast. Idealization derives from the innate feeling that an extremely good breast exists. The work of art is such a self-contained object that crystallizes experience symbolically. This feeling leads to the longing for a good object and for the capacity to love it. Since this is a condition for life itself, it is an expression of the life instinct. The true creator is an expert in suffering. He makes good a loss without recourse to manic denial or schizophrenic confusion. The act of creation restores the courage to contrive stability from what is admittedly diverse. Greek culture reflects the dislike and fear of schizophrenic attitudes to which, with the admission of machines, we have again become more accustomed. According to Adrian Stokes, it is the lawn tennis court, with its precise geometrical form together with the instruments, racquet and ball, appropriately weighted, that allows to the

human body a full exercise of skill, strength, and sometimes grace, which equals Greek spirit in modern life of today.

The book is difficult to read, but rewarding for the analytic reader who does not expect necessarily to find answers but methods for investigation. Adrian Stokes's ideas promise new light and insight into the understanding of art and creativity.

MARTIN GROTJAHN (BEVERLY HILLS)

THE MEANING OF DEATH. Edited by Herman Feifel. New York: McGraw-Hill Book Co., Inc., 1959. 351 pp.

This book is any reviewer's delight, since it comes with its own excellently written critique in the final chapter, a summary and evaluation by Gardner Murphy. The ambivalence and escapism of modern Western man and his attitude toward death are taken as starting points. Carl G. Jung begins the collective effort to describe the relation between the 'soul and death'. He does so with Nestorian fondness for broad generalization. He is followed by Charles Wahl in The Fear of Death, against which man defends himself with magic feelings of omnipotence. Paul Tillich uses the interpretative approach to theology in his essay, The Eternal Now, while Walter Kaufmann brings up Existentialism, which sees in death the quintessence of life.

Part Two offers clinical and other evidence but does not penetrate beneath some statistical data leading to a rather vague conceptualization. Discussion of Death Concept in Cultural and Religious Fields is opened by Frederick J. Hoffman with a sensitive interpretation of the treatment of death in the literature of the twentieth century. Arnold Hutschnecker speaks about his experience in the care of the dying patient who often appears ready to die. The strong and mighty fear death most. He advises, 'Do not let hope die; treat these patients as if "they have been what they ought to be" (Goethe)'. The wish to kill and the wish to be killed decreases with age, whereas the wish to die increases. August M. Kasper does not plead for the physician to become a metaphysician, but pleads against desensitization and against the cynical doctor whose conversation will horrify the squeamish, hurt the mourner, titillate the silly, and annoy almost everyone. The prospect of this desensitization may draw men into the study of medicine; it is something laymen envy. Whereas the scientist is interested in death, the doctor is against it. The doc-

tor knows he will die, as will all his patients. He accepts this fact, not with equanimity but with the cynicism of the frustrated idealist. Death, for him, is a personal affront—a symbol of his helplessness. His task should be 'to cure sometimes, to relieve often, to comfort always' (Trudeau). Curt Richter reports unexplained sudden death in animals, which seems to prove that wild rats stop living when placed in an experimental situation that causes hopelessness.

The reader, as he finishes the book, finds himself stuffed with phenomenological and existential appetizers, still waiting for the analytic interpretation of the unconscious meaning of death which remains to be given.

MARTIN GROTJAHN (BEVERLY HILLS)

DRUGS AND THE MIND. By Robert S. de Ropp. Foreword by Nathan S. Kline. New York: Grove Press, Inc., 1960. Originally published by St. Martin's Press, 1957. 310 pp.

Dr. de Ropp, a biochemist formerly associated with the Rockefeller Institute, and the author of a historical novel about the fall of Jerusalem in addition to his scientific publications, has written a 'popular' book on drugs affecting the mind. Dr. Kline, who has had an active role in the clinical use of the tranquilizers, writes in the foreword that the book characterizes 'a profound history of man's attempt to wiggle, worm, and squirm his way out of himself'.

De Ropp discusses the current emphasis on drugs in psychiatry and reviews the history of such drugs as hashish, which was used extensively in China in 2737 B.C., rauwolfia root, which has been used in India for twenty-five hundred years, and the more familiar drugs, coffee, tea, cocoa, tobacco, and alcohol. He also includes reports of self-observations of the dramatic effects of drugs by Baudelaire (marijuana), De Quincy (opium), Havelock Ellis (mescaline), Aldous Huxley (mescaline), and Weir Mitchell (mescaline). Although the fact that drugs which give relief or euphoria may also have deleterious effects is discussed, an attempt is made to clear up misconceptions about addiction.

Drugs affecting the mind fall into two main categories: sedatives and stimulants, which are now referred to as analeptics. In the past these drugs were endowed with a halo of divinity. For instance, peytal (mescaline) was sacred to the Aztecs and coca to the Incas. The witch doctors, and later the priests, exploited their knowledge

of plants or herbs which could soothe grief and provide delightful visions. The modern chemist has isolated the essences of the herbs and, in addition, has learned to synthesize natural and new drugs.

De Ropp is impressed by the reports of animal experimentation which indicate that 'pleasure and pain alike are brain functions' and not 'mere negative qualities, dependent on the absence of positive pain. . . . Deep in the hypothalamus . . . there are "pleasure areas", the electrical stimulation of which produce some exquisite form of titillation, the nature of which we can at present only guess.' He believes that 'drugs affecting the mind appear to exert their action by raising or lowering the sensitivity of these pleasure centers to stimulation'. In the reviewer's opinion this is a too hasty generalization.

The author describes the experimental use of marijuana in depression and depersonalization, and reviews the investigation of this drug by the Mayor's Committee of New York in 1944. Marijuana was generally used in New York in the form of cigarettes known as 'muggles' or 'reefers', predominantly in the Negro section of the city. The Committee concluded that the evils of marijuana were exaggerated, that it did not lead to addiction, but they did not claim that the drug was harmless. It could induce temporary insanity in the unstable and further antisocial acts in those predisposed to them. De Ropp includes the criticism of the Committee's report in some medical quarters, and thus provides an example of the frequently recurring disputes about the value and harmful effects of certain drugs.

One chapter deals with the character of madness. The recent chemical trend in etiology is indicated by the following statement: 'There is much experimental evidence to support the theory that schizophrenia results from the workings of a poison produced in the body as the result of what is called an "error in metabolism" '. Confirmation is adduced from the cases of 'phenylpyruvic idiocy' and the similarities between mescaline intoxication and schizophrenia. The author also cites in this connection the work on adrenalin and the more recent work on serotonin. He appears convinced of the chemical orientation and asks: 'Why should we enmesh ourselves in a tangle of complexes when the root of all evil lies in a chemical disharmony?' (p. 203).

Dr. de Ropp looks forward to the time when drugs will shorten therapy. He cites the experimental work being done with combina-

tions of pentathol and benzedrine which supply both depressive and stimulating factors. He also notes the more dramatic use of the hallucinergic LSD, which is credited with making it possible to recover and relive forgotten childhood experiences. It is apparent that he overemphasizes the cathartic factor in psychotherapy.

In his enthusiasm for the subject, de Ropp includes dramatic claims without sufficient emphasis on degree of proof or corroboration. Generalizations and simplifications at times mar the value of the book. However, it is an informative volume and useful for orientation and historical perspective in the field of drugs that affect the mind.

PAUL GOOLKER (GREAT NECK, NEW YORK)

ENCYCLOPEDIA OF MORALS. Edited by Vergilius Ferm. New York: Philosophical Library, Inc., 1956. 682 pp.

Assailed as we are by scholarship-made-easy packages not worth their paper, it is a welcome relief to recommend this scholarly and stimulating, as well as convenient, reference work. It was 'planned on the theory that substantial articles rather than brief notations of widely scattered topics serve better to fulfil the purpose of reference information'. The need for cross-reference is more than adequately met by a meticulous indexing of topics in the body of the work and a Name Index at the end. The selected references at the end of each article are to primary sources.

There are fifty-two contributors, most of them professors of philosophy; also represented are anthropology, sociology, and religion. The seven-page article on Freud by Walter Kaufmann of Princeton University is a model of lucid evaluation. The following is from the concluding paragraphs:

'There remains yet the most important point of all. No man before Freud had given equal substance to one of the most striking sayings in the Gospels (found only in the fourth Gospel, and not even in the early manuscripts of that, but first related of a Stoic sage): "He that is without sin among you, let him first cast a stone . . .". Nothing that Freud has done, and little that anyone else has done, is more relevant to ethics than his success in breaking down the wall between the normal and the abnormal, the respectable and the criminal, the good and the evil. Freud gave, as it were, a new answer to the Gospel query, "who is my neighbor?". The

mentally troubled, depressed, hysterical, and insane are not possessed by the devil but essentially "as thyself". Freud made men seek to understand and help where previous ages despised and condemned. . . .

'After Freud moral judgments become altogether questionable: they appear symptomatic rather than cognitive and tell us more about the judges than about those who are judged. In this respect Freud differs radically from Socrates and Jesus, and in many ways he is certainly closer to the Stoics and to Spinoza. The conception of moral judgments as symptoms can be found in Nietzsche, but recent proponents of an emotivist theory of ethics probably owe more to Freud, and the French existentialists are equally indebted to both men.'

In the Name Index, Freud has more page references than Aquinas, Aristotle, and Schopenhauer; almost as many as Kant and Spinoza. A sampling of a dozen of the longer articles reveals a generally high quality of substance and writing. Of great interest is the one on Nietzsche, also by Professor Kaufmann, that serves as a corrective for still current misconceptions of Nietzsche's thought. In effect, he is here convincingly separated from Wagner and Hitler, and aligned with Freud. He did not oppose the humane attitude in Christianity; 'what he opposed were such features as these: resentment, an antagonism against excellence, a predisposition in favor of mediocrity or even downright baseness, a leveling tendency, the conviction that sex is sinful, a devaluation of both body and intellect in favor of the soul, and the devaluation of this whole world in favor of another'.

H. ROBERT BLANK (WHITE PLAINS, NEW YORK)

STUDIES IN REMEMBERING: THE REPRODUCTION OF CONNECTED AND EXTENDED VERBAL MATERIAL. (Psychological Issues, Vol. I, No. 2.) By Irving H. Paul. New York: International Universities Press, Inc., 1959. 152 pp.

Paul, who reminds us that psychoanalytic theory provides no comprehensive explanation of memory, employs Bartlett's concept of the schema, supplemented by Hebb's concepts of fractionation and recruitment, in discussing his series of experimental studies of learning and recall. Bartlett's schema takes full cognizance of the active nature of learning and remembering and avoids the pitfalls of

theories based upon the assumption that the human being is a *tabula rasa* upon which experience is registered. Paul's handling of this concept is at the same time sensitive and creative as he applies it to his experiments. In exploring some of the basic determinants of the functioning of schemata, Paul has used a variety of procedures including an original variation on proactive and retroactive inhibition methods in which the subject reads a list of story themes several times, recalls the themes, then composes a story using the themes, and again recalls the themes. In several of the experiments, groups of extreme performers (e.g., in respect to accuracy or spontaneous introduction of new material) were tested further by the method of serial reproduction.

By careful variation of experimental conditions, Paul shows unequivocally that explication, familiarity, and coherence 'facilitate learning and remembering' and that 'their absence led to fragmentation, distortion, and forgetting'. In addition, he has carefully isolated striking individual consistencies in recall of verbal material and in importation of new material into the material learned. There are suggestions, too, of consistent individual differences in the use of imagery, although these tentative findings require further substantiation.

Two issues remain: How well has he conceptualized his findings, and how well has he linked them to other recent developments in ego psychology? The first of these can perhaps be dealt with most efficiently by summarizing the logical progression evident in Paul's interpretation of his findings. He begins with the concepts of fractionation (skeletonization) and recruitment (importation). For reasons that may be open to question, he feels that he made only limited observations of fractionation, but that there was abundant evidence of recruitment (spontaneous importation of new material). He then introduces a third concept: retention *ability*. The present reviewer is puzzled by this interpretation of the results. There seems to be a remarkable amount of direct evidence of fractionation (skeletonization) in the scores Paul uses to represent retention ability. Low retention scores seem primarily to represent one kind of fractionation. Since the author's major observational vantage point is that of the schema, the dropping out of individual thematic elements, idea units, etc., would seem to this reviewer to be as natural a form of fractionation as any other.

The distinction Paul draws between retention as an ability and

importation as a style seems even more questionable. If style has any useful meaning in explorations of individual consistencies, it refers to consistent patternings of cognitive behavior. That is, style implies structural arrangements of ego functions in individuals. Some of these arrangements automatically imply certain abilities, and in many situations the two terms may be interchangeable. Paul's distinction between ability and style is thus more in keeping with the anachronistic view that intellectual functions represent abilities than it is with the ego-psychological point of view.

As to the second general issue, inadequacies in linking his work to other recent developments in ego psychology, including experimental studies of phenomena very similar to those he has concerned himself with, may be the weakest aspect of Paul's presentation. Although this is the author's prerogative, his eschewing of some related experiments on individual consistencies in learning and remembering seems costly in that it dovetails with the questionable features of his interpretation. To take one example, studies of leveling-sharpening controls, originated by Klein and Holzman, have been done within the ego-psychological framework and deal with the accuracy in recall under certain conditions as but one expression of a general principle of cognitive control. Far from representing a cognitive 'style' in the sense employed by Klein and others, the limited group of individual consistencies in importation described by Paul may be but one component of a single dimension of cognitive control, or both retention and importation may be related to previously defined aspects of cognitive control not referred to in his monograph. Nor has Paul coped adequately with the interpretative issues involved here. One of these issues concerns the possibility that many importations and fractionations result from assimilative interaction among new percepts and memory traces. This useful conception is not as similar to Hebb's concepts of fractionation and recruitment as the author suggests. In view of the many clinical evidences of assimilative interaction among unconscious memories and current percepts, this determinant of importation seems unduly neglected.

To summarize, the author describes a series of memory experiments performed with skill and analyzed with sensitivity. His distinction between importations that explicate and those that embellish or unnecessarily elaborate the original material is a notable example of this sensitivity. The present reviewer would argue, however, that the monograph could have profited from an interpretation

more solidly anchored in some of the major assumptions implicit in the ego-psychological point of view. Not the least of these is a conception of emergent ego structures that allows no arbitrary distinction between the structures determining 'style' and 'ability'. In spite of these possible limitations of the report, the value of such a careful experimental attempt is not to be underestimated. When considered in relation to other recent studies of learning and remembering, it represents an important contribution to our understanding of some key aspects of ego functioning.

RILEY W. GARDNER (TOPEKA)

PSYCHODYNAMICS OF FAMILY LIFE. DIAGNOSIS AND TREATMENT OF FAMILY RELATIONSHIPS. By Nathan W. Ackerman, M.D. New York: Basic Books, Inc., 1958. 379 pp.

Ackerman offers two 'core concepts' by which the 'psychosocial dynamics of family life may be operationally defined'. The concept of psychological identity and values refers to the direction and content of strivings; the concept of stability refers to the organization and expression of behavior in action. Identity answers the questions 'Who am I?' or 'Who are we?', for identity of the self is closely related to identity of the family. Stability of behavior includes the continuity of identity in time, the control of conflict, and the adaptability and 'complementarity' of individuals in new role relationships. 'Complementarity' refers to 'specific patterns of family role relations that provide satisfactions, avenues of solutions of conflict, support for a needed self-image, and buttressing of crucial defenses against anxiety'. But these 'core concepts' are not clearly integrated by the author with family diagnosis and therapy.

Family therapy is described as complex. Diagnosis of the family is achieved by study of histories of members of the family, and records of group interviews with them, obtained by psychiatrist, psychologist, and social worker. The psychiatrist decides upon the treatment to be used with each member of the family; he may recommend social therapy, educational guidance, intensive psychotherapy of an individual, or psychotherapy of groups of two or three or of the entire family. In an emergency, a professionally trained person may be assigned to live temporarily with the entire family. The therapists must meet together periodically with the entire family group 'to deal with certain layers of shared conflict'.

Ackerman offers no formal criteria for deciding whom and how to treat. In one of his cases a mother and son were seen together, then father and son, then son alone, then mother alone, but mother and father were never seen together because 'circumstances precluded this approach'. In another illustration of family therapy, a boy is seen first, then boy and father, then mother, then mother and father, then mother again, then the boy's treatment is terminated because he has improved, then sister leaves the family and enters analysis, then older sister requests analysis.

Although the book is based on detailed study of fifty families, each of which had two or more family members in psychotherapy, it in no way resembles a report of experimental research. Ackerman acknowledges the comparatively unrigorous and unsystematic nature of his studies, and he almost continuously rejects individual psychotherapy and psychoanalysis. In restricting the application of psychoanalysis to autistic disorders emanating from faulty early relation of mother and child, he underestimates the intrinsic connection of later disorders of object relations, familial and societal, with the infantile neurosis of the individual. He seems to postulate a type of social problem beginning in adulthood which requires family therapy for its successful modification.

Considerable space is devoted in the book to an anticipation of criticisms of family therapy. To the thought that some patients may object to the loss of privacy in family therapy, the author speaks of a 'sick need for privacy' and about therapists who are 'overanxious about the preservation of privacy'. He refers to 'technicians who operate with precision but who are numb to the sufferings of people' and of therapists 'seduced by the sick values of the machine age'. He seems to justify his own imprecision chiefly on the grounds that he is being more human and humane than other therapists. One frequently repeated theme is that failure of the individual therapist to have an accurate understanding of the patient's current environment will cause analytic therapy to 'flounder'; for this reason he must have an unbiased direct picture of the patient's life situation. In view of the repetition of this theme it is surprising to find the following remarks in a description of the course of individual therapy: '. . . the patient's inner face and the face he presents to the outer world tend to merge and at the same time he reaches a clearer and more accurate perception of surrounding realities. These critical shifts in the interpersonal experience of patient and

therapist are increasingly reflected in the patient's performance in real life, in work, in personal relations with family, friends, and community. . . . Through the emotional interaction of patient and therapist, it becomes possible to correct the patient's distorted image of himself and also his view of social reality' (p. 300). Why, then, introduce techniques demanding participation by the therapist in the patient's family and social relations? Contrary to the author's claim that 'there is a conspicuous trend toward by-passing interpersonal levels of disturbance and plunging immediately into the intrapsychic conflicts of the individual patient', this reviewer believes that analysts and the analytic literature at first overemphasized productions of the id, then oscillated to the opposite extreme of selective attention to the ego and the environment, but currently show greater cognizance of the value of an analytic position appropriately in contact with and equidistant from id, ego, superego, and current reality.

Several additional contentions are pertinent to the author's understanding or misunderstanding of psychoanalysis. Ackerman complains that psychoanalysis does not provide a social experience for the patient. Analysts are told that their refraining from communicating with members of the patient's family is no 'magic device' for decreasing transference complications. The author believes that Freud failed to understand love, creativity, and emotional health as positive forces in human relations. Analysts fail to understand that loving and working cannot go on *in vacuo,* that 'to keep one's health, one must continuously share it with other healthy persons', that home visits need not interfere with the therapeutic relationship, that 'mental illness and mental health are, in large part, a product of contagion in human relations'. These assertions by the author are categorical and unproved.

Feeling, as he states in his preface, that 'something basic was missing in my understanding of the very disturbances I was trying to cure', Ackerman began to 'view the disturbances of the individual . . . in the larger frame of his ongoing experiences of emotional integration into his family group'. But in this book he obscures any analytically useful information by a predominantly contentious, iconoclastic, proselytizing style, scarcely mitigated by occasional concessions to the value of individual therapy and acknowledgments that he is exploring a new field. More concentration on the development of family psychiatry and less preoccupation with psychoanalytic

adversaries would facilitate the author's challenging therapeutic endeavor.

DANIEL PRAGER (WASHINGTON, D.C.)

PSYCHOANALYSIS AND AMERICAN LITERARY CRITICISM. By Louis Fraiberg. Detroit: Wayne State University Press, 1960. 263 pp.

This book may be devided into two parts: the first, a detailed summary of psychoanalytic writings on literature and art, including the works of Freud, Jones, Sachs, and Kris; the second, an evaluation of the application of psychoanalytic concepts by certain American literary critics—Van Wyck Brooks, Joseph Wood Krutch, Ludwig Lewisohn, Edmund Wilson, Kenneth Burke, and Lionel Trilling.

The summary of psychoanalytic writings is sufficiently detailed and accurate to make it a useful reference work and a source for further bibliographical study. The author presents psychoanalysis as a scientific discipline, the concepts of which are useful in literary criticism. He places proper emphasis on the importance of ego psychology and he insists, correctly I believe, that neurosis is not an essential condition of artistic creativity. There are some points, however, which the author maintains with a degree of certainty that many psychoanalysts do not share.

The discussion of the work of the literary critics is of a different order. Professor Fraiberg expects the critics to be informed of psychoanalytic theory in the greatest detail and he quarrels and scolds them for their inaccuracies. He is, one may say, more royal than the king. A vigorous attack on Van Wyck Brooks for his superficial use of psychoanalytic concepts in a book written in 1920 seems unfair; Professor Fraiberg has the advantage of the more developed psychoanalytic formulations of recent years. To expect a nonanalyst to be familiar with all the complexities of psychoanalysis in its early years is unrealistic. It would be more in order to search for what is valuable in these early contributions and to trace the development of later, more accurate studies. Among the critics, Trilling emerges with the fewest wounds.

It is surprising that an author so critical of others permits questionable editorial practices in his own book. For instance, why are the passages from The Interpretation of Dreams taken from the Brill translation and not from the Standard Edition, particularly as

the author himself criticizes Brill and notes the excellence of the new translation? And why are two successive references to Kris's article, On Preconscious Mental Processes, from different volumes in which the article has been reprinted?

But these are minor criticisms. The first part of this book is of sufficient value to make it a useful addition to the library of anyone interested in the relation of psychoanalysis to literature and art.

DAVID BERES (NEW YORK)

REPORTS AND SYMPOSIUMS. VOLUME III. 1956-1959. New York: Group for the Advancement of Psychiatry, 1959. 623 pp.

The Group for the Advancement of Psychiatry, as stated in this book, is 'organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations'. This volume consists of eight reports and four symposia published during the period from June 1, 1956 to May 31, 1959. They are arranged according to date of publication rather than content, and the range of subject matter is wide.

The reports are well-organized and informative. Each one covers a definite area of study, as for instance, The Diagnostic Process in Child Psychiatry as formulated by the Committee on Child Psychiatry. The symposia are less formal and contain the remarks of the various participants, with the result that they tend to be more interesting and stimulating.

In general, the subject matter impresses one with the tremendous scope of interest of modern psychiatry. The number of unsolved problems is even more noteworthy. Appropriately enough, two of the reports deal with methods of research. By its very nature, this collection is a valuable reference volume rather than a book for general reading.

WILLIAM D. HORTON (SEATTLE)

THE DISTURBED CHILD. RECOGNITION AND PSYCHOEDUCATIONAL THERAPY IN THE CLASSROOM. By Pearl Berkowitz and Esther P. Rothman. New York: The New York University Press, 1960. 204 pp.

The school for some years has been regarded as a crucial setting

for the detection and amelioration of emotional and behavioral disorders in children. In recent years, with the introduction of specialized personnel into the school system, an attempt has been made to help emotionally disturbed children via the school counseling service, the school psychologist and social worker, or the school child guidance clinic. The mental health consultation and group dynamic programs for teachers have approached the problem by adding to the knowledge and understanding of the teachers themselves regarding the principles of mental health and the emotional development of children. The special education programs, which are an integral part of a child psychiatric setting, represent a third area of collaboration between educators and mental health specialists.

It is the latter type of experience that Pearl H. Berkowitz and Esther P. Rothman describe in this book. The authors are psychologists and educators with long experience in the children's wards of psychiatric hospitals and in the special schools of New York City. They have written a concise outline of the recognition and treatment of the emotionally unstable child with chapters on childhood schizophrenia, organic defects, neuroses, sexual deviations, and psychopathic personalities, each illustrated by brief clinical vignettes. Programs for aiding the maladjusted child in the general classroom are suggested and methods of detection are outlined for the more complex cases of deviation so that appropriate referrals for specialized help may be made. The techniques of the trained psychoeducational therapist are discussed together with a transcript from an actual class session in a psychiatric hospital.

In alerting the public school teacher to a heightened awareness of emotional disturbance among his pupils, the authors are in accord with the aims of many mental health specialists over the past twenty or thirty years. There is undoubtedly also a need for a concise textbook on theory and technique for those students undertaking training in psychoeducational therapy. However, the authors make it clear in their first chapter that their book is directed to the teacher, with the aim of helping him carry out his 'responsibility for noting evidences of emotional disturbances as manifested in behavior and for recommending further psychological study. . . . The educational system, in this sense, can and should act as a preventive force.' With these statements we can have no quarrel; whether this kind of book will be entirely helpful to such an end is a question.

The brief chapters on psychopathology in children contain a

mixture of sophisticated and rather naïve clinical and theoretical formulations. It is a difficult task to present a psychology of human behavior, describe several complicated clinical syndromes, illustrate these with case material, and add comments regarding management within less than two hundred pages. The end product here appears too general and schematic for the person with a background in psychology; for those coming fresh to such material, it may be burdensome in its range of propositions and detailed diagnostic formulations.

Perhaps the most important issue which this book raises is a pedagogical one; namely, how best can one teach complex clinical and theoretical material so that teachers with little preparation in psychology and psychopathology can be alerted to the detection of emotional illness in their pupils? The reviewer doubts that a book which presents a brief summary of very complicated concepts and data, with the implication that the reader will then be prepared to make highly technical differentiations of child behavior and act upon such clinical judgments as a professional person, offers an optimal solution to a pedagogical problem which has plagued mental health specialists for over thirty years.

The material from a psychoeducational session is fascinating to the clinician. Somewhere the impression is left that the techniques described for the trained therapist may be utilized fruitfully in any classroom. A clear distinction between the activities appropriate to the trained psychoeducator and to the informed teacher would add to the usefulness of the book.

EVEOLEEN N. REXFORD (BOSTON)

TEACHING: A PSYCHOLOGICAL ANALYSIS. By C. M. Fleming. New York: John Wiley & Sons, Inc., 1959. 291 pp.

This book dedicated to teachers contains a careful analysis of the responsibilities of the teacher and of the factors influencing teaching and learning. It traces the development of the teaching profession under the influences of biology, physiology, sociology, anthropology, and social psychology. The modern teacher must be aware of the unique needs of the individual and of group interaction, and must be equipped with well-defined skills and scientific instruments of measurement. Fleming's view is dynamic; he insists that the indi-

vidual is unique and warns against supposing that there are discrete stages of growth, fixed and clearly defined types of children, or differentiated types of mental functioning.

The book opens with a brief chapter describing the teacher and his class as they take stock of one another for the first time, and the attitudes, expectations, and questions each has of the other. The next six sections deal with the teacher as a student of motivation, as a promoter of learning, as an observer of growth, as a craftsman and technician, and as an experimenter, administrator, and therapist.

Teachers can understand motivation if they keep in mind psychological need (which was demonstrated by the work of child guidance clinics in the nineteen twenties) and if they recognize the importance to the child of receiving affection and appreciation and of sharing in a coöperative endeavor. Fleming surveys theories of learning, including the work of association theorists and field theorists, and discusses the modern concern with individual characteristics and the behavior of groups. He discusses development, distinguishing maturation, educative influences, original endowment, and the effect of the group. He emphasizes that normal rate and direction of development varies and warns that prediction is hazardous at any age. Adolescence is not, he believes, a period of inevitable turmoil; on the contrary, aberrant behavior is a symptom to be investigated. The weakest passages are those concerning delinquency and 'backwardness', which are grouped together, but Fleming shows that we must work hard to educate dull children and must drop the notion that there is a hypothetical, ascertainable 'innate' ability.

Fleming is clearer in his discussion of the teacher as craftsman and technician. He stresses the desirability of different methods of teaching for children at different stages of development and experience. He discusses lucidly modern objective methods of testing achievement, standardization of grading, diagnostic testing, and the keeping of records.

The teacher, as administrator, must lead groups, learn to group children for a variety of purposes, and be flexible in what he teaches. He must be aware of the values of the neighborhood and consider himself and his school part of the community, making use of its social services. As therapist he can provide a harmonious school and be friendly to parents.

The book has references, bibliographies, an index, and tables to illustrate the history of education.

MARJORIE HARLE (ROCHESTER, N. Y.)

PSYCHOPATHY. A Comparative Analysis of Clinical Pictures. By Carl Frankenstein, Ph.D. New York and London: Grune and Stratton, Inc., 1959. 198 pp.

The author resurrects the old nosological concept of psychopathy, which he proposes to clarify, as he states frankly in the first sentence of the preface, by 'a study in clinical semantics'. The monograph bears this out. It is a discursive discussion with no clinical material, many disagreements with other authors, and a synthesis of Jung's typological scheme, together with some unique psychological concepts of his own designated as 'expansion', 'staticness', 'ego inflation', 'polarization'. Psychopathy, he postulates, is based on a constitutional weakness for experiencing anxiety, which may be congenital or due to early trauma in the mother-child relationship. He makes a special point of the difference between his structural theory and the psychodynamic psychoanalytic school, on the one hand, and the physiological hereditary neuropsychiatric school, on the other. The principle of structuralization which he stresses accounts for the irreversibility of psychopathy. This means, psychological function has its counterpart in cerebral structure, and that early patterns become structured organically.

This book is not easy to read or understand. I do not think it has much to offer psychoanalysts and since it presents no clinical material, I question its value as a contribution to psychiatric nosology and theory.

ABRAM BLAU (NEW YORK)

TRAINING FOR CLINICAL PSYCHOLOGY. Proceedings of the Springfield Mount Sinai Conferences on Intern Training in Clinical Psychology. Edited by Michael H. P. Finn and Fred Brown. New York: International Universities Press, Inc., 1959. 186 pp.

Teaching of all kinds and at all levels is an art that requires a happy combination of knowledge, special skills, sensitivity, and dedication. When what is being taught deeply concerns the lives of

others, when the pupil or 'trainee' is going to use what he learns for the benefit of mankind, a need for understanding, ability, and sensitivity far above the average is certainly indicated. Yet, while the course of study the clinical psychologist must pursue has been outlined in some detail by the American Psychological Association, in conjunction with the universities involved in such training, relatively little attention has been directed toward the 'on the job' situation, the nature of teaching that takes place during the psychological internship, and the problems this type of training generates.

The present volume is a collection of papers by various specialists in the field of clinical psychology and allied professions dealing with this particular aspect of clinical training. That the issues dealt with are crucial for anyone involved in the training process is self-evident, and stated by Finn and Brown, the editors. They say, 'The wish to turn out a professional clinical psychologist, who, with his shining Ph.D., will be a credit to the field wherever he functions, is paramount in the hearts and minds of internship directors. The path to this goal is beset with a multiplicity of problems which we have attempted to delineate by the topics assigned to participants in the conference.'

One fact quickly emerges from the papers offered by the participants—the lack of a unified concept of what a clinical psychologist is and what he should be prepared to do. The range is an unusually wide one, all the way from the concept of the clinical psychologist as little other than a therapist to an emphasis on those functions which have generally distinguished the clinical psychologist from other professionals working in the behavioral field, namely, testing and research. This is a problem which does not yet appear to have been resolved, either in the formal training program or at the internship level. Certainly then, except for rare exceptions, the student himself is confused and uncertain of his role, his identification, and his allegiances. He is torn between the unresolved issue of scientist and experimentalist as opposed to practitioner. In addition to this crucial problem the contributors have dealt in detail with such matters as the nature and structure of the training situation, the question of who should do the actual supervision, the psychodynamics of the supervisor-intern relationship, the policies and standards established for evaluating training in clinical psychology, and

the all-important question of research opportunities and activities for the intern psychologist.

Recognizing that other professions are grappling with the same problems, the editors of this volume wisely invited participation from a social worker and a psychiatrist. Doris Siegel's exposition on Supervision in Social Work is certainly a 'must' for every supervisor of clinical trainees. Similiarly, Dr. Languth's discussion of Psychotherapy and the Intern covers such important matters as who among the interns shall engage in psychotherapy and methods of control of the young therapist. While Dr. Languth's chapter is certainly a thought-provoking one, it seems to this reviewer that, in view of the temper of the times, the inclusion of a nonmedical therapist who has had extensive experience in supervising psychological interns in their therapy activity would have been desirable.

The chapters in this book are of somewhat uneven quality, both as to content and formal factors. Some contributors have an unusually clear concept of the problems they are expounding and a gift for communicating these problems in simple yet highly interesting fashion. Some problems seem less significant than others. For example, the selection of psychological interns is really a topic that belongs in a discussion of the selection of students for the clinical program rather than of training problems *per se*. Certainly in admitting a student to a graduate program in clinical psychology, his ability to handle an internship successfully is one factor that is given serious consideration.

While the book does not pretend to cover all the problems involved in the training of clinical psychologists or to give the complete answers to the issues raised, it certainly does identify and point up the many and complex questions associated with such training, especially the 'on-job' training. Such identification is the first step toward finding the much-sought-for answers and, as such, this work becomes invaluable for anyone engaged in the training of clinical students. It can only be hoped that there will be subsequent conferences which will give indication of growing knowledge and skill in this all-important area of clinical psychology.

FLORENCE HALPERN (NEW YORK)

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Tom C. Stauffer

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ABSTRACTS

Journal of the American Psychoanalytic Association. VI, 1958.

The Effect of Shedding the First Deciduous Tooth Upon the Passing of the Œdipus Complex of the Male. Harvey A. Lewis. Pp. 5-37.

Lewis's major hypothesis is that the shedding of the first deciduous tooth is a biological event at the height of the œdipal period and that, because it is so easily associated with castration, it plays an important role in the solution of the œdipus complex, at least in the male. Many data from folklore substantiate this. The rituals associated with loss of the first tooth are basically associated with castration anxiety. Freud noted the association of the loss of the first tooth occurring at six with the resolution of the œdipus complex and the basically biological nature of this resolution. The case of the Rat Man is especially relevant. Three of Lewis's cases, all male, illustrate the resolution of the œdipus complex occurring in close relation to the loss of the first tooth. Repression of the œdipal wishes occurs then and this also bears a relation to the beginning of formal education at age six, which is the beginning of continuous memory also. Behind this secondary repression of œdipal feeling at six, when the milk tooth is shed, is the primary repression which may well begin at six months when the eruption of the first tooth occurs. Thus a close association is postulated between these biological processes of eruption and shedding of teeth and the primary and secondary repressions of childhood.

Note on One of the Preœdipal Roots of the Superego. Paul Kramer. Pp. 38-46.

Kramer describes three main parts of the superego, namely, the ego ideal, the prohibiting superego, and the benign superego, and it is to the latter that he directs attention in this paper. The benign superego derives from the image of the loving and comforting parent, especially the mother. When a harmonious relation exists between it and the ego, there is a feeling of self-confidence and love; when a state of tension exists between the two there results a feeling of not being loved and a fear of abandonment out of which develops the feeling of guilt in the common sense of the word. A case is presented in which the developmental lack of the benign superego is so great that severe anxiety neurosis results, with gross inhibition of function caused primarily by the mother's not providing a loving relationship during the preœdipal stages. Other examples illustrate various results, including a feeling of complete ignorance in moral matters, impairment of reality testing, fear of being alone, and a general humorlessness. The author stresses the importance of the benevolent maternal element in the development of the superego, which has often been overlooked because of the conspicuousness of a sadistic component.

Preadolescent Drive Organization. Peter Blos. Pp. 47-56.

Discussion of a preadolescent patient illustrates the importance of the consolidation of the latency period as a prerequisite for entering the adolescent phase of drive organization. In this ten-year-old boy it was necessary before the analysis

could proceed to bring about some attainment of latency by having the mother frustrate the boy's open sexual advances.

The author next discusses the differences in the paths followed toward genital organization by the boy and by the girl, the boy following a more circuitous route by way of pregenital drive cathexis while the girl turns more directly toward the opposite sex. Castration anxiety is again dominant in the boy in preadolescence but primarily in relation to the castrating phallic mother and this theme is central for this phase. Eventually a turn toward a homosexual defense against castration anxiety is employed before a final thrust toward masculinity. In the girl a massive repression of pregenitality must occur before she can move into the œdipal phase; she defends herself against the regressive pull to the preœdipal mother by a forceful turning to heterosexuality. A failure in this process often has occurred in feminine delinquency; a case is offered for illustration. For successful analysis the adolescent needs a foothold on the œdipal level before the earlier fixations can become accessible.

Reading and Daydreams in Latency: Boy-Girl Differences. Lili Peller. Pp. 57-70.

Peller illustrates with many excellent examples the use to which fiction can be put in understanding the child in the latency phase. Referring to this literature she discusses the different constellations of drives and defenses for the boy and the girl in this period and concludes that certain of the sex-specific differences between them are just as definite at that time as in adult life.

The Importance of Characteristics of the Parents in Deciding on Child Analysis. Isidor Bernstein. Pp. 71-78.

Bernstein reviews the differences between child and adult in what we require and expect in analysis. The parents must take over some of the ego functions of the child during treatment. Because of the parents' role throughout the child's analysis, it is important to assess their psychological character. Bernstein discusses the psychological characteristics that indicate the ability of the parents to coöperate sufficiently with the treatment to give reasonable chance of success. The parents must be able to recognize the conflict and suffering in the child in order to tolerate the narcissistic injury of admitting the need for the therapist's help, have desire for the child's recovery greater than any neurotic gratification from the illness, detach themselves sufficiently from the child so as to report objectively and coöperate with recommendations, and value the analysis enough to endure the deprivations involved.

Pavor Nocturnus. Melitta Sperling. Pp. 79-94.

A systematic psychoanalytic study of pavor nocturnus is presented in this lucid article. The main differences from the nightmare of the adult are the hypermotility and retrograde amnesia in the child's experience as compared to the feeling of paralysis and the vivid recall in the adult. Three distinct types of pavor nocturnus in children are described. In one type seemingly psychotic behavior predominates and the condition grows worse from the œdipal phase into puberty. Characteristically these children have grown up in an atmosphere of sexual

seduction while simultaneously their own sexual activity has been severely repudiated, causing a pathological split of the superego. The corrupted superego then allows break-through of the forbidden impulses when the child is neither asleep nor fully awake, somewhat as occurs in psychotics who have disturbances in the ability to awaken during the day. This type is related to somnambulistic, fugue, and amnesic states, and to overt psychoses. A second type characteristically has sudden onset after a trauma and often represents the initial phase of a later traumatic neurosis; it is characterized by fitful sleep with frequent awakenings in anxiety from a dream which represents the original traumatic situation and a need to claim the protecting parent. The child can ward off memory of the trauma during the day when the mother is present and motility is possible, but at night the memory returns more easily, leading to revival of the traumatic experience. Awakening enables the child to attempt to master the trauma by securing protection of the mother, whereas in sleep he feels in danger of being overwhelmed by it, with loss of control and of reality. In this type aggressive impulses are more predominant as contrasted with the sexual impulses of the first type, and psychosomatic disorders are more likely to be associated with this type. A third type more closely resembles that of adults inasmuch as the child awakens in anxiety with vivid memory of the contents of the dream. Pavor nocturnus is a frequent phenomenon in childhood, has its origins in the conflicts of the œdipal phase, and is most often associated with neurotic disturbances.

The Ego and Motility in Sleepwalking. Zelda Teplitz. Pp. 95-110.

The role of the ego in sleepwalking is discussed and seven illustrative cases are presented. One adult was studied over a period of five years and six children were studied less intensively. The author found that an important aspect of sleepwalking is its service as partial defense against sleep itself. Sleep is frightening because it is associated with loss of control, loss of identity, and death, and the somnambulism serves to decrease these anxieties. Problems in expression of aggression, independence, and differentiation from the parents are found and, while the patients are outwardly compliant in waking life, they express these drives dramatically in sleepwalking.

The Art and Science of Psychoanalysis. Thomas M. French. Pp. 197-214.

French suggests a more scientific approach in the admittedly intuitive art of psychoanalysis. He seeks a method with better checks and balances, emphasizing especially the adverse effects on intuition of countertransference problems and the utilization of free-floating attention. As a guiding principle in therapy he recommends adhering to the 'focal' conflict of the patient, that is, that conflict which at the moment has been most intensely cathected by the patient. The focal conflict, related to current reality, is usually preconscious though it has unconscious connections and it may or may not be directly related to the nuclear conflict of the patient. If an interpretation is made at the level of the focal conflict, it will have most meaning to the patient at that moment, and the effects of the interpretation will be easier to predict as no peripheral factors will be activated which can lead to less understandable reactions in the patient. The interpretation itself will then serve as a stimulus for further material and a chain of interpre-

tations and responses will be started. Since it should be possible to predict the effect of the interpretation beforehand, this can be checked with the subsequent material and an accurate evaluation of the analyst's understanding can be made. In this way the results of the therapy can be measured more scientifically. The author recognizes the possible pitfalls in being more actively expectant in treatment and emphasizes that the basic rule of following the patient's free associations remains primary.

Counterresistance and Interpretation. Heinrich Racker. Pp. 215-221.

The author defines counterresistance as an emotional reaction within the analyst which prevents him from communicating to the patient something perceived by him and demanding interpretation. Counterresistances usually arise out of the analyst's identification with the patient's resistance, but nonetheless Racker believes that they are not chiefly due to conflict within the analyst but rather to his reaction to transference conflicts within the patient; it is this reaction that needs to be further analyzed. These transference conflicts often represent the patient's most important problems. The counterresistance to making the interpretation arises because the understanding it embodies is still incomplete; in order to overcome this it is necessary to discover what has been overlooked in the patient's personality. With this completed knowledge of the patient the counterresistance will be overcome and the interpretation made. The counterresistances described in the examples appear to be relatively superficial and more like reluctance or inhibition on the part of the analyst to give an interpretation which he has not completely formulated; they do not seem to be true counterresistances. It is not demonstrated convincingly that these are really an expression of nuclear or central problems in the patient.

On Countertransference 'Cures'. Jose Barchilon. Pp. 222-236.

Countertransference cures result from unconscious wishes and strivings in the therapist whereas transference cures are due to mechanisms operating entirely within the patient's mind. The patient's readiness for transference cure is a prerequisite for countertransference cure and moreover the solution, as unconsciously determined by the therapist, must be a socially acceptable one. Supervision of psychotherapy has shown that the physician has strong conscious desire to help his patient, immediate interest in the symptoms or conflicts, and a certain fascination with the case. On the unconscious level, the patient's conflicts arouse in the therapist conflicts from his own past and intrusion of these into the treatment leads to a countertransference solution of the patient's problems. An almost necessary condition is the therapist's conveying his admiration and sympathy for the way the patient solves his conflicts. This sympathy facilitates intense positive transference with mutual feelings of warmth, resulting in readiness for a transference cure in the patient. The six cases presented have more to do with countertransference solutions in treatment or countertransference problems than with 'cures'. In the three more successful cases, the physician handled his patients' conflicts as he was handling his own, and socially acceptable solutions of the patients' difficulties could emerge. In one instance, the patient identified himself with the therapist's masochism for adjusting to an unhappy

marriage. In another the physician helped his patient ward off neurotic depressive reactions by clowning. In a third case the physician encouraged his patient to act out by getting pregnant, which led to symptomatic improvement. The author discusses the meaning of dramatic cures sometimes obtained by beginners in psychoanalysis and also discusses the physician's motivation to cure.

A Note on the Connection Between Preliminary Communications and Subsequently Reported Dreams. Samuel D. Lipton. Pp. 237-241.

The casual remarks, comments, or expressions occurring at the beginning of an analytic hour often have latent content closely related to the latent content of a dream reported later. The author offers brief examples and concludes that these preliminary products result from the ego's attempt to adapt an unconscious wish to reality by using mechanisms such as displacement and condensation that closely resemble the dream work that had been acting upon the same or similar unconscious wishes the night before.

On Screen Defenses, Screen Hunger, and Screen Identity. Ralph R. Greenson. Pp. 242-262.

Disorders of identity have predominated in recent years in patients seeking analysis. 'Screen identity' is characterized by 'screen defenses' and by hunger for screen experiences and memories. Such patients appear ready and eager to make contact, seem warm and giving, yet are unduly concerned with social standing and long to be well liked. They are often successful but their production is sporadic and unreliable. They are impressionable and gullible and can be ingratiating. In analysis they easily produce free associations, make strong positive transference, and appear to progress, but in time it becomes clear that they isolate large segments of life from the analysis and make extensive use of denial and negation. They appear to be impulse-depressives with hysterical superstructures.

The self-image can be utilized as a screen. For example, a patient used one identity with less painful associations to cover another more painful identity. Screen activities also offer gratification, as shown by the intense hunger for them; these patients are constantly seeking new experiences and new objects, never taking no for an answer nor accepting defeat. Reliving instead of remembering past experiences is frequent. The patients constantly seek to change the past, to falsify it, searching for experiences to serve as memories for distorting it. Multiple identities and self-images are common, not fragmented as in psychotics but rather well organized. They have no capacity to fuse a loved and hated object into a single object. Object relations are only partially satisfactory because of the constant hunger for objects and the tendency to transference reactions and 'œdipalization' of relationships. These patients are fixed on oral and phallic levels. Sexual life is relatively satisfactory but the primary objective is to feel closeness and sense of oneness rather than orgasm. The superego is unstable and corruptible because the parents openly disagreed, lied, and distorted reality.

The Cliché: A Phenomenon of Resistance. Martin H. Stein. Pp. 263-277.

Stein gives examples of the use of the cliché in the service of resistance, and refers to its use in the analyst's counterresistance as well.

The Significance of the External Female Genitalia and of Female Orgasm for the Male. George Devereux. Pp. 278-286.

Data from Micronesian cultures throw light on the attitude of the male toward the female genitalia and the female orgasm. It is important for the Micronesian woman to have large, observable external genitalia, for the man is especially attracted by them; efforts are made toward artificially enlarging them. The enlarged genital is then referred to as 'full of things' and is said to aid the woman in achieving quicker orgasm. The enlarged genital is often treated as a penis by the man and he finds it highly desirable that the woman urinate at the climax (which he apparently equates with ejaculation), and that she have her climax first. The author suggests that this behavior helps the man to overcome his castration anxiety.

A Study of the Bisexual Meaning of the Foreskin. Brian Bird. Pp. 287-304.

An excellent case history illustrates the bisexual meaning of the foreskin in the young boy.

Some Comments on the Origin of the Influencing Machine. Louis Linn. Pp. 305-308.

Linn briefly summarizes the history of a fifty-year-old woman who had the delusion of being victimized by an influencing machine. After an interpretation that the delusion directly related to her masturbation, she had a marked emotional reaction with an apparently complete change in the delusion. The author regards this as presumptive evidence of the correctness of the interpretation and as a substantiation of Tausk's original formulation.

The Role of the Counterphobic Mechanism in Addiction. Thomas S. Szasz. Pp. 309-325.

Szasz discusses the role of the ego as distinct from the role of the instinctual life in the formation and course of addiction, and particularly develops the ego's use of the counterphobic mechanism. He found that three patients, one addicted to alcohol and two to smoking, used drugs as a means of exposing themselves to a dangerous situation in order to overcome and master it. An inner anxiety was displaced externally in an attempt to conquer it, as happens regularly in counterphobic symptoms.

Freud's Contributions on Stuttering: Their Relation to Some Current Insights. I. Peter Glauber. Pp. 326-347.

Glauber carefully reviews Freud's contributions on stuttering, especially the case of Frau Emmy von N. He relates Freud's findings to his own extensive observations and concludes that, besides the projection upward of anal material to the oral level which Freud postulated, there are other deeper and more significant dynamic factors. Fixations within narcissistic oral developmental levels play a determining role. Unresolved œdipal conflicts work more strongly to maintain the regression and symptom formations than had been appreciated. Moreover, the symptom of stuttering is not predominantly either a manifestation of a per-

version or a neurosis but rather, as in narcissistic or ego defect neurosis in general, a composite of both.

How I Came Into Analysis with Freud. The Wolf-man. Introduction by Muriel M. Gardiner. Pp. 348-352.

Gardiner persuaded the Wolf-man to write concerning his recollections of Freud. The present article (the first third of these reminiscences) deals with the beginning of his analysis. He describes briefly a succession of early treatments and then his initial contacts with Freud, including some of his personal reactions to Freud.

Education or the Quest for Omniscience. Bertram D. Lewin. Pp. 389-412.

In this scholarly paper, presented on the twenty-fifth birthday of the Institute for Psychoanalysis in Chicago, Lewin reviews the three forms psychoanalytic education has taken,—individual seeking for knowledge, then loosely formed instructional groups, and finally the formal institute. He discusses the desire for knowledge. It resembles the impulse to cure, satisfying the need to restore the infantile sense of confidence or omniscience.

He cites several historical parallels to the history of psychoanalytic education. One is the use of the universities. A second is the humanism of the Renaissance, which occurred mainly outside the universities as did psychoanalysis. A third parallel is the rise of the natural sciences and the role of scientific societies, where the same sequence,—individual enthusiasm, societies, institutions,—occurs. The fantasy of omniscience in the generation with which Freud's theories had to cope was different from earlier ones in that a change had occurred from faith in content to faith in method. Freud's radical empiricism threatened the fantasy of the Kraepelinians that scientific method leads to omniscience. The author concludes that in present-day psychoanalytic institutions the quest for omniscience continues and can be expected to survive the fantasy of already being omniscient.

Effect of Psychophysiological Research on the Transference. Henry M. Fox. Pp. 413-432.

A young married man with a history of disturbed gastrointestinal functioning associated with fluctuation in his emotional state was the subject of an experiment. Urinary creatinine, 17-hydroxycorticoids, and uropepsin levels were determined daily as a means of measuring indirectly the degree of gastric activity. His psychoanalysis continued concurrently. Significant correlation was found between phases in the analytic process and certain relatively constant biochemical rhythms and balances. It was concluded that although the research helped to make some of the patient's regressive trends more amenable to analysis, the use of the patient for this research problem added difficulties to the analysis, particularly to the resolution of the transference.

The Communication of Affect in Rhesus Monkeys: I. An Experimental Method. I. Arthur Mirsky, Robert E. Miller, and John V. Murphy. Pp. 433-441.

Nonverbal communication of affects was studied experimentally in rhesus

monkeys. A group of monkeys was conditioned to avoid an electrical shock by pressing a bar as soon as the stimulus monkey was seen through a one-way screen. This conditioned response was then extinguished. Later the test animal was again exposed to the stimulus animal but this time the stimulus animal received the electric shock and the test animal could stop it by pressing its own bar. Observing the affective response of the stimulus animal caused the test animal to respond as if frightened and to react appropriately by pressing the bar. This resulted from the memory of its own previous experience coupled with the visual stimulation of an affect; thus it could be shown conclusively that a communication of affect between the animals had occurred. This type of behavior relates to the phenomenon of empathy as conceived by Freud.

The Theoretical Implications of Hallucinatory Experiences in Schizophrenia. Arnold H. Modell. Pp. 442-480.

Tape-recorded interviews with psychotic patients who were hallucinating showed that the voices represented some formerly internalized objects now perceived by the patient as external objects. Direct libidinal discharge was associated with the hallucination of oral and anal as well as genital sensations, although the latter were most prominent and were associated with œdipal fantasies. The auditory hallucinations were not found to be primarily hostile but were considered helpful and beneficial. Some hostile and critical aspects were observed and these were interpreted as related not to the superego itself but to a stage in the prehistory of the superego. The traditional concept that the voices represent an external conscience was not confirmed.

Superego, Introjected Mother, and Energy Discharge in Schizophrenia: Contribution from the Study of Anterior Lobotomy. Eugene B. Brody. Pp. 481-501.

Eleven schizophrenic patients, six male and five female, all chronically ill with paranoid symptoms, were studied before and after a minimal lobotomy to determine the relation of energy discharge to psychic structure in schizophrenia. Psychological tests after operation indicated no organic brain defects, and one year postoperatively eight of the eleven patients were at home, some gainfully employed. Psychotherapy was given before and after operation. After operation aggressive discharge was less intense and better organized and the patients were less afraid of losing control of their impulses; useful aggressiveness became possible. Rigid superego was relaxed, leading to more energy discharge via laughter, joking, and instinctual gratification. Postoperatively males showed less guilt over incestuous desires and females had less homosexual anxiety and less disgust regarding sexual matters. Dreams became more effective discharges of excitation from the unconscious, and sleep was more easily achieved. Less concern over ego identity led to diminished anxiety over the wish for oral reunion with the mother, a problem which had produced tremendous defensive reactions preoperatively. The rejecting, prohibiting, introjective mother seen by the schizophrenic became less of a persecutor and allowed libidinal and aggressive gratifications. The ability to accept oral reunion with the mother seems to be a regression from a more differentiated superego to a simpler narcissistic ego ideal.

The schizophrenic psychotic apparatus is an energy system with limited capaci-

ties for discharge from the system into the environment and within the system itself, the limiting factor being a pathological superego which functions as a foreign body within the psychic system. It is hypothesized that after lobotomy the superego is disrupted, more energy discharge by gratification of previously denied wishes is possible, and there is better superego fusion. In symbolic terms this is equivalent to a state of relative unity with the mother, something which the schizophrenic had always wanted but defended himself against because of its threat to his identity. In this sense he has become a more successful schizophrenic.

How Autonomous Is the Ego? David Grauer. Pp. 502-518.

This article is chiefly a review and summary of various concepts of ego autonomy, especially Hartmann's and Rapaport's early formulations and Federn's, Weiss's, and Menninger's later contributions. The author favors Menninger's concepts, emphasizing particularly the presence of some ego energies that are independent of the id drive energies. These independent ego energies are seen especially in constructive and adaptive activities in contrast to other ego energies which are defensive and inhibitory in nature.

Prebody Ego Types of (Pathological) Mental Functioning. Augusta Bonnard. Pp. 581-611.

As the author states, this communication is an exercise into the realms of the unknowable, that is, an attempt to understand the function of the infantile mind in the very earliest weeks of life. It is an excellent presentation of very complicated prebody ego mental mechanisms and thus needs to be read in its entirety to be fully understood. In essence the author discusses the perceptual affective beginnings of the first weeks of life and shows how the mental mechanisms which exist then are different from such basic mechanisms as introjection, projection, and identification, although probably antecedents of these. Bonnard demonstrates how the continuance of these very early mechanisms into adult life is manifested, especially in severely disturbed people. She presents three cases, one adult and two children, and describes in considerable detail how she recognized and coped with the symptoms that resulted from these disturbed perceptual affective states of infancy.

Early Physical Determinants in the Development of the Sense of Identity. Phyllis Greenacre. Pp. 612-627.

Greenacre describes the effect of early physical determinants on the development of the sense of identity, especially the effect of awareness of one's genitals, face, and body form on the development of the body image, which is basic to the beginning of the sense of reality. The core on which identity is built is the inner awareness of one's own form and functioning, the inner structure and organization of the body. The sense of identity is influenced by awareness of external attributes of the outer surface of the body and involves repeated comparisons and contrasts with others. The sense of identity comes into being in the anal phase, though it is more fully developed in the phallic œdipal period,

but no real adult functioning identity is present until adolescence is well assimilated.

Disturbances in Abstract Thinking and Body Image Formation. Sylvan Keiser. Pp. 628-652.

The following symptoms often occur together: inability to learn, to know, to correlate facts or to understand except by rote, and inability to assimilate and utilize knowledge as, for example, in abstract thinking. This symptom complex is closely correlated with the inability to accept the existence of the vagina because it cannot be seen. A body image that excludes knowledge of the apertures has certain effects on the ego. Four cases are presented, one in detail, to illustrate this phenomenon. A difficulty in object relations results from the inability to assimilate the presence of the vagina, and there is impairment of the ability to assimilate knowledge. A disturbed, isolated, fragmented body image, never properly integrated into the ego, also results. Because existence of the vagina cannot be deduced, there occurs inhibition of deductive reasoning, and because the body image remains disconnected and disjointed, there is disconnected speech and body language. In fine, these patients cannot believe in or have true knowledge about anything. A good review of the literature correlates these observations with views on ego development.

Abstract Thinking and Object Relations. With Specific Reference to the Use of Abstraction as a Regressive Defense in Highly Gifted Individuals. Victor H. Rosen. Pp. 653-671.

Rosen describes some of the problems in analysis of gifted individuals, with special emphasis on the use of abstract thinking as a regressive defense. He reviews the analytic concepts of the development of abstract thinking, concluding that abstract thought consists of varying degrees of decathexis of objects in order to deal with certain nonrepresentational aspects of their attributes. A detailed case report illustrates the utilization of each of the specific elements of abstract thinking in the service of the primary process as regressive defenses, and at the same time in the service of the secondary processes as special gifts or abilities. Rosen also comments on the difference between the gifted individual and the schizophrenic: the intermediate stages of concept formation in the former are not only close to the primary process as in the schizophrenic, but are also particularly available to the secondary process, whereas the schizophernic can use them only for instinctual discharge.

Dream Resistance and Schizophrenia. Ives Hendrick. Pp. 672-690.

This is an abbreviated form of two papers otherwise unaltered as to content which the author presented more than twenty years ago, and which he considers valid today. His main interest is in differentiating the schizophrenic and the neurotic psychic processes. His emphasis in schizophrenia is on the role of an ego defect, for example the lack of ability to repress. This problem in repression leads to development of pathological sexual and destructive ideas. Such ideas are secondary to this basic defect; whereas in the neurotic the primary problem is excessive repression of the sexual drives. The schizophrenic need for a

retreat to autistic thinking closely resembles the neurotic's use of dream resistance as a withdrawal to defend himself against transference material, usually hostile transference feelings. The massive withdrawal of object cathexis in the schizophrenic is initiated by the biological need to combat or neutralize the primary destructive impulses with which the ego is unable to cope. Treatment should be directed toward understanding the biological or psychological origin of the abnormally intense destructive trend or the cause of the development of the defective ego incapable of normal repressive mechanisms.

TOM G. STAUFFER

Bulletin of the Philadelphia Association for Psychoanalysis. IX, 1959.

Brothers and Others. John M. Flumerfelt. Pp. 31-34.

A sixty-year-old man complained of severe anxiety coincident with the arrival at his job of a new superior, who was younger than the patient. This was interpreted as aggression toward a younger brother, with return of the repressed via transference to the young boss. Although the patient denied any memory of hostility toward his brother, he nevertheless brought in a college theme written forty years earlier, discovered by a suggestion in a dream which he had following the interpretation. The college theme, a jocular one, referred to the trials and tribulations of having a younger brother, and clearly confirmed the interpretation of sibling hostility.

EDWIN F. ALSTON

Bulletin of the Menninger Clinic. XXIII, 1959.

A Critique of Current Concepts in Psychosomatic Medicine. Maxwell Gitelson. Pp. 165-178.

In this review of current psychosomatic concepts, the author points out the growing disenchantment with specificity theories and his own dissatisfaction with extant partial explanations for somatic response. He briefly reviews the outstanding theoretical contributions, among which he finds Schur's ideas concerning ego regression and desomatization of anxiety, aggression, and libido most congenial, along with selected views of Margolin, Mirsky, and Deutsch.

Psychosomatic states may be viewed as states of ego regression associated with somatic regression to more primitive levels of physiological function. The genesis of psychosomatic disease seems to lie in the earliest stages of infancy, as psychic structure and patterns of somatic function develop out of a poorly differentiated psychophysiological anlage.

Cognitive Control Principles and Perceptual Behavior. Riley W. Gardner. Pp. 241-248.

A brief summary of the studies on cognitive organization is provided along with some suggestions as to their psychoanalytic background. A current research involving the assessment of patterns of spontaneous attention deployment (scanning) is outlined. The scanning mechanism is viewed as one of a number of cognitive control principles which is organized into a secondary process ego

structure. These ego structures bear some relationship to defense structures but develop from different antecedents. Some evidence points to a relationship between the extensive use of scanning and the defense of isolation. The work summarized is in the forefront of the integration of psychoanalytic ego psychology and academic psychology.

ROBERT D. TOWNE

Psychosomatic Medicine. XXI, 1959.

Infantile Experience and Adult Behavior in Animal Subjects. II. Age of Separation from the Mother and Adult Behavior in Cats. Philip F. D. Seitz. Pp. 353-378.

A series of observations, made on several litters of cats, demonstrate the hypothesis that early infantile traumata have lasting effects which can be observed in adult behavior. These experiments illustrated the effects of early separation from the mother on such activities as: reaction to novel situations, goal-directed behavior, recovery from intense stimulation, feeding behavior, and reaction to feeding conflict. The results tended to confirm the thesis that the earlier the separation from the mother, the more pervasive the effects produced in adult behavior.

Psychosomatic Aspects of Cancer: A Review. George M. Perrin and Irene R. Pierce. Pp. 397-421.

In this critical review the authors selectively appraised the literature on the psychosomatic aspects of cancer in connection with: 1, the incidence of cancer in mental institutions; 2, the patient's emotional reaction to cancer; 3, the psychological history or personality pattern of cancer patients; and 4, the relation of psychological phenomena to the rate of progression of neoplastic disease. For the most part the authors found the recorded studies seriously lacking in methodological design and execution, rendering the results equivocal. Several suggestions are advanced for improving research design.

ROBERT D. TOWNE

Psychiatric Quarterly. XXXIII, 1959.

The Classification of 'Mental Illness'. Thomas S. Szasz. Pp. 77-101.

Certain fundamental concepts and technical aims must first be clarified before the problems in current psychiatric nosology can be solved. Szasz suggests an operational mode of approach, with limited, socially and methodologically well-defined plans of attack on a specific problem. A nosological system worked out and suited to one type of psychiatric situation cannot validly be applied to another, very different psychiatric situation. For example, insights gained from the psychoanalytic situation cannot be directly applied to those like child rearing or the disposition of criminals in courts of law. A related consideration is that of terms that function as panchrestons—words that 'explain everything', e.g., the diagnostic term, *schizophrenia*. Such a category cannot be readily verified for classification, and it gives the impression of a more or less homogeneous group of mental

phenomena. A science requires a system of classification; therefore the need for a satisfactory nosology.

A Direct Analytic Contribution to the Understanding of Postpartum Psychosis. Jack Rosberg and Bertram P. Karon. Pp. 296-304.

The direct analysis of a schizophrenic woman in her thirties, a postpartum case, revealed fantasy structures which are considered the basic factor in postpartum disorders. To the patient, whose husband had replaced her mother in her life, intercourse meant being full of semen and milk; her vagina was a sucking mouth and being pregnant meant being filled with milk. The childbirth represented a sudden severe loss of the deep oral gratification, and the oral trauma precipitated the patient's psychotic reactions.

The Dying. Daniel Cappon. Pp. 466-489.

In his study of the relation between fantasy and bodily illness, carried out on general hospital patients where he attempted to obtain fantasy material 'at sleep and waking levels of awareness', Cappon compared material from nineteen patients who died in the course of the illness with that from another eighty-eight patients. His data suggest that no personality change took place in the period of dying, the ego defenses were usually overwhelmed, and the experience of dreaming ceased or went unreported. The majority of patients wanted to die or, at least, not to live. Their forebodings, often numerous, depending on the state of awareness, tended to increase with the preconscious perception of body dysfunctions occurring in dreams. Cappon applies these suggestions to what the physician may tell the dying about themselves and their condition.

Creativity and Mental Illness. Philip S. Herbert, Jr. Pp. 534-547.

In his study of the case records of sixty creative patients hospitalized for mental illness in New York Hospital, 1928-1955, Herbert found no instance of failure of creative capacity as the main causal or precipitating factor in the mental illness. 'Creative capacity was frequently the last realistic, organized activity' to be damaged by the illness and the first to begin to return on the patient's recovery. The case histories of three artists illustrate some of the findings.

A Second Contribution to the Study of the Narcissistic Mortification. Ludwig Eidelberg. Pp. 636-646.

Eidelberg discusses an aspect overlooked in his earlier reports on the narcissistic mortification. The phenomenon is due to the power of somebody else who thereby uses one against his will; and the 'somebody else' may be external or internal—that is, one part of the personality can 'force the *total* personality to do what it resents'.

Excerpts from a case history illustrate the problem of a male patient suffering from paranoid ideas. After he had given up his insistence that others hated him, he still believed that characterologically he must continue to suspect everybody of hating him. Slowly and painfully he then came to see his need to accept his conviction of the analyst's hatred of him and of his inability to do anything

about it. Such an idea protected him from recognizing his self-hatred and his conviction of inability to control it. Consciously he came to recognize his self-hatred as a destructive, primitive self-criticism, and to understand how his fear of being unable to control his aggression sprang from 'the unconscious fear of having to face and accept his sexual needs'. He feared his love more than his hate. The patient's projection of 'he hates me' thus included an acceptance of an external narcissistic mortification—'he can hurt me'; and a denial of his inability to control his self-hatred. 'The truth is, not that I cannot control my aggression, but that I cannot control his', helped the patient to 'deny his failure to control his own sexual wishes...'.

BERNICE ENGLE

Archives of General Psychiatry. I, 1959.

Some Difficulties of Psychotherapeutic Practice. John E. Gedo. Pp. 3-6.

The author is concerned with those patients encountered in private practice who refuse the recommendation of treatment or who drop out after a short time because of the therapist. Although this is really a paper on an aspect of countertransference, surprisingly none of the analytic literature on the subject is referred to. Personal material is cited which includes, mainly, rescue fantasies and inability to handle patients' hostility.

Obsessions of Infanticide. A. H. Chapman. Pp. 12-16.

Chapman, in a clinical, descriptive paper, stresses the chief symptoms of a group of twenty women—an obsession of murdering their children and fear of becoming insane. The dynamics are briefly presented but it is not explained why there should be this interesting coupling of symptoms. Fourteen of these women were followed in treatment; the more recent the outbreak of symptoms, the better the outcome.

Morphology and Other Parameters of Fantasy in the Schizophrenias. Daniel Cappon. Pp. 17-34.

In this long and complicated paper, the author examines fantasy material, grouped into broad categories according to degree of structural cohesiveness, from a large group of persons of all ages and psychiatric diagnoses. Materials used are dreams, drawings, and fantasies, both in the waking state and under light gas anesthesia. The group was divided into three categories: schizophrenias, character disorders, and neuroses. What emerged was the expected fact that the degree of regressive features of the fantasy material varied directly with the seriousness of the illness, that is, greater in schizophrenia than in neurosis. From this the author postulates a dream profile as a handy diagnostic test for clinicians.

Cultural Determinants of Response to Hallucinatory Experience. Anthony F. C. Wallace. Pp. 58-69.

The author, an anthropologist, examines the widely different attitudes toward

hallucinations in various human cultures, ranging from a 'good' spiritual quality to a 'bad' insanity. Because of these varying attitudes, he postulates that in research with hallucinogenic drugs, methodological controls have to be used.

Problems of 'Perception' and 'Communication' in Mental Illness. David McK. Rioch. Pp. 81-92.

In this Lasker lecture to the Institute for Psychosomatic and Psychiatric Training and Research of the Michael Reese Hospital, Rioch points out the interrelation between the patient and observer which determines perception and communication. These qualities cannot be differentiated because what an observer sees the patient as perceiving are inferences decoded from messages the patient sends. The therapeutic problem involved is illustrated by case material from hospitalized schizophrenic patients, in which the difficulty in understanding and reaching the patient is shown. The view is offered that regardless of what precipitates the state of disturbed consciousness, one has to recognize the significance of the symbolic behavior and interpret it to the patient in terms of the present and immediate situation that makes him feel isolated from life.

Maintenance of Stereotyped Roles in the Families of Schizophrenics. Irving Ryckoff, Julian Day, and Lyman C. Wynne. Pp. 93-98.

The authors examine the family of a schizophrenic as an integrated unit, under the questionable belief that this is more fruitful than investigating single environmental factors, including, presumably, the psychology of the individual. However, they introduce some interesting material as they describe a family in which the roles of the various members are so stereotyped, oversimplified, and restricted that it becomes very difficult for the individual member to rise above role-playing and identification in order to reach a personal identity, leading in one of the members to a schizophrenic reaction. They feel this may be a significant kind of family in the life of schizophrenic patients.

Direct Instigation of Behavioral Changes in Psychotherapy. Ian Stevenson. Pp. 99-107.

In this controversial paper, the author distorts the aims and techniques of analysis and of dynamic psychotherapy in order to justify brief treatment of a particularly active type as the treatment of choice in the psychoneuroses. Thus, he reasons, since the patient spends many more hours a day with other meaningful people than he can with a therapist, he has more opportunity to learn new behavior from them. It is therefore necessary that psychotherapy be focused around the present and especially the patient's dealings with the meaningful people in his life. The author acknowledges that this treatment constitutes a direct influence by the therapist upon the patient but insists that there are always elements of this, even in classical analysis. Case material is presented.

A Transactional Model for Psychotherapy. Roy R. Grinker. Pp. 132-148.

Grinker points out what he considers to be the current dilemma in therapy: for practical purposes, American psychotherapy has followed closely the psychoanalytic model, and, while this theoretical system furnishes the best psycho-

dynamic understanding, it interferes with psychotherapy as the therapist must see things and interpret them from this preconceived, theoretical bias and is therefore prevented from seeing and learning what is actually going on in the therapeutic situation. Grinker cites instances of young therapists trying to be analysts who are instead too passive, cold, interested only in content, and unaware of the patient's reaching out for help.

To correct this, the author proposes a form of treatment based on an operational theory of psychotherapy rather than on psychodynamics. What he offers is a model, derived from the behavioral sciences field theory, and role and communications theories. He calls the model transactional; the essence of it seems to be a higher or broader order in the relationship between two people, more than 'self-actional' or 'interactional'. And herein lies one of the weaknesses of his conceptualization. The assumption is that one cannot understand what goes on between a patient and a therapist by understanding the individual dynamics of each, but that the combination of patient-therapist is on a different hierarchal level, to which more has been added. Another questionable point is the implication that the young therapist cannot learn and improve through better analytic understanding, gained from personal analysis, training, and experience. Grinker maintains he can do a better job only within a different framework than analytic understanding and modifications of technique. His other major contention is the belief that theoretical bias or hypothesis is in itself bad.

The rest of the paper is concerned with a description, enhanced by case material, of good supportive therapy, utilizing interpretations upward, the avoidance of regression, stressing present situations, and reality testing. This is not in conflict with analytic understanding and is a modification of technique made possible because of analytic understanding. Grinker, however, views it differently.

Parents of Schizophrenics, Neurotics, and Normals. Seymour Fisher, Ina Boyd, Donald Walker, and Dianne Sheer. Pp. 149-166.

This painstaking statistical paper tests the broad hypothesis that the degree of illness of a patient is a function of the degree of illness of his parents. Both parents of twenty normal men, twenty neurotic men, and twenty schizophrenic men were tested and rated by a variety of psychological tests and interviews. The results were not striking. In general, parents of the normal were less disturbed than those of the other two groups. The only point of note was that in this study there was no evidence that the mother had the decisive role of impact on the child, but, rather, that the interaction between the parents did.

Self-Perceptual Patterns Among Ulcer Patients. Morton A. Lieberman, Dorothy Stock, and Roy M. Whitman. Pp. 167-176.

In this paper, a statistical approach to Alexander's specificity of 'ulcer type' hypothesis, ulcer patients were asked to sort cards according to whether the statements most or least described the patient. The type of statements used are supposed to be divisible into broad groups around the categories of dependency, intimacy, fight, and flight, but it is not known what each statement meant to

each patient, consciously or unconsciously. In the twenty-one patients tested, two main groups emerged, one revolving around dependency and the other around intimacy. One interesting finding was that all patients with intimacy difficulties showed no weight loss, while all those having a problem with dependency had a weight loss. Some speculations as to the meaning of this difference and to choice of treatment are offered.

Patients' and Physicians' Judgments of Outcome of Psychotherapy in an Outpatient Clinic. Francis A. Board. Pp. 185-196.

A comparison, based on questionnaires, is made between the evaluation of the efficacy of treatment at the Michael Reese Out-Patient Clinic, as seen by the therapist and as seen by the patient. Although there was considerable agreement, the major surprise came from a sizable group of patients, labeled by the therapists as unsuccessfully treated, who considered themselves successfully treated. The author speculates that this was due to the interest of the therapist in the patient, even though the therapist felt it in negative terms, such as in countertransference difficulties. It appeared that the therapist's pessimistic views stemmed from lack of gratification from patients of this type. The author feels that the interest of the therapist in the patient is the *sine qua non* of successful treatment.

KENNETH RUBIN

Journal of Abnormal and Social Psychology. LVIII, 1959.

The Present State of Psychoanalytic Theory. Merton Gill. Pp. 1-8.

Gill presents a number of basic assumptions of psychoanalytic theory and the changes that have taken place in them during the past twenty-five years. The assumptions are organized under the headings: 1, the motivational theory; 2, the introduction of independent variables other than drives; 3, emphasis on maturation; 4, the genetic emphasis; 5, the primary and secondary processes; 6, the unconscious; and 7, the introduction of the structural point of view. Recent changes reflect an increasing concern with ego psychology, the psychology of the surface, increased attention to the environment, and the introduction of cognitive and adaptive considerations. These changes indicate that psychoanalysis is becoming a total psychological system and so is effecting a rapprochement with the thinking of some academic psychologists. Congruences and differences between the disciplines in this regard are examined briefly.

A General Formula for the Quantitative Treatment of Human Motivation. Walter Toman. Pp. 91-99.

All of a person's motives are forever on the increase from the moment they were last satisfied until they are satisfied again. But various degrees of satisfaction reduce motive intensities by corresponding amounts. The level of a person's motivational development may be inferred, in comparative terms, through the use of a quantitative formula. This formula translated into words is that the sum of intensity increments of motives that can be distinguished within a given person at a given time of development is equal to a constant. An assumption is

that the number of distinguishable motives increases with development. Therefore, the intensity increments with which any given motive grows until it is once more satisfied must, on the whole, decrease with development. Major aspects of the formula were subjected to empirical tests and proved by these tests to be feasible. The formula articulates considerations by which the clinician implicitly proceeds. Repeated inspection of a few motives may tell whether a person is continuing to grow, beginning to slow up, or even regressing, and may suggest psychopathology before a person shows more conspicuous symptoms.

The Nature of Hypnosis. Martin T. Orne. Pp. 277-299.

The subject's knowledge regarding behavior in hypnosis influences his own hypnotic behavior. Five out of nine subjects, exposed to a demonstration and lecture on hypnosis in which catalepsy of the dominant hand was mentioned as a common feature of trance behavior, exhibited this phenomenon under hypnosis. No subjects in a control group, given a similar lecture and demonstration, but with no mention of catalepsy, showed the phenomenon. Demand characteristics of the experimental procedure—what the subject believes he is supposed to do—may be a significant determinant of his behavior, although that behavior may appear to be the result of an experimental variable. An experiment reported in the literature, which depends on hypnotic amnesia to explain the results, was repeated with the inclusion of a control group. Subjects in the control group simulated hypnosis but were otherwise exposed to the same experimental situation as the hypnotic subjects. The behavior of the simulating group was indistinguishable from that of the 'real' group and both were indistinguishable from the results of the original study. In another experiment it was found that motivated subjects in the waking state held a weight at arm's length for a longer period of time than they did while in the hypnotic state. This result casts doubt on the notion that enhanced physical capacity is a primary characteristic of the trance state. Experiments with pain stimuli did not reveal clear-cut behavioral differences between 'real' and 'fake' subjects. The major difference between these subjects appeared to be a tolerance by the 'real' subjects for logical inconsistencies. A subject's report of alterations in his experience is the best confirmation of hypnosis; in the absence of objective indices the existence of trance may be considered a clinical diagnosis.

Structural Analysis of Dreams: Clues to Perceptual Style. Bernice T. Eiduson. Pp. 335-339.

Cognitive system-principles, styles of perceiving, have been shown by previous research to operate as individual personality constants over a variety of waking conditions. Do they function similarly in dreams? The dimension of flexibility (openness to change, diversity in expression, tolerance for fantasy, and lability in emotion) and rigidity (tight defense against variation or change) were measured on the Rorschachs and in the dreams of patients in psychotherapy. To a significant degree the way a patient responded in this variable to one measure was correlated highly with the way he responded to the other. One inference is that more highly developed adult ego functions may have forerunners in the primitive ego formations seen in dreams.

Evaluation of Therapy by Self-Report: A Paradox. Jane Loevinger and Abel Ossorio. Pp. 392-394.

The ability to conceptualize oneself psychologically is the chief variable by which to measure maturity; and to conceive of one's impulses is to achieve some measure of control over them. Measurements by self-report of the success of therapy or of 'adjustment' are thus liable to error. They may accept as normal or mature a conventional or idealized self-portrait which issues from a non-psychological attitude founded on repression, denial, or avoidance. A more psychologically-minded person may report a less ideal image even though, through the ability to conceptualize his inner life and the capacity for detachment and self-criticism, he may be more 'normal' than the more numerous nonpsychologically-minded people.

STEPHEN A. APPLEBAUM

Journal of Abnormal and Social Psychology. LIX, 1959.

Leveling and Repression. Philip S. Holzman and Riley W. Gardner. Pp. 151-155.

The authors and others have previously demonstrated individual variations in adaptive behavior, called cognitive system principles, and the similarities between these and ego defenses. This study replicates a previous finding that on a neutral psychophysical task subjects who rely chiefly on repression as a defense mechanism are 'levelers' in the cognitive system principle of leveling-sharpening. Levelers were selected on the basis of their tendency to obscure size and weight differences in tests of successive comparisons, and their Rorschach protocols were judged on the variable of repression. Of several possible explanations for the linking of these adaptive and defensive processes the authors believe that repression relies, in part, upon the process of leveling for its execution, providing a plausible and partial explanation for choice of defense.

Subliminal Effects of Verbal Stimuli. Gudmund J. W. Smith, Donald T. Spence, and George S. Klein. Pp. 167-176.

The words *happy* and *angry* were presented tachistoscopically in a mixed sequence of gradually increased subliminal exposures, each alternating with a drawing of a relatively expressionless but clearly visible face. The subjects' descriptions of the face were classified as clearly more pleasant in *happy* pairings than in *angry* pairings. Thus, the experiment demonstrated that the meanings of words, exposed below the threshold of recognition, were able to influence impressions of a clearly supraliminal figure. These influences were subject to modulation by response preferences and certain reaction tendencies, being less when their meanings were at variance with the subject's initial opinion of the face. Based upon analyses of the TAT protocols, the subjects most likely to be influenced by the subliminally exposed words were those who showed a greater tolerance for the passive role and an ability to maintain moderate distance from the conscious stimulus which allowed for greater flexibility and attentiveness to it.

A Comparison of 'Dreamers' and 'Nondreamers': Eye Movements, Encephalograms, and the Recall of Dreams. Donald R. Goodenough, Arthur Shapiro, Melvin Holden, and Leonard Steinschriber. Pp. 295-302.

Using the eye-movement criteria developed by Dement and Kleitman, the authors substantiate the hypothesis that many more dreams occur than are usually recalled the morning after and that the difference between dreamers and nondreamers can be attributed to differences in the ability to recall dreams rather than to differences in frequency of dream occurrence. Continuous recordings of eye-movement potentials and EEGs were taken on each subject during three nights of natural sleep. Experimental awakenings from eye-movement periods led to the recall of dreams more frequently than awakenings at other times. The data were consistent with the proposition that a dream is experienced during every eye-movement period. So-called 'nondreamers' were less likely to recall a dream than 'dreamers', but every subject studied, even subjects who said they had never dreamt before, reported at least one dream during the study period. Eye-movement periods occurred as frequently for nondreamers as for dreamers. However, there were significant differences between dreamers and nondreamers in the EEG patterns which occurred during eye-movement periods.

STEPHEN A. APPLEBAUM

The Journal of Medical Education. XXXV, 1960.

Œdipus, Cain and Abel, and the Geographic Full-Time System. Maurice Levine. Pp. 244-250.

Using psychoanalytic insights, Levine shows the advantages of the geographic full-time system in medical schools, wherein a member of the staff devotes twenty-five to thirty hours a week to department activities and has the rest of his time for private practice. Among the problems in support of the thesis is the dependence of staff members upon the head of the department for security, income, and tenure, all of which reactivate previous family problems of dependence and aggression. The geographic full-time arrangements may minimize the neurotic acting out of staff members against directors, and among themselves, since opportunities for realistic adult independence are possible. Likewise there are advantages to the director, especially if he has problems about leadership. The only point not considered, perhaps because it is obvious, is the relation of director and staff to the alma mater.

NORMAN REIDER

British Journal of Medical Psychology. XXXII, 1959.

The Effort to Drive the Other Person Crazy—An Element in the Etiology and Psychotherapy of Schizophrenia. Harold F. Searles. Pp. 1-19.

Although it is a common belief that one person can drive another crazy, no one has systematically studied either the modes and motives for doing so or how this idea appears in the relation of patient and therapist. Searles describes a number of modes which have in common 'the initiating of . . . interpersonal interaction which tends to . . . activate various areas of [the other's] personality

in opposition to one another'. He lists eight motives encountered in schizophrenic patients or in their parents which may account for the desire to drive another person crazy: 1, the psychological equivalent of murder; 2, the attempt to externalize threatening craziness in oneself; 3, the attempt to find surcease from a situation of intolerable conflict and suspense; 4, the child's wish to expose covert craziness in the parent; 5, the desire to find a 'soul mate' (the precariously integrated parent is often a lonely person who hungers for someone to share his private emotional experiences and distorted views of the world); 6, a conscious or unconscious desire to draw the other person into a healthier closeness, which miscarries because of the weakness of the child's ego; 7, the mother of the schizophrenic keeps before the child the threat that she will go crazy if he becomes an individual by separating himself psychologically from her; 8, the attainment, perpetuation, or recapture of the gratifications inherent in the symbiotic relation.

The author also describes instances of the same motives and defenses in transference and countertransference.

Clinical Research in Schizophrenia—The Psychotherapeutic Approach. James Chapman, Thomas Freeman, and Andrew McGhie. Pp. 75-85.

The authors have studied in an unusual schizophrenic patient the pathological processes in ego function. Observations during psychotherapy indicated that schizophrenia causes a state in the ego that gives rise to unusual and frightening experiences. Defenses of the ego are 'reactive and represent a means of dealing with the breakdown of the ego'. The authors believe that 'psychotherapy in psychotic reactions must be primarily concerned with re-establishing the integrity of the ego'. They relate disturbances of auditory perception, body image, communication, and motility to concepts derived from psychoanalysis and from experimental and genetic psychology.

HARVEY POWELSON

The Communication of Distress Between Child and Parent. Thomas S. Szasz. Pp. 161-170.

In this theoretical paper the author proposes that the earliest communication pattern established between parent and child in the service of mastering distress serves as a prototype for later social relations. The crying infant induces tension in the parent. This tension then causes the parent to relieve the infant's distress, thus reducing the tension. Parents may be overwhelmed by their inability to relieve the crying infant and this inability may become associated with a sense of their own failure and guilt. The reciprocal reaction is the child's dread of his parents' unhappiness for which he feels responsible and which threatens him with the loss of security of parental care.

Both partners in this communicative network are faced with the problem of defining their boundaries. For the infant this task is a necessary first step toward a series of self-differentiations. For the parent unresolved elements of their own autonomic development are re-experienced. Some specific examples of the liabilities arising out of inability to attain 'mature interdependence' in the parent-child dialogue are illustrated. The physician who is unable to remain

inactive and tolerate the suffering of a chronically ill patient, the psychiatrist who makes a precipitate commitment of a patient threatening suicide, and a parent's inability to tolerate his child's crying (which may lead to a homicidal attempt to silence the painful sound) have all been unable to satisfactorily achieve individual separateness.

Contribution to the Understanding of Disturbances of Mothering. Imrich Gluck and Margaret Wrenn. Pp. 171-182.

As an adjunct to the hospital treatment of a selected group of disturbed mothers, their preschool children, aged two to four, were admitted to the hospital with them. The children were seen in group play sessions during their mothers' four-times-a-week psychoanalytically oriented group psychotherapy. Much of the mothers' early therapy material was concerned with their children. Some of them presented their children's behavior as the focus of their treatment rather than their own conflicts. Others expressed concern about the effects their illness might have on the children. In some cases the child was presented as being eminently free from emotional difficulties. Play session observations of these instances often led to the disclosure of disturbed and constricted patterns of behavior which in turn provided clues about the mother's psychopathology.

The mothers seemed to settle down to more productive work in their treatment after being convinced that their children's problems would be recognized. The authors felt that the opportunity to closely observe both mother and child helped them to see the dynamic equilibrium that had developed between them. This equilibrium was disturbed by changes occurring in the mother and a resistance of the mother to her treatment was noted. The authors felt that the children derived some benefit from their play sessions by being better able to respond to the changing attitudes of their mothers.

On the Dynamics of Repression and Ego Subordination. Imre Hermann. Pp. 210-212.

In this short theoretical paper the author considers one aspect of ego function in repression. He advances the thesis that in repression the strength of the repressed impulse is intensified and calls forth added vigilance from the censor. This 'reflex of self-regulation' requires an adequately functioning and relatively autonomous ego. Ego impairment as a result of organic impairment or ego subordination, as in the case of the shame-feeling ego, may compromise the self-regulatory function.

ROBERT D. TOWNE

Revue Française de Psychanalyse. XXIII, 1959.

The Use of Oneiric Material in the Psychoanalysis of Adults. Pp. 7-82.

This is a report of a round table discussion organized by the *Societé Psychanalytique de Paris.* The participants were Drs. M. Schlumberger, M. Benassy, S. Lebovici, F. Pasche, M. Fain, R. Diatkine, R. Held, S. Nacht, M. Bouvet, and P. Luquet.

Freud stated in 1913 that 'psychoanalysis is founded upon the analysis of dreams'. One is struck to read today the very divergent attitudes of experienced analysts on the use of dreams. There are indeed few who consider dreams the 'royal road' to the unconscious, and more surprisingly there are those who consider it a very bad detour.

The middle-road approach may be summarized by quoting Dr. Benassy: 'If the therapeutic action is oriented in the direction of analysis of repression, the dream is of great value. However, if one works in the modern technical sense, and if one respects the principle of analyzing the defense—that is to say, the ego—before the tendency, then dreams have neither more nor less importance than the other aspects of comportment.'

The more extreme view is that Freud discovered psychoanalysis through his autoanalysis and therefore his own dreams were of particular importance for understanding his unconscious; that dreams are nothing but dreams and have not the value of live experience. Dr. Nacht states that 'in 1913 Freud could then say that psychoanalysis is founded on the analysis of dreams, but we would prefer to say today that psychoanalysis was formerly founded on the analysis of dreams'.

The Personal Equation or the Psychoanalytic Art. A. Berge. Pp. 449-478.

The question is not to what extent the personal equation may be eliminated but rather the value of seeking to eliminate it at all. Scientific technique accepts with difficulty the personal equation and the difficulty is increased if we place this equation within the domain of the art of psychoanalysis. Accepting the quality of art, we are then led to a discussion of style for the psychoanalyst as an artist. Dr. Berge warns of the two great dangers inherent in a technique that is both a science and an art: rigidity (science), too great personal freedom (art).

SIDNEY STEWART

Revista de Psicoanalisis. XVI, 1959.

Contents in Discoveries. Emilio Rodrigue. Pp. 101-121.

The author was primarily concerned with a pattern in the analysis of children, investigating those situations in which his patients discovered or invented something during the analytic sessions. He found a sequence of expression of hostility followed by the discovery and then a change in mood. The patient became anxious and depressed, and finally applied the new discovery in a restitutive form.

Character of the Object Relationships in a Phobic Patient. Rebecca Grinberg. Pp. 122-138.

The analytic study of a patient with claustrophobia and phobia of elevators led to underlying paranoid mechanisms. The patient experienced feelings of depersonalization and of estrangement, as well as dissociation of affects. Before the phobia was resolved, the schizoid mechanisms underlying it had to be resolved.

GABRIEL DE LA VEGA

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Meetings of the New York Psychoanalytic Society

Walter A. Stewart, Joshua M. Perman & Eugene Nininger

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NOTES

The next meeting of the AMERICAN PSYCHOANALYTIC ASSOCIATION will be held at the Biltmore Hotel, New York City, December 9th through December 11th, 1960.

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

November 24, 1959. THE CONCEPT 'PRECONSCIOUS' AND THE STRUCTURAL THEORY. Jacob A. Arlow, M.D. and Charles Brenner, M.D.

Freud replaced the topographical hypothesis with the structural theory in 1923. Since then there has been a tendency to use both concepts conjointly, although they have fundamental differences. In the topographic hypothesis, conflict was seen as existing between the unconscious (and therefore inaccessible instinctual forces) and the accessible conscious (counterinstinctual defensive forces). The major defense was repression; symptoms occurred with the threat of failure of repression, and therapy involved the abrogation of repression. In the structural hypothesis, conflict was viewed as occurring between derivatives of instinctual impulses and a group of psychic elements which have as their function adaptation to reality. The structural theory allowed for the fact that instinctual forces being defended against might nevertheless be accessible to consciousness. Therapy concerned itself not only with the recovery of amnestic material but also with working through, which permits the integration of the material into the ego, and with the analysis of superego pathology. Finally, the newer hypothesis corrected earlier errors concerning the origin of anxiety.

The authors suggest that the two hypotheses are incompatible and that the structural hypothesis is superior, accounting for all the facts explained by the topographical hypothesis, and others in addition. They feel that the attempt to use both theories results in confusion and ambiguity. Adherence to the structural theory, on the other hand, improves the clarity and quality of therapeutic efforts.

One important implication of the change from the topographical to the structural hypothesis is the replacement of the concepts primary and secondary processes by concepts of a developing ego able to delay discharge. The energies involved form a continuum from those which are extremely mobile to those which are firmly bound. Another consequence of the change from the topographical theory to the structural involves the meaning of the term preconscious.

The term preconscious designated important concepts in the topographic theory, but in its integration with the newer theory at times led to confusion. Under the topographic theory, the idea of a system preconscious was abandoned on clinical grounds when it became apparent that both counterinstinctual forces and the need for punishment could be accessible to consciousness only with difficulty or not at all. Yet these functions had been considered part of the system preconscious. Freud, in introducing his new theory in 1923, proposed that the system preconscious be replaced with the new concept ego, which 'takes its origins from system Cs . . . and includes the Pcs'. The word preconscious was kept, and

in fact had two somewhat different definitions. In the New Introductory Lectures (1932), it is stated that what is preconscious is unconscious in the sense of being latent, and is easily made conscious. In The Outline of Psychoanalysis (1939), preconscious is defined as thoughts which function according to the secondary process, are part of the ego and superego, but may be accessible to consciousness only with difficulty or not at all. Hence, preconscious can be defined in terms of accessibility to consciousness (1932) or it can be defined in terms of operating in accordance with secondary process (1939). What are the relative merits of the two definitions?

The 1939 definition neatly equates preconscious-unconscious with ego-id. The disadvantages are that the term is misleading etymologically, and does not accord with current usage. According to the authors, when we say 'interpret the preconscious' we mean what is on the surface, i.e., the 1932 definition. Most importantly, the 1939 definition requires maintaining the concepts of primary and secondary process. Kris in 1950 employed the term preconscious to mean thoughts in the ego, but following either primary or secondary processes, that is, invested with either bound or mobile energy. In contrast, the 1932 definition is considered by the authors to be simple and unambiguous, to conform with current usage, and to have greater clinical usefulness. Because of the contradictions inherent in the two definitions, it is suggested the term be discarded, and that more precise phrases be used to describe what is meant, i.e., readily accessible to consciousness, or accessible to consciousness even though strongly countercathected. However, one must still guard against two possible sources of confusion. First, preconscious is often but not always synonymous with 'not strongly countercathected' (as in cases where denial is the defense). Secondly, there are transient alterations in ease of accessibility to consciousness (as in dreams or other states of ego regression), so that what is unconscious may become temporarily preconscious.

A clinical example of a thirty-year-old woman is offered. After months of treatment, she became aware of anger toward her mother, but by the next hour she had resurrected her usual defenses and was again able to deny the anger. The idea of revenge was conscious, but projected, and by this means strongly countercathected. The defense, not the angry wish, required interpretation. Ease of accessibility to consciousness was not an adequate criterion for interpretation; rather the likelihood of assimilation into the healthy ego was the basis for the interpretation.

DISCUSSION: Dr. Heinz Hartmann agreed to the superiority of the structural hypothesis over the topographical, but said it is questionable that one outmodes all aspects of the other. The terms conscious, preconscious, and unconscious were abandoned as mental systems, but retained as descriptive concepts. Also both definitions of preconscious are found in the 1939 Outline, so one was not consistently superseded by the other. The concept that secondary process thinking (derivatives of the unconscious) can be inaccessible to consciousness was a problem Freud struggled with as early as 1915. The inaccuracy inherent in trying to equate unconscious with primary process was known prior to the introduction of the structural hypothesis. Freud suggested that, aside from censorship, these secondary process derivatives might be held in the unconscious by some attraction

to the unconscious. Should the 1939 definition require a clear demarcation between primary process and secondary process thinking, this would be a serious argument against it, since it is more accurate to think of a continuum between the two extremes.

Dr. Victor Rosen questioned whether the 1932 and 1939 definitions of preconscious were so mutually contradictory and exclusive. Since Freud did not retract one, as he did with his entire theory of anxiety, he may have felt they were supplementary. The 1939 reference is more a discussion than a definition, and implies that an unconscious derivative must first be assimilated into a form compatible with secondary process thinking before becoming preconscious. It might be strongly countercathected and not immediately accessible to consciousness until some rearrangement of forces occurred. Dr. Rosen also felt that in our present state of knowledge the 'additive ambiguity' which exists has value.

Dr. Martin Stein also questioned the thesis that the structural theory should replace the topographical for every purpose. Though limited in scope, the latter approaches dream phenomenology very profitably. In spite of contradictions and inconsistencies, the topographical scheme is still stimulating and fruitful of ideas, and can be considered a special hypothesis to be included in the structural concepts when possible.

Dr. Charles Fisher agreed with the authors that the 1939 definition is less desirable than the 1932 definition because it links preconscious processes too closely with secondary process thinking and is obscure about accessibility to consciousness. Subliminal experiments have shown that the ego functions of perception and memory can occur with primary process mechanisms at preconscious levels. He pointed out that the authors speak of consciousness as a unitary state. It is likely that there are varieties of states of consciousness involved when we perceive, imagine, recollect, produce hypnagogic images, or dream. The shift of accessibility from preconscious to conscious varies with the state of consciousness and different distributions of attention cathexis. Another energy concept, the relative mobility of cathexis, is used to replace the concept primary and secondary process. Misrepresentations of reality may depend on a lack of maturation of the ego rather than on changes in the mode of energy.

Dr. Ludwig Eidelberg agreed that the 1939 definition of preconscious, focusing as it does on the ego and superego, ignores the important question of accessibility to consciousness. A great part of the ego and superego, the repressing forces, becomes conscious only after resistance has been overcome, and therefore must be unconscious. Also, elements of the id may be conscious. Both ego and superego contain unconscious material. The term preconscious as a descriptive term belongs to the system conscious, implies latency, and is accessible to consciousness without overcoming resistance.

Dr. Bertram Lewin spoke of the term preconscious as serving to describe the storehouse of memory traces. It is eminently applicable to the study of dreams, because they are made of nothing but memories. In attempting to apply this memory system to the neuroses, changes in its definition were required. The paper has merit in bridging this gap.

Dr. Rudolph Loewenstein stated that if, instead of speaking of preconscious and conscious, we were to speak of integration in the ego, we would still need to

qualify this by asking, which ego? An essential proposition of the structural hypothesis is the concept of an unconscious ego. Therefore we are led back to the terms unconscious, preconscious, and conscious ego functions. Some preconscious ego functions, such as those involved in skilled actions, are better described as due to the withdrawal of cathexis rather than as due to countercathexis.

Dr. Arlow limited his comments to the problems and difficulties of concept formation; in the utilization of ideas to marshal data, ambiguity must be avoided. He summarized the principle of complementarity, but felt it did not have to be applied to psychoanalytic theory. The structural hypothesis accounts for all the phenomena explicable by the topographic theory and more besides. The structural hypothesis has the advantage that it classifies psychic elements according to their functional relationship, rather than according to their accessibility to consciousness. For example, it helps us to understand the unconscious need for punishment, the censorship function, and unconscious resistances. Compromise efforts to equate the system unconscious with id and the system preconscious with ego lead to conflict with clinical data. Clinical experience has shown primary process functioning and regression can occur in the system ego. In the topographic hypothesis these functions were related to the system unconscious alone.

Dr. Max Schur emphasized that a continuum exists between primary and secondary thought processes. In a like manner, the terms unconscious, preconscious, and conscious underline the existence of a continuum of accessibility to consciousness, expressed in economic or temporal terms.

Dr. David Rubinfine distinguished two facets of consciousness, one directed outward toward the environment, the other toward inner stimuli. In the clinical example presented, the inner stimulus was projected onto the outer world and was treated as a perception. The term preconscious describes the quality of being aware of inner stimuli, as compared to outer. This distinction, 'mine and not outside', is lost in regressions which follow the threatened failure of repression.

In his closing remarks, Dr. Brenner stressed the need to review the value of the term preconscious. It should not be retained because it is sacrosanct or was once useful. Is it the best way of talking about the facts of clinical material? Dr. Fisher's remarks relate to experimental studies, which are somewhat apart from phenomena examined by the psychoanalytic method. Psychoanalytic theory mainly tries to explain phenomena related to intrapsychic conflict. The main issue is the fact that the structural hypothesis is superior to the topographical hypothesis for the ordering of clinical material. In no case, including that of dreams, does the topographic theory seem advantageous.

WALTER A. STEWART

December 15, 1959. FOLLOW-UP STUDY OF A SATISFACTORY ANALYSIS. Arnold Z. Pfeffer, M.D.

Continuing his research on follow-up interviews, Pfeffer reports his findings in a study of one patient described as satisfactorily analyzed. Particular attention was devoted to transference residues in an attempt to compare them with those observed in the less satisfactorily analyzed patients. The treating analyst requested and obtained the participation of the patient. For purposes of this study, the original analyst was asked to answer a series of questions concerning the patient's

neurosis, course of the analysis, and the outcome. This information was not read by the follow-up analyst until after the next to the last interview. For the follow-up study, the patient was seen in five weekly interviews. The reasons for analysis, results, and subsequent history were reviewed with the patient. Flare-ups of transference, accompanied by a brief recurrence of symptoms, were observed. This provided objective validation of results, in contrast to the patient's own subjective evaluation. An organized discussion of these observations was then reviewed by the treating analyst, following which both analysts met to discuss the findings and evaluate the data.

The patient, a married woman with two children, thirty-one years of age at the start of her analysis, had complained of feelings of depersonalization, derealization, overwhelming anxiety, and depression. Agoraphobia and claustrophobia had been at times incapacitating. The initial diagnosis was schizophrenia; the later one, masochistic hysterical character with obsessive and compulsive features. Four main themes had been observed: rejection by the mother, rivalry with her sister, primal scene material, and the birth of a younger brother. Denial of primal scene observations and projection of her own inner excitement underlay her depersonalization. Her ego was split into an experiencing ego, vaguely participating in the exciting activity, and an observing ego, highly cathected, which was the bystander relatively uninvolved in the activity. This split served both to gratify and repudiate sexual and aggressive feelings. After one year of analysis, she resumed her creative writing. She had been unhappy in her marriage to a sadistic, narcissistic, schizoid husband, from whom she was divorced four months prior to the termination of seven years of analysis. The follow-up interviews occurred four years later; she had remarried four months after termination, was less frigid sexually, and quite content with her second husband. Her relationship with her children and her family was no longer grossly impaired by her hostility. She was less masochistic and her phobias and inhibitions had disappeared.

With reference to the transference phenomena that recurred during the follow-up interviews, it was noted that: 1. The patient perceived the follow-up study as identical with analysis, and exploited the transference resistances as a means of warding off regression and sexual fantasies. 2. Her associations to divorce from the first husband were in part determined by separation from the treating analyst at the time of termination of analysis. 3. Her dissatisfaction with an internist who treated her for an organic illness six months prior to the interviews and her insistence upon obtaining the services of another physician were related to the theme of divorce and remarriage; this, in turn, was associated with consulting a new analyst for the follow-up study. 4. Anxiety that appeared toward the end of the follow-up interviews was related to her uncertainty as to whether or not she could get along on her own at the time of termination of her analysis. Separation anxiety, accompanied by a wild flare-up of her neurotic symptoms, also appeared following termination of the follow-up interviews. This was considered to represent a residue of the analytic transference neurosis and was not a new off-shoot of the infantile neurosis.

The author discussed the effects of analysis on the quantitative balance of conflict between instinct and ego. Structural changes could be observed in the patient as a consequence of treatment. Especially noteworthy in evaluation of

results of treatment was the repetition, in the transference, of conflicts that were central in the patient's neurosis and which reappeared in an attenuated form during the follow-up interviews. By this procedure, Pfeffer concludes that it is possible to demonstrate what has been accomplished by analysis, to assess the presence and nature of residua, and to make a reasonable evaluation of results. The transference residua are particularly useful for purposes of evaluation.

DISCUSSION: Dr. Annie Reich commented on the observable readiness again to form a transference. Such transference willingness is observed in those who have suffered from severe neurosis; it remains as a residue of the deeply ingrained conflicts, and persists as a tendency toward pathologic object relationship, or fixations to infantile libidinal and aggressive aims. Perfect cures cannot be achieved. What we do achieve and demand in a successful analysis is a new capacity of the ego to deal with conflict situations. In subsequent analysis, these ego changes are observable.

Dr. Victor Rosen discussed the difficulties in the problem of validation. He agreed that focus on the transference was the logical approach. He questioned whether we can regard the patient's reaction to the interviewer as a transference neurosis, particularly since the frequency and length of contact that is implicit in the analytic procedure could not be duplicated in the follow-up interviews. He suggested that the transference phenomena observed might be the result of the analysis, noting that there is a greater readiness for such reactions once they have been mobilized in full force by analysis. Also there is greater readiness by analysts to observe these reactions.

Dr. Mortimer Ostow asked why the analysis could not have been assessed by the patient's analyst, thus avoiding the introduction of new unknowns. This, he believed, would have afforded more information regarding results and a better estimate of the patient's future.

Dr. Max Schur remarked that organic illnesses may cause a reactivation of neurotic symptoms. He wondered what the meaning of the study must have been for the patient, since it occurred in the midst of her concern about an organic illness. He questioned whether this had influenced the observable transference phenomena.

Dr. Rudolph Loewenstein observed that it is difficult to correlate an immediate transference reaction with the severity of a neurosis. A considerable inhibition may also be seen. One should therefore carefully qualify any statement about transference readiness being a criterion for evaluation of the results of treatment.

Dr. Pfeffer emphasized that the aim of the present study was to understand what he labels 'follow-up transference' so that its place as a means of evaluating analytic results could be established.

JOSHUA M. PERMAN

January 12, 1960. REMARKS ABOUT AN ORAL CHARACTER DISORDER WITH BLANK HALLUCINATIONS. Max M. Stern, M.D.

This paper is based on eleven cases either analyzed or observed under supervision by the author. The majority were manic-depressive characters, the hypo-

manic type predominating, and included cases of perversion, addiction, and fetishism. Most were males, often gifted artistically and intellectually, who seemingly showed a good relationship to their families. However, closer examination revealed a predominantly oral-sadistic character formation, with demanding, vengeful attitudes, temper tantrums, inability to give, paranoid trends, and hypochondriacal fears. Stern was led to consider these patients as an entity because of their similar blank hallucinations ('elemental hallucinations close to somatic perceptions occurring in a stereotyped way without appropriate external stimuli', and lacking content as to persons, objects, or events). These hallucinations, which usually occur during times of stress, rage, or anxiety, include not only the well-known Isakower phenomena and the blank dreams described by Lewin, but also phenomena during waking hours: sensations of swelling or shrinking of the body, changes in size and shape of a room, oncoming gray or milky clouds, electric currents flooding the body, gritty or doughy feelings in the mouth, ominous noises, darkening of a room or its flooding with a peculiar light, and vestibular disturbances like dizziness or rotating on a disc.

Instead of being wish fulfilments of early nursing experiences, as suggested by Isakower, Lewin, and Spitz, Stern postulates that such hallucinations are repetitions of severe early oral trauma. Their positive elements of bliss and elation are denials and negations of anxiety and terror. Some of their negative elements, such as parched throat and sandy, gritty feelings in the mouth, point directly to oral deprivation and occur as a repetitive effort at mastery of past experiences, and are sometimes linked with somatic accompaniments of pavor nocturnus which served during the œdipal period as indications of the struggle to master oral trauma. Stern's patients deliberately invoked or 'experimented' with the hallucinations in their efforts at mastery. Vestibular symptoms apparently reflected reaction to the incompletely developed vestibular apparatus during the period of early deprivation. Projection and introjection were extensively used as defenses; expansion of the room in one case was a projection of the sensation of a swollen mass in the mouth. In eight of the eleven cases, there was specific pathology caused by oral trauma.

Analysis presented special difficulties. Protective overcontrol of thought processes made free association difficult but if this defense was overcome, the hallucinations increased in frequency and part-components appeared. This led to a working-through of the original trauma under the protection of identification with the helpful, understanding analyst.

DISCUSSION: Dr. Bertram Lewin noted that the cases were a predominantly hypomanic group, demonstrated here for the first time in an appreciable series. The first reported case of blank hallucination (by Dr. C. F. Rycroft) proved, on inquiry, to have demonstrated a 'hypomanic defense'. Several of Lewin's own cases showed a transient subsequent hypomania. Dr. Isakower and he described phenomena relating not only to falling asleep and sleep itself, but to other states as well. Dr. Isakower had specifically mentioned febrile states. He believed it was correct to label some of the described responses as denials and negations, but was inclined to include these under the more inclusive formulation of elaboration,

equivalent to the secondary elaboration of the dream. This would point up the similarity between the waking and the dream blanknesses. He noted that Dr. Stern correctly emphasized the predominance of severe conflict in the etiology of many blank symptoms; some of his own cases showed that the appearance of blissful blank dreams did not derive from a happy nursing period. The affect was variable; a conflict was present in which first the anxiety and stress, then the happy, denying state, gets the upper hand.

Dr. Leo Spiegel thought the contradictory or opposite elements in the blank hallucinations were probably due not to denial but to the fundamental ambiguity of the oral ego, in which contradictory elements lie side by side. In two of his own cases (conversion hysteria and compulsion neurosis) he found the hypnagogic hallucinations to be regressive oral defenses rather than direct expressions of oral-level functioning. He thought, however, Dr. Stern's material demonstrated that the phenomena occur most frequently in truly oral characters.

Dr. William Niederland questioned whether blank hallucinations always originated in the oral period, and whether, therefore, they could be considered a clinical entity. He cited two cases in which meaningful linking of hypnagogic phenomena with early traumas led to good therapeutic results, but in which later traumas also had to be taken into account. In his experience, 'experimentation' related not only to mastery of early traumas but to recapture of early pleasures.

Dr. Jan Frank thought the assumption of early experiences as an explanation for the blank hallucinations resembled the adultomorphic projections of Melanie Klein. The patients seemed to him to be hysterics who produced pseudo hallucinations in order to please the analyst and elude solutions of their conflicts.

In conclusion, Dr. Stern stated: 1. The problem of how to differentiate between sleep and wakefulness remains. While Dr. Lewin pointed out the recognition of blank hallucinations outside of sleep, Dr. Spiegel saw them as hypnagogic phenomena. The author believes many of them to be waking phenomena. However, one of his patients, drifting in visual imagery, was clearly in a kind of sleep. Whereas Dr. Lewin considered the patient on the couch to be in a state of sleep, Stern believes the basic quality of the analytic situation is that of a wakeful ego that integrates the primary process. 2. Seeing the contradictions in the hallucinations as merely manifestations of the primary process ego and, therefore, as simply wish fulfilments, seems to neglect the conflict and ignore the underlying traumatic oral deprivation. 3. The impact of excessive oral deprivation is stressed by almost all observers who have studied these phenomena closely. There is firm clinical evidence that the oral trauma is no mere adultomorphic projection. 4. Blank hallucinations, in his opinion, are not direct translations of early oral experience, but are telescoped expressions of many secondary revisions along the way.

EUGENE NININGER

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

February 15, 1960. THE FACE-BREAST EQUATION. Renato Almansi, M.D.

The intent of this paper is to develop Spitz's concept that from a perceptual standpoint the Isakower phenomenon and Lewin's dream screen do not represent the breast but rather the visually perceived human face. This is consistent with Spitz's observation that the infant's gaze is constantly fixed on the mother's face. The first recognition is of the gestalt of the human face—later comes the identification of the mother's face. Dr. Almansi presents material demonstrating the fusion of the face and breast. This is related to early perceptual experience and early phases of ego development; the breast may screen the earlier perceptual gestalt of the face. Three cases were presented to bear out this hypothesis. Evidence for the breast-face equation was also found in literary, philosophical, and archeological references.

The face-breast identification is based on the eyes rather than on any other facial feature. There is a strong correlation between the nipples and the eyes. Almansi feels that his clinical and other material bears out Spitz's hypothesis that in deep regression the percept of the face may re-emerge from its condensation with the breast image which acts as the screen for the face. In the breast-face condensation it is the percept of the face which is the most repressed and strongly cathected.

The genetic background of the condensation is placed at about three months. When the child is deprived of the nipples, his eyes deviate from the mother's face in the general direction of the breasts, leading to a superimposition of the two percepts which then become fused. Spitz feels it is at this time that the aggressive drive comes to the fore as a consequence of the repeated frustration experienced at the breast. In all four cases the phenomena were bound to large amounts of oral aggression. All the cases were strongly scoptophilic, and the scoptophilia was linked with early visual sensitization due to feelings of oral deprivation and object loss.

DISCUSSION: Dr. Mark Kanzer pointed out that an equation of body parts with each other facilitated a genital displacement in these cases and what was seen was a manifestation of castration anxiety. He cautioned that an overemphasis of the preœdipal material should not be at the expense of delineating the œdipal features. He felt that it was not the breast that was repressed but the phallus. Dr. Kanzer noted that the repression of the phallus is similar to that seen in cases of fetishism. Dr. William Niederland agreed with Dr. Almansi's finding and contributed a similar case of his own. He suggested, however, that it was more a case of a face-breast fusion than equation. He also contributed further corroborative material from archeology and literature. Dr. Gustav Bychowski noted that in early schizophrenia he has observed a face drawn into the torso. Such disparate condensations are suggestive of a thought disorder and based on an early fusion of two percepts. Dr. Warner Muensterberger noted a similarity between the case material and Australian cave drawings in which the female figures represent a phallus and in which the eyes are painted in but the mouth is missing. The mouth is missing in the art of many cultures, with the eye taking

on an oral character. Dr. Nathaniel Ross made reference to an African myth of a giant mother to whose innumerable breasts vast numbers of infants cling—her eyes are fixed on each one and she is thus firmly attached to them. Dr. Ludwig Eidelberg felt that the material in Dr. Almansi's case should also be examined for the latent content. Was the breast-face equation a break-through or a defense? Dr. Eidelberg felt that breast envy precedes penis envy.

In answer to Dr. Kanzer, Dr. Almansi stated that his material was not just a variant of castration anxiety because the material dealt only with the breast. He also felt that the therapeutic results justified his dynamic formulations. He agreed with Dr. Kanzer that the breast could conceal the penis, but in the cases discussed it was the breast that was more strongly repressed, not the penis. However, he agreed that this did not obviate castration conflict. He asserted that a major goal of the paper was to show that archaic memory traces can be clinically recovered, as with the Isakower phenomenon. He agreed with Dr. Niederland that breast-face fusion would be more correct than breast-face equation. In answer to Dr. Bychowski, he did not feel that any of his patients were overt or latent schizophrenics. He agreed with Dr. Muensterberger that what was being dealt with were perceptual phenomena that became telescoped. In conclusion, Dr. Almansi concurred with all of Dr. Eidelberg's points.

JOSEPH T. COLTRERA

Dr. Francis Pasche, President of the *Société Psychanalytique de Paris,* has informed us that his colleague, DR. MAURICE BOUVET, a member of the *Société,* died on May 5, 1960. Dr. Bouvet was a regular contributor to the *Revue Française de Psychanalyse.*

The Midwinter Meeting of THE ACADEMY OF PSYCHOANALYSIS will be held on December 10 and 11, 1960, at the Hotel Biltmore, New York City. The subject of the first day's meeting is The Role of Values in the Psychoanalytic Process; papers will be presented by Drs. John R. Reid, A. H. Maslow, Janet MacKenzie Rioch, and Marianne H. Eckardt. On the second day papers will be presented by members of The Academy. Inquiries may be addressed to Dr. Joseph H. Merin, Secretary, 125 East 65th Street, New York 21, N. Y. Recently elected officers, for 1960-1961, are: Frances S. Arkin, M.D., President; Roy R. Grinker, M.D., President-Elect; John L. Schimel, M.D., Treasurer, and Joseph H. Merin, M.D., Secretary.

The AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION will hold its Annual Institute and Conference on January 25-28, 1961, at the Henry Hudson Hotel, New York City.

The DEPARTMENT OF PSYCHIATRY of the UNIVERSITY OF MONTREAL is organizing an international symposium on The Extrapyramidal System and Neuroleptics, to be held on November 17, 18 and 19, 1960 at the University. The symposium will permit an exchange of ideas among researchers interested in this subject from the point of view of anatomy, physiology, neurosurgery, and psychiatry. Participation will be by invitation only. For information, address Dr. Jean-Marc Bordeleau, Department of Psychiatry, University of Montreal, Montreal, Canada.

The Hanns Sachs Fund of Boston has granted two thousand dollars to the ASSOCIATION FOR PSYCHIATRIC TREATMENT OF OFFENDERS for psychoanalytic research on juvenile murderers.