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THE ROLE OF MOVEMENT PATTERNS IN DEVELOPMENT

I. RHYTHMS OF MOVEMENT

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Pleasure and unpleasure, therefore, cannot be referred to an increase or decrease of a quantity (which we describe as 'tension due to stimulus'), although they obviously have a great deal to do with that factor. It appears that they depend, not on this quantitative factor, but on some characteristic of it which we can only describe as a qualitative one. If we were able to say what this qualitative characteristic is, we should be much further advanced in psychology. Perhaps it is the rhythm, the temporal sequence of changes, rises and falls in the quantity of the stimulus. We do not know (21, p. 160*).*

THE CONTRIBUTIONS OF FREUD AND FERENCZI

The problem of excitation, tension, and discharge occurs often in Freud's writings (for instance, [*18, 19, 20, 22*]). Many of his theorizations about instinctual drives and instinctual energy are based not only on neurophysiological models but on direct observations of movement as well. Breuer and Freud's concept of 'tonic intracerebral excitation', operative in the waking state, seems to be derived from the clinically observable tonus of muscles at rest *(18)*. The closely allied concept of bound and free energy, which pervades Freud's later theories, may well have been influenced by observations of tonic and clonic movements familiar to neurologists. Observations of muscular tensions and relaxations during certain affective and ideational states may have been a further source of Freud's theory of energy.

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Ferenczi contrasted the expression of emotions in which explosion predominates with those in which inhibition prevails *(13)*. Some years later he described thinkers who inhibited their motility in order to think. These, he believed, contrasted with 'rapid thinkers who move around in order to retard the overwhelming onrush of their ideas' *(14)*. Ferenczi appeared to be in agreement with Freud when he wrote: 'The regular parallelism of motor innervations with the psychic acts of thinking and attention, their mutual conditioning, and frequently demonstrable quantitative reciprocity, speak at any rate for an essential similarity in these processes' *(14,* p. 231*)*.

Freud and Breuer used their clinical observations of individual predilections for certain motor patterns as an index of differences in the nervous systems of individuals. They wrote: 'We are familiar with the great individual variations which are found in this respect: the great differences between lively people and inert and lethargic ones, between those who "cannot sit still" and those who have an "innate gift for lounging on sofas", and between mentally agile minds and dull ones which can tolerate intellectual rests for an unlimited length of time. These differences which make up a man's natural temperament are certainly based on profound differences in his nervous system—on the degree to which the functionally quiescent cerebral elements liberate energy' *(18)*.

RECENT STUDIES OF MOTILITY

As analysts' interest shifted from the drives to the ego functions, they have laid aside the early theories based on neurophysiology and on observation of movements. Study of character formation has occupied psychoanalytic thought ever since, whereas research on temperament, as expressed in both motor patterns and styles of thinking, has become almost obsolete. Yet the concept of discharge of psychic energy has remained important.

Papers concerned with rhythmic and nonrhythmic patterns of motor discharge have been few. Kris *(33)*, in a study on

laughter, said that 'in states of sensuous excitement everything presses forward with a different rhythm'. He quoted Glover's statement that the motor apparatus functions in many ways reminiscent of infantile motility *(26)*. Since the id 'has no expressive behavior', Kris postulated that only ego controls can alter primitive forms of rhythmicity into mimetic expressiveness. When the ego is overwhelmed by instinctual forces, a breakthrough of rhythmicity becomes evident in the shaking of laughter, in uncontrollable crying and sobbing. This type of rhythm, Kris pointed out, differs from rhythmic motility controlled by the ego. Perhaps we may restate the opinion of Kris as follows: the primitive rhythm of affective discharge as it is modified by the ego becomes a vehicle for nonverbal communication.

Kris' attempt to delineate the regulatory influence of the ego upon the primitive rhythmic discharge in laughter remained a unique contribution to the study of hierarchy of functions and change of functions (Hartmann [*28*]) until Erikson classified successive modes of ego organization, derived from drive discharge patterns *(10, 11)*. In 1952, Jacobson *(29)* examined the pace of psychic discharge processes and subsequently Greenacre *(27)* distinguished two types of rhythm in infantile motility. Piaget examined one aspect of the rhythmic quality of neonatal movements *(40)*. He pointed out that the early rhythms, such as the alternating opening and closing of the mouth, observable in the neonate, are given up in favor of a 'regulation' which controls later more complex behavior. Unfortunately Piaget did not pursue the study of motor rhythms and regulations of motility.

Although both academic and psychoanalytic developmental psychology are based in good part on observation of motor behavior, no systematic study of rhythms of motor discharge has been attempted. Deutsch *(6, 7, 8, 9)* analyzed posture and movement chiefly as they relate to the understanding of the subject's hidden thoughts. Fries *(23, 24, 25)* was the first analyst who tried to relate early motor behavior with later psychic mani-

festations. Her classification of temperaments as 'active', 'moderately active', and 'quiet', however, did not take into account the individuality of the motor rhythm. She did convey the impression that characteristic, though not well-defined, motor patterns are detectable in early infancy. Many subsequent studies have shown that one of the most important differences between early and later behavior is in motility *(1, 5, 12, 16, 17, 38, 39, 40, 42, 43, 44)*. But the lack of classification of infantile and adult qualities of movement made it difficult to compare early and later forms of motor behavior. Motor development has been primarily appraised by tests of specific achievements such as grasping or sitting, rather than of qualities or sequences of movement.

CLASSIFICATION OF MOVEMENT

About ten years ago I initiated a pilot study for the classification of movement. Three infants were observed and tested in the nursery and later at home.[1] General behavioral data were recorded with the aim of correlating them with corresponding movement patterns. Early recordings of movements were descriptive. Later recordings consisted of freehand tracings of the rise and fall of the flow of movements. Eventually the movement assessment method, as originated by Laban and developed by Lamb, was used *(2, 3, 34, 35, 36)*. While Laban's test was geared to the study of adaptive motility, the tracing of the rise and fall of flow was useful for the study of motor rhythms.

Rhythm notation consists of the recorder's freehand drawing of the increase and decrease of muscle tension during movement. It is based on the observer's kinesthetic mirroring identification with the observed subject. The tracing must be done

[1] Dr. Jacqueline Friend observed and tested the children regularly from the ages of three to twelve months; Dr. Stephanie Librach took over this task for several months of their second year. Dr. Sibylle Escalona tested them at fourteen months and Dr. Florence Halpern did so just before and during late latency. Irma Bartenieff recorded their movements several times in the years of latency. I am indebted to these investigators for their observations and evaluations.

with free-floating attention while at the same time one has to judge the rate of increase of tension, the degree of the intensity reached, and the frequency of fluctuations of tension during a given sequence of movement. One must note whether the tension of agonistic and antagonistic muscles is such that the movement appears inhibited or the relaxation of the antagonists has led to free motor discharge *(32)*. The attitude of free-floating attention is tempered by these considerations as well as by the recorder's awareness of her own preferences for certain rhythms which tend to distort kinesthetic perception and reproduction of another person's movements. (Note the similarity to countertransference.)

In the beginning of the study, it was possible to observe motor rhythms in gratification, frustration, random movements, and play. After the first year the data on gratification and frustration rhythms were not readily available. But the increasing availability of verbally communicated psychic content made it possible to study the correlation between ideation and rhythms of motor discharge.

The following two reports focus on the description and interpretation of motor rhythms. The preliminary report, which covers the time of the neonatal period to nine months, was originally written in collaboration with Dr. Jacqueline Friend and was presented at the Arden House Conference in 1954 (see Anna Freud's discussion [*15*]). In this preliminary report an attempt was made to correlate the behavior of infants and their mothers with changes in the infants' patterns of movement. Intuitive predictions formulated at that time will be re-examined later in this paper where the follow-up study, covering data accumulated during almost ten years of periodic observation and testing, is discussed.

PRELIMINARY REPORT OF THREE INFANTS

Rhythms of infantile movement seem to be determined by a congenital pattern. Preferences for certain rhythms may per-

sist into adulthood even though movement becomes more complex as the nervous system matures. As the child grows up, fantasies provide content, add purpose so to speak to forms of excitation and discharge congenitally determined.

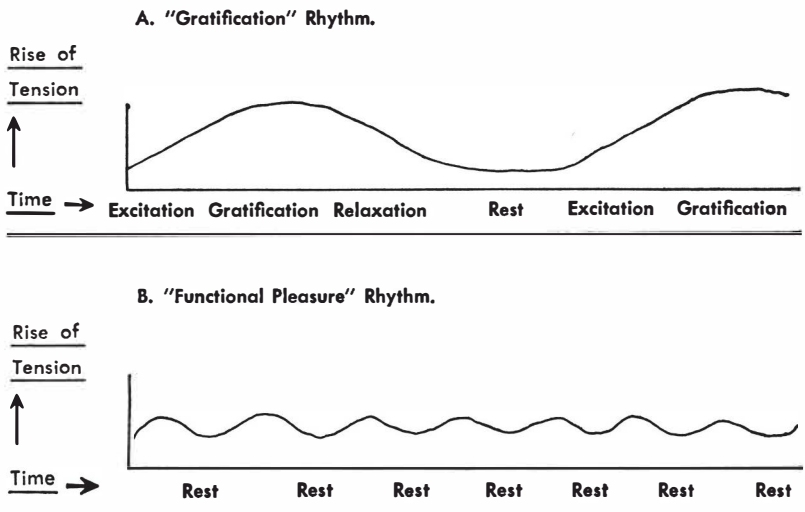
The infant is likely to respond to stimuli from the outside world as he does to stimuli from within. Sequences of excitation, gratification, and relaxation, which are dictated by inner needs, may be inappropriate for successful adaptation to the environment. If such 'undesirable' patterns are encouraged they may become fixed, indelible foundations of personality traits. But premature consistent interference with congenitally preferred motor patterns may retard development or enhance the early formation of rigid defenses. In either case we observe the beginnings of later pathology in the first year of life. Fortunately the early disturbances are often overcome, not only because young children respond quickly to better handling, but also because even if the environment does not improve, the infant is often able to recover by use of his own resources. Especially in the latter part of the first year the child becomes increasingly able to learn from his own experiences, achieving relative independence from the adults in charge of him. He is often successful in finding his own solutions, which may represent only slight modifications of the original pattern yet do not bring him into conflict with the demands of the environment. Children unable to recover may join the ranks of the many so-called borderline adults whose dealing with reality is forever precarious. Sometimes after analyzing and working through innumerable layers of the fantasies of such adults, we are still confronted with the same repetitive 'undesirable pattern'—a form without content.

'Form without content' is more simply explained by the Polish psychologist, Janusz Korczak. Whether they are Franks or Shmuls, he wrote, children fall into three distinct categories when presented with a dish of potatoes and scrambled eggs. The first type eats the scrambled eggs first and is left with the dreary potatoes for the end; the second type eats the potatoes

first, keeping the scrambled eggs to the last possible moment; and the third wisely mixes the potatoes and scrambled eggs, thus enjoying both throughout the meal.

The three children we observed seem to fit Korczak's classification of types. Each of the children had a decided preference for certain forms of motor discharge which could be noted not only in such excitation-gratification-relaxation cycles as occur before, during, and after nursing but also in random activity, play, and early achievement. Greenacre *(27)* has contrasted rhythms of gratification with those of 'lolling' movements in infants. A similar but not identical subdivision will be used in this report; namely, 'gratification' rhythms and 'functional pleasure' rhythms *(30, 31)*. In our three subjects these rhythms were intrinsically related to each other. The motor patterns during activities giving functional pleasure appeared to be miniature duplications of the more intense rhythmic discharge during periods of excitation, gratification, and relaxation (see Illustration 1).

Illustration 1. A. "Gratification" rhythm.
B. "Functional Pleasure" Rhythm.



I

Glenda resembled Korczak's first type, who ate the scrambled eggs first and then the potatoes. From the start she drank her milk for a short time only; her initial interest quickly waning, she would fall asleep and cease to suck. Her mother was able to feed her frequently, but briefly. When the time came to spoon-feed her, she was presented with spoonfuls in rapid succession so that feeding time was still a brief affair. Glenda showed extreme agility from birth. In the hospital she would propel herself to the very end of her bassinet. She did this lying on her back, a feat that provoked admiration not only from the nurses but also from people visiting other babies. She propelled herself by successive cycles of leg motions and rest periods. When, after several alternations of motion and rest, she arrived at the head of the bassinet and could move no farther, she would cry.

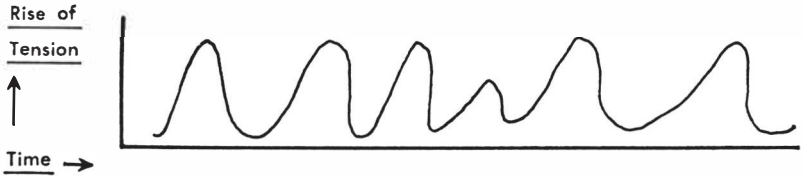
Soon after Glenda went home, her mother recognized the infant's need to move in the crib and ceased covering her tightly. As a result of this understanding between mother and child, Glenda was able to develop freely and became extraordinarily resourceful when left to her own devices. When she was nine months old, she fell while trying to climb a rocking chair; the chair fell on her and imprisoned her underneath. She gave the observer a look as if to say 'help me', but when no help was given, with some effort she turned face down, lifting the chair as she did so. After a satisfied moment of rest, and giving the observer another brief look, she attempted to sit down which partially freed her foot. Again she rested, playing with the chair and examining a toy which had fallen from it. Then she turned her attention to her still imprisoned foot, and with a sudden movement freed this foot too.

Although at first it had seemed that Glenda was a child who gave up quickly, it was clear later that she did not give up for good, but merely needed frequent periods of relaxation between spurts of activity. Her mother started prohibitions early

and these soon became quite effective during certain phases of her cycles of excitation and relaxation. She adopted the moments of prohibited activity as her rest periods, experiencing them, it seemed, as pleasant interruptions (or, better, as interpolations) quite in keeping with one phase of her preferred rhythm. When the prohibitions were not given at the start of an activity, they did not seem to represent interferences or interruptions. At nine months, for example, Glenda was creeping to the bathroom. When she came close to it, her mother told her not to go there. She immediately stopped creeping, sat down, and looked at her mother pleasantly. After a short interval, she proceeded to creep in the forbidden direction again. But an admonition that coincided with the onset of her creeping had no effect.

Two changes in rhythm which later became noticeable did not seem to be related to maternal interventions. Glenda's periods of rest became even shorter than before, perhaps because of an increase in motor impulses. On the other hand, Glenda became cautious at times. Instead of suddenly plopping down from standing, she now released her hold on the supporting object, such as a chair, more gradually. Through her own experience of climbing and falling she may have learned that sudden drops in muscle tension are followed by displeasure. Glenda's preferred motor rhythms can be represented graphically.

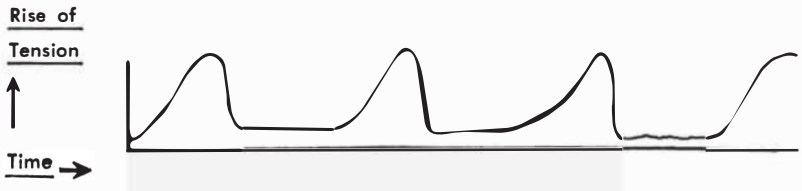
Illustration 2. Glenda's preferred rhythm



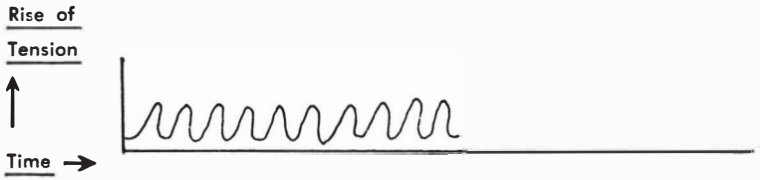
To be more precise the observed rhythms would be subdivided as follows:

Illustration 3. Subdivision of Glenda's rhythms at nine months.

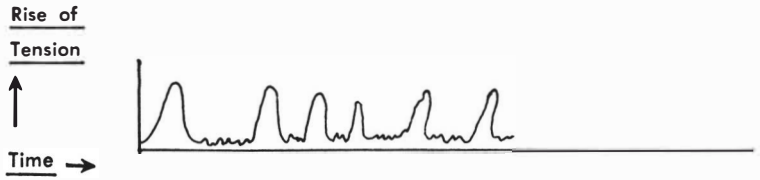
A. "Gratification" Rhythm.



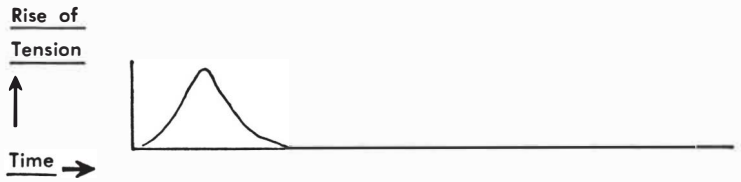
B. "Functional Pleasure" Rhythm.



C. Small Movements During "Rest" Periods, not reported in the above description (see Follow-up Report). It is not clear from the record when they began.



D. More Gradual Release of Tension, observed at nine months.



Glenda was a well baby, relatively free of conflict even though she preferred a pattern of motor discharge that began abruptly and ceased prematurely, not permitting prolonged uninterrupted activity. Despite a serious sickness at the age of five months, which led to hospitalization for several days and separation from her mother, Glenda steadily progressed in her development and was a happy, contented, normal child.

The other two infants showed behavior destined to become pathological.

II

Nancy roughly resembled Korczak's second type: she might keep her scrambled eggs until the last minute. She was quite hungry in the hospital and her formula had to be increased several times in her first few days of life. Long before feeding time she would cry, move about, and only briefly find some satisfaction. When nursing from the bottle she did not appear avid, but showed signs of great enjoyment. Soon after feeding, however, she seemed dissatisfied. She acted as if satiation was never possible.

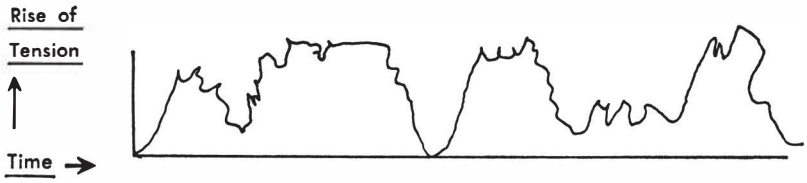
Her movements gave the impression of an irregular staccato rhythm. Even in what seemed to be peace, there was an irregular increase of tonus.[2] Her period of excitement was long and her relaxation short. She cried soon after her feeding. When put on her belly, she made irregular locomotor strides and would end up at the head of the bassinet, rooting with her mouth like a puppy in search of food. For this type of locomotion her good tonus served her well. In contrast to Glenda who moved like a dancer, Nancy jerked, pushed, and went on and on relentlessly.

[2]Tonus is used for lack of a better term; it pertains by definition to the state of muscle tension at rest. A better term might be 'bound flow' which adequately describes Nancy's main characteristic. The concepts of bound and free flow will be introduced in a subsequent paper *(32)*.

She seemed to be in a perpetual cramp except when deeply asleep for a brief period shortly after feeding. In a frantic way she would maneuver her head and arms until she sometimes got her hand into her mouth; occasionally she would hold one hand with the other in order to accomplish this. Complete relaxation would then ensue just as after feeding, but soon her hand would fall out and the struggle would begin again; she would stiffen, cry, and appear to 'seek' with head, mouth, and hands.

Nancy's curve of excitation, gratification, and relaxation might be drawn as follows:

Illustration 4. Nancy's "rhythmicity".



Nancy's mother responded to her urgent need by appeasing her quickly, not allowing her to cry. But no sooner did the child get home from the nursery than feedings by her mother ceased. Her bottle was propped on a pillow and the baby was left to fend for herself. When she lost the nipple, she sometimes retrieved it but at other times could not. Whether by natural inclination or because of the frustration caused by losing the nipple, Nancy would fall asleep holding the nipple in her mouth. When grasping developed the mother handed her two spoons; Nancy would hold a spoon in each hand for most of the day and sometimes even during the night.

The prop-feeding prevented Nancy's moving around much. Lying on her back all the time, she soon started to raise her head and maintain this position for long periods. She was slow

to sit without support because she attempted to sit stiffly, raising her head and trunk; this exposed her to the danger of losing her balance and falling backward like a board. She was unable to creep in a normal fashion, probably because she had hardly any practice in the prone position. When at eight months she finally jerked herself around onto her buttocks and propelled herself grotesquely on one thigh, her mother was amused.

Nancy's mother discouraged her moving about but urged her to rock rather violently, in a way reminiscent of the forceful pushing forward in her earliest months.[3] Although she cried easily and could be consoled only by being picked up by a member of the family, her mother considered her a peaceful, untroubled child. Nancy's facial expression, however, seemed tense, anxious, and sad. Her motor retardation, peculiar locomotion, and inability to play with objects did not worry the family.

The mother's frequent prohibitions and commands, such as 'stop crying', 'rock, Nancy, rock', or 'stop rocking', were absorbed in the numerous tension states of the child's sequence of excitation and relaxation. These prohibitions and commands became rigidly enforced and fixed. The degree of Nancy's obedience was demonstrated, for example, when her mother forbade her to interfere with the eating utensils during feeding. Soon thereafter Nancy, aged eight months, was being fed her favorite custard, in each hand holding a spoon while her mother fed her with a third spoon. When, at the observer's suggestion, her mother removed the two spoons from Nancy's hands and the observer offered her the feeding spoon, she would not reach for it. Her arm and face stiffened. She withdrew her arm from the spoon when it was brought nearer to her hand, apparently not only unable to accept it but also actively avoiding it.

At nine months there was a change in Nancy's behavior. She still looked stiff and tense but she now was able to release ob-

[3] In retrospect we must note that neither rocking nor pushing were done with force but rather by an alternation of explosiveness and inhibition which gave the observer an impression of forceful violence.

jects. After her return home from the hospital soon after birth, her stiffness and tension had increased considerably so that her newfound ability to relax and release was the more striking. She seemed so fascinated by this experience of release that she even used it while eating. She would drop her lower jaw and let food spill out of her mouth, despite her obvious enjoyment of it. There was however a peculiar quality to her movements of release. They were almost casual, slow, and meek, giving the impression of involuntary movements in absentmindedness.[4]

Nancy's environment steadily supported her tendency to hold on tensely. Unless her ability to relax, which she developed at nine months, could free her from the pervasive tonic pattern, her subsequent development could be expected to be further hampered by lack of practice and her personality to suffer from an unusual rigidity of ego and superego.

III

From the start Charlie impressed one as likely to be the type who mixes potatoes with scrambled eggs (Korczak's third example). Particularly noticeable were the intensity and persistence with which he responded and his unusual ability to absorb and enjoy experiences ordinarily felt as unpleasant, frustrating interruptions. The impression of persistence and intensity was created by a smooth, gradual increase of excitement that would not deviate from its course despite disturbing stimuli and would rise to a high plateau.

During nursing Charlie made sounds of delight of an orgastic quality. He would persevere in drinking unusually steadily

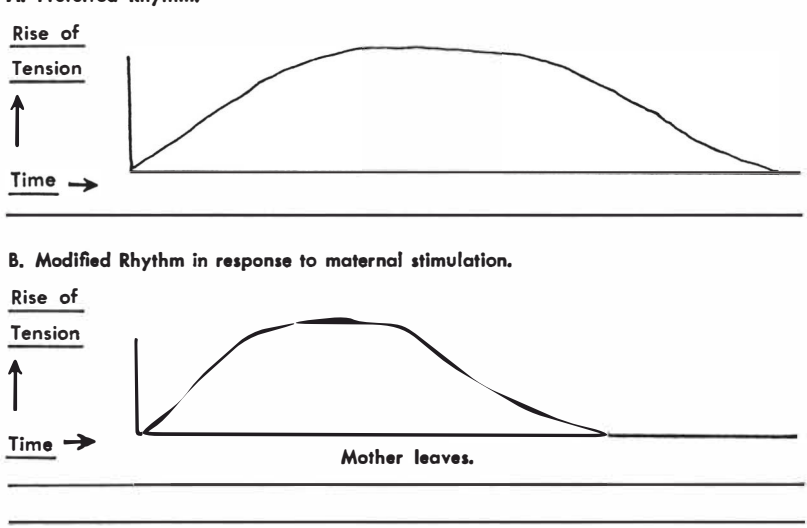
[4] Even as a neonate Nancy could pass from stiffness to limpness. Glenda at nine months had learned to inhibit her preferred explosive discharge while Nancy at the same age was going from the extreme of cramping, not to controlled release but to limpness, which only accidentally produced release. Thus Nancy did not really acquire control; she merely relinquished inhibition.

for prolonged periods, all the while watching the constant coming and going of his family and neighbors. If he stopped drinking for a moment, he did so only because he needed to 'burp'. It took some time to release the bubble; this prompted his mother to call him stubborn. Charlie ordinarily gave the impression of great composure, even in frustration, but once he reached the limit of his endurance he became inconsolable. He would cry steadily and uninterruptedly with the same intensity and endurance seen when he experienced gratification.

Whether Charlie nursed happily, cried in frustration, played, or practiced early motor skills such as grasping, his excitement would rise gradually and steadily. He seemed placid. There was nothing abrupt or explosive about him, but his excitement would rise more quickly and was subject to more fluctuations when he was stimulated by his mother. When his mother tried to get him to 'talk' to her, she would nod and vocalize in a rhythm characterized by abruptness and by frequent changes in intensity. Charlie responded with a quicker arousal than was usual for him. His motility seemed to mirror his mother's fluctuating pace. When only a few weeks old, he 'talked' back to his mother with great excitement. His face would get red, his trunk and neck would strain forward toward her as he vocalized in response to her voice and movement. His excitement would not cease when the stimulation stopped. When she did not return to his side he became frustrated much quicker than was usual for him.

The change in rhythm of motor discharge which Charlie displayed in response to his mother may have been due to his natural tendency to arouse more quickly in response to the type of rhythm with which she stimulated him. It may have been even then an adaptation of rate of arousal to better mirror his mother's excitation pattern. His usual rhythm of motor discharge and the modification of it in response to his mother's stimulation are illustrated as follows.

Illustration 5. Charlie's rhythms. A. Preferred Rhythm.
B. Modified rhythm in response to maternal stimulation.



Charlie sat up early and was skilful in reaching for toys. He was used to being fed or bathed in a very busy, noisy kitchen where he also sat in a low chair and played. Occasionally he would stare ahead with 'glassy' eyes in a manner that suggested that he was then oblivious to his surroundings. By the time he reached six months, Charlie, who had been able to absorb a variety of stimuli and could enjoy many experiences simultaneously, began to show signs of shock and withdrawal. He refused to reach for toys and protested when he was taken into the kitchen. He preferred to be left alone in the crib where he played peacefully with his hands and feet, for which he reached quite well. He drank his milk less happily than before. By the time he was seven months old, he refused solids, especially while teething. Even at nine months when there was beginning evidence of recovery, his mother found it impossible to feed him solids except when he was ready to accept them. No coax-

ing and no distraction helped. This 'negative' period taught the family a lesson: no one can force Charlie.

Yet it would be incorrect to say that Charlie was negative and withdrawn during the few months he refused to mingle with others and preferred to be by himself in his crib. When one approached him there in a friendly way, he still smiled broadly and talked his baby language. If one did not insist that he reach for toys while sitting, he could be coaxed to do so after a while. But he would choose the toy he liked and play with it when he felt like doing so, and not when it was offered to him. The observer was able to feed him solids at the time he refused them from his mother. He would not take the spoon when it was brought to his lips but he would move his mouth toward it if it was patiently held in front of him. Feeding him at his own time and speed took a tremendous amount of time, which his busy mother could not possibly give him. Treated in ways acceptable to him, Charlie responded well; he withdrew only when approached in a different manner.

What went wrong? Why did Charlie give up activity he had started to enjoy? We can only guess. There are probably several cumulative reasons for his regression. His enjoyment of oral gratification was spoiled by the introduction of solids, which was preceded by an earlier habit of propping the bottle for him rather than holding him. The solids may have been distasteful because of the impatient, quick way his mother fed him. This very intelligent, alert mother had neither time nor patience to feed in her arms a child who took over half an hour for most feedings. The quick succession of spoonfuls presented to him was more than he could endure. He could absorb interruptions but he could not accept hurrying. He protested against solids after a while by moving his head away and spitting. He refused toys because of the chaotic way they were given to him. Several toys were pushed at him at once, and quickly taken away before he had a chance to decide which one to take. Almost all toys were too large for his grip. To top it all, Charlie began to suffer intensely from teething and no relief was offered for his aching

gums. Putting his hands in his mouth was discouraged early and he did not seem to find his way back to it. Yet in other respects his mother could fulfil his needs very well. She would stimulate him vocally by an excited sing-song way of talking. The fact that he reacted to her intensely, rising to a high and persistent peak, was a source of great pleasure for her. His good relation to his mother did not really change during the period of self-imposed solitude. He gave up performing except at his own rhythm and still did not lose his broad, friendly smile when approached in the right way. He seemed to develop a successful method of passive resistance against interference with his own mode of life. Furthermore, he needed peace to cope with the pain in his gums. By nine months he already had six teeth and another one coming. It is possible that the experience of repeated relief from pain after each eruption of a tooth contributed greatly to his newfound ability at nine months to assert himself without having to resort to withdrawal and regression. He now wanted to sit with others and cried when someone took a toy away from him. He still refused solids most of the time. He evolved a 'no' gesture which he used well, although not always appropriately. He began to fight for his own rights which his active family had to respect.

Charlie's curve of excitation-gratification-relaxation did not change in the period of withdrawal. He merely refused gratification that did not conform to his pattern. His placidity and relaxation remained essentially the same. His old tenacity was used successfully in his insistence on withdrawal. After the period of withdrawal was over, his ability to absorb and enjoy several stimuli at once was not lost. He became, however, very selective in what he enjoyed, but continued his interest in various activities that required synthesis and organization. He became an excellent imitator and a good learner. He played pat-a-cake very easily, but only if his mother kept a certain rhythm in reciting the jingle to him. He refused to fall asleep unless his mother sang a special pat-a-cake tune at his bedtime.

Despite all the efforts of those about him to bend Charlie's

rhythm to fit theirs, he seemed to remain basically unchanged in temperament. The tenacity and rigidity with which he held onto his innate rhythm led to early conflicts. For a while it seemed that withdrawal and restriction of his ego would result, but instead he came out of these conflicts with his environment with signs of an ego development ahead of that of Glenda, the healthy child.

As we completed our nine-month observation of Glenda, Nancy, and Charlie, we made predictions—or perhaps we should say, asked ourselves questions—about the future development of the three children.

'Were it not for a number of complicating factors, omitted here for the sake of clarity, we might be able to predict the ideational content to which these early patterns may lend themselves in the future. Will Glenda develop a strong penis envy which will be quite difficult to resolve because she will only give it up for short periods to resume her fight for it again and again? Will Nancy hold on to what seemed to her an all-giving mother with iron clutches and develop an everlasting hatred for her because of the frustration this mother is bound to inflict upon her? Will Charlie hold on to his masculinity with determination and strength throughout periods of passive withdrawal? Will Glenda be inclined to incorporate and project in quick succession and Nancy tend to incorporate persistently? Will Charlie be able to relinquish his œdipal attachment to his mother quickly to transfer it to someone more suitable to him in temperament? Will he merely withdraw without much hard feeling or will he progressively turn to his more placid father, creating a united front with him against the rest of the family? Maybe we shall find out; maybe not.'

ANALYSIS OF PREDICTIONS MADE IN THE PRELIMINARY REPORT

The questions asked concerning the future of the three children can be classified as intuitive predictions *(4)*. They differ in fo-

cus: some refer to drive specific wishes, others to defense mechanisms, and still others to object relationships. The clearest prediction concerned the children's temperament. Glenda was expected to become a person who habitually alternates between initiative and giving up. Nancy was expected to become rigid and clutching. Charlie was expected to become a placid individual who would be capable of holding on with strength and determination. These predictions were based on the assumption that the children's preferred motor rhythms would be discernible in their future activities.

By implication, the children's preferred motor rhythms were correlated with specific zonal modes of drive discharge. The prediction of penis envy and of incorporation and projection implied that Glenda's dominant motor rhythms were appropriate for phallic and oral forms of discharge. The emphasis on clutching and on persistent incorporation suggested that Nancy's habitual motor rhythms were representative of oral-sadistic trends. The possibility that Charlie would hold on to his masculinity with determination throughout periods of passive withdrawal indicated the proneness to conflict which was predicted for him. Charlie's favored motor rhythm apparently suggested a propensity for anality but his response to his mother's stimulation was taken as an indicator that phallic trends would vie with the dominant anal drive organization.

The behavior of the children from infancy through latency was used to test the validity of the following intuitive predictions which were suggested in various ways in the preliminary report. The congenitally preferred rhythms of motor discharge would be discernible in whole or in part, with or without modification, in the children's motility and actions. The preferred motor rhythms of early infancy would be modified by maturation as well as by interaction with maternal motor patterns. Features of the preferred rhythms of discharge which were enhanced by the environment would not only become discernible in the children's temperament, but would decidedly influence

their character formation, normal or deviant. Clashes between the child's and the mother's preferred rhythms of motor discharge would lead to specific conflicts and corresponding pathology. The preferred rhythms of motor discharge would prove to be representative of specific forms of drive discharge: phallic and oral in Glenda, oral-sadistic in Nancy, and anal in Charlie.

These predilections would lead to the following personality traits:

Glenda's propensity for sequences of phallic and oral discharge forms would lead to: 1, strong penis envy; 2, a temperament in which giving up for a very short time would alternate with reinitiating activities; 3, quick alternation between incorporation and projection.

Nancy's 'oral-sadistic' rhythm of discharge, if those about her continued to encourage tonic holding, would lead to: 1, unusual rigidity (perhaps of ego and superego); 2, ambivalent clutching and a hateful relationship to her mother.

Charlie's innate rhythms (gradual steady increase of tension to great intensities, maintained on a plateau and followed by a gradual descent), possibly suggestive of an anal form of discharge, together with his early ability to respond increasingly promptly to his mother, would lead to: 1, a temperament characterized by placidity, determination, and strength, unhampered by periods of withdrawal; 2, proneness to conflict and premature ego development; 3, a quick giving up of his œdipal attachment to his mother and a turning toward his father.[5]

FOLLOW-UP REPORT OF THE THREE CHILDREN

Glenda, even in the neonatal period, displayed a tendency toward sudden rises to high tension, and sudden abatement of it.

[5] It is interesting to note Dr. Escalona's remarks to the children when they were fourteen months old. To Glenda she said that she need not do the suggested task right away, she might come back to it later. To Charlie, she said encouragingly that he could do what was asked of him in his own way. Nancy, who could not relinquish test objects, was told that she could let go of the test items so that she might turn to a new thing offered to her.

After a short 'rest' she would abruptly resume her activity. (See Illustrations 2 and 3.) Glenda has continued to favor this rhythm of motor discharge over others. It is very likely that this particular rhythm is expressive of phallic discharge modus. Whenever Glenda's interest betrays an intense phallic preoccupation, her originally preferred rhythm of motor discharge becomes more intensified than is usually the case.

Before Glenda was one year old, her 'rest periods' were frequently occupied by a motor activity which consisted of sharp reversals between small amounts of inhibited and free discharge of tension (see Illustration 3). Because of the deficiency in the early recording, it is not clear when this type of rhythm began to be noticeable. It may well have started in the beginning of the oral-sadistic phase. When Glenda's brother was born, she was four years old; she became preoccupied with fantasies of biting and fears of being bitten and eaten. At that time the rhythm of her 'rest periods' could be seen to accompany her oral-sadistic strivings. A 'biting and chewing'-like rhythm was now clearly recognizable. It permeated most of her movement at that time and even overshadowed her usual phallic thrusts. Even though the oral tensions decreased in time, they left a permanent trace in Glenda's facial expression. Her perioral muscles became tense and her hitherto charming smile became forced.

As expected, Glenda has become tomboyish. Her behavior and her communications betray a strong phallic interest. This trend has been supported by her particular family constellation. But maturation and training widened Glenda's repertoire of rhythms. In the anal phase of development she learned to inhibit the free flow of her movement and she began to use a more gradual rise and fall of tension when necessary. Her mother had been able to tolerate the rapid rise and fall of tension in early infancy, but problems of bowel training intensified her own propensity for a more steady and more gradual mode of functioning. Glenda's mother was always able to maintain

her excitement longer than her daughter. She was worried by Glenda's lack of enthusiasm for the pottie and pressed her to remain seated on it for a longer time than Glenda's inclination allowed for. A similar conflict arose later when Glenda found it difficult to sit still while doing her school work.

In the phallic phase, Glenda's preferred rhythm of motor discharge reigned supreme. Her mother took pride in her motor feats but expressed her conflict by both admiring and scolding Glenda for being on the go all the time and playing like a boy. At the same time she encouraged femininity by showering Glenda with dolls. Once when Glenda excitedly told a story which revealed sex play with a male playmate, her prevailing motor rhythm exhibited a wavy quality, which may have been vaginal in nature.

Pressed by her own needs, by her mother, and by the exigencies of reality, Glenda has evolved two distinctly different ways of behaving. One, when engaged in work, she seems tense, awkward, and unhappy; the movements of her writing, her drawing, and of other activities involving small muscle coördination, retain an oral-sadistic type of rhythm. Two, as soon as the arduous task is over, and even more evident when she can escape her mother's watchful eyes, she reverts to sudden eruptions of high tension; she jumps up like a jack-in-the-box and joyfully pursues her originally preferred phallic rhythmicity. Her purposeful, adaptive movements in gross motor activity have become skilful and she exhibits qualities of movement that attest her talent for motor feats. She does not mind sedentary activities as long as they do not last too long. What makes her unhappy is that she is not allowed to jump up periodically while she studies. She seems to fall in the category of Ferenczi's motor types *(14)*. Because her rest or work periods have been artificially extended beyond her endurance, Glenda does not function intellectually up to her capacity.

Even in the newborn nursery, Nancy evidenced a dysrhythmia difficult to classify but clearly suggestive of deviant devel-

opment. Her excitation was prolonged and intense, but most of all it was unpredictable in its course. She would go from prolonged stiffness to limpness of short duration. The strange quality of her states of tension was often produced by a mixture of cramping and limpness which would be followed by fluctuations between high tension, rapidly rising, soon subsiding, or persisting for a long time, and explosive eruptions of free and diffuse tension discharge.

Nancy's tendency to rigidity and cramping was encouraged by her mother, who provided her with objects she could clutch. Even though at about nine months Nancy was given more opportunity to move about freely and release her spasmlike contractions, her motility continued to be strange as she now tended to alternate rigidity with an exaggerated release to the point of limpness. At that time I asked: 'Will Nancy hold on to her mother with iron clutches and develop an everlasting hatred for her?' This did not happen. Instead Nancy developed a rigid attachment to her sister, who became her nursemaid and constant companion. Her aggression was openly expressed in unpredictable hitting out at her siblings.

Toward the end of the first year of life Nancy's rigidity combined with waxy limpness reached the point of catalepsy during sleep. Thereafter Nancy went through several periods of apparent relaxation of tension and greater ease. When her mother's encouragement of holding and clutching diminished, she became more mobile and caught up with motor functions in which she had been retarded. As she followed her 'softer' sister around, she became more pliable. When she joined the outdoor life of a group of children at about two or three, her excessive muscular tension subsided still more.

It is difficult to evaluate how Nancy's quite early toilet training influenced her development. Neither is it easy to say what changes occurred during her phallic phase at four or five. During most of our visits at that time and later in latency, she would sit slumped in a chair, speaking only when spoken to. She

would mouth, distort her lips into a snout, or pucker them, chewing real or imaginary objects. At the same time she would fiddle with her fingers, pulling and releasing, pressing, twisting, and picking, all in an aimless, contentless manner. She would snap out of this perseverative behavior to snatch something from her siblings or pull it away with tension rather than strength. Once she got hold of the desired object, she handled it in the same random style as she showed without it. Possessive and reluctant to give up anything, she would become still more tense while clutching an object, but she became limply compliant in the presence of her parents.

Only recently could I again see some signs of improvement which may or may not persist. During my last two visits, which occurred when Nancy was nine years and eight months old, the excessive mouthing was no longer a conspicuous feature of her behavior. The impression of violence she gave as an infant and at times as a toddler no longer existed. But her total behavior was still unpredictable and deviant. When she danced at my request, her movements were perseverative, automatic, and stereotyped. Even though she was failing in two subjects, she reported that her teacher thought her brilliant. Her learning is done by rote. How similar her thought processes have been and still are to her deviant motor patterns can be best exemplified by the manner in which Nancy at five or six, and even now at almost ten, would recount the story of Goldilocks and the Three Bears. According to Nancy, Goldilocks tasted the porridge of the big bear and found it too hot, then she sat down on the big bear's chair and that was too hot; then she lay down on the big bear's bed and that was too hot. When she was younger, she showed her native intelligence when asked why the bed was too hot. She would quickly answer that the bear lay on it so long that he made it hot. But now her powers of rationalization are hampered further by an immature form of 'repression'. At nine she thought for some time before she answered the question why the chair and bed were too hot. With a sheepish smile she

then explained that the sun had shone on the bed of the big bear and made it hot.

Both the records of movement and Nancy's total behavior suggest the following constellation of deviant drives. She seems dominated by several conflicting rhythms of discharge. Oral repetitive suckinglike tensions and releases, oral-sadistic biting, grinding, and holding seem to vie with each other and with various anal, anal-sadistic, urethral, and phallic spurts which hardly ever develop in an undistorted rhythm that is clearly recognizable. Whereas the 'anal', 'urethral', and 'phallic' ways of discharge almost disappear in the avalanche of oral impulses, the various kinds of oral discharge exist side by side. They seem to compete with one another and do not produce a compromise. To function Nancy must give in to one or another of her divergent rhythms, especially when there is enough environmental pressure on her to facilitate a selection. The inborn need for rigid responses which seem to be part of an oral-sadistic discharge rhythm (rocking, tensing) was fostered by early training and has become the main source of Nancy's primitive defense mechanisms. Threatened with being overwhelmed by too many divergent impulses, she responds by perseveration, the only means she has to prevent disorganization. Her mother has little to offer to help stabilize her modes of discharge of tension, and still less can she help her control diffuse discharge.

Nancy's early dysrhythmia seems to have been indicative of a clash between various oral libidinal and aggressive modes of discharge.

Even in the nursery Charlie gave the impression of being an important citizen. He looked and felt like a heavy viscous mass. He could respond to stimuli by a gradual increase of attention which attained high levels of intensity and only gradually subsided. In nursing he became increasingly excited and noisy, reaching a plateau of high excitement which gradually abated. He would fall asleep gradually and sleep long. His awakening was equally gradual, as he proceeded from depth to lightness of

sleep and on into several stages of awakening. Once he reached a high level of excitement he was capable of more explosive movements and of many more variations of level and quality of tension than during the rise and abatement of his excitation. He was both very responsive to stimuli and able to absorb them. During the time of gradual increase of excitation he took in visually and acoustically what was going on. When his mother stimulated him, his excitement rose quicker than usual. When he was undisturbed his movements evidenced a prematurely deliberate quality, although his coördination was by no means better than that of the other children. His transitions were smoother, his sequences much less disjointed than is usual for infants and young children.

His mother and his siblings were intense, energetic, and quickly changing. It was when Charlie began to sit with the rest of the family and had to respond actively to solid food as well as many objects offered to him that he began to withdraw; he would show a vacant stare that left him in a world of his own. Eventually he gave up reaching for objects handed to him, and occupied himself only with his bottle and parts of his own body which 'came to him' in his very own mode of discharge. This mode included not only the rhythm of discharge, but also the spatial configuration of stimulus and response. Charlie seemed to prefer to have objects presented in space so that he could reach for them by moving forward or laterally. His mother habitually fed him while standing, her body in half retreat and only her head bent forward and down toward him. The spoon approached him from above while his siblings piled toys on his table, thrusting them on him and removing them out of reach. He withdrew from the spoon by turning his head sideways. When the spoon was held in front of him long enough, he did reach forward and his lips got hold of it. When toys were presented to him and moved horizontally in front of him while he was in a supine position, he still took his time before he reached, but he could do so with greater ease by a forward and

lateral movement. When they were held too high, so that he had to direct his gaze and arm upward to get them, he would not even look at them. This does not mean that Charlie could not move in all directions. He tended to choose his preferred directions over others when he also had to do new things or adopt a mode of discharge that required a quicker and more fluctuating manipulation of tension than the one he naturally favored.

On realizing that she needed to adjust to Charlie's ways, his mother began feeding him with greater patience. But after some time she would slide back into her accustomed pattern of quick changes and alert readiness for new actions. It was hard to understand precisely the basic clash between Charlie and his mother, especially as it became clear that Charlie had a varied and rich repertoire of rhythms available to him. He seemed to function well, using all kinds of rhythms provided they were subordinated to his basic over-all rhythm of gradual rise and abatement of excitement. Once he reached a high enough plateau of excitement, he could include all kinds of variations of tension.

My prediction when Charlie was nine months old was that he would hold to his masculinity with determination and strength throughout periods of passive withdrawal, and would prove able to relinquish his œdipal attachment to his mother quickly so that he could transfer his allegiance to someone more suitable to him in temperament. Thus far this has proved false. Charlie's capacity to respond to people intensely and steadily tended to distort my objectivity. The wording of my prediction suggests that, because I believed that Charlie's natural inclinations must be respected and that his struggle was deserving of support, I sided with the child against his mother.

As a toddler Charlie conquered his mother's preference for standing up; he insisted that she sit down and hold him on her lap. The intensity of his desire and the ponderous fashion in which he gave orders pleased and amused his mother. There was an excited quality about their relation, already presaged by the 'talks' they had when Charlie was only a few weeks old.

Even in infancy Charlie alternated between constipation and loose stools. The period of toilet training was prolonged and the bathroom became the focal point of Charlie's relation to his mother. She had to sit there with him and engage in conversation long after he was able to attend to his own toilet needs.

His phallic needs became most evident in the bathroom, where he would also go when his mother was using it. He had begun to call his penis a 'boy' and he insisted for more than a year that his sister and especially his mother had one, even though he was allowed to observe that he was mistaken. With further progress of the phallic stage he seemed to adjust better to his mother's and his siblings' prevailing agility; but his speech became increasingly sexualized and he began to stutter. The clash between what seemed 'anal' modes of movement and thought with those which served his phallic attachment to his mother resulted in a succession of cramplike holding and explosive outbursts when he wanted to interest his mother in what he had to say. His siblings reached her more quickly, but he could in effect hold her longer as she was forced to wait patiently until he managed to 'eliminate' his words. When speech training improved his stuttering, he developed a variety of tics. In time Charlie became competitive and played with children, but he soon began to prefer staying home with his mother to being outdoors with his friends and siblings.

Charlie's history is a near-decade of struggling to adjust to the needs of his mother and to bend her mode to his own. The compromise formation between his own preferred rhythm and other rhythms impinging upon him during different maturational stages, from within and from his family, has led to clearly neurotic disturbances in his latency period.

He suffers from severe disturbances of learning. In the first three grades he dawdled over his work and stared vacantly instead of finishing it. He became compulsive in his need for perfection, but his thought processes and movements decelerated so much that he failed to grasp and solve simple problems. Placed in a classroom with a progressive teacher he is now do-

ing rather well. But when his mother asks him a question that requires thought, he gets caught in a situation similar to his early feeding of solids. She stands over him, forcing herself to be patient, but she is ready to retreat in expectation of his failure. Only her head bends down to him. Their bodies are close but their gaze is apart. He begins to stare into space and slows down to the point of immobility. Her waiting only accentuates his failure and her leading questions fall flat as Charlie at that point is not accessible to her. He can answer the same question when the observer, approaching him at eye level, gives him ample time to gather his thoughts and helps him to arrive at the solution of the problem step-by-step. When he comes up with the right answer, he is sure of himself, yet he blurts it out explosively in triumphant, hasty speech.

Clinical data tend to strengthen the observer's impression that Charlie's preferred rhythm of excitation and discharge is of an 'anal' variety. This preference seems to be so strong that it colors and subjugates all other maturational phases and environmental influences. Faced with many divergent stimuli at five to seven months, when he was burdened by an influx of oral-sadistic impulses which clashed with his native rhythm, he had his hands full trying to cope with conflicting tendencies in himself. He had to withdraw from outside stimulations by his mother and his siblings who introduced what seemed a 'phallic' type of rhythm to complicate further his already extended battle front. His relation with his mother became quite intense and most satisfactory during the anal stage of development when normally mothers tend to regress to their own level of anality. It reached an even higher intensity in the phallic phase when he satisfied his mother's needs by consistently endowing her with a phallus and presenting himself to her as her phallus. But at the height of phallic interests, during the most intense œdipal relation to his mother, his stuttering became severe.

In latency, an obsessive trend threatened to take over. Toward the end of his latency, when early prepuberty began to appear, Charlie's blinking, shaking, and tic betrayed the renewal

of conflicts between divergent forms of motor impulses. These were based on the early clash between his mother's and his own preferred rhythms of discharge. They were also currently renewed by the disharmony between his mother's preferred adult patterns and his own matured motor qualities.

PREDICTION AND OUTCOME

The periodic observation of these three children from the neonatal through the latency period indicates a correlation between their preferred rhythms of motor discharge and their specific drive endowment. Certain features of their originally preferred rhythms are still in evidence today. A result of the study which had not been predicted is that two of the children (Glenda and Charlie) function better and enjoy doing things more if they are free to use their originally preferred rhythms. Modifications that occurred through maturation as well as through interaction with persons important to the children enhanced or diminished certain components of the originally observable rhythms, but they did not eradicate the children's preference for these motor patterns. A clash between Charlie's and his mother's favored motor rhythms, discernible in early infancy, did become a source of Charlie's neurosis.

While the general proposition that preferred motor rhythms would correspond to favored component drives proved to be correct for these three children, specific predictions about their personality traits, based on this assumption, had a varying outcome. Some could not be tested, others seemed correct, and still others were wrong.

Whether Glenda's phallic orientation is primarily due to her congenitally strong phallic drive cannot be established with certainty. There are indications that this trend has been supported by the family. Her mode of giving up after a short while and resuming activities again is now interwoven into a complex pattern of behavior. When left to her own devices she proceeds in this manner. When she has to do sedentary work she seems persistent enough but at great cost to herself. There is not sufficient

evidence of a tendency to incorporate and project in quick succession. Neither is it possible on the basis of observations and reports to judge the structure of her superego. What emerges instead with great clarity is Glenda's skill and enjoyment of activities in which she is free to use 'phallic' motor discharge. The 'oral-sadistic' rhythm of motor discharge is preferred in sedentary occupations, which Glenda neither enjoys nor excels in.

Nancy's early dysrhythmia seems to have been produced by a variety of unfused oral libidinal and aggressive rhythms of discharge. They often operate all at once, competing with each other and not allowing compromises with other forms of discharge. Until recently Nancy has continued to be very rigid and clutching. Her immature defensive structure seems to be based on rigid perseveration. Little can be said about her superego. We can say, however, that whereas Glenda has become a mildly neurotic child, Nancy remains highly deviant, possibly psychotic. There is some indication that she tends to incorporate persistently. The dearth of information about her behavior and her interests attests to the fact that her individuality can be best described as having 'form without content'.

Charlie's neurotic development can be traced since early infancy. His predominant rhythm since birth has been gradual ascent of tension from low to high levels, followed by a plateau of tension from which it gradually descends. This type of rhythm seems to correspond to one variety of discharge of anal drives (see Illustration 5). His mother tended to use abrupt rises of tension and was prone to many more fluctuations of tension than Charlie. The superimposition of this quality of her rhythm upon Charlie's own gradual and steady mode has led to early clashes between them. It has contributed significantly to Charlie's neurotic symptoms and traits. He has remained determined and placid but in his symptoms one can detect a vying between a gradual and an explosive ascent of tension. He did not give up his strong attachment to his mother, and there is no evidence that he turned to his father. His premature ego development may have fostered his neurotic solutions, and these in

turn resulted in a restriction of the ego. It has remained clear throughout his development that he functions better when allowed to proceed in accordance with his congenitally preferred anal rhythm of discharge.

COMMENTS

The method of rhythm notation which was developed during a near decade of study was not used in the beginning of the observation of these three children. Descriptive recording does not do justice to the variety and combinations of rhythms observable even in the neonate. The classification of motor rhythms into 'oral', 'anal', and 'phallic' constitutes only a beginning of the study on correlations between motor rhythms and drive discharge. It is possible that only a few children show as pronounced permanent preferences for certain rhythms as could be seen in this pilot study. (Compare the views of Escalona and Heider [*12*].) It seems likely that a notation of motor rhythms will permit the detection of preferences for certain combinations of rhythms which may be representative of drive constellations. A comparison of motor rhythms with rhythms of autonomic responses (heart rate, blood pressure, respiration, etc.) would be helpful in examining the possibility that there is a central regulation of rhythms specific to processes of discharge of particular component drives, as hinted by Freud and Breuer *(18)*. Rhythms of discharge through various channels need to be correlated with rhythms of stimuli which, according to Freud, may explain the physiological substrate of affects *(21)*. Within the narrow confines of my study, I could only record early and later motor patterns which emerged with the progressive differentiation of id and ego.

As the rhythmicity of movement observable in these young infants became modified and incorporated into more complex patterns, the recording of rhythms alone did not suffice for the study of the role of motility in the children's development. As the ego took over the controls of motility, the original rhythms

were altered by regulatory mechanisms ranging from primitive inhibition to adaptive controls which related to space, gravity, and time. Moreover, the shaping of movement went through different developmental stages that reflected changing relationship to objects. Further papers, based on the same pilot study, will consider how the ego regulates motility and adapts it to communicative expression *(32)*.

CONCLUSION

Observation of three children from birth to about ten years of age suggests several areas for study in a larger number of subjects.

1. Preferences for certain rhythms of movement in early infancy.

2. Maturational and environmental influences that modify the originally preferred rhythms.

3. Early manifestations of disturbed development due to clashes between the rhythms of infant and mother.

4. Later behavior which may be derived from motor rhythms.

5. Identification of specific motor rhythms as expressive of specific drives such as oral, anal, phallic, and others.

6. Transitions between drive and ego dependent motility.

7. Methods of notation that would permit objective differentiation between rhythmic discharge of tension and the more mature components of movement which serve complex ego functions.

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SOME SUGGESTIONS FOR TREATING THE DEPRESSED PATIENT

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Most depressed patients who consult psychoanalysts do not have the more severe forms of depression that are diagnosed as 'depressive illness' but suffer essentially from neurotic disorders. Furthermore, since most neurotic patients feel depressed to some degree, in practice one is confronted more often with a depressive component of neurosis than with a typical depressed state. Treatment for many depressed patients therefore uses the general techniques of psychotherapy and psychoanalysis; yet when a patient is even slightly depressed therapy must be influenced by our understanding of depression as a disturbance of the ego. Bibring *(2)* defined 'basic depression [as] a state of the ego whose main characteristics are a decrease of self-esteem, a more or less intense state of helplessness, a more or less intensive and extensive inhibition of functions, and a more or less intensely felt particular emotion'. This definition applies not only to depressive illness, but also to the whole range of lesser degrees of depression found in neurosis.

The numerous contributions of psychoanalysts to depression have been ably summarized by Mendelson in his comprehensive review of the literature *(14)*. Most of these contributions deal with theory and only a few refer to treatment. This paper contains suggestions for treating depressive symptoms and neglects consideration of other aspects of these patients' neuroses. This does not mean that the author believes that therapy of every neurotic patient with depression should be directed chiefly at the depressive symptoms; that is not so. Nor is treatment of depression a simple matter, though a condensed paper such as this may make it seem so. The suggestions presented may have to be repeated, modified, and combined with other therapeutic

efforts in a variety of ways over a period of months or years. The analysis of depressive currents, either in psychotherapy or in psychoanalysis, is no less difficult and prolonged than that of other aspects of neurosis.

GENERAL CONSIDERATIONS

Many patients with definite signs of depression are not conscious of feeling depressed. They may complain of fatigue, insomnia, or other symptoms, and may require much analysis of their defenses against depressive affect before becoming aware of it. A twenty-year-old male college student, who entered therapy because of academic failure, initially complained of severe fatigue but denied feeling depressed. It was found that this denial was his defense against the memory of a sister's suicide and against feelings of weakness and lack of masculinity, which were equated in his mind with being depressed. It was only after the reason for the denial was clarified that he became aware of his depressive feelings.

In some patients, depressive feelings may not be denied but remain unrecognized or poorly defined until the therapist points them out. By using the term 'depression' or 'depressive feelings' at appropriate times, the therapist can give the patient a label to apply to his psychic state which is so often experienced with bewilderment and fear.

Some depressed patients may express the same self-critical complaints over and over again—the 'broken record' response. Such a patient may be helped to see that by this he is avoiding exploration of his problems, and that by directing all his complaints against himself he is blotting out the external world. The therapist, by exerting gentle continuous pressure and introducing topics which he thinks the patient can discuss, may often help him talk of a wider range of subjects. Also, by asking specific questions the therapist may help the patient overcome his inability to talk about particular subjects and furnish those details conspicuously absent. If the therapist is too passive, the

patient's silence may increase, or he may become drowsy, and after each interview may experience a sense of failure with increased depression. Unfortunately, the reluctance of some therapists to use active techniques such as asking questions may hamper their treatment of inhibited patients. Such reluctance may occur in those who believe a good analyst or analytically oriented therapist is not active in his therapy. It may also occur in those who are somewhat inhibited themselves and therefore limited in the degree of activity they can comfortably employ. Some of these are not fully conscious of the degree of their blocks and rationalize their involuntary silences as decisions to wait for the patient to talk.

Patients who bring little psychic content to therapy frequently report their dreams. In some instances the dreams have to be written down on awakening to avoid forgetting them by the time the therapeutic hour arrives. When this special effort is made, the patient often has a sense of relief, because he then feels better prepared for his therapeutic session and does not expect the intense emotional suffering he has experienced in the past when facing his therapist in stony silence.

It is characteristic for depressed patients to have preconscious or unconscious fears of insanity. Some of these fears result from depressive symptoms such as lack of energy and diminished ability to perform certain tasks. If the patient has difficulty concentrating or feels confused, he may interpret these symptoms as early manifestations of severe mental disorganization. Furthermore, there may be some return of the repressed, which often leads to obsessive fears. Brought to consciousness, these fears tend to lose some of their intensity. One may also help the patient to understand that depression is typically accompanied by some depletion of psychic energy which may lead to a variety of symptoms such as fatigue, sensitivity to outside stimuli, fearfulness, and withdrawal.

A not uncommon symptom is unrealistic fear of the consequences of losing control of aggressive and regressive impulses.

It is often helpful to point out that the patient's fears of losing control imply lack of confidence in his 'automatic control'. He may be able to see that control is to a high degree involuntary. The therapist might use as an illustration the automatic controls that come into play when a person drives for long distances in his car. The driver may be absorbed in fantasy, yet his basic patterns of behavior persist. When the patient has less fear of losing control he may be ready to analyze the genetic basis for this fear, proceeding, for example, to explore childhood experiences of bladder and bowel incontinence or sexual and aggressive acts. Thus he can understand why he has no confidence in his automatic controls; often it is because he saw that his parents lacked this confidence and believed vigilance necessary to check impulses.

Many patients do not know the immediate precipitating causes of their depressions. A teacher became depressed immediately on hearing of the promotion of one of his colleagues but did not realize the effect this news produced in him. Helping such a patient examine the circumstances of onset of his depression may make him willing to explore further, give him hope, and make therapy more meaningful. The patient who believes that his depression arises entirely from hidden internal sources may feel victimized by forces over which he sees no hope of getting control. When he understands that events of his life have contributed he may become more optimistic.

A middle-aged man with recurrent depressions entered psychotherapy in a depressed state one year after terminating a successful course of treatment. It soon became clear that, although he had acquired considerable insight during his treatment, he was not aware of a major precipitating cause of his depressions. When the circumstances surrounding the onset of several depressions were carefully reviewed, a common incident stood out: each depression had developed shortly after he had become associated with a highly aggressive man. His current depression came a few months after he started a new job under such a man whom he had initially idealized, but who, as time

went on, became increasingly overbearing. The patient, who felt weak and unassertive, unconsciously attempted to borrow the strength of aggressive men, but sooner or later became the object of their aggression. When he finally understood his pattern, he decided to work for an unaggressive man whom he could respect for ability alone. After this change there was improvement.

When a person becomes depressed his use of projection may increase, especially projection of self-critical feelings. Early in treatment the patient can often become aware of his tendency to project, even though he may still not be able to control it. This understanding enables him to suspend retaliatory action and to view his projections with some scepticism. A young doctor who entered therapy with a moderately severe depression was considering quitting his job because he thought his associates were dissatisfied with his work. He mentioned that after he had presented a case at a recent staff meeting those present were highly critical. When asked how they showed it, he could say only that one doctor made a disparaging remark and that the others hurried off after the conference. Pressed for details, he stated that one doctor had commented 'nice going' in a sarcastic manner; he had considered this remark sarcastic because of the doctor's tone. Now he began to wonder if he might have misinterpreted the doctor's attitude; after the staff meeting, he recalled, he had at first thought the doctor sincere, but something told him this was not so and he brushed the idea aside.

He also began to doubt whether the other doctors, who were always in a hurry, had really left the conference more abruptly than usual. He soon came to see that he projected his self-criticism in many other situations and perceived his associates to be unfriendly whether they were or not. He tended to suppose that the rejections of others made him feel depressed, when in fact his state of depression made him feel constantly rejected. He became aware that it was only after onset of his depression that he felt generally rejected by his associates; furthermore, this

feeling fluctuated in intensity with the level of his depression. This understanding led him to resolve not to quit his job but to remain and work out the reasons for his depressed state.

Another depressed patient, a middle-aged woman, withdrew from her bridge club because she felt the other members rejected her, supposing that they avoided her. The truth was that their 'avoidance' began only after she became depressed and seemed to her friends to want to be left alone. She had misinterpreted as rejections the attempts of others to be considerate of her feelings. Knowing this helped her return to the club where she was welcomed. Psychic impotence and frigidity often become an obsessive preoccupation and are seen as causes of the depression rather than symptoms of it.

Much attention must be given to the complications and vicious circles that develop when a patient becomes depressed. For example, failures in performance may lead to depression; the resulting depression by its inhibitions of thought and action leads to further failures in performance, which accentuate the depression. Such failures may have disappointed others—employers, for instance—in the patient. It is important for the therapist to acknowledge the possibility of such changes of attitude in others, regardless of how much the patient seems to be distorting them, so that they may be realistically evaluated.

His family often urges the depressed patient to 'pull yourself together'. Their critical responses may increase his depression and lead him to complain that they do not understand his difficulties. Such a patient can often be helped to see that it may be as unrealistic for him to expect his family suddenly to understand his emotional difficulties as it is for them to expect him suddenly to get over his depression.

Depressed patients are usually unaware of their intense anger, much of which is redirected internally through the superego, leading to guilt and loss of self-esteem. Efforts directly to counteract the guilt and loss of self-esteem are generally unsuccessful and frequently elicit a distrustful feeling that the doctor is merely trying to be supportive. One usually has greater suc-

cess if he points out that the patient castigates himself primarily because much of his anger has nowhere to go but toward himself, since certain inner forces do not permit its discharge toward external objects or even its abreaction. The patient may then realize that his excessive guilt will continue until he finds and eliminates the source of the anger or finds some temporary outlet for it. This helps the patient avoid seeking reassurance or ease for his guilt from the therapist and leads him instead to search for the sources of his hostility.

Attempts to counteract directly the archaic superego of 'borderline' or melancholic patients are also bound to be unsuccessful. An archaic superego is characterized by regressive narcissistic aspirations and pathological guilt, both of which occur only when there is considerable regression. Regressive narcissistic aspirations reflect primary narcissistic libido directed into the superego, and pathological guilt results from primary aggression directed into the superego and then turned against the self. Until the underlying regressive process is reversed and new outlets for libido are found, the archaic superego tends to persist. This type of superego should not be confused with the strict superego that arises from internalization of excessive demands of parents and parent-substitutes in early life. A strict superego is nonregressive and may be directly counteracted by insight, by suggestion, or by encouraging identification of patient with therapist, which permits replacement of the excessive demands of parents by the more moderate demands of the therapist.

Some depressed patients turn so much of their hostility inward that the therapist may not know how much hostility is being aroused by his therapeutic efforts unless he watches the patient closely, especially for indirect indications of hostility. If a patient becomes self-critical or bemoans his fate immediately after an interpretation, the therapist can infer that the interpretation has met resistance and that the hostility thus aroused is being detoured into the superego and then directed against the self. A comparable detour of hostility through the superego

may occur following frustration of unconscious transference wishes; this anger, instead of being directed at the therapist, may be expressed through guilt, self-castigation, or feelings of inadequacy. By observing these reactions the therapist can evaluate how much interpretation and how much frustration of transference wishes the patient can tolerate without becoming more depressed.

When a patient becomes conscious of hostile feelings, he may begin to discharge some of them outside the therapy. A middle-aged man who had entered psychoanalysis for treatment of long-standing depression became conscious of his hostility toward his thirteen-year-old son, and after abreacting some of this felt less depressed. But before his hostility could be analyzed he decided to express it directly to his son. He began to criticize the boy and his son became more rebellious. The patient then increased his attack, believing he must do so to prevent his son from becoming delinquent and to protect himself from severe depression. Urged by the analyst to restrain his criticism until he understood his hostility, he at first said that the therapist did not understand how intense were the son's provocations. Gradually he began to see that he had formerly dealt with his anger by repression and withdrawal but now by tantrums. It then became clear to him that awareness of hostility should lead to exploration of its sources. The patient checked his outbursts without experiencing the recurrence of depression he had feared, and as he gained new insight his relation with his son improved.

In many depressed patients therapy must be directed largely toward relieving excessive repression of libido, which prevents adequate sexual satisfaction and causes depression. A nineteen-year-old college girl complained of depression and weeping for about a year. She was preoccupied with thoughts of her mother's death six years before and supposed that this was a delayed grief reaction. Psychotherapy revealed that she was inhibited sexually and could tolerate little bodily contact with men. She was convinced that she could never marry or have sex-

ual intercourse. The sexual inhibitions were the chief cause of her depression and her preoccupation with her mother's death showed a powerful regressive wish to return to 'the good old days' of childhood. Therapy was directed chiefly to increasing her tolerance for sexual fantasies, feelings, and impulses.

Analysis of the transference is of great importance in depression. Libido is sometimes withdrawn from important objects and concentrated on the therapist; transference frustration becomes intense and the depression becomes accentuated. If the concentration of libido on the therapist is pointed out, the patient can usually see that by disengaging himself from outside relationships he has created a state of frustration that cannot be satisfied by the relation with the therapist. A twenty-five-year-old married woman who attributed her depression to being completely blocked in writing her Ph.D thesis developed an intense positive transference and expressed a variety of sexual fantasies toward the therapist, such as lying close to him or masturbating him. During this phase of treatment she became more discouraged about her thesis and was convinced that she would never complete it. As therapy continued she regressed to a masochistic transference in which she had fantasies of the therapist beating her and forcing her to write. These fantasies were related to childhood fantasies of being beaten by her father. After analysis of this content, her writing block was temporarily relieved, but in a few days it returned and she again felt hopeless. When it was pointed out that she was withdrawing from her husband and her friends she was surprised but recognized that she had been doing so for many months and did not understand why. She was told that concentration of her sexual interest in the therapist indicated withdrawal of sexual interest from major objects; that she wished to get everything from the therapist and could therefore expect only frustration. Next day she did not seem depressed and was neater; she was also more optimistic about completing her thesis on which she was again at work.

Analysis of a patient's tendency to withdraw may cause him

to change and quickly become overengaged with others. A depressed young physicist, who had withdrawn to his laboratory for several months, suddenly became consultant for a number of other projects. His resulting competition with several highly aggressive scientists made him feel inadequate and depressed anew and he fell behind in his own experiments. When he understood the counterphobic nature of his activity and how it caused his depression to return, he confined himself to more appropriate jobs.

In treating depression, one obviously tries to support the patient's hopefulness; a hopeful therapist transmits this feeling to his patient. Also, the manner of presenting interpretations can determine the degree of support they offer. After an operation for herniated disc a middle-aged woman in my care developed a postoperative infection which prolonged her hospitalization and depressed her, chiefly because of intense fear of death. She complained that her wound took long to heal and that it seemed she had been in the hospital for several months (actually for only four weeks). I told her I could understand her dissatisfaction and suffering but that ten years later her hospitalization would seem a brief interlude, diminished by time. After this brief conversation the patient was less depressed. By indirectly transmitting the idea that she would be alive ten years hence, I was able to make her more hopeful and, since this idea was slipped in as an incidental comment, it was not perceived as a direct effort to reassure and therefore did not meet the natural resistance to such efforts. Eissler *(8)* produced a similar effect in a dying woman by giving her a subscription to the monthly programs of her favorite broadcasting station. Aside from its symbolic significance, this gift conveyed the message that the doctor expected her to live long enough to enjoy the subscription. It therefore counteracted her fear of imminent death.

A therapist usually cannot 'manipulate' a patient out of feeling hopeless *(3)*, but he can often help the patient see that the hopelessness is not realistic but rather an inevitable manifesta-

tion of depression itself and deserving analysis. Hopelessness is usually associated with fears and a moderate amount of pressure may be necessary to help the patient spell out what he fears is going to happen. For example, when a patient expresses a fear of losing his business, one can encourage him to elaborate on what he thinks would happen after its loss. He may give voice to childhood notions about poverty and starvation. He may thus be helped to face the expected humiliation of being exposed as a failure and also to say whose ridicule he fears most; this may show him the importance of object relationships he previously minimized.

Hopelessness is often expressed as 'I can't do this or that'. The patient's conviction that he never will be able to face his fears is analyzed. The graduate student who 'cannot' write a thesis may be saying not only that he fears exposing his thoughts in writing but also that he believes his fear will continue to be overpowering. This conviction is often related to early experiences of intense anxiety or humiliation.

Some patients retain false hopes in defense against underlying feelings of hopelessness; they are reluctant to abandon highly cathected goals and fear intense humiliation if they admit defeat. The business of a sixty-two-year-old man began to fail and he was unsuccessful in attempts to refinance it, sell it, or merge it. His attorney convinced him that the business was hopeless and should be liquidated, but the patient could not bear to do this and lived in hope of finding an investor to save it. His underlying hopelessness was warded off by false hope. Unfortunately his therapist, because of countertransference, at first supposed the hopelessness merely a product of the man's depression, identified himself with the patient in his wish to save the business, and thought refinancing it a realistic plan. When the therapist understood his countertransference, he analyzed the situation, noting that the patient feared not only loss but also humiliation from business associates if he admitted defeat. The patient accepted liquidation as wise and began to work through his grief over loss of the business.

A similar problem was present in a first-year medical student who became depressed after failing his mid-year examinations and sought psychotherapy with the hope that it would help him succeed. In college serious academic difficulties had necessitated repeated tutoring, summer school courses, and a fifth year of study. Psychoanalysis at that time had yielded insight but little improvement in his work. He passed all premedical courses but had great difficulty gaining acceptance to medical school; he had had, he said, to 'sell myself' to the director of admissions. All the evidence indicated that he was ill-suited for medical school. However he was extremely reluctant to consider withdrawing and talked of taking summer courses and repeating his first year of study. It was necessary for the therapist to explore the patient's fear of leaving school which led to analysis of his relation to parents and siblings and his fear of their ridicule. A change now appeared: the patient saw that he was compulsively repeating a pattern and that, if he continued, his work would continue to be poor if he survived at all. He decided to withdraw and at once became less depressed; after his mourning over loss of a highly cathected goal, he turned to a vocation for which he showed talent.

It is common for a depressed patient to believe that the therapist has underestimated both his suffering and the severity of his illness. The therapist can help by showing that he knows how depressed the patient feels and is willing to face the difficult problems of treatment. It is generally better for the therapist not to minimize the severity of the depression but to seem hopeful concerning its outcome.

Fluctuations in the level of depression are likely to be confusing not only to patient but also to therapist. A temporary relapse may convince the patient that he is getting worse, but the therapist should expect these relapses and must interpret them to the patient as not necessarily indicating lack of progress. The patient's course may be generally a rising curve though fluctuations produce many hills and valleys. To sketch such a hypothetical graph may encourage the patient.

In some instances interviewing two members of a family together may be effective in treating depression in one of them, especially when the one who is well has unconscious ego-syntonic patterns of response that put continuous stress on the other member and is reluctant to undertake therapy. After a few unproductive interviews with a severely depressed thirty-year-old woman, I called her husband into the office with her. He spoke fluently and had complete mastery of the situation. When after some time it appeared that his wife wanted to say something, I turned to her and she made a brief comment but she was quickly and subtly squelched by her husband; he monopolized the interview. His tyranny forced her to submit to repeated narcissistic wounds. She feared him intensely and internalized her hostility toward him; the more depressed she became the more dependent on him she grew, and the more fearful of antagonizing him. The three of us continued to meet and I told them what I saw. It was not long before the wife began to assert herself and her husband reacted with overt hostility; shown this, he checked his aggression and began to examine it. When they understood their interaction and its effects she was cured of her depression and has stayed well for the five years since.

Thus 'identification with the aggressor' can contribute to depression, provided the aggression is directed toward the self, a process that is fairly common and can at times resemble *folie à deux*. A twenty-eight-year-old married woman, severely depressed, at times had hysterical reactions during which she pounded the walls of her room and screamed at herself in despair. She praised her husband for his tolerance and patience and in general idealized him. He prided himself upon never losing his temper and always being polite to his wife. She is emotionally disturbed, he said, and thus he is more fortunate than she; he would show himself a man of endurance who had married for better or for worse and would live up to his marital vows. He considered her emotional state to be similar to a physical illness and denied that he contributed to it in any way.

Therefore he was a devoted, long-suffering husband. It soon became apparent, however, that he was a highly intolerant man who managed to hide his hostility and maintain a polite and disarming façade toward both his wife and his colleagues. She had responded by becoming intolerant of herself—one might even say that she had permitted herself to be 'brainwashed' by him—and also critical of herself, rather than fighting back against his subtle aggression. Becoming aware of the underlying hostility of her husband she saw how he contributed to her own; she pointed out to him some of his responses and eventually helped him to become aware that he did in fact have intense angry feelings and was scornful and disrespectful toward her. Thereafter he sought therapy for his own emotional difficulties.

Masochism, which is usually found in states of depression, puzzles us because experiences we should expect to interfere with satisfaction actually produce it; but we can understand this if we appreciate how often experiences that appear to create disturbances in libido economy really improve it. A simple example is a depressed patient, suffering from impotence, who found that only when he subtly provoked his wife to attack him could he freely show anger toward her and then become reconciled with her, with the result that his impotence temporarily disappeared. He masochistically sought narcissistic injury—a circuitous route toward improved libido economy.

It is important not to confuse nonmasochistic behavior that happens to result in unpleasant consequences with behavior in which the 'aim' is masochistic. For example, a patient's failure in an examination is not necessarily due to a 'wish to fail' for it may be the result of inhibitions in studying that accompany a depressed state.

Analysis of masochistic patterns is important in treatment of depression; since it has been discussed by many authors *(1, 4, 5, 6, 7, 11, 15, 16)* only a few technical suggestions are mentioned here. When the masochistic patient bemoans his fate and repeatedly castigates himself, I have at times found it helpful to tell

him that he is behaving like a person who throws himself into a ditch, smears himself with mud, and then complains about how dirty he is. Such a comment can facilitate analysis of underlying self-destructive tendencies. If the patient indulges in 'brinksmanship', I may compare him to a man who leans over the bank of a river to see how far he can lean before falling in but must fall in to find out. Such preliminary clarifications are to be followed by more careful analysis of the sexual and aggressive components of the masochism.

Some therapists have argued that one should freely express anger at such patients to satisfy some of their masochistic needs, a recommendation, unfortunately, likely to come from those who find it difficult to control their anger and seek to justify behavior they cannot control. Others out of shame try to hide their anger from the patient and even from themselves. But we ought to accept the fact that we sometimes get angry, for some patients are adept at evoking our anger and are strongly motivated to do so. To tell the patient that he has succeeded in evoking the therapist's anger often helps to clear the way for analysis of his provocations; to understand that he has achieved a neurotic victory is an important insight.

The negative therapeutic reaction, not uncommon in the depressed, may reflect not only a desire to defeat the analyst as well as oneself, but also a re-enforcement of this desire due to the mounting hostility likely to result from sensitivity to the analyst's interpretations as severe narcissistic injuries. Careful dosing of interpretations and tactful clarification of sensitive reactions to them may help to counteract the negative therapeutic reaction. This reaction may also arise from intense transference frustration due to concentration of libido on the therapist. When this is clarified, redistribution of libido to other objects may occur and relieve the negative therapeutic reaction. In still other instances, negative therapeutic reaction may result from the therapist's reluctance to use active techniques when the patient is severely blocked; the patient tries unsuc-

cessfully to overcome his block and hence feels failure after each interview.

Many patients seek relief from depression by acting out sexual impulses. A thirty-five-year-old man entered analysis because he wished to understand why he was repeatedly unfaithful to his wife. He said his marriage was a happy one but, nevertheless, he sought extramarital affairs which, although temporarily satisfying, left him feeling guilty and anxious. It soon became apparent that his infidelity counteracted feelings of depression. As he examined his depression he gradually became aware of the problems in his marriage; but he was afraid to acknowledge them to himself because of fears, for example, that he might be tempted to get divorced like his cousin who was now lonesome and unsuccessful. He also feared that if his marriage broke up his father would disown him. The patient eventually saw that he was very angry at his wife and was repeatedly running away from her in actuality or in fantasy, even though he was much in love with her. All his life he had run away—when he was young, for example, into military service to get away from his mother with whom he fought. After long analysis this patient became able to deal with the tension in his marriage without developing a depression and running away.

A thirty-year-old married man entered psychotherapy because of depression of a year's duration, accompanied by impotence. After a while he confessed that when most depressed he sought homosexual affairs, which disgusted him and convinced him that he was basically 'a homosexual'. The patient's employer had replaced his father who died when he was eight and at first they had worked closely together, but as business expanded and new assistants were employed the patient felt brushed aside, although actually he had simply withdrawn in a sulky manner and become depressed. Moreover during the previous year the boss had been going through a trying period and was also depressed. The patient saw nothing of this; he found it hard to believe that this man whom he had so idealized could

have emotional problems of his own. But as the patient saw that his employer's irritability was not directed only at him he began to seek out and respond to his employer and the improved relation ended his depression, his impotence, and his homosexual activity.

ANALYSIS OF REACTIONS TO PSYCHOLOGICAL STRESS

Four categories of psychological stress may contribute to depression: loss, attack, restraint, and threats *(12)*. These categories have theoretical as well as clinical utility. A thirty-year-old man undergoing analysis became depressed when a contract upon which his business depended was cancelled. Convinced that his business would fail, he spoke mostly of his own guilt; he was responsible for losing the contract since he had failed to meet the requirements of the 'parent' company. It became clear that he was directing all his aggression against himself in a manner typical of the depressed. It was difficult to mobilize his anger at the executive who had cancelled the contract, but when he finally expressed it, he revealed that the man was generally considered ruthless and gave several examples of his unfairness to the patient who had made many concessions to him. The patient had always withdrawn from conflict with men. As a child he had feared his father and repeatedly tried to appease him and he ran from fights with other boys. He was doing the same thing now, blinding himself to the other man's aggression and dishonesty. As the patient saw that he had been cheated and had not deserved to lose the contract he began to fight back rather than surrender as he had always done previously. This roused anxiety until he could understand his fears of the other man and of his father. He took successful legal action and reorganized his business and his depression improved.

Continuous pain may have depressing effects and may be experienced as an attack, even a frightening one. It is common for patients with continuous pain to imagine that they have serious illness, even though repeatedly reassured, and it is also common

for these notions to disappear when the pain is relieved. The attending physician may not realize how important it is to give the patient an adequate amount of pain-relieving medication. Some physicians become especially reluctant to give narcotics when a patient is depressed, supposing depressed persons more susceptible to addiction.

Realistic fear often causes depression. For example, a young man in service overseas became depressed because his orders for returning home were delayed, causing him to fear he was to be sent to Laos. As soon as the crisis there subsided, his depression disappeared.

Once depression develops from any cause, minor physical symptoms seem to mean serious physical illness, rousing unconscious fear of death. Making the fear conscious helps but only relief of the depression can remove the fear. Showing that the patient's fears are groundless may relieve the depression, as in the case of a scientist who feared—needlessly, since only he could provide evidence to substantiate them—that his ideas had been stolen for another man's book.

Awareness of the effects of 'restraint', both external and internal, can also be useful in treating depression. When a patient with a coronary attack is kept in bed for several weeks, he may become depressed as much from restraint as from reaction to his illness. Modification of the medical regime to permit greater mobility usually can be effected. In such a case one must also take into account not only the immobility imposed but also the patient's reaction to the physician's recommendations. The restrictions placed upon a patient by his own fears are often most important.

A woman referred—seemingly with full agreement and acceptance—to a gynecologist by her doctor revealed in psychotherapy that she resented the doctor's having, as she felt, constrained her to accept the consultation. Her sense of restraint was due to her fear of self-assertion; understanding this she told her doctor that she wished to be free to decide herself whether to submit to any gynecological procedures recom-

mended. After this she felt freer to reserve judgment. The same patient supposed, wrongly, that her therapist did not approve of her dating a man unless there was a clear possibility of marriage. Analysis showed that she imputed to her therapist some of her father's attitudes about dating which she had made hers at an early age. Her self-restraint was now mitigated and she became freer in her dating.

NARCISSISM AND DEPRESSION

Those susceptible to depression are at times called highly narcissistic. Freud *(9)* noted that their object choices are made 'on a narcissistic basis' and that when they are disappointed by the loved object they readily regress to 'original narcissism'. Yet much evidence indicates that these individuals are vulnerable not only to loss but also to other types of psychological stress. Many such persons can remain free of depression only if they are largely free from stress. Therefore they tend to seek relationships that promise to protect them from loss, attack, restraint, and threats. They also employ a variety of narcissistic defenses such as the illusion of excessive love. Menaker *(16)* described a patient who maintained his libido economy by the illusion that he was greatly admired by the analyst and became depressed when the analyst pointed out his marked passivity.

Since patients susceptible to depression may need excessive love, their ability to obtain it may be critical. The readiness to initiate relationships—to give love to others—is important if one is to receive love, but narcissistic individuals tend to be blocked in this ability. Some of them search for love not only from specific objects but also from people in general. One patient who spoke often to audiences was not satisfied unless he could have their full and favorable attention. Patients susceptible to depression may over-react to lack of warmth in others. Unless their advances find a response their libido economy becomes disturbed; once such a person has shown positive feelings he becomes enraged if they are not returned. Hence he may size

up the situation carefully before revealing his feelings in order to make sure that the other person is ready to reciprocate.

The ego ideal of the narcissistic individual shows his intense desire for freedom from stress: through attainment of high aspirations he hopes to obtain excessive quantities of love from external and internal objects as well as sure protection from attack, restraint, and external and internal threats. Such a person may therefore make great demands not only upon others but also upon himself and be highly perfectionistic.

Analysis of the narcissistic core of the depressed patient's personality is essential, with constant effort to delineate over-reactions to innumerable experiences of stress. There must be repeated clarifications of what Murray calls attitudes of 'narcissistic entitlement' *(17)*, attitudes that follow the basic formula 'I have a right to what I want' and are likely to produce both indignation when one's self-defined 'rights' are not recognized by others and a sense of righteousness in making repeated demands for such recognition.

We must pay attention to the patient's sensitivity. When a patient becomes aware of reacting sensitively, he has made a significant step forward and another comes when he realizes that his sensitivity fluctuates with the level of his depression. A young woman patient, moderately depressed, became upset when a friend made a not unkind remark about the patient's excessive sweating; the patient was helped by her therapist to see that she was ashamed of her sweating and resented having it pointed out to her, and that it was only when she was depressed that she was so very sensitive. Many patients deny their sensitivity and rationalize their responses by exaggerating the intensity of the stimulus, a distortion of reality. A simple illustration can make this clear to the patient; for example, that an oversensitive person may explain his over-reaction to dental pain by claiming that his dentist is very rough, even eventually charging that all dentists are sadistic.

A highly sensitive patient may have to learn to avoid certain stresses to protect himself against recurrences of depression.

Sometimes the patient gravitates toward the very stresses to which he is most sensitive. A sensitive young graduate student repeatedly dated hypercritical girls who depressed him. Understanding his ambivalent attachment to his mother helped him avoid his œdipal problem by finding pleasure in more tolerant girls.

Highly narcissistic patients may have to be helped to obtain increased narcissistic satisfaction to get relief from depression. Some patients, by achieving more, attain a sense of increased competence and greater admiration of others. Some can obtain increased narcissistic satisfaction from love objects if their relation with them can be improved. Hence insight into how the patient complicates his major relationships is essential. A young narcissistic woman who entered analysis in a state of moderate anxiety and depression complained that her husband repeatedly withdrew from her. It was necessary to clarify the subtle excessive demands she made upon him and her spitefulness toward him when he did not meet her demands; she thus became aware of the reason for her husband's withdrawal.

Tact is necessary to protect the patient from narcissistic injuries during treatment. The patient's self-esteem is already broken down, and any clarification or interpretation may lead to a narcissistic injury. The therapist may convey that he knows the blocked patient is trying to talk and is not being uncoöperative. We can support the patient's narcissism by recognizing his efforts to live up to his principles in therapy and elsewhere. In discussing a patient's hostility, it can be made clear that one is fully aware of his repeated efforts to be kind and considerate. The therapist's tact depends in part on careful observation of the patient's sensitivity to specific types of therapeutic intervention, a sensitivity the patient often attempts to hide.

It is not uncommon for patients to use for defense the understanding acquired in therapy concerning events in their early lives. When a patient revives memories of early traumatic experiences, he may use this knowledge to justify his present difficulties by blaming his parents and others for some of his cur-

rent failures,—for his trouble in learning, for example, whereas further analysis shows the parental pressure he complains of came after the trouble started from a different cause. Such a patient may justify his anger at his parents by comparing them to his idealized analyst. This sort of narcissistic prop for the patient's self-esteem may tempt us to analyze it prematurely, accentuating the patient's depression. Such defenses may even have to be temporarily re-enforced to support a shaky narcissism until the patient's depression improves sufficiently to enable him to tolerate analysis of them.

The strong oral character traits and the excessive envy that accompanies them in many depressed patients must be analyzed. This envy is often expressed thus: 'Others get whatever they want; why not I?' This patient does not perceive clearly the inevitable frustrations of other people and the innumerable compromises they must make, and his failure to perceive is probably defensive. If others get what they want, the patient also hopes to gratify all his wishes. Such illusions perpetuate envy and, as a result, the patient who acts on this principle may lose his friends. Such patients also envy the therapist, who seems to be omnipotent and able to gratify every wish.

Depressed patients often demand special consideration from the therapist, sometimes in a subtle way, as did a middle-aged woman who repeatedly brought her psychotherapist inexpensive gifts. When she brought a small sculptured donkey it was learned that she thought of donkeys as being as clumsy as herself and the gift was a way of leaving a symbol of herself in the therapist's office. Her gifts turned out to be motivated not, as she rationalized, by the golden rule but by her special modification of it: so do unto others as to force them to treat you as you want. The underlying wish was for special attention. When she did not get it she became angry and shouted 'ingrate!' because she did not get what she claimed was merely an appropriate response. When she finally understood her forcing maneuvers she also understood why her gifts were not as well received as she had hoped.

In treating depressed patients it is important to analyze those patterns of behavior that lead them to feel humiliated. At a recent symposium on narcissism, Waelder *(19)* told of a young man who could not say 'no' to his girl for fear of losing her love. He would reluctantly agree to her demands but this made him feel humiliated and impotent. His consequent anger and depression led him to pick arguments with her and she, in turn, would also become angry. Analysis of his inability to say 'no' and its consequences led to his becoming less compliant and no longer depressed. A man I treated was equally unable to refuse his mother's demand that he and his wife travel one hundred miles every weekend to visit her. These visits made him irritable and his appeasements of his mother made him feel ashamed before his wife. Only when his fears of his mother were brought to consciousness and analyzed was he able to change his behavior and protect himself from the humiliation that led to his depressed state.

Humiliation causes shame and to analyze the origins of shame is a long process. These origins are two in number. Sexual thoughts, feelings, and impulses mobilize shame and are inhibited or repressed in consequence. More superficially, a secondary shame is roused by the basic shame and its accompanying inhibitions; or to put it simply, 'one feels ashamed of reacting with shame'. This secondary shame leads one to hide inhibitions and 'carry on' in spite of them. Both levels of shame require analysis if economy of the libido is to be improved and relieved.

Some persons are easily made ashamed by encountering overfriendliness. The therapist may therefore have to remain somewhat aloof initially to avoid arousing uncomfortable shame while he and the patient get to know each other; otherwise the patient may break off treatment. Later the patient can tolerate greater warmth from the therapist and communicate without experiencing intense shame, though it may take some time for the patient to reveal his fantasies or to relate embarrassing events. Many patients fail to reveal basic problems be-

cause of intense shame but may speak so that the therapist can guess the secret and thus help expose the problem. (Freud [*10*] tells of doing this in a case of depression. When the 'Rat-man' could not bear to describe the punishment that so disturbed him, Freud said, '. . . I would do all I could . . . to guess the full meaning of any hints he gave me. Was he perhaps thinking of impalement? "No, not that . . ." ', the patient replied, but with this help gradually and haltingly went on to tell what he had in mind.) A single woman of thirty-five with a moderately severe depression talked a great deal about her fear that she would never be able to marry because men invariably dropped her after a brief relationship. It was only when the therapist introduced the topic of homosexuality that the patient confessed her homosexual affairs and her intense shame concerning them. It is worth noting that this patient had previously been in treatment with another therapist for over a year without revealing these facts.

When the patient through treatment ceases to avoid tasks, formerly feared, that satisfy his narcissistic aspirations, his depression may be replaced by fear. If he continues to face some of these tasks in spite of his fear, he may gradually become less afraid *(13)*. A young physician undergoing analysis for anxiety and depression avoided all professional activities other than his practice. When he saw that this avoidance was due to fear of speaking up in professional groups, he began to attend hospital meetings regularly, making himself heard increasingly as time went on. As he thus became more satisfied with himself he experienced considerable relief from depression.

Sometimes, after becoming aware of certain fears, a patient goes too far and undertakes tasks that severely frighten him; if this causes mild feelings of depersonalization, new fears appear. A thirty-five-year-old man who undertook for the first time to speak without notes before a large audience sensed mild depersonalization and when his talk was over feared he was going insane. When he understood that the depersonalization arose from intense fear of a large audience, the secondary fear of in-

sanity disappeared. Such a patient can thus learn how much fear he can tolerate without depersonalization and, thereafter, usually stays within his range of tolerance.

The patient's withdrawal from everyday activities may, by depriving him of major satisfactions, accentuate his depression. A forty-year-old man rarely accepted invitations to social functions unless urged to do so. He avoided many tasks around the house such as bringing in his young children's bicycles or playing with them. He explained that his work demanded most of his energy. Becoming aware—to his surprise—through analysis how many activities he was avoiding, he resolved to seek out other people instead of hiding behind a book. His new participation pleased him, he saw that it caused only slight tension, and it rendered unnecessary the fantasies of successful business ventures and torrid sexual affairs that had compensated him for his feelings of weakness and impotence.

In many patients, analysis of fears that prevent their taking advantage of their opportunities is essential to relieve depression. A twenty-two-year-old woman with recurrent severe depressions had been used by her very disturbed divorced mother for narcissistic purposes. The mother repeatedly attacked the girl, her only child, shattering her self-esteem and convincing her that she was responsible for all the mother's suffering. Her jealous, emotional, and even violent mother taught her to expect that if she showed interest in anyone else the mother would desert her or murder her. Although she had made one attempt to live away from home, she had to return after a few months. In therapy her fear of her mother's threats and their implications had to be made conscious and worked through before she could seek new objects and new aims. She became able to live away from home, to satisfy some of her own narcissistic aspirations, and to recover from her depression.

Depression may diminish when a patient gains new sources of satisfaction in physical activity such as golf or dancing, which led to a career and largely prevented depression in an adolescent patient of mine. It is especially helpful to direct the de-

pressed patient into satisfying activity; in fact one should be wary of doing anything to discourage activity in the depressed patient even if some of it is clearly symptomatic. As long as the patient is not destructive to himself or to others, his activity may give him purpose and narcissistic satisfaction. To be verbally blocked deprives one of interchange of positive feeling with others but withdrawal from activity causes an even greater loss.

To reverse the depressed patient's tendency to withdraw may take much therapy, as the following case shows. A thirty-five-year-old man, depressed to varying degree for many years, entered psychoanalysis because of what he wrongly considered lack of success at his work. The fluctuations in his depression proved to correspond with the state of his marriage. He was often angry at his wife for what he supposed to be coldness. He would often stay up reading much later than she and then, furious at finding her asleep, would feel rejected and would masturbate. After this he would be depressed for several days, distant and spiteful to his wife, pushing her away if she tried to be affectionate. After he had punished her thus for several days, his depression would begin to lift and they would have sexual intercourse. Although he reached orgasm, he experienced only partial satisfaction, blaming his wife's 'frigidity'. If she delayed even briefly when he made advances to her he accused her of unwillingness to have intercourse. She feared his irritability, but when she fought back he became temporarily more considerate and less depressed and found more satisfaction in the relationship.

After many months of analysis the patient saw that it was when he was most hostile to his wife that she seemed to him most rejecting and that it was mainly when his impotence was most pronounced that he supposed her frigid. He realized that by his hostile behavior he had intimidated her and had even subtly threatened her with divorce—a thought he could not admit to having entertained until analysis made him more conscious of it. He recognized that to feel affectionate embarrassed

him and made him hostile. As he now saw the problem, he said, he had the choice of resolving his embarrassment and liberating his affectionate feelings or going through life as a chronically depressed man. At first he found it difficult to overcome his embarrassment and show affection, but although he still became angry at his wife, especially if she was reluctant to have sexual relations, he gradually ceased to sulk and withdraw. He found that his previous notion that he could get relief from depression only through sexual intercourse was incorrect, and he tolerated postponements of intercourse without anger. His wife became less depressed as he improved and he realized that she was far from frigid, although she was less responsive sexually when she was depressed, just as he was.

The patient attributed some of his improvement to finding out how stubborn he was and to learning how to 'give in' rather than remain trapped in a neurotic battle against his wife. He also stated that, since he could not always obtain quick relief from his tension, he had to learn to be patient. His anger had to be resolved to some degree before he could become affectionate. He became able to trust his wife and know that she loved him. Whereas he had gained much of his sense of strength from stubbornness and rebellion, he now obtained it from 'giving in' and taking responsibility for resolving some of the tensions in the marriage.

NEGATIVE REACTIONS TO THE DEPRESSED PATIENT

Depressed patients can be frustrating especially if they resist treatment or show negative therapeutic reaction. Some are highly provocative, in particular those who repeatedly complain that they are making little progress in therapy and imply that the therapist is not doing enough to help. In addition, just as enthusiasm is contagious, so is depression. The physician treating a depressed patient may become mildly depressed himself, partly through identification (as in treating a patient dying from malignancy). The therapist may therefore develop his

own resistances, resent the depressed patient, and wish to avoid him. The therapist's resentment may lead him to imagine that the patient is exaggerating his suffering, 'putting on a show' to gain sympathy. The negative reaction of the therapist may also take the form of general lack of interest, theoretical and clinical.

Since major precautions against suicide cannot be taken for all depressed patients, one is often in the uncomfortable position of knowing that if the depression should increase the patient may attempt suicide—a threat to the therapist's reputation since suicide may expose him to criticism either as a poor therapist or as one who takes too many risks. Many therapists therefore avoid treating patients with tendencies to suicide. The justifications used for transferring such patients to others are many and ingenious; in fact, when an analyst refers a depressed patient to another, it is not uncommon for him to minimize the risk of suicide to avoid having the patient rejected.

When a depressed patient comes to a therapist for his first interview, he may present himself as incompetent, inadequate, and even hopeless. He may do so partly to protect himself from the narcissistic injury of rejection, like students who do little studying before examinations so that if they fail they can feel sure that had they really tried they could have done well. The therapist may be misled by a patient's manner of presenting himself, since he may appear more disturbed than he actually is. Furthermore, the therapist may intuitively feel the patient's strong narcissistic need and may fear the expression of transference hostility which may arise if narcissistic supplies are not forthcoming. Such reactions can lead therapists to avoid psychotherapy or psychoanalysis of many depressed patients who would benefit from it.

SUMMARY

This paper offers some suggestions for the treatment of depressive aspects of neurotic illness. It includes discussion of problems of narcissism, negative therapeutic reactions, transference

and countertransference, and other practical questions encountered in treatment of depressive symptoms.

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EXPLOITATION OF THE SENSE OF GUILT

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I

The establishment in infancy of a pervasive sense of guilt within children is the effect in rearing of influences brought to bear upon them during their earliest years. Whereas the ego and the id are inherited components of the psyche, the superego, and the sense of guilt which derives from it, are acquired and fashioned anew in the children of each generation by training and example. The introjection of parental standards, prejudices, ambitions, and prohibitions curbs primitive impulses and adapts the child to the environment in which he is to live.

Freud *(5)* distinguished an external antecedent to the formation of the superego—when the child first senses that he has evoked the displeasure of those upon whose love and approval his happiness and comfort depend. Guilt proper arises autonomously after there has been an internalization of the parental admonitions, which constitute the primitive superego. The superego, then, stands in relation to the ego as the parent did to the child; any infringement of its canons leads to a state of tension between it and the ego and is experienced as a feeling of guilt which serves, like anxiety, as an affective signal urgently requiring cessation. Freud differentiated guilt that occurs as a reaction to sinful thoughts, wishes, or feelings, from the remorse that follows the perpetration of a misdeed. He noted furthermore that the superego is much more severe than the parent in so far as it punishes not only misdeeds but such sinful intents as thoughts, wishes, and feelings. Freud attributed the ubiquity of the sense of guilt in mankind to impulses of hatred that are mobilized for action, then curbed in a process of re-

nunciation of instinctual gratification, and displaced to the service of the punitive superego for discharge.[1]

To exploit means both to make beneficently available (as the coal in a mine) and, more commonly, to make use of dishonorably for one's own satisfaction or gain. It is in the latter sense that exploitation of the sense of guilt, once recognized, is found to be exceedingly prevalent in our society. It pervades all walks of life, all sorts of relationships between people; it has institutional as well as personal modes of functioning. The widespread incidence of the phenomenon establishes that it is of substantial importance in human behavior and prompts investigation of its origin and history, its motivation and mode of operation, its effects on the exploiter and the exploited.

II

During World War II when the vexing problem of the proper management of neuropsychiatric casualties was often the occasion for acrimonious controversy between regular army psychiatrists and those recently inducted from civilian life, a British psychiatrist with extensive experience presented, not without relish, his strategy for coping with the challenge whenever he was confronted by a tough, 'treat-'em-rough' adversary with whom he could get nowhere. It was his wont deliberately to provoke his antagonist until he lost his temper and showered him with abuse. Promptly thereafter, the once implacable officer gave him carte blanche to manage his charges as he saw fit.

In the course of one of his visits to the United States, Khrushchev was grossly provocative and abusive about the American way of life. When some in the audience reacted to this with understandable indignation and rancor, he chided and reproached them severely for their boorishness and incivility as hosts to a visiting dignitary. Throughout the remainder of his visit his audiences, though no more sympathetic to his views than the ear-

[1] How much more common this is than can be surmised without psychoanalytic insight, and what unlikely guises it may assume, Freud showed in his studies, Criminals from a Sense of Guilt and Those Wrecked by Success *(6)*.

lier ones had been, treated him with the utmost deference as if through identification with the original offenders they seemed to be atoning for the 'sin' by their exemplary behavior.

The dream of a patient lends itself to a similar interpretation.

> I am riding a horse. I do something which causes him to rear and throw me. As I lie on the ground, the horse approaches and licks my cheek. I feel sensuously pleased and tell myself: 'It was worth it!'.

The dream is a faithful reproduction of a circumstance in his childhood. Morbidly sensitive to his mother's coldness, he had striven desperately to elicit some token of love from her. A device that had proved effective was to nag her to the point of exasperation. She would then become penitently indulgent.

Patients in analysis frequently try by provocation to goad the analyst into a display of temper in the hope that subsequently he will feel remorseful and give the patient some of the indulgence he craves. One man, to whom such an interpretation was given, readily assented that he tended to manipulate others in this way. His mother, he recalled, had often contrived to play on his emotions in this manner.

Much more frequent are those instances of exploitation of a sense of guilt which is inherently operative to an intense degree in many individuals. The exploiter unerringly appraises the vulnerability of his exploitable victim whose treasonable superego will render his ego at least acquiescent, if not helplessly compliant.

A literary instance of this type is Shakespeare's Lady Macbeth who, intent on prodding her vacillating husband to commit the murder of Duncan, upbraids him.

> Was the hope drunk / Wherein you dress'd yourself? hath it slept since? / And wakes it now, to look so green and pale / At what it did so freely? From this time / Such I account thy love. Art thou afeard / To be the same in thine own act and

> valour / As thou art in desire? Wouldst thou have that / Which thou esteem'st the ornament of life, / And live a coward in thine own esteem, / Letting 'I dare not' wait upon 'I would', / Like the poor cat i' the adage?

Knowing well that her husband's 'vaulting ambition' is strongly countered by moral revulsion, and by his being 'too full of the milk of human kindness', she taunts him in words that she knows will stifle the protests of his conscience and mobilize his resolve to act in accordance with her will.

Every analyst in his practice hears of countless instances—in families, between friends, in business relationships—of the flagrant and often systematic inculcation of an unreasonable burden of guilt upon a hapless victim for the profit or convenience of the aggressor.

Analysts inevitably are objects of this technique of exploitation acted out in the transference by patients predisposed to engendering a profitable sense of guilt in others. A successful businessman (who regularly falsified his income tax returns) had bargained for an analytic fee vastly disproportionate to his income. It was his rationalization that whatever he did was justified because his profits were reinvested in his business. Every service should have a fixed price, he declared, and the practice of scaling fees to accord with differences in income was unconscionable. He asserted that analysts took advantage of supply and demand to charge exorbitant fees; that a dedicated man of science should not be so concerned with material gain. It later proved that this man had considerable contempt for and guilt about his highly profitable business activities. In striving to place a burden of guilt on the analyst, he was repeating a method that had served him well in business and other relationships; in addition, he was seeking by projection to deny his own unsavory motivations.

From lack of experience, analysts in training sometimes fail to detect this mode of exploitation, and when they are assailed by the patient with various charges of callousness, aloofness,

complacency, and the like, lose their analytic composure, become conciliatory, and succumb to the wiles of the patient.

In times of war the military establishment, whose function it is to win the wars, requires for this purpose several armies of men. Because of the pressure of need, the military must perforce disregard all but the most patent disabilities (i.e., psychoses) among recruits in their capacity to withstand the rigors of training and the ordeal of battle. That some who appear 'normal' are psychiatrically deemed sufficiently neurotic, psychopathic, or otherwise unfit for military service is hotly contested. Among them are many inductees who, despite acute awareness of their vulnerabilities, are equally phobic about rejection for service and the subsequent dread of being called 'slackers' and cowards. These prejudices, in which an unenlightened public concurs, constitute in a special way exploitation of a sense of guilt. During World War I there was widely displayed an enormous poster of Uncle Sam as a stern looking gentleman with a piercing glare, pointing an accusing finger at the passer, with the caption: 'Uncle Sam Needs You'. What more graphic representation of an accusatory superego! In England the white feather, sent to everyone suspected of evading the draft, served a similar purpose. A similar psychological process operates in those instances of confession under pressure to a crime one never committed.

The influence of organized religion in engendering or promoting a sense of guilt is a highly controversial subject. Among psychoanalysts are those who with Freud consider religion a vestige of psychic infantilism, and those who find no inconsistency in accepting the tenets of both religion and freudian psychoanalysis. Nevertheless there are among religions a host of taboos and commandments, dogmas and rituals, atonements and expiations which compel those who are susceptible to conform from fear or to suffer the consequent sense of guilt.

III

The objection may be raised that the military psychiatrist who

successfully exploited his commanding officer's sense of guilt was actuated only by a benevolent determination to protect his crippled charges. The poster intended to promote recruitment by intimidation was, after all, intent on sustaining the war effort. In both instances an altruistic motive seems to predominate. Our concern, however, is not with the ultimate effect of the maneuver but simply with the intent of the exploiter in a dyadic relationship which, in both, was to produce a psychic imbalance in a susceptible individual and thus to control his behavior. The differentiation we are seeking is better illustrated by citing the example of the parent who prefers for his own comfort and convenience a docile child to an enterprising one; or by contrasting the teacher who exploits the curiosity and creativeness of children to one who deems heretical or subversive any questioning of the 'truths' he propounds.

Since something akin to moral bankruptcy has occurred in our time, it is often maintained that there are too many individuals without any sense of guilt, and that any measures which would reverse this trend are justifiable. Specifically, it is said that the defective superego of the psychopath can be most constructively repaired by mobilizing and exploiting his sense of guilt. From the point of view of society this is reasonable and laudable. For the psychopath, however, such measures if they succeed at all are simply a brittle conformity, not likely to outlast the pressures brought upon him.

IV

Adaptation is defined as modification of an animal or plant fitting it more perfectly for existence under the conditions of its environment *(11)*. This definition does not adequately account for the process. The bird in building a nest, the beaver in building a dam, does something *to* the environment which promotes survival of the individual and the species. Dewey stressed this aspect of the adaptational process and noted that the higher the form of life, the greater its prevalence *(2)*. In a detailed study of adaptation as a function of the conflict-free ego, Hart-

mann also distinguished autoplastic and alloplastic modes of adaptation, and called attention to a third form: seeking a new environment as the basis for more effective performance *(7)*.

In so far as exploitation of the sense of guilt controls the behavior of another individual and directs it into channels desired by the exploiter, it is a type of alloplastic adaptation brought about by modification of the human environment. Since the device depends for its effectiveness on a relatively recent acquisition of man, the superego, it suggests that the device itself is a recent development in the life cycle of the human race. It may accordingly be profitable to try to establish its historical antecedents.

Exploitation of one creature by another is as old and as constant a feature of biological functioning as is exploitation of the natural physical environment. Side by side with the bird that builds a nest and the beaver that builds a dam is the cuckoo that lays its eggs in the nests of other birds, and the ant that abducts ants of another species into slavery. Man, to survive, is compelled to exploit all realms of nature—mineral, vegetable, and animal—and despite his aspirations to the contrary, is prone to exploit his fellow man as well. Until recent times brute force and physical domination prevailed, and still do. A highly developed, truly democratic society, with its emphasis on the dignity of man and professed equality under the law, requires the development and elaboration of new and more highly refined psychological measures to control human minds. Of these, exploitation of the sense of guilt is not the least important.

As we know, the sense of guilt is attributable to the mobilization of aggressive energies generated by frustration of instinctual drives, which subsequently are invested in the superego. As stated by Freud, '. . . the more virtuous a man is, the more severe and distrustful [the superego] . . . so that ultimately it is precisely those people who have carried saintliness furthest who reproach themselves with the worst sinfulness' *(5)*. A chart of the development of the human race, based on the degree of instinctual gratification, would show an ever-increasing renunciation,

and consequently more and more frustration, in the progression from prehistoric times to the present. Assuming that the 'original sin' was that of patricide, we can further assume that primitive man had subsequently to give up other substantial gratifications of aggressive and sexual drives such as homicide, infanticide, cannibalism, human sacrifice, incest, rape. Further advances in civilization brought additional restrictions: for example, monogamous marriage and enforced celibacy outside the marital state. Saint Augustine, who considered not only carnal desires but æsthetic pleasure as sinful, is representative of the increasing trend toward subjugation and degradation of instinct, a trend revitalized at a later period by the Puritans. Simply stated, the history of man is a chronicle of more and more things that he is made to feel guilty about.

The summation of strictures by the superego on the instincts is seen to have reached a degree which led some individuals to assume responsibility and guilt for the state of things in the universe. Both before and after Spinoza's insistence that all existence is embraced in one substance, Nature, voices were raised in dissent. The Greek dramatist's 'but best of all is never to have been born' and the Greek legends which picture the gods as lecherous, conniving, vindictive, and deceitful are evidence of this. The Prometheus myth can similarly be interpreted as protest against gods who begrudge man his ingenuity and thwart his efforts to tame the ruthless forces of nature. The invention of the devil solved for some the problem of evil in the world by absolving God of the responsibility. Others, like Voltaire, with his scathing denunciation of this best of all possible worlds, or Mark Twain, with his tragic view of life under a façade of humor, would seemingly have preferred to return the world to its maker for repairs (as would Helmholtz the imperfect structure and function of the eye). It is as if nature had spawned a cosmic superego that observes and judges it, as the superego judges the ego. Unlike God, who after the creation contemplated the products of his labors and found them 'good', these critics are more impressed by the cruelty, the pain, and

the suffering that result from the operation of blind forces. However, the ultimate refinement of the sense of guilt is the assumption of personal responsibility for this order. It appears, for example, in such phenomena as revulsion against killing animals not only as a sport in hunting but even as a means of sustenance, in antivivisection despite the value of animal experimentation in conquering disease, and in vegetarianism. In many instances, such often fanatic aversions to demonstrable biological laws are idiosyncratic taboos imposed by the superego—individual or collective—to deny, ritualistically, oral-destructive drives. But this need not always be the case.[2]

In the development of the individual, separation anxiety is succeeded by castration anxiety which, in turn, is supplanted by moral anxiety. In phylogeny, the fear of annihilation and the need for security are the overriding primitive factors, followed later by a phase in which the influence of the superego prevails and the sense of guilt becomes increasingly pervasive. Exploitation of the sense of guilt as an adaptational process results then from the favorable convergence of two complementary elements. One is an innate human tendency to exploit others; the other, guilt-ridden exploitable victims.

V

In accordance with the mechanism of overdetermination (not only in the formation of dreams and symptoms but also of human behavior), and on the basis of the principle of multiple functioning *(10)* (which invokes the operation of several psychic agencies to account for a given psychic end-product), one would anticipate with a fair degree of certainty additional uses and meanings that derive from exploiting the sense of guilt in others; and, in fact, evidences of them are readily discernible. The exploiter discharges his aggressive drives in provocations,

[2] Eissler considers the vegetarianism of da Vinci to be a reaction-formation to cannibalistic fantasies and considers it a sign of depression *(4)*. One wonders, without discounting the importance of this unconscious factor, whether such contemplative vegetarians as da Vinci and George Bernard Shaw did not also judge the world and find it wanting.

attacks, and abuses. He defends his ego from anxiety with regard to objectionable impulses in himself by projecting them onto a victim and attacking them there. By rationalizing his exploitations as a striving to correct improper attitudes or behavior in another, he appears virtuous and deserving to himself.

That exploitation can serve as a mechanism of defense makes clear what Hartmann has observed in another connection: '. . . the same process of defense quite commonly serves the twofold purpose of acquiring mastery over the instincts and of reaching an accommodation with the external world' *(8)*. The process of adaptation is by no means limited to the conflict-free area of the ego for its achievement.

The genetic principle leads us to assume that a characteristic of the type we are discussing must be derived from definite experiences during childhood which render one individual more inclined to resort to psychological modes of exploitation than another, and to develop an acutely sensitive perception for the susceptibility of others to such exploitation. The fairly common and amusing spectacle of a child who has hurt himself ceasing to cry as the pain wears off, only to burst into tears again when an adult capable of offering comfort appears, provides evidence that something akin to psychological manipulation is already operative at an early age. It seems plausible that a child may be conditioned to exploit the feelings of others by observing repeatedly that after provoking an outburst of anger in or physical punishment by a parent, the parent becomes unusually kind and indulgent. Physical weakness, real or fancied, may likewise predispose a child toward psychological exploitation of others, just as such weakness seems to stimulate in other children a compensatory striving for intellectual or artistic superiority. The child of a parent who exploits him may, by identification, perpetrate on others a method of which he himself had formerly been the victim; or having noticed in himself the sequence of uncontrolled behavior—remorse—atonement by good deeds, he may by experimental projection find that he can often count on eliciting a similar response in others.

While identification may play a significant role in creating the psychological exploiter, it seems more specifically that it is likely to determine just who is to be exploited. Thus, while the prosecuting attorney who identifies himself with authority and the forces of law and order will exert himself to exploit a sense of guilt in the criminal in order to get him to confess, an attorney who identifies himself with the hard-pressed criminal, and in his choice of a profession devotes himself to defending criminals, will seek rather to exploit the sense of guilt of the judge and the jury. We need to know much more about the exploitative character before we can fully account for it. We now can only surmise how an arch-exploiter develops the instinct to detect a suitable victim and his vulnerable spot as unerringly as the wasp finds the only host in which she must lay her eggs. Turning to the other participants in this relationship, it is highly probable that the susceptibility to exploitation of the sense of guilt is most easily activated among individuals who are depressive, obsessional, or masochistic.

The capacity of some individuals heroically to espouse and defend what reason dictates in the face of denunciation, punishment, social ostracism, rests in no small measure on the soundness of an adequate superego, sustained in its values and goals by an independently strong ego. Although the establishment of a superego represents an internalization of an originally external authority for the discrimination between right and wrong, good and bad, few, if any, mature individuals bring the process to completion. The individual most closely approximating a state of autonomy would be one endowed with the superego of the exceptional character just cited; most removed from it, those who lend themselves too readily to exploitation of their sense of guilt because of dependency on the moral judgment of others *(9)*.

VI

At first glance the mechanism of exploitation of the sense of guilt, in so far as it influences and controls the behavior of

another person by provocation, resembles masochistic provocation *(9, 3)*. In masochistic provocation, however, the aim is generally considered to be punishment, humiliation, frustration because of the pleasure to which they are a precondition, whereas in exploitation of the sense of guilt we assume that the aim is to exact obedience, indulgence, special consideration. The masochist seeks sadistic love; the exploiter, acquiescence and submission. It is possible, and perhaps common, for both mechanisms to occur in the same individual as one or the other of his sadomasochistic components come to the fore. Thus, the masochist by provocation obtains the flagellation he craves, but he may go on from there to a further benefit, counting on a display of his wounds to arouse guilt, compassion, and atonement in his assailant.

The common element of playing on the emotions of another person to gain indulgence invites comparison to what Alexander *(1)* called 'bribing of the superego', in which, after the superego has been appeased by sufficient atonement, it relents enough to permit reindulgence. Manipulation plays a role in both processes. However, in bribing of the superego it is an intrapersonal process in which the superego is appealed to. Exploitation of the sense of guilt, on the contrary, is a personal process in which another individual is the object of appeal. One seeks indulgence from his superego; the other, in accordance with the dictates of his superego, seeks indulgence from an individual.

SUMMARY

The ubiquitous phenomenon of venally exploiting the sense of guilt in an individual and among groups large and small is studied psychoanalytically. The evolution of the device as a mode of adaptation in more complex and sophisticated societies is traced. In accordance with the principle of multiple functioning, other mechanisms and applications of the device are identified. Genetic precursors of the phenomenon are suggested,

and speculations proposed to account for predispositions to the roles of exploiter and of exploited victim. Comparisons with and differentiation from analogous phenomena are drawn.

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SOME ASPECTS OF THE DEVELOPMENT OF THE EGO IDEAL OF A CREATIVE SCIENTIST

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Recent emphasis on ego psychology has been paralleled by an intensified interest in the creative process. Many authors have studied the adaptive role of various ego mechanisms which have served as integrating concepts toward understanding the metapsychology of creativity.

Conceptualization of the ego as an apparatus with diversified functions in subsystems is one of Freud's contributions. The history of ego psychology need not be explored here since key articles have been written on this subject. Two articles, however, are particularly pertinent in introducing the line of inquiry to be pursued. Freud *(7)* discussed the interaction of id impulses, ego mechanisms, and memory traces in normal thinking. Hartmann *(16)*, in a similar and comprehensive fashion, expanded this theoretical approach, placing the ego as a pivotal concept in a theoretical framework. He attempted, in his formulation of autonomous ego functions, to explain phenomena outside the realm of psychopathology. There has been considerable debate as to whether creativity is such a phenomenon.

In a previous communication *(12)*, I attempted to demonstrate by clinical observations that psychopathological processes hindered and sometimes completely inhibited creative activity. Lee *(21)*, Klein *(18)*, and others consider creative activity a healing factor in overcoming a depressive episode. Kris *(19, 20)* studies the various ego mechanisms in somewhat more detail and concludes that the ego undergoes a regression, controlled in nature, during creative activity. Eissler *(4)* believes that there is an expansion of the ego which has to be differentiated from regression and, in his pathobiographical study of

Goethe *(6)*, concludes that conflict has to become encapsulated so it cannot interfere with other ego functions responsible for artistic innovation.

No attempt is made here to define creativity since the definition itself is controversial and cannot be settled on a purely descriptive basis. Rather, the ego process accompanying creativity is considered the essence of creative phenomena. The special environments, developmental potentials, and particular sensitivities of both creative artists and scientists have been discussed by many authors, particularly Greenacre *(14)*. These studies have also helped us in our understanding of psychic structure. The study of the creative process, one of the 'higher ego functions', is a useful method which may contribute to the formulation of a comprehensive ego psychology. The circular situation of conceptualizing within a fluid and impermanent theoretical system from a series of clinical observations may have paradoxical elements but is not unusual in an empirical science. Whether one is interested in creativity per se and wishes to utilize ego psychology for its study, or is primarily interested in ego psychology and wishes to use the study of the creative process as a referential position, should not make too much difference if our observations are extracted from psychoanalytic material.

Here certain theoretical principles, derived from the observations of scientists in psychoanalysis and postulated in a previous paper, are expanded. Energic shifts between primary and secondary processes and the increased efficiency of various integrative and synthetic ego mechanisms are scrutinized further and enlarged upon with the presentation of more detailed clinical material and special references to genetic and developmental areas which were not previously emphasized. Instead of exploring psychoeconomic factors and specific energy distributions, the role of memory traces and their organization as introjects are stressed with specific reference to the formation of the ego ideal. The nature of the ego ideal, the specific introjects, and the ego's constriction or expansion when faced with conflict distinguish one person from another. Although the creative person

tends to handle his conflicts in a characteristic manner, defensive techniques common to the noncreative person are also used.

The infantile experiences to be described are not considered as necessary determinants for creativity. One cannot reach conclusions about the source of a scientist's talents from a clinical study. The men I have studied were precocious, and constitutional factors must have been significant. Certainly they were not creative because they had particular psychic conflicts.

This study stresses that the techniques used to master problems may be effective in creative activity. Similar ego processes may operate during psychic development and in scientific creativity. The concepts discussed are derived from observations of the transference reactions of a patient who received universal acclaim for his discoveries. Genetic material is considered when it is relevant to the primary data. In the interest of discretion the following presentation is purposely vague about data which is of minor importance to the thesis.

The patient, a young unmarried man, sought treatment because of episodically recurring depressions during which he could not do creative work. Although many people sought his company he did not believe that they were really interested in him but that they gravitated toward him because of the fame that he had achieved as a scientist. He was particularly vexed because he was not able to form any deep, lasting, or 'inspiring' friendships.

His relationships with women were transitory; he indulged in occasional sexual relationships but felt no emotional bond with any of his partners. Toward men he felt that he was never able to effect any particularly close tie and his friendships were characterized by shallowness. He had idealistic notions concerning a deep bond with both a man and a woman and desperately wanted someone that he could look up to and respect. All the people he had met had 'feet of clay'.

The only area in which he did not feel disappointed was that of science. He spoke of science in anthropomorphic terms and

worshipped the ideals of truth and discovery. It was sometimes difficult to distinguish whether he was talking about a deity or concepts from his particular field of work. He emphasized the strength of science, its immortality, omnipotence, and trustworthiness.

He described his mother as a dominant ambitious woman who idolized him. The patient enjoyed this attention and the fact that he was in the spotlight, but was also made uncomfortable by being shown off. He was sensitive to the fact that he felt 'exhibited' and as a consequence grew to distrust her. An aspect of this conflict was his recognition that his mother was inconsistent. She tended to revere and praise him but could at other times act very cruelly. He was never able to predict her outbursts of anger. For example, serious transgressions were overlooked or forgiven quickly, while on other occasions he was treated harshly for only minor offenses. He developed the belief that women were paradoxical and unfathomable creatures.

He went on to describe his mother as charming, talented, and able to use tact which sometimes bordered on manipulativeness. She displayed an outward demeanor of selfless submissiveness to men and had a superficial feminine attitude indicating docile and gentle qualities. The patient, however, felt that this was deceptive. He remembers that after he had come home late from a date during his adolescence, his mother went into an intense rage and spanked him brutally. The patient could never forget the anxiety as well as the shame and humiliation of this assault.

His father ostensibly had a position of supreme authority. He was dominant, vocal, and seemingly made all the important decisions in the household. He demanded and commanded respect and was considered sagacious, cosmopolitan, intellectual, a veritable fountain of wisdom whose authority and strength would protect the family against any calamity. This idealistic picture received more than just re-enforcement from the mother; in fact she clearly helped create this portrait.

The patient reported a rude awakening during latency in his

estimation of the father. In so far as his social world had expanded beyond the confines of home, he was able to compare his father with those of his friends. Perhaps he 'had never noticed before' but now he compared his father's competence and social poise with that of other men, and recalled instances, such as parties, social events, scout meetings, or other community affairs, where he had noticed that his father was shy and withdrawn and behaved in an inept and ineffectual manner. He stressed the fact that his negative re-evaluation had occurred precipitously, almost overnight, and that his disappointment had known no bounds. He was extremely melodramatic when he revealed this material.

This reaction, which is frequently seen in adolescents, occurred when this patient was seven years old. The patient was now aware of his mother's dominance and, in retrospect, he believed he had then decided she was really the ruler of the household. All of her ambitions were directed toward him (he was an only child), and she tended to exploit his intellectual abilities. She had supreme confidence in his talents, and the patient became accustomed to thinking of himself as potentially creative.

This close relationship also had erotic components. She would often undress before him and not only bathe in his presence but sometimes took her bath with him. The relationship with his mother became the pivot around which all activity revolved and his father was pushed into the background. He was treated as a 'miniature adult' and was given the prestige, authority, and status that 'should have belonged to father'. The mother treated him as a confidant, discussed matters of adult importance by the hour with him, and respected his comments and decisions. The patient revealed how frightened he was of this 'honor', although, at the time, he believed he was pleased.

During latency he became a hero worshipper. Eighteen months after having experienced the disappointment he 'sought and found' an understanding and sympathetic male teacher whom he greatly admired. From his description it became ap-

parent that the reverence and adoration he had felt for the father had been shifted to the teacher. The teacher, in turn, reciprocated in that he was enthusiastic about the patient's scientific potential. Since he was always so far ahead of his classmates and displayed a sophistication considerably beyond his years, he constantly found himself in the position of a protégé with an enthusiastic mentor. He had a series of such teachers, many of them spending much time tutoring him. During high school he continued to receive praise and more definite encouragement to pursue science. He recalls being engaged even then in innumerable discussions that were passionately devoted to scientific ideals. Although he maintained some contact with his contemporaries, these relations meant less to him.

Even in elementary school the teachers treated him as if he were an adult. He felt that his teachers had been able to open up a new vista, to show him a horizon with unending possibilities, and to point out a world that he never suspected existed. Through them he achieved an 'intensive learning experience which reached sublime and blissful levels'. His propensity for hero worship reached even greater heights when his mentors introduced their own personal heroes through conversations and literature. These were the great men of science, the builders of the foundations of the particular field the patient later pursued. First the patient revered the men, then arduously and eagerly assimilated the pioneers' work which led increasingly to an attitude of self-reliance. This form of idealism continued in his adult life. The original teachers were, of course, left behind. But the patient succeeded in forming a relationship with the scientist his first teacher revered. It was shortly after this man's death that the patient sought analysis.

The transference neurosis revealed in meaningful detail the sequence of object relationships that were presented from the genetic background of this patient. He began his analysis with complete trust and confidence. As observed in other scientists this patient had a feeling of reverence for psychoanalysis

and considered Freud one of the greatest geniuses of all time, ranking him at the same level or even above some of the great men in his own field. Consequently, he thought of the analyst as a god who could accomplish almost any miracle and attributed qualities of flawless perfection and infinite wisdom to him.

The patient's unconscious wish was to incorporate the omnipotence he had assigned to the analyst not only to gratify all of his infantile longings but to become a superman in his own right. His idealization took on grandiose and magical qualities. For example, his dreams always portrayed the analyst as a person of supreme strength who would nurture him and rescue him from some mysterious and destructive force. The alliance of patient and analyst would make him invulnerable and superior.

After about six months, the inevitable disappointment occurred and the patient was so bitter and depressed that he nearly terminated the analysis. At this point he felt that the analyst was unable to do anything for him, and described him in exactly the same terms he had previously used in speaking of his father, i.e., dull, materialistic, passive, ineffectual, crass, and stupid. Interpretation which he had previously valued so highly now became meaningless. He was depressed and withdrew from all object relationships too. His interest in science diminished and he was unable to produce anything. He vehemently denied that he had ever learned anything from the analysis and told of a dream in which a man who was a composite of the analyst and his father gave him something to eat which he found distasteful. He did not feel the substance to be particularly harmful but he believed that it would not do him any good nor have any nutritional value. He then defecated the substance and felt relieved because of the bowel movement. His associations dwelt on the conviction that his father was unable to teach him anything useful and that he had to extrude what was incorporated from him and of him after he discovered his weakness. This dream is very much like that discussed by Abraham *(1)* in his classic paper on the dynamics of depression. It will be recalled that Abraham tells of his hair turning gray

after the death of his father, which he interpreted as indicating his introjection of the lost love object, and that he overcame his depression when he was able to expel this introject anally, a situation which was manifest in his dream life. Shortly after his dream, my patient's depression lifted and was followed by a period of enthusiastic creative activity.

After this the patient felt he was able to see the analyst in a new light. He commented that he now realized that what he wanted from life did not really exist and that the ideal qualities that he believed me to have possessed (similar to those his father had prior to the 'catastrophic disappointment') were not to be found without some special effort. He could not passively wait for some such person to appear. On the contrary, he felt that he had to construct such a person himself.

As he elaborated this, he indicated that it was not simply that he had to create such a person in fantasy. He did, in fact, mean that but, more important, felt that he also had to turn toward the outer world to find a person to whom he could give the ideal qualities his father lacked and which I also could not supply. He was preoccupied with the task of creating an ideal person and of including this ideal in an object relationship.

He gradually began feeling positive toward me and his behavior vacillated between the position of a student and that of a teacher. At times he cast me in the role of being able to learn a good deal from him, and patiently preached standards of conduct, integrity, and scientific idealism. He wanted me to learn what it meant to be curious and to pursue knowledge assiduously for its own sake. On the other hand, he felt that I had a good deal of technical information and was a master in logic, well-grounded in the philosophy of science, and thereby could supply him with the power to master the mysteries of the universe. This latter attitude was similar to the former one where he deified the analyst but he now felt that these were not qualities that were inherent in me but qualities that I possessed because he had been able to help me develop into an omnipotent person. He definitely felt responsible for my omnipotence

and the material clearly revealed that he believed that he had succeeded in creating a 'superman'.

Often his descriptions of transference feelings indicated that he was not speaking of a person. His 'creation' became so esoteric that it gradually lost most of its human qualities. His descriptions of me became so abstract that my person was no longer required. In other words, he was speaking of an ideal which was itself science but his conviction was that he had created it. As he incorporated elements of this ideal within his personality and grew more confident he did not feel he acquired his abilities from me. Rather, he believed that he had created his own ideal in the outside world, in this case by making a superman out of me, and then introjecting it. At this time, the patient was reaching a peak in his creative abilities and was so ecstatic that once again he saw no need to continue analysis.

Fortunately, some inroads had been made into the defensive meaning of such an idealization and into his need to believe that no one gave anything to him. He now spoke of his fear of his mother and brought it up contiguously with his precipitous disappointment and consequent irreverent attitude toward the father. His reconstruction was that she subtly exerted a marked influence on his attitudes and loyalties. She was the one who had set the father up as a god and he, being somewhat a martinet, had enjoyed the role. She propagandized for him to her son; his attitude of reverence was, as a result, founded more on her influence than on actual experiences in his relationship with his father. His mother was equally adept at tearing him down and had subtly undermined his confidence in his father for a long time. His confidence and esteem in his father gradually eroded under the influence of her insidious destructiveness, but the final collapse seemed to be traumatic and sudden. At this point in the analysis the patient became preoccupied with unpredictable women. He felt then that he had to turn toward the outer world and find a protector against his mother's engulfing destructiveness. The need for an idealized father was

particularly strong in that he represented an escape and a protection from mother. He had to be alert against a surprise attack.

During the latter phases of analysis, when he had insight into the conflicts just described, his ego ideal differed in that it had considerably less magical omnipotent qualities as its protective function was less evident. He still felt that he had created his own ideal and had had few actual life experiences after which to model himself, but he acknowledged that his mentors as well as his father in some way contributed to the content of this ideal.

DISCUSSION

The unique quality in this case was the time and manner that the patient attempted to master conflicting parental ties. He actively sought the idealized teacher, remote from the original parental object, during latency rather than at puberty or adolescence when this more frequently occurs. Many children go from disappointment to disappointment in an attempt to recapture the lost object and in some instances may even find it in an abstraction or cause.

His mother was reported as being extremely involved with him in early infancy. Similar to the description of Loewald *(23)*, it is possible that her narcissism provided her with sufficient empathy for his needs so that he gained the strength to seek new objects. The first disappointment may have occurred when her narcissistic investment blocked his maturation but had already sufficiently contributed to his ego strength[1] to facilitate his turning to the father rather than remaining fixated.

The patient was able to withstand the maternal onslaught because his father helped him in more ways than he was willing to acknowledge. After age seven, however, with the broadening of his social world, his father no longer afforded the needed

[1] Dr. Phyllis Greenacre stated that the mother 'contributed to the development of the autonomous ego inherent in gifted children, in that she permitted and encouraged his activities . . .'. (Personal communication.)

protection from his frightening fantasy of being engulfed by his mother. Seeking a remote idealized object was an attempt to make up for this lack.

The patient prided himself in believing that he had a forceful personality, one that had no difficulty in answering the questions of who he was and where he fitted in the fundamental scheme. Undoubtedly, his self-appraisal was narcissistically tinged, but a good deal of his self-satisfaction was without smugness as he contrasted himself sharply with his father's passive orientation and mechanistic materialistic outlook. He had a need to stress that his early introjected version of the father was for the most part repudiated and replaced by something else. The ideal qualities that had been previously attributed to his father not only ceased to belong to him but also ceased being ideal.

In this connection, the autobiography of the physicist, Michael Pupin is apropos *(26)*. Pupin goes into lengthy and admiring descriptions of his mother's strength of character, her confidence, and her interest in him, without which he felt he never could have been able to elevate himself to the pinnacle of academic achievement that he finally obtained. Still more interesting is the fact that his father is infrequently mentioned. The reader does not get a clear-cut impression of him as a personality, though the mother is described in considerable detail.

The lack of material about the father becomes especially interesting when Pupin goes on to describe his highly personal attitude toward science. That he had a need for a father became quite evident, but apparently he was disappointed in reality, and had to seek an idealized father elsewhere. Science, which he endowed with spiritual and religious overtones, served this purpose. He states that 'every American college and university could raise an invisible capital consecrated to the eternal truth and fill it with the icons of the great saints of science'. He felt that the 'saints of science' imparted their knowledge (secrets) to their sons, the young, eager, and sincere students

of science. Finding people of his own age inadequate as teachers, he sought older men and then revered them as if they were gods. He also implied that his attitudes were acquired without the help of a father in real life, but certainly the mother's role is not neglected. He felt that she inspired him to pursue what he considered to be the pathway to immortality.

The creative product is an expansion of reality, a new accretion to the outer world that is constructed and given form by the scientist. In a study of the ego processes accompanying creative activity, I have observed that this expansion occurs when the scientist is able to effect an expansion of his own ego, reflected in a heightened inner and outer perceptual awareness and unusual effective executive responses. The executive, integrative, and synthetic ego systems operate with greater efficiency and economy. They seem to have at their disposal energy which was not dissipated in countercathexis. The ego is free of conflict and, as Kris *(20)* has emphasized, secondary process extends to include primary process instinctual elements.

In describing reality-attuned behavior, Freud *(7)* pointed out that the id impulse cathects an appropriate memory trace that associatively corresponds to its content. These memory traces, which are found in the preconscious system, represent intrapsychic registrations of past experiences, situations, or relationships that have been meaningful to the developing psyche. When a need is stimulated, the ego executive system must function in accord with reality in order to supply the elements required to satisfy that need. Needs seek immediate gratification, but survival necessitates that executive systems be integrated with inner and outer reality. Freud pointed out that the process of thinking includes delayed action and testing potential action in graduated doses. In order to achieve this, the well-integrated ego draws upon a series of memory residues which have been gratifying and pleasurable or frustrating and painful. Integrated in these memories are the objects that have made possible the pleasure or pain.

Freud *(8)* said that a thought whose formation is stimulated

by an inner need reached preconscious existence 'through becoming connected with the word-presentations corresponding to it'. The verbal image constitutes the content of the preconscious memory system. Rapaport *(27)* extends this concept somewhat in that he believes that an idea, initally an instinctual representation, becomes conscious by being hypercathected and may or may not include a 'relationship to the verbal trace'. However, an idea, when elevated to the position of a thought retains its relationship to reality, which, according to Rapaport, occurs 'through experientially meaningful connections of ideas'. The latter are part of 'an experiential connection system of progressively more differentiated and discrete ideas' and are also part of the memory system. When the id impulse does not go through the secondary process refinement of thought, Freud *(9)* wrote that hallucinatory wish-fulfilment may result. In this instance, the memory trace of the archaic object affording gratification is revived and the aim of the psychic apparatus is merely to re-experience that perception which is connected with the gratification of the need. The object is viewed in a primitive fashion rather than as part of a gratifying reality-attuned experience. According to Freud *(10)*, ideas are cathexes of memory traces, whereas in a hallucination 'the cathexis passes over the memory system to perceptual consciousness' *(8)*. In this connection, Piaget *(24)* wrote that a thought requires no outside object to produce it (similar to Beres' concept of a mental representation) because it occurs from a combination of memory traces. Beres also considered this combining of memory traces a determinant of imagination and part of the process of creativity *(2)*. It should be stressed that in the case of thought oriented to reality the id impulses seek gratification through techniques acquired through past satisfactions and made part of the memory system. A hallucination does not.

My patient emphasized the object as a most important memory trace that could become integrated in behavior governed by the secondary process. During regressed states, his magical attitudes about objects were highlighted, but these attitudes

later became more sophisticated and refined when his integrative capacities were once again functioning. He felt earlier that he could 'command' the appearance of the archaic object for the satisfaction of infantile wishes or for protection. His fantasy was that, like a magician, he could conjure the object. The belief 'I see it, therefore it must exist' and the subsequent 'because I can bring it into view I am responsible for its existence' coexisted with intense scopophilic needs and may in some way be related to his vivid external perceptions.

By observation of the transference neurosis the megalomanic aspects of the 'peek-a-boo' creation of the object could be detected alongside his abstract scientific credo, his passionate idealization, and his creative fervor, all of which had become synthesized into an ego ideal.

The belief that he created the object stemmed from such primitive mechanisms of control but later, when secondary process integrative mechanisms were also effective and he could turn to the outer world, an expansion of the ego resulted instead in psychotic defenses and constriction of the ego. The ability to find substitute objects has been called a talent by Greenacre *(14)*, one which she included in the concept of 'collective alternates'. The gifted patient, according to her, turns to the outside world, to a variety of objects in order to fulfil needs and to seek protection in areas in which he had been disappointed with his own parents. I think that this patient and other creative scientists demonstrate this phenomenon which is accompanied by a high and abstract ego ideal.

The formation of the ego ideal is not being considered here as a causal factor to explain this patient's creative abilities nor is the reverse implied, i.e., that the patient's innate creative potential would inevitably lead to the formation of such an ego ideal. That creative ability and the ego ideal are in some way imbricated is obvious, but the connection cannot be understood without further exploration of genetic factors.

One of the first determinants of the early idealization of the father was the anxiety this patient felt in relation to his mother.

The image of the idealized father then protected him from the anxiety related to the early maternal introject. Since it was characteristic of him to be able to use the mechanism of seeking a new external object even as a child, as evidenced by his finding enthusiastic mentors, it is not surprising that his father image underwent changes, including partial decathexis, when his expectations of the idealized father were disappointed. The decathexis of the initial image enabled him to use the energy to cathect the ego systems active in the creating and seeking of new objects.

The decathexis of the father image was re-enacted in the transference neurosis but in this case it did not lead to what Eissler *(5)* described as the canceling out of a psychic element. Rather, the change in the image or in the elements superimposed on it lessened its power to deal with inner impulses or master external situations. The position the idealized father previously held as the central core of the ego ideal was no longer an active one; instead, he had been relegated to the realm of the negative, and whatever elements of the earlier identification remained led to a negative self-esteem and a sense of shame. Frequently, this patient's derogatory self-descriptions were almost identical to those of his father at another time. As a defense he sought out objects which he felt conformed to a standard that he had constructed. He then had to establish an object relationship in order to re-enforce the 'self-constructed' qualities he wished to achieve. He did what is done by every patient as the transference neurosis unfolds—he attributed certain qualities to an external object.

Heimann *(17)* has commented on a similar process in the discussion of sublimation and internalization. The ego normally 'assimilates' the qualities of the internalized parent if it succeeds in replacing the fantasied objects of early oral and anal sadism with more benign objects. The patient experiences such revision of objects as 'creating [or re-creating, according to present views] his parents rather than swallowing them'.

The introjected archaic object which is later transferred is, of

course, not identical with any person. A continuous revision of internalized objects occurs in the service of both the pleasure and reality principles. Nevertheless, certain elements, which vary according to the analytic situation, of infantile and archaic mental representatives are transferred. In this patient the early father ideal was replaced by the ideal of science which had to be 'objectivized' as the patient called it. After this occurred, he responded to the analyst in the same way as he did to his esteemed mentors. Later, in deeper transference states, the early idealized father image became obvious.

The influence of the precœdipal idealized father became apparent in spite of the fact that the patient denied its significance. This early image contributed to the later ego ideal and certain positive attributes seen in the father were projected onto others and reintrojected. Later, the elements of the introject formed part of a larger context—scientific idealism and ideals that he had attributed to teachers were introjected. Then this image was elaborated by many details. The details themselves became further and further removed from human attributes and, because of the increasing distance, took on an abstract quality. However, that which seems particularly significant is the refinement of the megalomanic fantasy of creating a needed object originally utilized for defensive purposes, and its application to realistic creative tasks.

The megalomanic fantasy of creating the object had a strong visual cathexis associated with it—its 'peek-a-boo' quality. Greenacre *(13, 15)* describes a strong sensory awareness and an unusual vividness of sensory impressions in such patients. This patient demonstrated a similar vividness and had many fantasies with intense scopophilic elements. He was very curious which was somehow related to seeing. The visual modality was pre-eminent in all his fantasies and he sought objects primarily by seeing. His thinking was also dominated by visual elements. Obviously, he was involved with primal scene elements but these need not be elaborated.

The integration of a primitive id impulse with scopophilic

elements into such a sophisticated mental representation as an abstraction then includes a reality-oriented refinement of the impulse. The elevation of a psychosexually induced need to that of an abstract idea is similar to the formation of the scientific ego ideal from the need for a supporting father figure.

In his autobiography, Pupin commented that his most meaningful learning experiences came from his mentors who introduced him to the works of some 'great ones'. My patient, like many scientists, felt that the elements of his most meaningful and lasting experiences were transcendental. He could not explain in any logical, coherent fashion what he actually experienced while learning, but revealed that he felt his most potent knowledge was assimilated in some magical way. This included experiences of awe (Cf. *13*) somehow, but vaguely, related to his highly esteemed hero teachers. Others have described this more graphically as having 'learned through the process of osmosis' and, as one patient said, 'by fusion with an outside powerful inspirational force that comes from another reality'. My patient's descriptions of his teachers were so esoteric that they did not seem human or concrete at all but, in themselves, represented a kind of abstraction. This was the direct antithesis to what he felt about his father, but it is interesting that he could feel so powerfully about object relationships and elevate them to superhuman levels.

In this connection, Greenacre (*15*, p. 11) pertinently states, '. . . the developing gifted child, even in very untoward circumstances, will sometimes be able to find a temporary personal adult substitute or even to extract from a cosmic conception some useful personalized god conception on which to project his necessary idealized father and himself to enable him to develop further'. Greenacre also felt that one of the parents, usually the father, had to 'qualify for the mantle of greatness'. Although my patient denied any such qualities in his father it was quite apparent that his father's role was significant.

In this analysis, idealizations served to avoid experiencing hostile feelings toward the revered object while directing them

toward the debased one. The self-image and the ego ideal became fused and the debased images decathected during zestful creative activity. Klein *(18)* spoke of this decathexis of a debased image as a restoration of it in the ego ideal and the restitutive quality of creativity has been referred to by many authors, Lee *(21, 22)* in particular.

This patient insisted on the important distinction between creating something new and simulating creativity through the elimination of an interfering element. To remove crabgrass was not, according to him, the same thing as an original landscaping arrangement. To exorcize devils within oneself or to destroy their projected counterparts in the outside world is a process of constriction, in contrast to the expansion of the ego in the creation of an 'addition' to reality. Since the father had become an object of disappointment, because he felt the mother had destroyed him, he had to find moral and æsthetic values in the external world. Being unable to depend on father as a model produced a 'gap'. He then had to fill it by seeking other models for he could not accept the paternal image, either as he saw it at the time or as he had previously seen it in its positive version. This he felt was a laudable pursuit in that it represented independence. Independence and initiative also had defensive qualities, of course, in that they represented a reaction-formation against passive longings. He did not believe that he had been 'discovered by his teachers'. Instead, he emphasized that he found the teachers and attracted them to himself by being an active and brilliant student.

Ordinarily there is a continuum from the father to a culturally accepted hero and then to values and ideals. The progressive abstraction of the ego ideal previously described leads to a similar abstraction of the discovered outside objects required to sustain it. The primary identification with its archaic and primitive features furnishes later objects with primary process qualities, giving them their transcendental, superhuman, magical, awe-inspiring characteristics. Abstraction, on the other hand, is a secondary process function, the antithesis of the concreteness

of the id. *The combined action of the primary process associated with this early father introject and the progressive abstraction of the later object into a scientific idea or concept leads to an ego ideal that values creative discovery.*

In the formation of the ego ideal there is a synthesis of a variety of perceptual experiences which later determine the roles and strivings of the person. Rosen *(28)* speaks of a progression from early stages of image formation to later stages of concept formation requiring the synthesis of projective mental contents along with an introjection of external objects. He considers such processes in terms of their relevance to imagination and, in an earlier paper *(29),* discusses how such operations are pertinent to the process of abstraction.

Thoughts, like any psychic element, must be viewed in terms of a developmental continuum. The psychic model has been conceptualized as consisting of a variety of systems including the physiological as well as the psychological. Freud's earliest model basically was one of stimulus and response. An outside stimulus was conceived as passing from lower systems to higher ones, at the highest levels being experienced as a thought. An impulse can then be considered as having to pass through a variety of stages, roughly from being experienced as a vague visceral sensation to an animistic affective perception and, at the most sophisticated level, as an idea, autonomous and separated from personalized factors.

Similarly, in the development of the ego ideal, such a synthesis and introjection of percepts of external objects takes place gradually in a serial hierarchal fashion, each object being perceived in a progressively more sophisticated manner that is consonant with the particular phase of psychosexual development. In many instances the progression (from primitively perceived part objects to the complex and sensitive evaluations of individual persons) is beset with a variety of vicissitudes. Its course is not necessarily smooth and, as with this patient, there can be severe disappointments. The child may go from disap-

pointment to disappointment in objects and finally turn to an abstraction or a cause.

As has been previously discussed *(12)*, there is a wide range of energy, a broad spectrum of extremes of primary and secondary processes, operating during creative activity. The ability to vacillate between primary and secondary processes has been noted by many authors as a particular feature of the creative person, one that involves all ego systems, including the superego and ego ideal. At the secondary process end of the spectrum, the psyche can form concepts and deal with abstractions. One notes that for this patient the early father introject determined the direction of the later abstractions. Finally, abstraction proceeded to a point where a person was no longer required (Cf. *24)*; instead, elements that extended beyond the perceivable concrete reality were sought. Bronowski *(3)*, Poincaré *(25)*, and other introspective scientists remarked that a theory or an abstraction always extends beyond the observable data and it is that extension that constitutes the creative product. The creative activity, the mastery implicit in such activity, becomes the axis around which the ego ideal maintains itself.

The activity described here, turning toward the outer world to seek objects in order to construct an ego ideal, and then the progressive abstraction of the object, constituted a talent for this man that was relevant to his creative ability. Nevertheless, it must again be emphasized that the developmental vicissitudes that he experienced are in no way considered to be responsible for his special abilities. The origin and source of his talent cannot be discussed here, since there are no data from the frame of reference that I have introduced that would be relevant. The sources of creativity are still as much a mystery as ever, and all one can attempt to do is to explore further certain developmental factors in a person known to be creative.

SUMMARY

Pertinent object relationships of a creative scientist undergoing psychoanalysis are given in order to understand the develop-

ment of his ego ideal. The transference neurosis highlighted some of the introjective-projective mechanisms used to form a composite father-science-image of lofty proportions transcending any concrete experience.

The patient remembered an early attachment to his father described as forceful, confident, but more or less tyrannical. At the beginning of latency he suddenly saw his father as an ineffectual, passive martinet. His previous image of him was destroyed and the reaction was extreme disappointment. His mother, seductive, dominant, manipulative, and unpredictable, significantly affected his assessment of the father. In order to master the conflict in his relationship to his mother, the patient sought a strong, consistent father image with spiritual, esoteric qualities, one that was best embodied in the canons of science. This led to a progressive abstraction of the personified aspects of the ego ideal as his ability to abstract was a well-developed talent.

The techniques employed in the formation of the ego ideal were particularly relevant for later creative activity. The acquisition of such techniques is not discussed since the psychoanalytic data do not contribute answers to the question. It is possible that specific developmental vicissitudes, by producing a need for such integrative methods, served to stimulate their use and led to their development though other life circumstances could have had a similar influence. The same circumstances in other patients can produce an entirely different clinical picture showing no significant creative ability.

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RELIGIOUS PREJUDICE IN AN EIGHT-YEAR-OLD BOY

BY KENNETH H. GORDON, JR., M.D. (PHILADELPHIA)

A fragment from the analysis of a child during the period of latency is presented to demonstrate some of the defenses at work in the development of a prejudice.

Brian Bird traces prejudice to important steps in the development of the ego and the superego by way of the mechanisms of identification (incorporation) and projection. These mechanisms, Bird and others observe, do not lead in such cases to constructive self-evaluation and self-criticism, but to grossly biased judgment and criticism displaced to others. Bird defines prejudices as nascent self-criticism within an ego that cannot tolerate or utilize it. He speculates that children, generally, incorporate the criticism of adults and defensively project it in varying degrees onto others to avoid an intolerable burden of guilt. When the immature ego grows sufficiently strong, it can tolerate the pain of acceptance. At that point projection should lessen and be inwardly integrated, the guilt should be consciously acknowledged, and prejudice unnecessary.[1]

A six-and-a-half-year-old boy was continuously anxious, afraid of darkness, of his own bed, and of fire. His mother said of him, 'He is impossible to live with. Nothing is right.' During what little sleep he had, he was frequently awakened by terrifying dreams of which he, as a rule, would say only, 'I can't stand them. I want to forget them.' To allay his fears the parents, who slept nude, had for many weeks taken him into their bed when quite regularly he was terrified during the night. It had become his

Presented at the Annual Meeting of the American Psychoanalytic Association, in St. Louis, May 1963.

1 Bird, Brian: *The Etiology of Prejudice.* J. Amer. Psa. Assn., V, 1957, pp. 490-513.

recent habit to dress for school at two o'clock in the morning and sit waiting in a lighted room for morning. He told his parents one recurrent nightmare: 'I push a red button. There is a blast of air that pulls me into the basement and then a fire breaks out.' He remained anxiously convinced that he would be destroyed by pushing the red button.

From the age of six months he had slept very fitfully, his parents being roused three or four times each night to quiet him. He had first had some transient fears shortly after an only sister was born, when he was three-and-a-half. Until his third birthday his pants were always wet and he was a 'real messer' with his feces. At five-and-a-half he was masturbating frequently and openly. When the analyst first saw him he was usually clinging to his penis through his clothes.

Both college graduates, the boy's liberal Jewish parents were intensely emotionally involved in their son's problems. They responded well to direct advice, promptly instituted some reasonable limits to nudity in the family, and discontinued what had amounted to giving the boy rewards for being anxious. In spite of much symptomatic improvement he continued to have a severe, unresolved œdipal conflict which led to psychoanalytic treatment.

The child was unable to recall for me a dream, and could not tell a fairy story because 'Jack and the Beanstalk is too scary to tell. . . . At school they have picture books that scare me. There is one that I can't even tell you about. It's the worst of them all. It's about superdog. I'm afraid of being alone in bed.' On the cover of the superdog book, brought at my request by his mother, was the photograph of a dog with erect ears. He turned his back to the book and ordered his mother and me to get rid of it. 'If I don't look at it', he said, 'it will go away'. The child could only try to dispel his fearsome fantasies and painful affects by denial, displacement, and intellectualization. The intensity of his castration anxiety was proportional to the external provocation of his œdipal conflict.

During the second year of his analysis he became preoccupied with what mothers and fathers do in bed with each other. It

worried him that in chess the queen is much stronger than the king. An old daydream recurred to plague him: boys are born with a root inside of them which flies out through the end of the penis, cutting the end of the penis open so that urine can escape. 'My root', he confided, 'shot out the first time I urinated and hit my father on the nose and cut it open. . . . I am afraid I might get a cut myself; it would be so big that you could fall into it.' This led to concern that the radiator might fall off his toy automobile. He could still dispel his fears with fierce activity, intellectualization, and a striving for omniscience.

Two toy animals, Wuzzy and Fuzzy, which he took to bed with him, liked, he said, to dance all night. He sang 'I Could Have Danced All Night', and said that these animals first embraced, then sat on each other's faces. He was beset with worry that Fuzzy was ruined because he had a hole in the bottom. He was next seized with the notion of a huge wound. Either he or I would get it and the other would fall into it. In this context was the fantasy, 'Mother has a terrible huge cut in her and maybe you will fall into it'. There was troubled speculation about brides, and something about someone who had a big operation. Persisting some months was the fantasy that a hole was being dug outside. Children who might come to the hospital might die and be put in the hole.

The day after his parents returned from a vacation he fell from a tree and broke two upper front teeth. He pretended not to care, and denied that it hurt although he was much preoccupied with fantasies of physical injuries at this time. 'Women', he said, 'are made from men by cutting off the penis and that is why they have such a big cut. . . . A man on the third floor of a factory sawed his penis off. The penis fell into a can of green paint on the second floor and then fell into a pickle barrel on the first floor. A lady bought the pickle, which she thought was fine, but complained that it squirted her in the face when she bit it.' He first laughed at this story but concluded it scared him.

Repeated interpretations of his various denials and displacements of his fear of losing his penis gradually enabled him to

endure the associated painful affects and to begin to bind and master them. After a year and a half of treatment he was able to talk about how worried he was that his penis might be chopped off: 'I am afraid that I will be changed into a woman that way; then', he consoled himself, 'the only way I can get any strength will be for you to fall into my cut. It will close over you and I will have you and your strength.' Once on biting into a candy bar he was frightened when one of the caps that covered his fractured teeth was dislodged. As he regained composure, he first guessed that he was worried about losing that tooth but then decided that the real fear was of losing his penis.

The following autumn he was much pleased that he was entering a new school. 'At my old school', he explained, 'if you are in the third grade they make you go to the principal's office and get your penis cut off. I'm glad I don't go *there*. Oh, how they suffer! . . . I know they don't really do this but I thought about it so much that it seems almost real.' An upsetting daydream was of his wish to take his father's penis and use it on his mother. Concurrently he began to express a dislike of anything having to do with religion, especially Christianity. 'I don't know why', he said, 'except that religion is not nice'. Although his family professed no religious faith or practice, they had sent him to a sectarian school where he had been exposed to Christian teaching. Allusions to religion were interspersed among fantasies of castration and genital bleeding. The following sequence is typical: 'I am worried about something. Period. I don't know what it is. Period. Why is there so much blood? Period. A penis eater comes around each month and destroys the penis which causes the bleeding. Period. I am worried about Jesus' penis. That's a bad word and I shouldn't have said it.'

It was after almost two years of treatment when he started to talk about hating God, whom he wished to destroy. He formed a 'Hate God Club', wanted me to join, and he wrote many notes which stated, 'Dr. Gordon hates God'. Asked why he hated God so much, he explained his reasons. 'God', he declared, 'is the meanest man in the world. God's son, Jesus, was down on earth

and went around boasting about how he had the biggest penis on earth. Everyone admired it and loved it. It was beautiful. God hated him for doing this, and got a bunch of soldiers to come. They nailed Jesus onto a cross. They threw penis cutters at him. They cut off his penis a little bit at a time until there was nothing left. He suffered so. It was terrible. I will never forgive God for this.'

The next day he announced: 'I am now the penis cutter man. I work at hospitals and remove penises from all the little girls so that they will then be little girls. . . . God gave me this job and gave me a special big vacuum. I just go around and suck the penises off and remove them. . . . Maybe the penis eater has eaten my penis.' (His mother had been in a hospital where she had had a spontaneous abortion.)

In the succeeding session he drew a picture of Jesus on the cross with a huge penis 'over a mile long'. 'It was cut off and Jesus said as he died, "I hate God".' The child was told that his problem was not hating God, not hating Jesus, but that he was worried about his own penis, and about what he thought when he rubbed his penis: 'You want to be a father penis cutter yourself and seem to think that you will get punished terribly for wanting that'. He shouted, 'Oh boy! You are so right.' Because he wanted to cut off God's penis, he feared that God would cut off his penis.

He had projected onto God his own wish to castrate his father. He hated God for that wish, as he thought father would hate him for having it. He was identified also with Jesus in his wish for the biggest penis, and in his fear of being castrated for it.[2] God and Jesus were clearly displaced representations of his father and himself. In addition, however, he was partially identified with the vengeful father-god whom he wished, in a reversal of roles, to castrate: 'I am now the penis cutter man'.

A month later he reported that his mother, who had found him crawling about in his sleep, asked him what he wanted.

[2] Cf. Lubin, Albert J.: A Boy's View of Jesus. In: *The Psychoanalytic Study of the Child, Vol. XIV*. New York: International Universities Press, Inc., 1959.

Still asleep he had said, 'I am hunting for a hole to put my oil burner in'. He laughed while telling this. As I was about to ask him to recall the repetitive dream about pushing a red button—which he had had just before beginning analysis—he interrupted to say that he was reminded of 'that red button dream'. I said that it sounded as if he was hunting for a very special hole to stick something into, something of his own. He said, 'You're going to tell me that it is a penis and that I want to stick it in my mother, and that is what's causing my worries'. He laughed and observed: 'You would have been right last week but I am getting rid of such nonsense'.

SUMMARY

An intense religious prejudice erupted in the second year of an eight-year-old boy's analysis. It represented the conflict originating from externally exacerbated œdipal conflict. He required treatment for continuous anxiety, numerous phobias, insomnia, nightmares, and intractable behavior. As the œdipus complex emerged into consciousness, the wish to rob his father's penis for an incestuous relationship with his mother created such a fearful threat of castration that the entire conflict was projected onto God (the castrating father) and Jesus (the castrated son). He criticized God for doing what he himself wished to do. With insight he was able to accept and control his own wishes and fears and no longer needed to project them onto God and Jesus. The prejudice disappeared.

Psychoanalytic studies indicate that an unresolved œdipus complex frequently underlies racial and religious intolerance (Cf.: Bird, Brian, *loc. cit.*). Such prejudice is manifestly an irrational fear that a racial or religious group will usurp one's own or his group's most cherished privileges and possessions, material or spiritual. This fear of losing something, be it money, status, prestige, or other, basically appears to be anxiety about being castrated. A suggestive confirmation of the sexual nature of prejudice is the ultimate cliché of racialism: 'Would you want your sister to marry one of them?'.

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A CIRCUMCISION FANTASY

BY RICHARD V. YAZMAJIAN, M.D. (NEW YORK)

Analysts have always been keenly interested in the psychoanalytic and anthropological implications of circumcision: however, as Nunberg *(4)* observed, detailed accounts from patients of fantasies about circumcision are notably rare in the psychoanalytic literature. A singular circumcision fantasy that appeared in identical form in two patients prompts this report.

Both patients were intelligent, well-educated Jews whose moderately orthodox religious training provided familiarity with Jewish religious practices and lore. One patient, treated by intensive analytically oriented psychotherapy, was a latent schizophrenic whose difficulties included an exhibitionistic perversion of many years duration. The other, in psychoanalysis, was a neurotic whose only perverse trait was an occasional compulsive drive suddenly to exhibit his penis to his wife. Both patients had been in treatment approximately four years. In both instances the conscious fantasy was that circumcision consists simply of incising the dorsal aspect of the prepuce, thus permitting it to roll back behind the glans penis.

Questioning revealed that as children they both had attended circumcision rites. The exhibitionist recovered memories of observing the actual proceedings, while the neurotic reported memories which only strongly suggested that he had also directly witnessed the surgery. It was definitely established that both men had repressed their knowledge of the reality and had defensively elaborated the conscious fantasy. These well-educated patients had managed to avoid connecting the term circumcision with their conscious knowledge that the prefix *circum* signifies around, about, or on all sides.

The lifting of his defenses brought to light the extraordinary value of the prepuce to the exhibitionist. Thinly disguised fantasies included the possession of a prepuce which could magically protect his glans from injury and castration, and his penis from destruction by phallic penetration. The neurotic patient promptly repressed

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the facts he had relearned in analysis and maintained the fantasy up to the time of his own son's circumcision. Unconscious identification with his son first aroused vague conscious fears of mutilation and death and led to the subsequent re-emergence into consciousness of his terror of circumcision.

The efficacy of the defensive function of this fantasy is reflected in the years of treatment which its uncovering required. These patients were able consciously to acknowledge that they were circumcised, could discuss circumcision in various contexts (including psychoanalytic and anthropological literature with which they were somewhat familiar), and at the same time totally deny the fact that the foreskin had been removed. This defense would appear to have a relationship to fetishistic mechanisms.[1]

The many colleagues with whom these cases were discussed have never encountered this fantasy among their patients. This is surprising since Jews constitute a major ethnic group in metropolitan New York and circumcision is also prevalent among Christians in this area. Initially these two cases were thought to represent a statistical oddity but anthropological data altered this impression.

Bettelheim *(1)*, Darlington *(2)* and Devereux *(3)* refer to various primitive tribes whose pubertal initiation rites consist solely of incising the dorsal surface of the prepuce. Bettelheim uses the term 'superincision' to describe this procedure. It has also frequently been demonstrated that wishes or fantasies which are culturally inculcated and enacted in one society appear in individual members of another society in the form of idiosyncratic conscious or unconscious fantasies. Accordingly, the correspondence of the fantasies of these patients and the pubertal rites of some primitive tribes probably represents more than mere coincidence. If this is so, the fantasy cannot be as rare as it seems.

The seeming clinical rarity of the fantasy might then be a result of the powerful effectiveness of a defense which permits conscious acknowledgment and simultaneous denial of circumcision. A contributing factor may stem from special countertransference difficulties which interfere with careful investigation of this topic. It is noteworthy that both patients had made numerous references to

[1] Though obvious, it should be stated that this obsessive distortion of reality is a defense against castration anxiety. Slitting would then appear to be a lesser threat than total ablation. [Ed.]

circumcision before the fantasy was elicited. Clinical experience has led the writer to adopt the practice of directly asking all patients, whether male or female, what are their conscious conceptions of circumcision as soon as the topic presents itself in their associations.

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Suicide in Scandinavia. By Herbert Hendin. New York: Grune & Stratton, Inc., 1964. 153 pp.

George Gero

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BOOK REVIEWS

SUICIDE IN SCANDINAVIA. By Herbert Hendin. New York: Grune & Stratton, Inc., 1964. 153 pp.

The point of departure of this interesting and challenging study is a statistical one, the well-known fact of the high suicidal rate in Denmark and Sweden and the perhaps less well-known one of the comparatively low rate in Norway. Hendin, a follower of Kardiner's interest in cross-cultural studies, saw an important opportunity to study and compare what he calls the psychosocial character of three closely related and relatively homogenous societies and at the same time scrutinize subtle differences in parental attitudes in the three Scandinavian countries. His hope obviously was that the discovery of these differences may shed some light on the discrepancy between the Danish, Swedish, and Norwegian suicide rates. He approached this task with thoroughness and dedication. He learned the languages of the countries and familiarized himself with their history and the modern expressions of national folklore, such as women's magazines and the popular cartoons. He then interviewed suicidal patients in all three countries, studied the case histories of others, and interviewed as a study in contrast normal members of the population. The result of his labors are presented in this book.

A general discussion of the history of theories of suicide and an outline of the psychodynamics of suicide serve as an introduction to the specific problem, suicide in Scandinavia. In his search for understanding the psychodynamics of suicide, Hendin interviewed patients who had made severe suicidal attempts but survived. He was especially interested in eliciting the various fantasies of these people about death. To find the unconscious fantasies he ingeniously used the dreams of the suicidal patients, dreams that occurred just before the suicidal attempt. He distinguishes seven different attitudes: death as abandonment, death as omnipotent mastery, death as retroflected murder, death as reunion, death as rebirth, death as self-punishment or atonement, and death as a phenomenon that in an emotional sense has already taken place. Hendin believes that these fantasies represent the leitmotifs characteristic of the suicidal patient. However it seems to this reviewer that in every

suicide all the basic conflicts and forces in a human life are mobilized and it is extremely difficult to ascertain which one is the leading motif or the foremost driving force behind a suicide.

The idea that there are different leading fantasies in every suicide, that suicides have their own characteristic styles, must have contributed to the author's expectation that he would find the difference between Danish, Swedish, and Norwegian suicides. To find those differences he endeavors to study the psychosocial characters of the three nations. The term, psychosocial character, is used to describe characteristics usually summarized as national character. Abstractions of this kind should be considered, to use a felicitous term of Max Weber's, as 'ideal types'. Hendin's observations on the differences in the Scandinavian national character, keeping in mind that they are generalizations, are well-taken.

Hendin emphasizes the great dependency needs of the Danes which have roots in the typical Danish mother's attitude to her children. She likes to fondle and baby the child, puts more emphasis on how well the child eats, how much he weighs, than on those of his activities and qualities that separate him from her. The Danish mother tries to curb the child's aggression or disobedience by making him feel guilty, indicating that the child's behavior causes suffering to the loving good mother. Hendin believes that the great dependency needs the Danish upbringing fosters are responsible for the fact that Danish suicides are so frequently motivated by the need to be reunited with a deceased beloved one, parents, or another love object. The Danish suicide, one could say with some exaggeration, is characterized by Hendin as the 'sweet', sentimental suicide whereas the Swedish is the bitter, angry one. But could it be that the suicidal individual in Denmark is less ambivalent in his relation to his love object than in other countries? To this reviewer's mind this is a very unlikely assumption.

The author describes well the peculiarities of the Swedish national character. Swedes are reserved, they do not show emotions, and in extreme cases one can observe a detachment that approximates an emotional deadness. Swedish men consider show of emotion feminine, not becoming to a man. Swedish mothers often resent being tied to their children and therefore try to force independence on the child too early. A critical rejecting mother is even more harmful to a girl-child than to a boy, who has more socially

sanctioned outlets for aggression, first in play, later in work. Hendin believes that the rejecting mother is an important factor in the high suicide rate among Swedish women, especially if in marriage the husband repeats the mother's unaffectionate attitude. The male suicide in Sweden, according to Hendin, is seldom motivated by loss of the love object. It is rather the failure to reach ambitious goals.

What are the reasons for the conspicuously lower suicide rate in Norway compared with its neighbors? Hendin's hypothesis is based on a comparison of the attitudes to child rearing. Among the three Scandinavian countries, Norwegian mothers succeed best in achieving encouragement of independence in their children without withholding loving care from them. Arousing guilt in the child is not a major method of discipline used by the typical Norwegian mother. They encourage greater emotional freedom in their children and correspondingly the Norwegian adult is emotionally much less restricted than the Swede. Achievement of ambitious goals is also less stressed. At the same time dependency needs are less strong than in Danish people.

The typical method of Norwegian child rearing seems to produce less tension and inner pressure and thus fewer individuals are predisposed to suicide. Such a thesis is difficult to prove or disprove. Yet it deserves careful consideration because its consequences, if the thesis is correct, are stupendous. To this reviewer, unfortunately, it does not sound too convincing. Psychosocial character may influence certain aspects of behavior, such as eating habits, in a somewhat uniform way, but such a complex phenomenon as suicide is the secret of a unique individual life. But even for those readers who will not share Hendin's approach, his book can be highly recommended. It is a thoughtful, carefully documented contribution to the understanding of Scandinavians and the problem of suicide.

GEORGE GERO (NEW YORK)

LA PRÉSENCE DU PSYCHANALYSTE. By S. Nacht. Paris: Presses Universitaires de France, 1963. 203 pp.

The decade 1952-1962, during which the author has been a distinguished leader of the psychoanalytic movement in France, is covered in these selected papers. The topics discussed range over a wide area, from an essay on unconscious anxiety to a treatise on de-

pressive states, with several papers on variations in analytic technique and finally an exposition on what he calls the 'presence' of the analyst. In spite of the disparity of the subjects, a fact acknowledged by Dr. Nacht, there is a thread of continuity. He views the problems of psychoanalysis from the point of view of the clinician concerned with the primary role of unconscious anxiety in the pathogenesis of the neurosis and with the crucial role of the 'presence' of the analyst in dealing with this anxiety. The emphasis is thus on the relationship between doctor and patient.

The value and special interest of this book lies in the fact that Dr. Nacht discusses in detail the basic unconscious attitude of the analyst in effecting a cure. He addresses himself courageously and honestly to problems involved in maintaining the so-called analytic neutrality and attempts to delineate technical situations, especially in the termination of an analysis when this 'neutrality' must be modified. He indicates what he means by such modification and attempts to steer between the Scylla and Charybdis of too rigid analytic neutrality and the temptation to act out in the countertransference. He emphasizes in his closing chapter that the most important contribution of the analyst is not what he says but what he is, whence the title of the book.

Besides a rich discussion of technical problems and the role of the unconscious attitudes of the analyst, Nacht also clarifies his concepts of primary organic masochism and the 'pre-object' stage of development of the infant, concepts relatively unfamiliar to American readers. The chronological arrangement of the chapters does not always make it easy to follow the thread of the book; for example, chapter eight is on criteria for termination of analysis, chapter twelve deals with technical problems of termination, and the intervening chapters are on such diverse subjects as depressive states and the death instinct. This arrangement requires the reader to do a good deal of re-reading.

The volume represents a most worthwhile contribution, especially in that it illuminates controversial topics with wisdom derived from long years of analytic experience, as well as with honesty and a sharp analytic mind.

HENRY F. MARASSE (HARTSDALE, N.Y.)

PSYCHOANALYSIS AND THE HUMAN SITUATION. Edited by Jessie Marmorston, M.D. and Edward Stainbrook, M.D. New York: Vantage Press, Inc., 1964. 270 pp.

Contributors to a *Festschrift* often make special efforts to produce original and significant papers, hopefully trying to emulate the highest achievements or the unique approach of the man being honored. This volume drawn from the proceedings of the Symposium on Psychoanalysis held in Los Angeles in honor of Franz Alexander's seventieth birthday, offers little that measures up to the worthiest of Alexander's contributions. Each author seems to have contented himself with either a brief panegyric or a mildly contentious reworking of familiar material. Three papers, for example, are profiles of Alexander but they deal only superficially with the man and his career. Two studies by nonanalysts discuss the parallels between psychoanalysis and history (Meyerhoff) and the problem of evaluation of the results of psychotherapy (Strupp). Although the latter paper deals with familiar ideas it has the special merit of stressing methodology in its critique of the various studies in the literature.

The paper by Roy S. Grinker, Sr., does little to live up to its title, Psychoanalytic Theory and Psychosomatic Research, other than to point out the obvious need for understanding the interpenetrations of psychological, cultural, and biological factors in any given experience or response. In this paper, and in several of the others, small barbs are tossed (or heavy lances tilted) at 'psychoanalytic theory' which are obviously pertinent only to instances of methodological ignorance or technical sloppiness.

This type of sniping also discredits the papers of Edith Weigert and Leon Saul, which take up a few clinical and technical problems in a most casual and frequently redundant fashion. With simplistic zeal and Procrustean diligence they attempt to reduce all psychoanalysis to what they consider its essence, a 'technique of re-education', but their arguments fail to convince or impress, or even to appear novel.

A feature of the Anniversary Symposium seems to have been an extended panel discussion on Psychoanalysis and Medical Education. Unfortunately, only summaries of the remarks of the five par-

ticipants are given in this volume. Although these are too truncated to be very instructive, it seems clear that Pumpian-Mindlin made an effort to introduce some terminological clarity into the discussion, describing useful and precise designations for psychoanalysis, dynamic psychotherapy, and the other psychological approaches referred to by the panel. Since there was no great uniformity of understanding about the crucial distinctions involved, the contributions of each of the authors represented here is marred by one aspect or another of this confusion.

The paper by Alexander which provides the title for this volume has some parts of special interest. In attempting to evaluate the place of psychoanalysis in Western culture he makes use of a historical perspective and an epistomologic focus to put forth some interesting ideas on the evolution of this science. In passing he mentions that 'Neurophysiology never will bury psychology; it only will complement it. Human interactions, and therefore the social process, constitute a dimension of phenomena other than brain physiology, and the expectations to reduce the universe relentlessly to the laws of physics and chemistry are as hopeless as they are senseless. On the other hand, the hope that by more precise psychologic understanding of human behavior, man may be able to gain a similar mastery over his personal fate and the social process as he has been able to achieve over the forces of the inanimate world, may be utopian today but not senseless' (p. 76).

However, in another direction his emphasis is exemplified by the following. 'Even more ominous is the trend pervading the psychoanalytic community itself in the direction of standardization, uniformity, and ritual, as the unavoidable consequence of growing institutionalization' (p. 79). This lament is echoed by several of the other participants in the Symposium but nowhere is the charge amplified or documented.

By a fortuitous circumstance this book was read by the reviewer immediately after coming upon an article by Professor Edwin A. Boring.[1] For an instructive lesson in the significance of simultaneously held incompatible beliefs or attitudes in scientists, this book might well be read together with this interesting paper. Otherwise

[1] Boring, Edwin A.: *Cognitive Dissonance: Its Use in Science.* Science, CXLV, No. 3633, 1964.

there is little to recommend it over other well-known publications of the various authors involved, a fact that makes this a less than festive collection.

HERBERT F. WALDHORN (NEW YORK)

INSIGHT AND RESPONSIBILITY. LECTURES ON THE ETHICAL IMPLICATIONS OF PSYCHOANALYTIC INSIGHT. By Erik H. Erikson. New York: W. W. Norton & Co., Inc., 1964. 256 pp.

In this, his most recent volume, Professor Erikson offers the collected fruits of his thought as delivered in a series of lectures over the past eight years. Addressed to a variety of audiences, and previously published in a variety of professional and academic journals, they are bound together by a common and continuing concern with the ethical implications of psychoanalytic insights.

It is not entirely clear to what audience this book is directed. Most of the lectures were prepared for and originally presented to non-analysts—German university scholars, interdisciplinary groups of social scientists, Indian students, and the like. One, however, is an expanded version of Erikson's memorable address on Reality and Actuality, presented at a Fall meeting of the American Psychoanalytic Association, and specifically designed for listeners and readers with a high level of analytic sophistication. The marriage of the two classes of subject is a somewhat uneasy one; for the psychoanalyst, and particularly for one familiar with Erikson's ideas, much of the book is repetitious and oversimplified, and becomes wearing on repeated confrontation. Yet, the discussion of the Dora case and the Count Thun dream in the psychoanalytic lecture will surely be obscure and trying for the lay reader (though it may send some analysts scurrying back to their Standard Editions!).

Beyond the reiteration of his basic epigenetic concepts, his preoccupation with the problem of identity formation, and his efforts to enlarge the scope of ego psychology to include consideration of what he calls 'virtues' (by which he refers to certain varieties of 'inherent human strength'), Erikson is here involved with application of psychoanalytic modes of thought and humanistic concern for broad social, historical, and ethical problems. That he does not 'solve' any cosmic issues matters less to us than does the fact that he

succeeds in suggesting some potentially fruitful modes of approach to serious thinking on these questions.

'Serious' is a critical term here. It is a fact, however unpleasant, that much psychoanalytic thought in these 'applied' fields has been, in the worst sense of the word, frivolous. Uncritical extensions of individual psychology to group psychology, of pathology to normal social movements, of child development to the development of social institutions, of utopian 'culturalist' popularizations of analysis to complex social problems—all have at one time or another been offered as major contributions to our understanding of man and his world. It is to Professor Erikson's credit that he exposes, both directly and by implication, the defects of such methodological naiveté, and that he succeeds here, as he did so brilliantly in Childhood and Society, in demonstrating a method by which the psychoanalytic study of the individual can be integrated with the sociological study of cultures into a unitary frame of reference.

Overriding Erikson's methodological interests, however, are his concerns with the ethical future of man and with the problem of human survival in an era of unparalleled technological and ethical crises. In his efforts to extend his concepts of mutuality, fidelity, and identity formation to the sphere of social action, he adds an ethical dimension to psychoanalytic theory that avoids the mushy sentimentalizing and evasions of fundamental biological fact that have marked the efforts of some other thinkers in this field. His conceptualization of the distinctions between 'morality', 'ideology', and 'ethics', and their relation to phases of individual and social development, is a masterpiece of clarity and a superb paradigm of his mode of intellectual operation.

For the practicing psychoanalyst, however, it is his thoughtful differentiation between 'reality' and 'actuality' that has the most immediate interest. In this distinction Erikson offers a much-needed corrective to the all too frequent model of psychoanalytic thought that equates 'action' with 'acting out' and that, at least in its more perverse form, tends toward a pattern of obsessive rumination over motives that leads to situations in which 'the native hue of resolution is sicklied o'er with the pale cast of thought, and enterprises of great pith and moment . . . lose the name of action'. The problem of distinguishing socially or individually constructive action—or 'actualization'—from 'acting out' is, of course, not always easy, but

Erikson suggests that more than one analysand has been fixated in his identity as a 'patient' by the failure to clarify it.

The applications of insight to action, both in the individual and the social realm are, then, the objects of Erikson's attention in this book. Despite the occasional floridity of his style, the somewhat tedious reiteration of the phases of the life cycle, and the effort to appeal to a heterogeneous readership, this book will be of interest and value to analysts concerned with the genuine ethical dilemmas to which Erikson modestly and humanely addresses himself.

AARON H. ESMAN (NEW YORK)

THE ANNUAL SURVEY OF PSYCHOANALYSIS. A COMPREHENSIVE SURVEY OF CURRENT PSYCHOANALYTIC THEORY AND PRACTICE. Vol. VII, 1956. Edited by John Frosch, M.D. and Nathaniel Ross, M.D. New York: International Universities Press, Inc., 1963. 517 pp.

The seventh volume of the Annual Survey contains abstracts of articles culled from twenty-eight journals, eight of them foreign. Each category summarizes the literature and emphasizes the direction and progress of psychoanalytic thought. A concluding summary offers a critical appraisal of the abstracts, providing a background for estimating their relative importance. There is hardly an article of major significance in psychoanalytic literature for the year 1956 that has been omitted. It is inevitable, however, that some prove to be of less value than others.

As the Survey is primarily a book of reference, shorter abstracts may be preferable to longer ones. The writing of abstracts is difficult at best and, as might be expected, the quality varies. By and large, however, a high level of excellence is maintained. Epitomes of nine books which are included could have been abbreviated. Of outstanding interest is the Section on History which is devoted to Freud's Centennial Celebrations. It includes Freud's influence on contemporary thought, biographical contributions, predecessors who influenced Freud and the evolution and the dissemination of psychoanalysis. The volume is worth owning for this feature alone.

PAUL SLOANE (PHILADELPHIA)

PROBLEMS OF SLEEP AND DREAM IN CHILDREN. Edited by Ernest Harms. New York: The Macmillan Co., 1964. 147 pp.

Presented as a symposium, this collection of papers from various sources here and abroad is a curious combination. It includes some behavioristic essays, others speculatively mythological, a summary of recent experimental observations in this country, and several antiquated criticisms of freudian theory.

The Gesell Institute presents a normative study of sleep patterns up to the age of sixteen. We are told that in 'primitive' cultures where children are allowed to stay up until they are sleepy there are no sleep disturbances. Some of the data are interesting and difficult to explain. For example, between two and three years of age children often awaken from naps in a very irritable state, which is also a common distressing symptom of older psychotic children. Dreams are found to have a definite sequence of content: what are daytime fears in the child today are likely to appear in dreams twelve to sixteen months later. A significant change appears at the age of seven when the child becomes the 'central acting figure' of his dreams; this change is said to coincide with the child's becoming aware of himself as separate from his mother. The author concludes that individual differences are based upon Sheldon's constitutional types; fat people sleep better than thin.

The second paper is a review of some of the literature concerning the etiology of sleep and the physiological changes that accompany it. There is also a simplified presentation, based upon psychoanalytic ideas, of the intrapsychic factors related to sleep. Next comes a criticism of Freud's theory of dreams from the 'scientific logical' point of view. For example, the author states that symbols cannot be present in dreams because symbols are signs intended to express an idea, 'but in the dream intentional and coördinated thinking has ceased to exist'. The author's theory of the dream has to do with prelogical thinking which is not clearly distinguishable from what psychoanalysis calls primary process thinking, including most of the dream mechanisms mentioned in Freud's The Interpretation of Dreams. The objection apparently is to freudian theory of motivation and conflict.

A review of data correlating rapid eye movements, presumed to be associated with dreaming, with electroencephalographic patterns

associated with stages of sleep shows that periods of these eye movements are present in the neonate; it is concluded that although patterned dreaming is not present at birth there may be a re-experiencing of the past, a memory—perhaps transient—and certainly a 'unique physiological sleep state' which later becomes associated with dreaming. The periods of eye movement are shown (by studies of a center in the pontine reticular formation in cats) to be a pure brainstem function. Physiologically, these periods resemble the waking state, and perhaps in the infant the content of the mental phenomena matures in both states, from such modalities as olfactory and kinesthetic to the visual. The periods of eye movements indicative of somatic and central nervous system activity are considered as discharge phenomena and account for up to eighty per cent of the total sleep time in neonates and forty per cent in infants.

A short note criticizes Freud's statement that the dreams of small children are simply wish-fulfilments—which is hardly worth doing, since Freud's later studies and the development of child analysis long ago led to the same conclusion. A paper on dreams used as part of initial diagnostic interviews at a children's clinic shows that they were useful for the examiners, but one must deplore the emphasis on manifest content alone. Other papers offer metaphorical interpretations of symbols and Jungian interpretations of childhood dreams remembered by two adult patients. An eclectic discussion of the pathology of sleep, observations on head-rocking, and a paper on dreams that emphasizes visual function in dreams (they represent conflict between the forbidden wish-fulfilment of the dream and a defense by wakening) conclude a volume hardly worthwhile for the analyst, except perhaps as a reference on certain behavioristic data.

MANUEL FURER (NEW YORK)

RESIDENTIAL TREATMENT FOR THE DISTURBED CHILD. Basic Principles in Planning and Design of Programs and Facilities. By Herschel Alt. New York: International Universities Press, Inc., 1960. 437 pp.

Alt covers the full range of the problems of residential therapy for children with balanced consideration of the total therapeutic milieu, the educational program, the place of individual psychotherapy, and the complexities of administration which underlie the

effective work of all such institutions. The expository sections of the book and the illustrative case reports reveal clinical practices that have grown out of thirty years of experimentation and self-study at Hawthorne Cedar Knolls School.

The description of methods for individual psychotherapy employed at Hawthorne will be of interest to analysts. Although the clinical program relies strongly on psychoanalytic thinking, Alt reports discouraging results in attempts to employ an analytic child therapy for the severe ego disturbances encountered among the children there. The individual therapy developed at Hawthorne is directed primarily upon the immediate experience of the child 'on the assumption that he is not capable of being involved in any earlier or deeper layers of his growth'.

We may reflect that child analysis has, as yet, made no significant contribution to the development of psychotherapeutic methods for the residential treatment center. This is all the more extraordinary when we consider that developments in child analysis during the past two decades have expanded the range of childhood disorders that can be treated by it to include a wide variety of behavior disorders and ego disturbances. In private practice the problem of 'analyzability' of such children often has less to do with the nature of the disorder than with the problem of treating the child within his environment. Here, of course, the therapist in the residential treatment center has the enviable advantage of working with these damaged children within an environment that is designed not only to support and augment the individual psychotherapy but to provide corrective experiences for the past.

Within this favorable environment, child analysis or a psychoanalytic child therapy should be able to demonstrate its usefulness and, in many cases, its indispensability. Hawthorne's 'therapeutic guidance' has great value, demonstrated by the cases illustrated in this volume; yet there are, in every psychiatric residence for children, cases that cannot profit from a therapy that makes use of current experience alone. These are the children who cannot free themselves from the morbid experience of the past, who are driven to interminable repetitions of the past in the daily life of the institution. These are the children who transfer, almost indiscriminately, the attributes of the dangerous figures of the past to the personnel of the institution, and who relive the past as if the psy-

chiatric residence were their theater. For these children a psychotherapy that makes use of the past as well as the present, one that works with the repetitions from the past to the present, may be the only therapy that can free the child from illness and make it possible for him to build a new life through residential psychiatric care.

SELMA FRAIBERG (ANN ARBOR, MICH.)

THE BENDER GESTALT FOR YOUNG CHILDREN. By Elizabeth Munsterberg Koppitz, Ph.D. New York: Grune & Stratton, Inc., 1964. 195 pp.

As the author notes, the chief contributions of this work 'are probably the objective scoring systems which were standardized on more than 1200 public school children'. Dr. Koppitz emphasizes the special efficiency of the Bender Gestalt Test, since it can be used both as a developmental and projective procedure, and can, as a result of the work presented here, also be used in the screening of beginning school children and the prediction of school achievement.

The author's cogent review of the literature makes it clear that the time has come for this monograph which not only integrates previous research, but establishes more definitively the levels of performance that can be expected from children at various ages and the significance of the different deviations in the copying of the figures. In her own collection of normative data of 1100 school children, Dr. Koppitz differentiates between those distortions that reflect immaturity or perceptual malfunctioning and those that are not related to age but reflect emotional factors. She achieves her stated aim to provide ways of analyzing the Bender records to evaluate perceptual maturity, possible neurological impairment, and emotional adjustment, from a single test protocol. Many well-presented actual test protocols illustrate the conclusion.

This excellent, comprehensive manual for the use of the Bender Gestalt Test as a perceptual and projective test for all children between the ages of five and ten years, enhances the increasing usefulness of the test and is a necessary addition to the library of those engaged in diagnostic evaluation of young children. There is nothing in the book of particular psychoanalytic relevance.

MANUEL FURER (NEW YORK)

AN INTRODUCTION TO PSYCHOTHERAPY. By Sidney Tarachow, M.D. New York: International Universities Press, Inc., 1963. 376 pp.

Directed to psychiatric residents and their supervisors, this book consists primarily of edited tape-recorded conferences with residents and supervisors at Hillside Hospital. The first part is devoted to general problems of treatment, the second to special clinical problems, and the third to supervisors' conferences. A variety of subjects is presented including the theory of the therapeutic relationship, types of psychotherapy, the theory of hospital treatment, administrative problems, goals of treatment, the structure of the treatment relationship, education and reality, values in psychotherapy, interviewing, obsessive-compulsive defenses, acting out, depression, masochism, and the transference.

To quote from the cover, 'The author combines tightly reasoned chapters on basic theory and rationale of psychoanalytic psychotherapy with freely structured conferences in which the application of his approach and underlying thinking are illustrated in specific clinical settings'. These are consistent with the broad framework of traditional psychotherapy though many analysts would disagree with some of the concepts. For example, there is to be no therapy in the first session because the patient is entitled to one session to decide whether he wants to be treated by that particular therapist or wants to change his mind and not go into treatment at all. A correct interpretation results in object loss and depression and one may disagree with the author's prognosis of the patient with homosexual behavior, or with his differentiation between psychoanalysis and psychotherapy.

As an introduction to psychotherapy the book is a worthwhile contribution. It is written in a clear, concise, straightforward manner with a good balance between basic concepts and clinical examples. By presenting cases in the form of clinical conferences, Dr. Tarachow reveals the interplay between teacher and student; he presents his ideas in context, and offers numerous illustrations of his conduct of therapy. His basic attitude toward teaching is stated in the chapters on supervision, in one of which he states, 'the teaching of the resident should be instruction in terms of the problems and needs of the patient, as expressed in the specific clinical phenomena of the patient'. He emphasizes that the supervisor is an instructor

and not a psychotherapist. One chapter title is Teacher or Critic?. Dr. Tarachow is a serious student of the teaching and supervisory process and evidently enjoys it. I strongly recommend the book to anyone interested in psychotherapy and the teaching of it.

NORMAN H. RUCKER (NEW ORLEANS)

LA RELATION THÉRAPEUTIQUE. MALADE ET MÉDECIN. (The Therapeutic Relationship. Patient and Physician.) By Jean-Paul Valabrega. Paris: Flammarion, Editeur, 1962. 276 pp.

All doctors are involved in transference reactions from their patients and countertransference reactions to them. Excepting psychoanalysts, and perhaps most psychiatrists, other specialists, general practitioners, and surgeons are totally or insufficiently aware of this unconscious interrelationship. Its therapeutic importance cannot be exaggerated. Valabrega calls it an 'intersubjective process' with deep emotional implications. Full awareness of the psychic factors involved in this interrelationship inevitably leads to much more competent management of every patient.

In the physical illness, the author agrees with Freud that there is a narcissistic investment of the ego and of the body. This, he says, does not constitute a complete withdrawal of the libido from the object; rather, there is a regressive redistribution of the libido, which has been partly withdrawn from objects previously cathected and reinvested in new objects in accordance with the sick person's dependent needs. The secondary narcissism is a regression to a state of primary love which involves introjection of the object.

Valabrega discusses at length the significance and importance of the œdipus complex, particularly its displacement onto the doctor as father and, in turn, the partial identification with the doctor which includes an element of aggression. Illness is equated with death, evil, and punishment, and therefore unconsciously connected to each patient's feeling of guilt. Disease in some instances may be conceived as a 'substance introduced into the body' or as a 'theft of the soul'. Magical thinking is conspicuous; a wish to contaminate others may derive from the wish to protect oneself; also, the person of the physician and the 'medical ceremony' are heavily invested with magic. The author reminds us the physician is not so far removed from the shaman and medicine man as we like to believe.

Latent homosexuality may distort the patient-doctor relationship. The doctor is often presented as a magician and as a hero. His knowledge may be interpreted as sexual omniscience. His sexual performance may be belittled or, when it is exaggerated, place the patient in a passive, castrated feminine position. Fantasies of being beaten are closely correlated with this unconsciously erotized wish.

Among women, feminine physiology itself—menstruation, pregnancy—can become equated with illness. Pregnancy may be confused with bowel functioning and the therapy may be equated to a delivery. In both sexes the homosexual component is often of the greatest significance in the therapeutic relationship, patient and physician being placed in the unconscious in varying bisexual roles.

The book closes with Glauber's study, A Deterrent in the Study and Practice of Medicine,[1] to illustrate the source of some of the inhibitions and difficulties which medical men may encounter in working with their patients.

This is a solidly based psychoanalytic essay. It may not add much that is new to the psychoanalyst or to the unconscious forces operative in the relationship between the patient and his doctor, but for physicians generally and for students of medicine it is a valuable, detailed, and conscientious review of the subject.

RENATO J. ALMANSI (NEW YORK)

MODERN PSYCHIATRY. A HANDBOOK FOR BELIEVERS. By Francis J. Braceland, M.D. and Michael Stock, Ph.D. New York: Doubleday and Co., Inc., 1963. 346 pp.

This handbook of psychiatry is a lucid and comprehensive history, description, and psychology of psychiatry. Not wholly committed to the freudian viewpoint it nevertheless gives a clear psychoanalytic introduction to psychopathology and psychotherapy.

A relatively small part of the book is devoted to the imbrication of psychiatry with religion. If one accepts the premise of the existence of God there is little quarrel with the authors' discussion of the relationship of psychiatry to religion, morals, philosophy, and free will. The authors quote Freud to reconcile the coexistence of free will and psychological determinism. These various issues are

[1] Glauber, Peter I., M.D.: *A Deterrent in the Study and Practice of Medicine.* This QUARTERLY, XXII, 1953, pp. 381-412.

presented without arrogance or self-righteousness; the delimitations of psychiatry from other disciplines is clearly defined. The discussion of psychotherapy is on solid ground. There is a brief, unnecessary, and irrelevant lapse into anti-Communism. In general, this book may be recommended as a suitable text for the education of a religious public in the place and meaning of psychiatry.

SIDNEY TARACHOW (NEW YORK)

DETERMINANTS OF HUMAN SEXUAL BEHAVIOR. Edited by George Winokur, M.D. Springfield, Ill.: Charles C Thomas, 1963. 230 pp.

The Fourth Annual Conference on Community Mental Health Research, held by the Social Science Institute of Washington University in St. Louis, is reported herein. Representatives of various disciplines discussed social and biological factors in human sexual activity. The data of Masters and Johnson provided an anatomic baseline for such study. Attitudes toward sexual activity, sexual identification, and lust orientation were discussed.

Kallmann and Money concerned themselves with genetic and biological determinants of human sexual behavior; their work shows the need for a better integration of biological with psychological research into the early determinants of gender identity. Despite the fact that a psychoanalytic approach was conspicuously absent, the factor that emerged as indisputable was 'rearing' with its implications for body image and object choice as a determinant of heterosexual or homosexual development. The papers that attempted an evaluation of human sexual behavior from the social and sociological point of view leaned heavily on the use of question and answer which gave little insight into the underlying fantasies of the individuals interviewed. This left one with a relatively superficial impression of dynamics.

Unfortunately the diversity of approach and variety of interests made it impossible to come to any over-all concept. Nonetheless, the conference did point up the need for further detailed study of human sexual behavior with dynamic psychology of an analytic variety as an essential part of such a study.

ANITA I. BELL (NEW YORK)

SOUNDMAKING. THE ACOUSTIC COMMUNICATION OF EMOTION. By Peter F. Ostwald, M.D. Springfield, Ill.: Charles C Thomas, 1963. 186 pp.

Psychoanalysis has been persistently criticized for its failure to provide 'objective evidence' for its concepts, and has been repeatedly admonished to be 'more scientific', by which is usually meant—imitate the physical sciences and use a statistical method best applicable to precise measurements of variables that can be expressed numerically. Dr. Ostwald's experiments may arouse a certain sceptical expectation that a study of the acoustic communication of emotion may give confirmation to some psychoanalytic tenets about affects and their expression by providing a nonanalytic method of investigation, and thus perhaps meet some of the clamor for objectivity, precision, and measurable variables.

The author introduces his monograph by stating that communication by sound is necessary for human comfort and survival, emphasizing the predominance of auditory over visual communication in psychopathology. He inveighs against dividing the content of human communication into the denotive and the emotive and stresses their inseparability.

The history of human soundmaking begins with the mystical assignment of omnipotence to various sounds by primitive civilizations which develop into the various forms of musical expression as we know them in the modern sense. The evolution of the science of sound starts with Hippocrates' discoveries of human sounds as diagnostic aids, the studies by the Pythagoreans of the relationship between physical stimuli and the sensation of sound, leading eventually to the studies of Helmholtz which put the physiology of sound perception on a firm scientific basis. Such sounds as animals make, baby sounds, the inarticulate speech of developing infants, and psychotic regressions are characterized as rudimentary. Learning to speak adds new sounds to one's repertory and suppresses infantile patterns. Deteriorated psychotics regress 'acoustically' as everyone knows.

There are seven qualitative attributes of sound, each with a gradient between extreme endpoints: rhythmicity, intensity, pitch, tone, speed, orderliness, and shape. The method by which intensity and pitch are measured is described. Sound analysis allows the in-

vestigator to record the total intensity, in decibles, of the sound output in each half-band range of frequency, providing a sound spectrographic record of the results.

An analysis of various human sounds, a baby's cry and four varieties of adult vocal productions, is made, each presented with typical spectrograms. Similar studies are made of one patient's speech during eleven psychotherapeutic interviews, of twenty normal individuals subjected to the experimental stress of a foul-smelling chemical, of thirty psychotic patients compared before and after standard physical and chemical therapies, of four mute patients, and of four with speech disturbances. The results show that it is quite possible to characterize acoustically many of these varieties of human sounds in terms of the patterns of the distribution of sound energy for each frequency range; that is, the human voice at any given moment can be described on the basis of how much of its soundmaking is concentrated in which pitch range or ranges.

Despite the care with which the data are presented, and despite the author's conviction 'that there are significant relationships between soundmaking and psychopathology, and that these relationships can be defined scientifically', the psychoanalyst is left with a sense of disappointment and a scepticism about studies of this kind. Nowhere is there considered the difference between emotions experienced intrapsychically and emotions expressed in words which, from the psychoanalytic point of view, is an integral part of the broader problem of the motivations of behavior, of which speech is but one aspect. There is frequent resort to highly charged descriptive terms for which any method of measurement is lacking. The attempts to relate psychopathologic entities to acoustic spectrographs lack both the variety and refinement of genetic-dynamic formulation which alone would provide sufficient specification of a significant relationship. Ostwald acknowledges at the end the limitations of his method and, in a personal communication, states he is extending acoustic measurements.

The use of such colloquialisms as 'think big' and 'hocus pocus' are inappropriate in a book addressed to a scientific audience. The inclusion of an interest in communication with creatures from other planets is, even if prophetic, a bit premature. The analogy between idiomatic speech and lexicography is a confusion of orders of language; also in including with speech other bodily

visceral sounds, involuntary or semivoluntary. The author's previous warnings to the contrary, he separates denotive and emotive speech, a troublesome and contradictory dichotomy.

A more fundamental criticism brings the entire method of acoustic analysis of brief segments of taped vocal material into question. With the recent development of analysis of the communicative significance of body motion by Birdwhistell,[1] and the development of the analysis of sound film by several groups of investigators (studies to be published by G. Bateson, H. W. Brosin, R. L. Birdwhistell, F. Fromm-Reichmann, C. F. Hockett, and N. A. McQuown; Albert E. Scheflen; Felix F. Loeb; William S. Condon; and the reviewer), the characterization of communication of emotion limited to acoustical analysis of two vocal variables is plainly insufficient. Investigators of human communication are currently demonstrating that it occurs simultaneously at the linguistic, paralinguistic, motor, and visceral levels; that no one channel has exclusive claim to emotional communication; that any given piece of communication takes its place among others.

The development of a system of notation for linguistic and kinesic modes of expression enables an investigator to delineate specific behavioral concomitants of affective expression without having to wrench them from their context in the communicative process. Although further detailed investigations of the acoustical properties of human soundmaking are undoubtedly of scientific value, the linguistic-kinesic synthesis appears to be a more fruitful approach to elucidation of the communication of emotion.

E. JOSEPH CHARNY (PITTSBURGH)

THEORIES OF THE MIND. Edited by Jordan M. Scher. New York: The Free Press of Glencoe, 1962. 748 pp.

Scher has brought together the predominantly original contributions of thirty-five prominent psychologists, philosophers, physiologists, psychiatrists, and theologians to suggest answers to his basic

[1] Birdwhistell, Ray L.: The Kinesic Level in the Investigation of the Emotions. In: *Expression of Emotions in Man*. Edited by Peter H. Knapp. New York: International Universities Press, Inc. 1963. Also, Body Motion. In: *The Natural History of an Interview*. Edited by Norman A. McQuown. New York: Grune & Stratton, Inc. To be published.

question, 'What is Mind?'. The volume has three parts: 1, Mind as Brain: physiological aspects of the brain, nervous system, endocrine glands, and the behavior of animals and men; 2, Mind as Participation: humane, psychiatric, and cybernetic definitions; and 3, Mind as Method (Of Elephants and Men): a miscellany of methodologies—introspection, memory, mathematics, hypnosis, and paranormal communication.

As not uncommonly occurs with such an arrangement, the book suffers from a wide variety and unevenness of styles and orientations. Two quotations seem appropriate here: Angell's dictum, 'We should glean information wherever it can be found', and Wittgenstein's, 'Whereof one cannot speak, thereof one must be silent'. Thus it is indeed distressing that several contributors, apparently established and distinguished in their academic fields, still harbor so primitive and distorted an understanding of both clinical and theoretical psychoanalysis. Moreover the articles by Percival Bailey and Jules Masserman are marked by diatribes against classical psychoanalysis. It is equally unfortunate that no definitive psychoanalytic article or point of view is included. Several quotations may suggest the flavor of the articles dealing (usually peripherally) with psychoanalysis. Bailey: 'Classical psychoanalysis applies a somewhat peculiar form of demi-theology'. Taylor and Wolpe insist that we 'must correct the widespread belief that abnormal mental processes are responsible for neurosis', the etiology of which is 'an intrinsically simple conditioning process'. Glad, using an inflated beach ball as a metaphor, remarks, '. . . psychoanalysis expresses the intensity and anxiety of being overfilled with a seminal surplus'. Fortunately Angell's dictum about gleaning information is also applicable. There are a number of interesting, well-documented articles which may be of general interest to psychoanalysts despite a major emphasis on anatomic, physiological, and molecular psychology. Ralph Gerard even suggests that 'there is no twisted thought without a twisted molecule'.

In the first section, the articles by E. Roy John and Charles Shagass emphasize the neurophysiological indicators of emotion as well as physiological models for learning. Harold Himwich contributes an interesting article on tranquilizers and antidepressant drugs, describing their interrelations and mode of action through the thymencephalon. Another worthwhile contribution is by How-

ard Liddell on The Biology of the 'Prejudiced' Mind. ('Prejudice' refers to conditioned reflexes.) His experiments with sheep and with the mother-child relationship are fascinating. However, too many contributors still base their hypotheses on the 'black box' concept of the mind introduced by the behaviorists and certain learning theorists. In the second section, Harold Kelman's article discusses mind as 'minding—a creating, emerging, evolving process', and correlates his concept of psychoanalysis with the Zen doctrine of the East and with existentialism. Several articles deal with the relation of the human mind to various mechanical models and automata ('androids'), the consensus being that the machines have not captured the 'essential' aspect of mind, including consciousness, and also are mute about the subjective aspects of human behavior. The editor, Jordan Scher (also editor of the Journal of Existential Psychiatry), offers a cogent presentation of the existentialist position in an article on Mind as Participation, emphasizing 'presentness' and availability as fundamental aspects of man's nature. In the final section, Herbert Feigl offers an interesting solution of the mind-body problem through an identity theory of the mental and physical, comprising a reality that is represented in two different conceptual systems. There are also creditable articles on hypnosis, introspection, and the growth of culture.

In summary one can, with care, glean some interesting information from this volume, but the strong bias toward mechanistic, behavioristic concepts of the mind makes it difficult to recommend.

BERNARD D. FINE (NEW YORK)

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Edwin F. Alston

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ABSTRACTS

Bulletin of the Philadelphia Association for Psychoanalysis. XIII, 1963.

Maturity in Religion. Abraham Kaplan. Pp. 101-119.

Kaplan considers the religious attitude rather than religion as an institution. He contrasts infantilism in religion with a number of deep basic attitudes which constitute a more mature religious attitude. Infantilism in religion is as prevalent as it is in politics, art, and love. Some persistent infantilisms are discussed, such as the belief that adequate submission to an external authority assures salvation; that God, priest, and savior are essential to religion; that there must be faith in the sense of accepting propositions without any evidence; that religion is an instrument of personal wish-fulfilment. Mature religion is rare and difficult to achieve. It expresses humility, seriousness of purpose, responsibility, joy, and gratitude for the world as it is, rather than dependency, anxiety, guilt, and fantasies of complete wish-fulfilment.

A Specific Problem in Adolescent Boys. Difficulties in Loosening the Infantile Tie to the Mother. Liselotte Frankl and Ilse Hillman. Pp. 120-129.

Much of this material centers around a young boy who began treatment at eleven and continued through adolescence. At the same time the boy's mother was in analysis, presenting an unusual opportunity to study the interactions which served to perpetuate the psychopathology in each. The mother was excessively dependent upon the boy to fulfil her own narcissistic needs and to assuage feelings of guilt. The boy was bound to his mother by his pregenital needs, his fear of harming his mother by leaving her, and his guilt over gratification in being apart from her. The intensifications of id impulses during adolescence led again and again to infantile ties rather than to realization of the growing wish for freedom. These fixations became quite clear in the patients' transference reactions. Such ties between mother and child have serious pathological consequences; it is important to recognize and treat them early.

The Psychological Significance of the Omen by Which Dreams Were Interpreted. Gerald H. Pearson. Pp. 130-135.

Pearson examines fourteen dreams from ancient peoples of the Old Babylonian period along with the omens they were supposed to signify. If speculations are made about the possible unconscious wishes represented according to psychoanalytic experience there is a strong suggestion that the persons who made the omens had some understanding of the unconscious wishes of the dreamer.

The Driver's Test as a Modern Puberty Rite. Norman D. Weiner. Pp. 136-141.

A patient confronted with examination for a driver's license reacted with paralyzing and self-defeating anxiety reactions. Symptomatic acts such as cutting his finger appeared in his behavior. During this period associations brought up various œdipal difficulties and castration fears evoked by the examining officer. The patient reflected that all of this had something to do with becoming a man.

Weiner points out that the patient was reacting to the examination as if it were a puberty rite with ritualistic physical and psychological ordeals leading to a sort of rebirth with social rewards and privileges upon satisfactory completion. Working through some of the aggressive and homosexual conflicts which had become focused on the examination made it possible for the patient to view it more realistically and enabled him to pass without further difficulty.

Intellectualization and Intellectual Defenses. Morris D. Galinsky and Maurie D. Pressman. Pp. 153-172.

Intellectualization is defined as the development and use of insights for self-deception rather than for tolerating and understanding affect. A concept of 'affect-thought ratio' is developed. Intellectualization does violence to this ratio as a defense against affect and passivity, especially in the transference reaction. It prevents 'true' insight in that it prevents optimal fusions of understanding and feeling. Intellectualization per se is not an indication of ego strength or weakness, although there are differences in the manner in which the weak and strong ego will use it as a defense. The whole subject of intellectualization and intellectual resistance is held to be important, too little studied, and in need of further study.

Some Observations on a Mild Sleep Disturbance in a Three-Month-Old Girl. Gerald H. J. Pearson. Pp. 173-181.

A three-month-old girl had a mild sleep disturbance consisting of an unwillingness to go to sleep coupled with a startlelike jerk into wakefulness as her muscular system became relaxed when she fell asleep. Pearson considers that both of these disturbances arose from the same cause: it seemed most likely that the little girl dreaded the loss of a new ego pleasure in muscular activity and the emerging ability of her ego to direct her actions for this pleasure in movement. This dread could be the same as that suffered at the beginning of psychosis, in the change of a psychotic state, and sometimes in adolescence—a dread of the dissolution of the ego.

On Negativism and the Character Trait of Obstinacy. Alexander Carons. Pp. 182-197.

A severe obsessive-compulsive neurotic patient illustrated in analysis some of the meanings of obstinacy, a character trait which expressed itself in treatment as well as in every other area. The obstinacy was a general defensive reaction against passive submissive tendencies and also an unconscious expression of hostile aggression. The patient periodically indulged in limited homosexual activity. This was seen as an act of submission; the obstinacy was an undoing of this anxiety-provoking act. With the analyst, the patient was compliant and deferential but also revealed aggression and hostility by a quiet argumentativeness along with passive defiance in remaining impervious to interpretations. The pathologic character attitude of obstinacy is an order of defense against being subjugated to the will of others. It is the outcome of a defense which has engulfed the ego. The development of the defense into a character trait is indicative

of the instinctual danger that has to be warded off. In the obsessive-compulsive neurotic this danger is centered around the struggle between the partial instincts of activity and passivity, with attendant sadistic or masochistic significance.

EDWIN F. ALSTON

Bulletin of the Philadelphia Association for Psychoanalysis. XIV, 1964.

Luck: Bad and Good. Sandor S. Feldman. Pp. 1-12.

There are people who regularly complain of being unlucky; more rare are the individuals who assert that they are lucky. This conviction about good luck and bad luck occurs in people who are not otherwise superstitious. Feldman concludes that this belief in luck, good or bad, is a compromise achieved by the ego in its attempt to reconcile demands from the id for gratification of aggressive and sexual drives opposed by prohibitions and restrictions from the superego. The chronic complainer in effect is denying the excessive infantile demands he makes upon the world.

The Original Persecutor—A Case Study. Jack Greenspan. Pp. 13-28.

Greenspan presents an analysis of letters written by a woman patient to a hospital where she was confined from 1917 to 1920. The letters cover a span of forty-two years. During all of this time the patient suffered from paranoid delusions that she was a victim of persecution by a 'community movement'. The content of these letters offers clear support for Freud's hypothesis that in paranoia the original persecutor is a person of the same sex toward whom the patient has had a strong sexual attraction. In the present case the letters clearly depict the patient's original attachment to her mother, defended against by ideas of persecution which in turn were extended onto others by virtue of their relationship to the mother.

Some Psychological Implications of Comic Strips. Stanley H. Cath and Bruce Fischberg. Pp. 29-36.

The authors analyze a number of popular comic strips. They postulate that the comic strip is one of the means by which man is able to work over many of his anxiety-producing problems at a distance, so to speak. The net effect is reduction of over-all tension.

Language and Its Pre-Stages. Lili E. Peller. Pp. 55-76.

For human beings the world is conceptually organized, principally by language, their most important tool for dealing with life. Observations on the development of language reveal that it is a far more complicated process than formerly supposed. It is no longer so tenable that the acquisition of language arises solely from the human being's powerful instinct to imitate. Among the important factors in language development which are discussed are prolonged dependency, playful contact with objects available to senses and motor apparatus, narcissistic pleasure in self-created stimuli, awareness of the similarity between the self and others, pleasure from vocal functioning, and the greater importance of the distance receptors for the human infant.

Memoirs, 1905-1908. By the Wolf-man. Translated by Felix Augenfeld and Muriel M. Gardiner. Pp. 80-103.

These memoirs, with an introduction by Muriel M. Gardiner, begin with an account of the suicide of the Wolf-man's sister. The Wolf-man continues with a description of his profound depressive reaction accompanied by suicidal thoughts and paralyzing indecision about his career and studies. During the latter part of this period the Wolf-man had a first experience with psychotherapy, supposedly hypnosis. This failed and a decision was made that he should go to Munich to see Kraepelin for examination and advice. The section closes with a description of what turned out to be a last farewell to his father.

EDWIN F. ALSTON

Journal of Nervous and Mental Disease. CXXXVII, 1963.

Parental Loss by Death in Childhood as An Etiological Factor Among Schizophrenic and Alcoholic Patients Compared with a Non-Patient Community Sample. Josephine R. Hilgard and Martha F. Newman. Pp. 14-28.

With a sample of a large number of schizophrenic and alcoholic patients and an appropriate control group, the writers correlate admission to the hospital and parental death in childhood, most frequently found in schizophrenics admitted to the hospital between the ages of twenty and forty. The older schizophrenics and alcoholics did not differ significantly from the control group. The hypothesis is advanced that role transition from immaturity to adult responsibility is more difficult when there is a death causing a traumatic deficit in parental protection during childhood.

A Psychotic Family: Folie à Douze. Herbert Waltzer. Pp. 67-75.

A family is presented in which both parents and all ten children possessed the same persecutory delusions. The etiological importance of noxious environmental stimuli is stressed. A developmental scheme for *folie à deux* is suggested: a phase of sensory isolation and ideational deprivation which is disorganizing and regressive, followed by a phase of identification with the aggressor (the psychotic parent), and a re-indoctrination period when delusional ideas are incorporated. The author feels that the process is similar to that which occurs in brainwashing, hypnosis, and psychotherapy.

Conformity and Achievement in Remitted Manic-Depressive Patients. Charles D. Spielberger, Joseph B. Parker, and Joseph Becker. Pp. 162-172.

The authors attempt to test the hypothesis that persons who develop manic-depressive reactions in adulthood experienced excessive parental expectations for conformity and achievement as children, to which they reacted by adopting the prevailing values of their parents and other authority figures in order to placate and win needed approval from them. The study investigates the extent to which chronic dependence on others for guidance and approval was manifested in the opinions, attitudes, and social convictions of manic-depressives. A group of manic-depressives and controls were tested with four psychological scales. Remitted manic-depressive patients varied significantly from the control group, which sup-

ports the authors' hypothesis that the adult personality structure of manic-depressives is characterized by conventional authoritarian attitudes, traditional opinions, and stereotyped achievement values, but not by internalized achievement motives.

A Questionnaire Study of Psychoanalytic Practices and Opinions. Thomas S. Szasz and Robert A. Nemiroff. Pp. 209-221.

The members of the American Psychoanalytic Association 1958-59 roster were sent questionnaires about practices and opinions. Four hundred and thirty members (or fifty-six per cent of the membership) returned the questionnaire. Of interest to the authors was the unexpected frequency with which analysts engaged in 'various medical practices', such as physical examinations, laboratory examinations, prescription of drugs, prescription of shock treatment, and signing of commitment papers. Also of note was the fact that few analysts excluded third parties completely from their relationship with the patient. Other interesting facts elicited were that sixty-eight per cent of the analysts stated that they belong to no organized religious group, fifty-two per cent approved of lay analysis, seventy-one per cent approved of training analysts communicating with the officers of the institute about their candidates, and about fifty per cent believed that legal prohibition of abortion is socially desirable.

From the study the authors feel that analysts are not so purely analytic and psychological as had been suspected but that various medical, directive, and organic practices have crept in, blurring the distinctions between psychoanalysis and psychiatry. One criticism of the study mentioned by the authors is the failure to distinguish between what the analyst does with analytic patients and with non-analytic ones. A second criticism might have to do with the missing forty-four per cent of the sample whose opinions and practices may for various reasons differ from their brethren who answered the questionnaire.

Body Experiences of Schizophrenic, Neurotic, and Normal Women. Seymour Fisher and Richard Seidner. Pp. 252-257.

An attempt was made, chiefly by projective tests and questionnaires, to find whether there are body image experiences which distinguish psychiatric patients from normal persons, and to determine if neurotic and schizophrenic patients differ in their body perceptions. Areas of concern included general body interest, over-all size, size of parts, depersonalizations, boundary, and references to feeling dirty. The psychiatric patients reported a greater number of body distortions than normal women. Efforts to distinguish neurotics from schizophrenics were not successful. Psychiatric patients tended to have experienced sensations of diminished body size more frequently than normal subjects—the only relatively unique kind of distortion.

Psychodynamic Approaches to Childhood Schizophrenia: A Review. A. J. Gianascol. Pp. 336-348.

The author reviews the literature on childhood schizophrenia and then gives some observations from the experience at the Langley Porter Neuropsychiatric

Institute with two hundred and three schizophrenic children. The parents of one hundred thirty-nine children undertook collaborative therapy, the majority for periods ranging up to four years. Of note was the substantiation of Kanner's description of the parents of autistic children as being 'successfully autistic adults'. The disorder of the psychotic child is seen as representing both identification with and futile rebellion against the disorder of each parent.

Transference Revisited. Donald D. Jackson and Jay Haley. Pp. 363-371.

The authors feel that the definition of transference as a projection of the patient's infantile feelings, thoughts, and wishes onto the analyst is inadequate because it does not take into consideration the interpersonal framework, patient and analyst, in the analytic situation. They argue that what seems infantile in the patient is really quite appropriate when one considers the unusualness of the analytic situation—free association, time, money, recumbency of patient, unresponsiveness of analyst. They feel that the patient's adjustment to this awkward situation, rather than interpretation of the transference per se, is what is responsible for change in the patient. Self-understanding may be an accompanying, but not necessarily crucial, factor. They conclude that it is the context in which understanding takes place, rather than understanding itself, that leads to improvement in the patient.

BENNETT F. MARKEL

Journal of Nervous and Mental Disease. CXXXVIII, 1964.

Multiple Determinants of Suicidal Efforts. Lawrence S. Kubie. Pp. 3-8.

In an editorial Kubie reviews some of the complexities and difficulties in formulating ideas about the problem of suicide. He enumerates a number of variables, different types of fantasies, and diverse psychopathological states which may, under a variety of circumstances, lead to a single end, suicide. He urges that we not be misled by the common denominator of death to forget the multivalent objectives of suicidal behavior. Numerous questions are raised: where therapy fits in as a preventative, and occasionally as a provocative, factor; how can hospitalization be best utilized; where do drugs fit in; what are the warning signals and what do they mean? He concludes that further investigation is needed and indicates several lines of research.

Abolish the Insanity Defense—Why Not? Jay Katz and Joseph Goldstein. Pp. 57-69.

The authors in a closely reasoned and convincing way argue that the insanity defense should be abolished. They offer other solutions that would both protect the community and be humane. They attribute the present cloudy state of affairs to the ambivalence surrounding the 'sick . . . criminal which is reflected in conflicting wishes to exculpate and to blame; to sanction and not to sanction; to degrade and to elevate; to stigmatize and not to stigmatize; to care and to reject; to treat and to mistreat; to protect and to destroy'. They conclude that the abolition of the insanity defense would do away with the knotty problem of determin-

ing who is responsible and who is not. Other problems such as the restraint of persons who might harm the community and the care and treatment of the mentally disturbed then can be confronted as issues in their own right.

Birth Order and Schizophrenia. Sharadamba Rao. Pp. 87-89.

A statistical study of over two thousand schizophrenic patients hospitalized in India, aged fifteen to forty-five, seventy-five per cent males, revealed the predominance of psychotic disorders in the first or second born. The author speculates that the first or second born may be under greater stress as the carrier of the burden of family tradition.

Dogmatism and the Medical Profession. Eric H. Marcus. Pp. 114-118.

A 'dogmatism scale' designed to test the individual's private network of political, religious, philosophical, and scientific beliefs was administered to various medical groups, to determine the flexibility of one's belief systems. The level of dogmatism was found to decrease during college and medical school. Psychiatric residents, the least dogmatic of all groups tested, showed relatively less dogmatism than their medical and surgical counterparts. Board qualified specialists—surgeons, internists, psychiatrists, psychoanalysts, scientists in industry, industrial department heads—all rated about the same.

Environmental Stimulus Reduction As a Technique to Effect the Reactivation of Crucial Repressed Memories. Anthony Suraci. Pp. 172-180.

The author subjected himself to seven weeks of 'environmental stimulus reduction'—isolation, asceticism, and relative sensory deprivation. After passing through a hallucinatory phase, he proceeded to what he calls 'a new condition during which repressed memories were recalled and relived . . . eight hundred pages of crucial repressed memories and other events, the existence of which I had never up to that time suspected'. After the experiment there was a residual effect of reorientation as far as sense of identity, sense of reality, motivation were concerned. There is a religious conversion aspect about the whole experience which arouses suspicion, but the relationship between sensory deprivation and the return of repressed memories is of interest, particularly as it might relate to sleep and dreams.

The Bearing of Psychoanalytic Theory on Selected Issues in Research on Marginal Stimuli. Fred Pine. Pp. 205-222.

This article deals with work on marginal stimuli (subliminal, incidental, or partially seen) as a means of experimentally studying thought processes outside awareness. There are a number of ways of introducing marginal stimuli—brief, dim, obscured, incidental to other activity—which are reviewed. The connecting links between these stimuli and their effects on the one hand and psychoanalytic theory on the other is developed. The day residues in dreams provide a useful parallel. Those stimuli that are retained are felt to make some contact with drive activity, in the way that dream activity is organized around drives. However, in addition to the importance of primary process to explain the phenomena involved, the author cites the importance of the subjects' expectations, thinking

processes, and response modes. The article is an excellent review of the experimental work and discussion of the theoretical considerations.

A Second Look at Sensory Deprivation. Eugene Ziskind. Pp. 223-232.

The author feels that the failure of extensive experimentation in the field of sensory deprivation to provide more conclusive answers lies in the inadequate recognition of the complexity of the variables that enter into the situation of sensory restriction. The article attempts to classify some of these variables and assess their importance—factors such as the extent of deprivation, the sense organ deprived (visual, auditory, tactile), duration, and interpersonal isolation. The problem of evaluating the output and the behavioral signs that emerge from sensory deprivation is discussed.

Ego Disturbance in TAT Stories as a Function of Aggression-Arousing Stimulus Properties. Lloyd H. Silverman. Pp. 248-254.

TAT cards, varying in degree of aggressive 'pull', were given to a group of twenty adolescent schizophrenics and twenty neurotics and personality disorders. The stories that the patients developed around the aggression-arousing cards contained more manifestations of ego disturbance than stories told about cards judged low in aggressive 'pull'. Criteria of ego disturbance came from a long list including peculiar verbalization, slip of the tongue, confusion, incoherence, self-reference, and perception distortions. The study was felt to bear out Hartmann's assumption that schizophrenia is a consequence of failure of sufficient neutralization of aggressive drive energy. As a corollary, after the schizophrenic illness has developed, the degree of ego disturbance manifested will increase when the individual is confronted with stimuli possessing aggression-arousing properties. These findings were felt to apply to certain nonschizophrenics also.

BENNETT F. MARKEL

American Journal of Psychiatry. CXX, 1964.

C. G. Jung's Contributions to Psychoanalysis. Sheldon T. Selesnick. Pp. 350-356.

The contributions of Jung to classical psychoanalytic theory are enumerated and described, the author pointing to the cross-fertilization of ideas between Jung and Freud. Jung's association experiments were felt to support the cornerstone of psychoanalysis: his most important contribution the pointing out to Freud the latter's failure to separate sharply neurotic and psychotic phenomona in the Schreber case, which ostensibly led Freud to revise his libido theory.

The Dynamics of Psychiatry in the Light of Learning Theory. Franz Alexander. Pp. 441-449.

In this, one of the last papers published before his death, Franz Alexander traced the evolution of some of his contributions to psychoanalytic thought. He stated his conviction that the therapeutic process could best be understood in terms of learning theory, and this paper represents an attempt to view the process of psychoanalytic therapy and the problem of 'emotional insight' in these terms.

He concluded that 'at present, we are witnessing the beginnings of a most promising integration of psychoanalytic theory with learning theory, which may lead to unpredictable advances in the theory and practice of the psychotherapies'.

LAURENCE LOEB

Archives of General Psychiatry. X, 1964.

Olfactory-Gustatory Mentation. A. D. Jonas. Pp. 36-42.

An attempt is made to explain the mode of thinking of certain schizoid persons in terms of the thought processes operative during early feeding experiences. The patients tended to be narcissistic and extremely demanding. All had frustrations in early feeding experiences that were characterized by confusing changes in feeders and feeding technique that strained the growing adaptive capacity of the child. This produced mental functioning characterized by digital computer-like classifying of perceptual data with resulting faulty logic and a breakdown in learning and communication.

Security as a Motivation of Human Behavior. Jack C. Borel. Pp. 105-108.

Borel conceptualizes human motivation as the individual's striving toward control of cause and effect in his environment, to overcome the reality of infantile helplessness in regard to his parents. This striving is called security seeking. Unless parents are secure enough to allow a child to develop his own independent actions within his capabilities, he will be forced to go through life behaving in ways to please others, with resultant anger and ambivalence toward love objects. Thus the person will obtain only the illusion of controlling his environment. In the broad sense the author attempts to fit all behavior into this mold.

Visual Imagery and Preconscious Thought Processes. Harvey H. Corman, Sibylle K. Escalona, and Morton F. Reiser. Pp. 160-172.

Using tachistoscopic presentation of subliminal stimuli, the authors begin a sophisticated investigation of issues in psychoanalytic ego psychology, especially perception, image formation, ego function, preconscious processes, and the continuum of primary process-secondary process thinking. Major determinants include ego state, the experimental situation, especially the experimenter, and incidental stimuli, all of which can be studied with their technique.

Reminiscing. Arthur W. McMahon and Paul J. Rhudick. Pp. 292-298.

Our attention is called to the tendency of elderly persons to reminisce, not related per se to intelligence or intellectual deterioration. Reminiscing is seen as performing an adaptive ego function which enables the elderly individual to maintain self-esteem, reaffirm a sense of identity, re-establish continuity with the past, and perform the work of mourning in regard to lost love objects. In addition calling upon the wisdom of the past offers at least the illusion of contributing to solutions of present problems.

KENNETH RUBIN

British Journal of Medical Psychology. XXXVII, 1964.

A Note on the Origin of Male Homosexuality. W. R. D. Fairbairn. Pp. 31-32.

Through the analysis of a patient with strong homosexual tendencies, the author illustrates Freud's thesis that the substitution of the penis for the breast provides the essential basis of male homosexuality. Weaning therefore equals castration and the castrator is the mother rather than the father. The penis then becomes the sexual object in preference to the vagina.

Percival Lowell and the Canals of Mars. Charles K. Hofling. Pp. 33-42.

This paper considers the case of a famous and dedicated investigator whose report on Mars seized the imagination of masses of intelligent laymen and resulted in a major scientific controversy. Lowell, who was a distinguished modern astronomer, devoted a great part of his life to the scientific investigation of the various surface features of Mars. Hofling's study is based on Lowell's writings and biographical data. The perception of the canals may be categorized as illusory, and his conviction of their presence contrary to fact is described as an *idée fixe*. The heavy influence of unconscious forces taking the final form of incompletely sublimated voyeuristic impulses resulting from unresolved œdipal conflicts are given as the explanatory conclusions by the author.

HERMAN HIRSH

Revista de Psicoanalisis. XX, 1963.

Two Types of Guilt: Their Relation to Pathological and Normal Aspects of Mourning. Leon Grinberg. Pp. 319-330.

The pathologic form of guilt is seen in melancholia; the severe superego implies that the destructive impulse appears as 'a pure culture of the death instinct'. This type of guilt is always accompanied by resentment, desperation, fears, psychic pain, and self-reproaches. The other and more normal type of guilt is predominantly manifested by sadness, nostalgic feelings, feeling of responsibility, and a preoccupation with the ego and the love object in an attempt to preserve both. The author describes 'micro-depression', or 'micro-mourning', as an ego state characterized by feeling tones such as irritability, apathy, tiredness, and boredom, and not as a clinical depression. These micro-reactions are provoked by daily living when, for instance, a goal cannot be achieved, a dream cannot be remembered, a haunting memory occurs, or one changes one's place of living, as well as when there is any fleeting threat to one's identity.

Psychological Difficulties Encountered in the Beginning Analyst. Marie Langer. Pp. 333-345.

A well-rounded exposition of the specific anxieties of a candidate is presented. These indicate the confusion caused by the double role of analyzing while being analyzed. The candidate is a rival with his own patients; he envies the patient if he improves; some patients are experienced as younger siblings. The danger of the candidate's incomplete analysis is discussed.

Kafka's Metamorphosis. A Clinical and Applied Psychoanalytic Study. Gilberte Royer. Pp. 346-358.

Infantile stories, fables, fairy tales, and such characters as Mickey Mouse and Donald Duck reveal how easily an animal becomes a hero. In the metamorphosis the switch between animal-man produces a sinister element, an undefinable, severely unpleasant feeling. The sinister elements related to the repression of the castration complex, the familiar which has been handled (animism), the perception of the 'double', the need to repeat in a compulsive way, and the infantile fears about loneliness and darkness are all condensed in Kafka's stories. It is postulated that as a defense the ego which feels impotent in the presence of a magic, primitive, chaotic, and terrifying world has the need to repeat the infantile situation. The defense, mind and body, is a specific dissociation, defending against a total dissolution by creating the shell of a body and also protecting the body against all these terrifying unconscious fantasies. In the story, by the return of the repressed, the author managed to gratify the fantasy and at the same time had no need to abandon the defense mechanism.

Introduction to the Study of Genetics and the Sense of Omnipotence. Alberto J. Campo. Pp. 359-376.

Methodically, omnipotence is described from the point of view of its genetic, economic, dynamic, and structural aspects; feelings of omnipotence and omnipotence of ideas; its relationship to the reality principle, mechanisms of defense, and finally the resolution of the feelings of omnipotence. A theoretical construction, this paper attempts to systematize concepts which appear to be contradictory in relation to omnipotence.

GABRIEL DE LA VEGA

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Meetings of the New York Psychoanalytic Society

Milton E. Jucovy

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NOTES

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

May 19, 1964. THE PROBLEM OF DEATH IN FREUD'S WRITINGS AND LIFE (Fourteenth Freud Anniversary Lecture). Max Schur, M.D.

The author, who was Freud's personal physician during the last ten and a half years of his life, uses Freud's writings, some unpublished correspondence, and personal observations to develop his thoughts about Freud's attitude toward death, including his own, as a biological, psychological, and clinical problem.

In The Interpretation of Dreams and the Fliess letters, Freud reveals his early encounters with death and the reconstruction in his self-analysis of the death of his younger brother, so crucially important for his later relationships. During this period he suffered from neurotic fears of dying, travel phobias, and cardiac symptoms accompanied by dread of death. He was obsessively preoccupied with the superstition that he might die at certain ages: forty-two, sixty-two, and in his eighty-second year. Self-analysis enabled him to subject the problems of death to psychoanalytic inquiry and many of his neurotic symptoms yielded to this supreme feat. In later years his correspondence reveals a dislike of aging rather than fear of dying, especially a repugnance for decline of creative activity.

Freud first discusses death as an analytic problem in The Interpretation of Dreams, and later as a theme dealt with by writers and poets. In the Gradiva paper he expressed his fascination with the artist's ability to fathom the working and language of the unconscious and to deal with death and immortality. In The Theme of the Three Caskets he first indicated that death may be the object of an unconscious wish. He was then preoccupied with the preparation of Totem and Taboo, where his discussion of animism is based partly on assumptions about the impact of death on primitive man, and where he links developmental change from the primal horde to modern civilization with man's attitude toward death.

The impact of World War I made death seem real and shattered many illusions. In Timely Thoughts on War and Death, Freud subjected illusions about death to analytic appraisal and concluded that in the unconscious everyone is convinced of his own immortality. His creative outpouring during the war years, which included papers on metapsychology, Mourning and Melancholia, and the Introductory Lectures, indicates that he did not succumb to unproductive pessimism, and his relative state of serenity may be noted in the paper, On Transience, where he disputes the pessimistic view that the transient nature of beauty involves any loss in its worth. Freud's unceasing battle since the beginning of his self-analysis to establish and reaffirm the supremacy of the ego and the intellect without the help of any illusions now had to face the problems of aging, personal tragedy, what looked like the complete breakdown of Western civilization, and eventual pain and misery. Although he may be regarded as the incarnation of strength, wisdom, and courage, he was also intensely human, and several letters written toward the end of the war revealed some of his doubts, fears, and superstitions. In 1918 he passed the age of sixty-two, one of his superstitious

deadlines, and in 1919 began work on Beyond the Pleasure Principle. It seems likely to Dr. Schur that this essay had multiple determinants in Freud's inner life. There had been an early assumption that it was a response to the death of his daughter, Sophie, but it was actually half finished when she was still alive. However, the war had stimulated recognition of the importance of aggression in mental life, and his self-analysis had revealed the strictness of his own superego and the preoccupation with death as manifestations of aggression turned against himself. The scientific contributions of this work were of significance to the further development of psychoanalysis and led to the widening of the libido theory, to the dual instinct theory, to new and better understanding of ambivalence, and to the concept of fusion and defusion of instincts. Otherwise it seems also to have fulfilled an important function in Freud's inner struggle with the problem of death. The uncovering of an instinctual drive may have been determined by the need to treat death scientifically in order to accept it without fear and to reaffirm its accessibility to ego control.

Further mild hypochondriacal preoccupations were revealed in 1921 when he wrote to Ferenczi that he had the impression that seven of his internal organs were fighting for the honor of bringing his life to an end. Dr. Schur points out that this was probably an ironic paraphrasing of the Greek pentameter, translated as 'Seven cities are competing for the honor of being the birthplace of Homer'. Freud then wrote that he viewed this hypochondria coolly; he permits himself to complain and to engage in a short daydream, and then responds to the call of reality and duty. The year 1923 was a fateful one when Freud became aware of a lesion in his mouth and visited a dermatologist who probably recognized the nature of the lesion and advised excision. The decision to withhold the truth from Freud and tell him it was leukoplakia due to excessive smoking was explained by Felix Deutsch on the basis that Freud was not sufficiently prepared to face the reality. Deutsch apparently concluded that Freud was contemplating suicide because he asked for help if doomed to die in great suffering and spoke of his mother finding the news of his death hard to bear. Schur feels this conclusion unfounded and feels obliged to set the record straight. Freud never considered suicide and wanted to prolong life as far as possible.

Radical surgery was performed by Hans Pichler and followed by X-ray and radium treatment, which caused tissue damage and violent pain. Forced to use denial as a defense, since he was not told the truth, Freud must have resented it, but he showed exemplary loyalty and consideration toward his family and friends. The death of his grandson, Heinele, from tuberculous meningitis with the resultant grief and mourning, merged with the reaction to his own illness and led to a fatalistic attitude and some depression, but his resilience enabled him to overcome this crisis. Surgery performed at this time was successful and Freud did not die of a recurrence. However, repetitious formation of precancerous lesions required surgical intervention thirty times thereafter; only in 1936 was one of them again malignant. A satisfactory prosthesis proved impossible to construct so that eating and talking became a painful effort and radically altered his ability to savor life.

The members of Freud's family agree with the author that it is permissible at this time to scrutinize some areas of Freud's life which may throw some light

on the adaptive mechanisms operating in the development of his attitude toward death. In his daily life he retained the utmost self-control, and his dignity and serenity had an impact on everyone. Letters to friends, however, indicated how hard his suffering was to bear; in a letter to Lou Andreas-Salomé on May 10, 1925, he spoke of his 'crust of indifference' and the gradual transition from life to death. Motivation for living in order to work and to further the cause of psychoanalysis resulted in highly productive years. 1923-1925 saw the publication of The Ego and the Id, The Economic Problem of Masochism, and Inhibitions, Symptoms and Anxiety.

Freud turned seventy in 1926 and now passed into the patriarchal age; in a celebration speech he admonished his 'sons' to be on their own. During this period, while his daily life was dominated by misery with his prosthesis, he started to write The Future of an Illusion, a return to his earlier interest in cultural problems. In this work, presenting his thesis in the form of a dialogue with an imaginary adversary (probably Pfister), he ends on a note of triumph, convinced that the primacy of the intellect will prevail. A letdown in productivity ensued, and in 1928 he went to Berlin, returning relieved but exhausted after the construction of a new prosthesis by the oral surgeon, Schroeder.

The author became Freud's personal physician in 1928, at the suggestion of Marie Bonaparte, and he describes their unforgettable first meeting when conditions for their patient-doctor relationship based on mutual respect, confidence, and scrupulous honesty were established. Dr. Schur's function was to watch over his patient's general condition, try to relieve pain and suffering, and to detect any new lesion at the earliest possible moment. Except for his refusal to give up smoking, Freud was a model patient; over the years a nonverbal communication developed between patient and doctor which proved meaningful to both.

The two main factors in Freud's life during this period were his illness and the sweep of historical events. Between 1930 and 1932 several surgical interventions were necessary for new leukoplakias. The summer of 1930 brought the award of the Goethe prize and the death of Freud's mother at ninety-five. This event liberated him from the dread thought that she might be alive to learn of his death. His seventy-fifth birthday passed without celebration and he wrote to Stefan Zweig of his loss of energy and enjoyment, and of taking a huge step out of the circle of life. Work however continued; he wrote Civilization and Its Discontents, which was his most succinct presentation of the intricate relationship between the destructive instinctual drive, the superego, character, and symptom-formation, and its application to education and history. The relative pessimism of this work was perhaps determined by the bleakness of the Western world, his suffering, and the rise of Nazism. The first stirrings of the Moses project might be gleaned from a letter to Zweig where his range of interest is revealed in his feelings regarding Palestine. He also began to write the New Introductory Lectures with great lucidity and mastery of style. Renewed enthusiasm for Logos may be seen in the statement about the draining of the Zuider Zee, which is an allusion to Faust's final vision of having reclaimed land from the destructive forces of the ocean. The final chapter about a *Weltanschauung* was perhaps to tell others that a voice still existed that could speak for reason.

March 1933 brought Hitler to power; Freud's sons left Germany with their

families and all Jewish analysts had to flee. The impact in Austria was overwhelming, but paradoxically Freud who had uncovered the whole force of the aggressive drive was unable to believe it could be unleashed in an entire nation. Five days after his seventy-seventh birthday the great bonfire in Berlin took place with the burning of Freud's works. In September of that year he went into a mild shock which looked like a coronary insufficiency after a minor electrocoagulation procedure. In February 1934 a modified Fascist regime took power in Austria following the civil war. Freud was urged to leave and he even conceded that possibility in a letter to Arnold Zweig. Preoccupation with Moses and Monotheism indicated an upsurge of creativity and helped him to endure his physical suffering and the deterioration of the political situation.

The main event at Freud's eightieth birthday celebration was an address delivered by Thomas Mann. Freud could not be present but Mann read it to him personally and Freud was profoundly moved, since it was vindication for him of the calumny and misrepresentation he had endured. In July 1936 a new lesion was removed and reported to be malignant. Keeping his promise, Dr. Schur told Freud the truth and it was received with composure. When the end of Austria seemed near, Freud considered leaving but the Germans marched in March 11th and it was then too late. Freud's home was ransacked and searched by Gestapo agents and his daughter, Anna, was summoned to Gestapo headquarters. When the situation had seemed hopeless, Anna had asked her father if suicide was not perhaps desirable. His emphatically negative answer was not that of a man who might have considered it in 1923 when told he had cancer, and indicated a wish still to live.

Permission to leave Vienna was finally granted. Freud left on June 4th without his physician, who was recuperating from acute appendicitis, stayed with Marie Bonaparte, and then emigrated to England. His furniture, library, and collection arrived and they were arranged in a study at 20 Maresfield Gardens as they had been in Vienna, a large comfortable room in which Freud eventually died. A new lesion appeared in September 1938 and Pichler agreed to come to London to operate. During recovery from his surgery a malignant epithelioma appeared which was inoperable and X-ray therapy was started.

At this time Dr. Schur, who had planned eventually to emigrate to the United States, was faced with a painful decision when he was granted his last visa extension. Although aware that Freud felt that he was being abandoned, it was necessary to go quickly to America and return after taking out first citizenship papers. Dr. Schur returned to find Freud looking much worse, and the situation went rapidly downhill. Freud grew weaker and stopped seeing patients. He read the papers and knew the war had started but his detachment grew more pronounced. On September 21st he indicated to his doctor that his suffering no longer made any sense and asked for sedation. Given morphine for his pain, he fell into a peaceful sleep and then lapsed into coma and died at three o'clock on the morning of September 23rd. The author concludes: 'Can we fail to feel admiration, love, and gratitude for Freud, for the way he died as well as for the way he lived?'

MILTON E. JUCOVY

June 9, 1964. INFANTILE TRAUMA. Phyllis Greenacre, M.D.

Dr. Greenacre's further studies of the nature, origin, and sequelae of pregenital disturbances reveal that there is a greater and more frequent incidence of disturbed conditions in the first one or two years of life in psychotic and severely neurotic patients, as compared to cases of anxiety hysteria and compulsion neurosis. In her papers on the predisposition to anxiety (1941), the author indicated that illness, injury, difficult birth process, and conditions in the mother that are passed on to the infant in his early dependent state may intensify narcissism, impair the developing sense of reality, and accentuate and prolong the tendency to primary identification. Clinically, frequency of compulsive masturbation and an unusual display of various habitual autoerotic responses during latency, as well as in the infantile period, were noted.

In contrast to those who define trauma as limited to sexual trauma, perhaps because of Freud's original belief that sexual trauma lay at the core of a neurosis, Greenacre widens her conception to include traumatic conditions which are unfavorable, noxious, or otherwise drastically injurious to the development of the young individual. She feels that in the precœdipal years and later there is a maturational pressure which will generally cause the child to reach out and utilize the slightest opportunities for experience. The child himself may act as the seducer and either get little response and suffer frustration, or attract a response which transcends his specific needs in content and intensity. While the fantasy that accompanies the experience is of primary importance, its later derivatives may be considerably influenced by whether the experience is active or passive, accidental or deliberate.

Dr. Greenacre discusses trauma under three general headings: 1, the significance of actual experience associated with fantasy; 2, the effect of early traumatic experience during the pregenital period; 3, the influence of severe trauma on the total homeostatic balance of the individual. In situations where overt traumatic experiences have been associated with an underlying fantasy, the residual memory trace is more intense and the tendency to fixation greater. The basic fantasy always represents an amalgam of the genetically determined instinct representation with whatever stimulation the environment offers in response. In cases of sexual experience with an adult, the factor of discrepancy in size alone may be important. Physical pain, shame, and humiliation may cause the experience to be deleted from memory, but leaves an especially sensitized pattern in its wake. A younger child in an experience with an older child or an adult may disclaim responsibility. Freud found that fantasies of seduction often hid the individual's masturbation fantasies. In cases of true accidents of fate the sequelae may be most severe. Thus illness or death of a parent or sibling may overfulfil the child's most powerful fantasies. Fantasies which are apparently confirmed in reality are likely to be repeated actively with the purpose of testing reality and need for mastery, or with a pressure for revenge.

In considering the role of trauma during the precœdipal years, it is emphasized that such events have first to be seen in relation to the first year or eighteen months of life. Any condition impairing the mother-infant relationship at this time interferes with the foundations of object relationship, increases and pro-

longs primary narcissism, and tends to damage the early ego, with special harm to the sense of reality and often to the beginning sense of identity. These disturbances could be the result of pathological conditions in the infant, such as severe sequelae of prematurity and congenital defects, or they may arise through maternal disturbance of any sort which alienates the mother from emotional and bodily contact with her baby in the first months of life.

There is a whole area of possible investigation involving the question of the degree of imprinting in the human infant during the first year to eighteen months when he is still so plastically receptive to exogenous stimulation. He is sometimes exposed to configurations of activities from the outside which may impress themselves on him in a sensory way, as they cannot be 'understood' in the sense of striking any responsive and familiar patterns within himself. Dr. Greenacre speculates whether very early exposure to the primal scene, or some other violent event, might result in such patterned discharge impulses in certain infants destined by other elements in their lives to become delinquents or criminals of the type where crimes, usually robbery or rape, are repeated in a regular, patterned way. Severe traumatic stimulations which are overwhelming tend to be disorganizing in their affect on the other activities of the individual. They may result either in states of aimless, frenzied overactivity culminating in tantrums or rage, or a shocklike, stunned reaction.

In a discussion of fetishism and imposture, the author states that disturbances of the mother-infant relationship were found in the first twelve to eighteen months. Prolongation and accentuation of primary identification and severe and early castration fears developed as a result of special experiences, such as exposure to bloody accidents or injuries. In the imposture poor relationships between the parents with mutual derogation is conspicuous. Fetishism and imposture are related conditions; in the former a supplementary phallus is assumed, and in the latter the accoutrements of a whole character are purloined in the interest of supporting the ego.

In discussing the influence of severe trauma on the total organizational (homeostatic) balance of the individual, Dr. Greenacre takes up the problem of primary masochism and repetition-compulsion, picking up Freud's discussion in Beyond the Pleasure Principle. She feels basically it is driven by endogenously generated pressures from a more archaic level of mental organization and with more primitive operational features than the libidinal phase—oral, anal, phallic, and genital—representatives. It is pre-ego in origin, involving a total organismic response; it cannot be considered as an ego function, though ego defenses may be discerned in its secondary involvements. Trauma of this nature exceeds the limits of the stimulus barrier. Freud considered the demonic force of repetition-compulsion regressive; Dr. Greenacre feels it gets its force partly from the forward thrust of deep but continuous maturational factors and is a biologically self-balancing effort.

An organism may respond to severe trauma with a shock reaction followed by inactivity or by a new balance, with some kind of habituation to the pain. Recovery in such states is only maintained at the expense of a particularly tenacious and primitive defensive denial and utilization of an increase in primitive narcissism, both of which have deep biological roots.

DISCUSSION: Dr. Robert C. Bak spoke of Dr. Greenacre's unceasing efforts to penetrate developmental factors and actual occurrences during the crucial, partly preverbal phase of development that disorganize maturational sequences. He emphasized how Dr. Greenacre maintained continuous harmony between clinical data and conceptual generalizations and differentiated the underlying dynamics in various clinical phenomena. He added that traumatic stimulation detrimental to steady body-image formation may not appear to be dramatic. Prolonged overexposure to the maternal body, or to that of both parents, both for touch and vision, may promote in the boy a sense of weakness, smallness, and fragility of the body image, induce extreme separation anxiety and merging with the maternal body, and delay self-object differentiation. He traced the prephallic phase of fetishism, transvestitism, homosexuality, the impostor and perhaps the swindler, in which the above traumas play an important role, and stressed Dr. Greenacre's contribution to clarifying the preœdipal history of these perversions. Dr. Bak also hoped that specific differences will become discernible in relation to drug addiction, creativity, and compulsive activities that are suspected of being displacements or other vicissitudes of fetishism. As a result of traumatic conditions in the first eighteen months of life, we have to consider the excitation of undifferentiated libido and aggression. Overstimulation of the undifferentiated drives leads to damage in ego development, which in turn may be responsible for both lack of control over the drives and their inadequate differentiation. Beyond the first eighteen months of life, overstimulation leads to increased frustration and excessive rage that cannot be discharged.

Dr. Albert J. Solnit defined traumas as conceptualized by Freud, and stressed consideration of the stimulus or challenge, the individual's tolerance or intolerance of the challenging stimuli, and the setting in which the interaction of challenge and tolerance occurs. Dr. Solnit gave a clinical example from the Yale Longitudinal Study of a childhood trauma in which a three-and-a-half-year-old girl was violently threatened by abandonment in a deserted marshland by her mother. In treatment sessions following the acute trauma, the child began to play out and talk about being left alone when the mother had gone to the hospital eight months earlier to give birth to her sister. This was used by the child to screen in an ameliorative way the traumatizing impact of feeling abandoned in the wasteland. Using the clinical example, Solnit attempted to define the concept of infantile trauma and its limitations.

HILDA SHANZER

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

February 17, 1964. A FURTHER CONTRIBUTION TO THE PSYCHOANALYTIC STUDY OF MIGRAINE AND PSYCHOGENIC HEADACHES: THE RELATION OF MIGRAINE TO DEPRESSION, STATES OF WITHDRAWAL, PETIT MAL, AND EPILEPSY. Melitta Sperling, M.D.

This study is a continuation of Dr. Sperling's previous work, reported in 1952. She then described patients suffering from migraine as predominantly orally fixated individuals with very low frustration tolerance. Libidinal development

was incomplete and object relations showed marked ambivalence and sadomasochistic attitudes. The basic denominator was a pregenital character structure. Further, Dr. Sperling noted that the psychosomatic patient, like the neurotic, represses his dangerous impulses and internalizes his conflicts; thus he is not in conflict with his real objects, environment, or society, but discharges the repressed impulses in his somatic symptoms which represent the expression and fulfilment of specific fantasies and impulses of a pregenital nature. The specific dynamics of migraine headaches were described as unconscious fantasies and impulses to kill the frustrating object by an attack upon the head. These patients had sought treatment not because of headaches but because of depression.

The present study describes further work with migraine patients and provides additional material on the relations between migraine and depression on the one hand and between migraine and states of withdrawal, petit mal, and epilepsy on the other.

Dr. Sperling relates the phenomenon of alternating symptoms of depression and migraine to sudden changes in object relationships. In the psychosomatic patient there is an increase in object cathexis in the situation of loss or threatened loss of object. In the case of depression there is a decrease in object cathexis and withdrawal from the external object. Narcissistic injuries, real or imagined, bring about these fluctuations in object cathexis. In discussing the relation of migraine headaches to states of withdrawal, petit mal, and epilepsy, she notes that patients suffering from migraine also have a tendency to withdraw from reality. In one patient the author was struck with the similarity of his fantasies to those of patients with epilepsy and petit mal; further, both conditions can be triggered by specific stimuli. When there is a transition from petit mal and epilepsy to headaches, it is considered to be an indication of progress in the treatment and represents a different mode of dealing with the same conflicts and impulses. Thus, these conditions are not similar because they are based on common inherited somatic constitutions but rather on a specific and early acquired attitude of the patient toward dealing with overwhelmingly strong destructive impulses. Finally, environmental factors, in particular the interrelated dynamics of the maternal (parental) attitudes and the child's responses, are of great importance.

Dr. Sperling differentiates psychogenic headaches and migraine headaches. The former, she notes, represent conflicts belonging to the œdipal and phallic phases with castration anxiety the main dynamic force; the latter, as noted previously, represent pregenital conflicts. Migraine is far more frequent than previously supposed and is not restricted to intellectuals. The author reported that twenty-three patients (fourteen adults and nine children) followed for thirteen to sixteen years, were successfully treated. There was no recurrence of the migraine headaches in any of the cases and their pregenital character structure had been exposed and changed.

DISCUSSION: Dr. Mortimer Ostow noted that Dr. Sperling's observations about migraine and depressed patients were similar to his own. It was his experience that these patients suffer from disturbances of libidinal energies in the ego; thus many of them respond to some of the newer drugs. In migraine, there is

an abrupt impoverishment of the ego and as soon as equilibrium is achieved the headache disappears. The attacks are also associated with hypersensitivity of sensory modalities. Antidepressant medication is thus helpful in preventing migraine, whereas tranquilizing drugs often precipitate it in predisposed subjects.

Dr. Renato Almansi referred to one case of migraine that he analyzed in which he felt that the cure of the migraine attacks was due to analysis. In his patient, who suffered from monthly attacks from the age of seventeen, an important genetic factor seemed to be a meningeal illness that his sister suffered from when he was six. While in analysis, this patient, who had begun to gain more insight into his castration problems, after seeing an alligator developed a severe attack of migraine in the course of which he saw, in a hypnagogiclike fashion, an alligator surrounded by a halo. The attack then ceased and migraine headaches did not recur. Thus it seemed that the analysis deprived the migraine of the psychogenic mechanisms that would trigger the attack.

Dr. Jan Frank raised the question of somatic-psychic versus psycho-somatic. He noted that in 'petit mal' epileptic attacks one finds dysrhythmia in the EEGs and frequent attacks, which do not respond to medication, can lead to a brain syndrome with personality changes. But migraine attacks in adolescence, due to hormonal and autonomic nervous imbalance, sometimes spontaneously disappear after puberty without treatment. Dr. Frank said that caution should be used in regard to analyzing organic lesions or illnesses.

Dr. Gustav Bychowski spoke of his experience with a small number of 'epileptic' patients who failed to respond to barbiturates. In two of the cases the patients were cured by psychoanalysis but he regarded them as 'pseudo-epileptics'. He then spoke of a physician with severe migraine, who had become a demerol addict. He was relieved of this symptom by analysis. However, Dr. Bychowski did not find in this case any of the dynamic conflicts that Dr. Sperling reported; rather, there was much hostility and conflicts that produced hostility.

Dr. Judith Kestenberg felt that Dr. Sperling described a new syndrome that clarifies clinical phenomena, namely, accident proneness, hypermotility, and migraine. She discussed certain children with marked hypermotility who run until they fall; they have such tremendous impetus that they can drive themselves to exhaustion. They may also have headaches. Dr. Kestenberg wondered whether such patients hurt themselves at first because of hypermotility, which counteracts normal caution, and then become masochistically accident prone.

Dr. Charles Brenner pointed out that Dr. Sperling's paper was intended primarily to demonstrate that the mental mechanisms of migraine patients are similar to those she found in depressive and convulsive patients. In addition she reported unequaled therapeutic success in her series of analyzed migraine patients. Dr. Brenner noted that he has not had comparable experience with these patients. He also discussed some aspects of Dr. Sperling's remarks about the psychopathology of the epileptic patients.

HENRY ROSNER

The twenty-fourth INTERNATIONAL PSYCHOANALYTIC CONGRESS will be held in Amsterdam, The Netherlands, from July 25 through July 30, 1965, under the auspices of the Dutch Psychoanalytic Society. The program will emphasize clinical psychoanalysis, with the focus on the technical problems in the psychoanalysis of obsessional neurosis. Inquiries should be addressed to: 24th International Psychoanalytic Congress, c/o Holland Organizing Center, 16, Lange Voorhout, The Hague.

The second INTERNATIONAL CONGRESS OF PSYCHOSOMATIC MEDICINE IN OBSTETRICS AND GYNECOLOGY will be held in Vienna, Austria July 28th to July 31st, 1965. Papers will cover the psychosomatic aspects of conception, pregnancy, labor, delivery and lactation. For further information, write Doz. Dr. A. H. Palmrich, Secretary General, Wiener Medizinische Akademie, Alserstr. 4, Vienna 9, Austria.

The CHICAGO INSTITUTE FOR PSYCHOANALYSIS will award its fourth biennial Franz Alexander Prize of three hundred dollars in 1965 to the author of a paper in the field of psychoanalysis. All graduates of the Institute since 1955 are eligible to submit papers, which should either be unpublished or published no earlier than 1962. Papers should be submitted in five copies, before May 1, 1965, to: Dr. Louis B. Shapiro, 664 North Michigan Avenue, Chicago, Illinois 60611.

A conference on diagnostic research and treatment trends in childhood schizophrenia will be held at the HILLSIDE HOSPITAL, Glen Oaks, New York, on February 27 and 28, 1965. Speakers will include Drs. Lauretta Bender, Stella Chess, William Goldfarb, and other distinguished authorities in the field.

The AMERICAN INSTITUTE FOR PSYCHOANALYSIS announces an orientation course on Karen Horney's Holistic Approach to the Theory and Practice of Psychoanalysis, to be conducted by their faculty, beginning March 16, 1965. For further information write to Dr. Harold Kelman, American Institute for Psychoanalysis, 329 East 62nd Street, New York City 10021.