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QUANTITATIVE DREAM STUDIES:

A METHODOLOGICAL ATTEMPT AT A QUANTITATIVE EVALUATION OF PSYCHOANALYTIC MATERIAL

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1.
THE METHOD

The comparative study of organ neuroses has shown that the same dynamic tendencies predominate in cases with similar symptomatology. As in all psychoanalytic studies, our judgment regarding the preponderance of a certain dynamic tendency has been based on the usual criteria: behavior in transference, the actual life situation, the early history and finally the direct expression of the dynamic trends in free association and particularly in dreams. We do not question the validity of such judgments and are convinced that an experienced analyst, after long contact with a patient, receives a correct impression regarding the relative intensity of oral aggressive and receptive, and anal sadistic and retentive tendencies. It is well established that in compulsion neuroses anal sadistic impulses play a dominant rôle, and that in melancholias the oral incorporative tendencies and the wish to retain the incorporated object are paramount. However, since Freud introduced into his metapsychology the structural, the dynamic and the economic analysis of psychoanalytic material, the economic approach has remained the least reliable of the three, indeed merely a theoretical postulate.

Detailed records containing the complete free association material and the reported dreams of our patients offered us an obvious opportunity for a quantitative evaluation of analytic material, such as Freud probably had in mind when he intro-

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Based on an address delivered at the joint meeting of the American Psychiatric and American Psychoanalytic Associations in Washington, May 15, 1935.

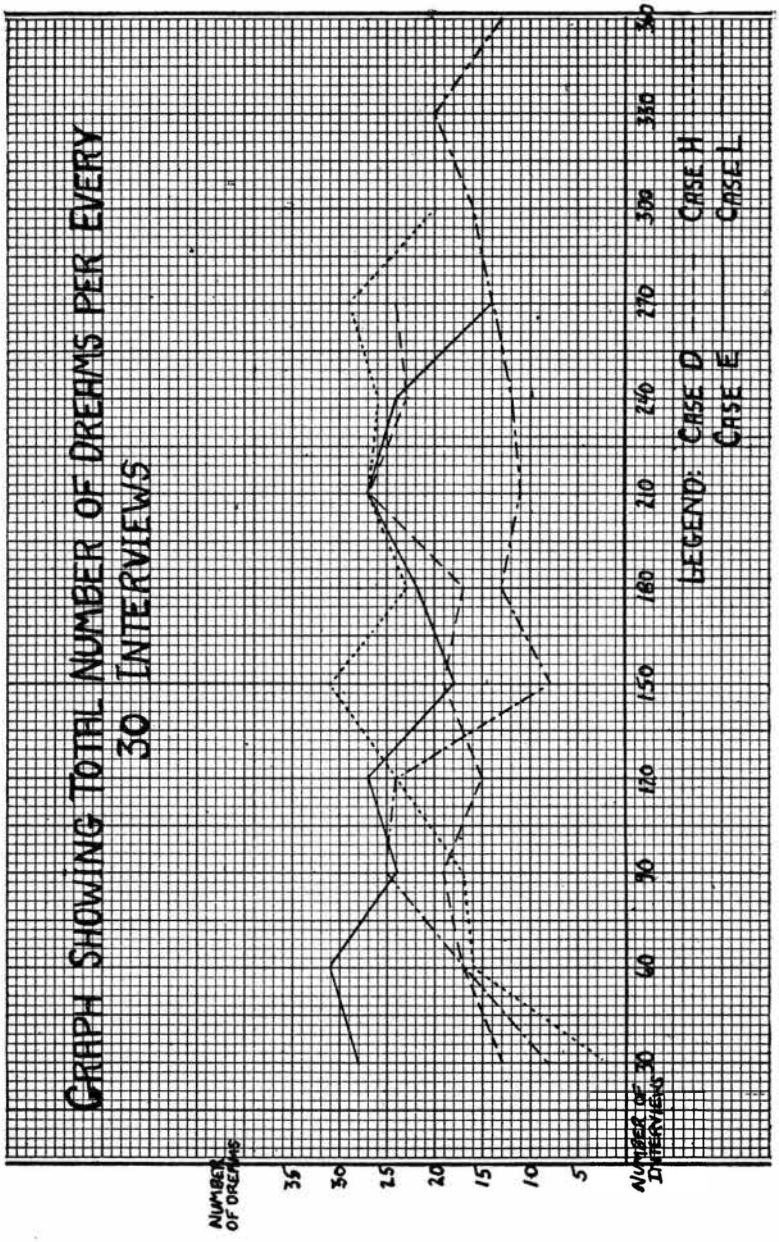
duced the concept of economic investigation of psychic phenomena. As first choice, dream material seemed to be the most appropriate for a quantitative study. The following graph shows the frequency of the reported dreams of four patients during analytic periods lasting over a period of from eight months to two years. (See Graph I.)

We assumed that the frequency of certain types of dreams in a certain period of analysis could serve as an approximate indicator for the estimation of the intensity of certain wishes, active in the patient's unconscious during the same period. Since what we desired was the comparison of the intensity of different dynamic trends, it was obvious that the dreams must be classified according to the different dynamic trends they expressed. The problem then was to find a conclusive basis for such a classification. In the study of gastro-intestinal cases the division of unconscious tendencies into three groups—intaking, eliminating and retaining tendencies—proved of great significance.[1] This classification is based on the vector qualities of psychic tendencies and corresponds roughly to the pregenital impulses of oral incorporation, anal elimination and retention.

The intaking tendencies we again subdivided into passive receiving and aggressive taking, corresponding to oral receptive and oral sadistic (biting) tendencies. In our classification, however, we have avoided the expression "oral" since the study of organ neuroses has clearly demonstrated to us that the mouth or the gastro-intestinal tract is only one of those organs by which such intaking tendencies can be expressed. The localization of a certain tendency in an organ seemed to us secondary in importance to the nature of the tendency itself, i.e., to its vector quality.

This concept deviates from the original theory of pregenital

[1] Alexander, Franz: *General Principles, Objectives and Preliminary Results*—part of a symposium on *The Influence of Psychologic Factors upon Gastro-Intestinal Disturbances,* delivered at the midwinter meeting of the American Psychoanalytic Society in Washington in December, 1933; published in this QUARTERLY III, 1934.


GRAPH SHOWING TOTAL NUMBER OF DREAMS PER EVERY
30 INTERVIEWS
NUMBER OF DREAMS
35
30
25
20
15
10
5
NUMBER OF 30 INTERVIEWS
30
60
90
120
150
180
210
240
270
300
330
360
LEGEND: CASE D
CASE E
CASE H
CASE L

GRAPH I

tendencies in that it does not consider the so-called erotogenic zones to be the anatomical localization of these dynamic tendencies. According to this view the pregenital tendencies correspond to the fundamental biological trends of the organism and come to expression in different organic functions. For example, oral incorporating tendencies are considered as one manifestation of this incorporating drive, unquestionably the most important one connected with the greatest pleasure sensations in the child, but the same tendency manifests itself independently in the inspiratory phase of respiration and probably also in acoustic and optic sensory functions. Oral erotism then would be fundamentally related to other intaking tendencies which to certain individuals may supply equally intensive pleasure sensations (for instance, the erotization of optic functions in scoptophilia, or the curiosity expressed in learning—absorbing information). The words *capire* and *comprendre* express understanding as well as grasping and incorporating. In English, "grasp" has the same double meaning.

Following the same principle, we did not restrict the concept of eliminating tendencies to anal and urethral trends but distinguished more generally between a giving urge and a sadistic type of elimination. These two subdivisions again correspond in the main to the anal form of giving (gift, restitution) and the anal sadistic destructive significance of the excremental function. Thus we see that both the intaking and the eliminating tendencies may assume either a constructive or a destructive form, i.e., intaking may take the form of passive receiving or of aggressive taking; eliminating may be either a passive giving of values or an aggressive use of the excrements for destructive attack. Theoretically also in the third group we tried to distinguish between a constructive and a destructive type of retention, described in Alexander's paper, The General Dynamic Analysis of Unconscious Processes,[1] but we have not

[1] Alexander, Franz: an address delivered at the Midwinter Meeting of the American Psychoanalytic Assn., Chicago, December 21, 1934; to be published under the title *The Logic of Emotions,* in an early issue of the International Journal of Psycho-Analysis.

found it possible as yet to apply this theoretical distinction to the actual classification of analytic material.

This classification of dynamic tendencies has been used as the basis for the classification of our patients' dreams upon which the present study is based. Many dreams of course contain references to more than one of these classes of tendencies. In such cases we have classified the dreams according to the major tendency expressed in it. We have also made a further distinction between dreams in which the major tendency appears satisfied and dreams in which the same tendency is more or less interfered with by inner conflict (superego reaction). We thus distinguish between ten types of dreams: satisfied receptive, inhibited receptive; satisfied taking, inhibited taking; satisfied giving, inhibited giving; satisfied attacking, inhibited attacking; satisfied retaining and inhibited retaining.

After considerable practical experience we have found it possible to classify the majority of our patients' dreams in these groups without feeling that we have been arbitrary in our judgment. It is noteworthy in fact what a predominant rôle pregenital impulses play in dreams. This, however, is not surprising as we know that the dream is a product of primitive unconscious processes rather than of more highly developed tendencies. There were, however, a number of dreams which we could not classify either because we were unable to decide which of two or three pregenital tendencies were predominant or because the dream remained unintelligible to the extent of our being unable to decide which major tendency was expressed. Another group of unclassified dreams were certain exhibitionistic ones in which it was difficult to decide whether the exhibitionism served more the masculine tendency of bragging about giving potentialities (size of penis, masculine potency, etc.) or whether the exhibitionism served the female receptive tendency as an invitation to induce masculine giving activity. Some of the female exhibitionism also consists in the exhibiting of the breasts and therefore it belongs in the class of giving tendencies. Exhibitionistic dreams we left unclassified unless the

one or the other of these major pregenital tendencies involved in the exhibitionistic act was predominant. In scoptophilic dreams we did not encounter the same difficulty because the majority of them were aggressive taking dreams.

We classified dreams expressing self-castration as giving dreams because in such dreams the dreamer offers a sacrifice, gives up some narcissistically evaluated substitute for the genitals in order to avoid real castration.[1]

Genital dreams offer another difficulty in classification. According to our present concept, genitality represents a mixture of all pregenital trends. Therefore it might be considered as somewhat arbitrary to classify masculine genitality as a giving tendency because it includes a certain amount of destructive aggressiveness (overcoming the resistance of the female) as well as (projected) oral receptive tendencies and, according to Ferenczi, also retentiveness. In the same way it might seem arbitrary to say that female genitality is exclusively passive receptive, as it also includes aggressive taking tendencies and some giving impulses. In general, however, we feel justified in saying that in normal masculine genitality the giving tendency predominates, and that in the female genital relationship to the man the passive receptive tendency is the leading feature, and we have classified upon this basis all dreams in which normal genital tendencies predominated. These, however, constituted an astonishingly small percentage of the dreams in all of the cases included in this study. All dreams expressing pseudo-genitality were appropriately classified according to the predominating pregenital trend. Unclassified dreams have ranged between 0% to 14.6% of all dreams.

To give a more precise general concept of our classification of dreams, we quote one example of each type:

Example of a dream expressing a satisfied receptive wish:

> "A mother robin places food in a baby robin's mouth and then sits back and observes the baby robin admiringly."

[1] See Alexander, Franz: *About Dreams of Unpleasant Content.* Psychiatric Quarterly, July, 1930.

Rado also refers to this principle as the "lesser evil" in his article, *Fear of*

The associations reveal that the patient identifies herself with the baby robin.

Example of an inhibited receptive dream:

"Patient is sitting at the table with the family about to have dinner. She is afraid there will not be enough chicken and that she will not receive anything to eat."

Example of a satisfied taking dream:

"A patient, who is very interested in photography (which for him is a symbol of sexual knowledge) in his dream goes into a drug store to buy a certain lens for his camera. While he and his brother are waiting for the clerk to find the lens, he puts a lens, which he sees lying on the counter, in his pocket.

"The dream shifts and in the second part he takes the lens of a friend who in reality possesses several different lenses, with the excuse that he wants to try it out."

Example of inhibited taking dream:

"A robbery occurred in the home of a patient while his father was away. The robbers took an antique chair and liquor from his father's secret liquor cabinet in the library. During the robbery the patient was in another part of the house."

In his associations the patient makes the slip, "I was in the room," instead of "I was *not* in the room when the robbery took place." In the dream the inhibition of the aggressive taking tendency is expressed by the fact that he is *not* the one who robs the father and he even seeks an alibi by emphasizing that he was *not* in the room while the robbery was taking place.

Example of a satisfied giving dream:

"A patient teaches his brother to play golf, deprives himself of the satisfaction of playing and tries to make of his brother a better player than himself."

Example of an inhibited giving dream:

"A patient has to string beads for her brother who owns a jewelry store. There are so many that when she finishes, it is too late for her analytic hour."

The dream expressed her reluctance to do something for her brother; stringing beads symbolized the diarrhœa from which she suffered.

Example of a dream expressing satisfied eliminating attack:

> "A patient has just married and with her husband goes to her own home. She is menstruating at the time of the marriage and decides that not only is it an excuse to prevent her husband from having sexual relations at the time but also an excuse to prevent intercourse for a year. Then she goes to the toilet, her sister is there, the patient has a bowel movement, the toilet runs over and the sister is soiled by the fæces while cleaning up the mess."

Example of a dream expressing inhibited attack:

> "A patient is in a summer resort. There is a revolution. A number of the guests are like Bolsheviks and revolt against the other guests. He and another very neurotic guest are the revolutionists. He has a revolver but his companion excitedly shouts to him to lay it down and not carry it around."

Example of a dream expressing satisfied withholding:

> "A male patient is seated in an automobile alone. Three men come along and sit down in the back of the car. They give the impression that they are about to steal the car. Patient gets out of the car and leaves the key in the ignition. Then he says to himself, 'Why should I let them have it?' He walks back to the car, locks the ignition and takes the key with him."

This dream expresses the wish to protect his property against robbery.

Example of a dream expressing inhibited withholding:

> "A female patient is in bed with some man. She has some papers which she wants to keep to prove that he means something to her. She tries to hide them in a washing machine. Then she sees a Mrs. S. and is afraid she will see them and know that patient has intentions directed toward her father."

Without going into a detailed interpretation of this dream, we see that the tendency to retain a valuable object is connected

Although most of the dreams could be placed in one of these classes without hesitation, certain difficulties were encountered. It is not always easy to differentiate between inhibited giving and retentive tendencies, the reluctance to give something and the wish to retain it having the same vector quality. The basis for distinction in such cases was the emotional attitude toward the object which the patient refused to give or wanted to retain. Only where a possessive attitude toward the object was clearly expressed do we speak of retentive tendencies, where the process of giving, as such, was rejected without emphasis on the object itself, we consider it as inhibited giving.

There was an even greater difficulty in classifying certain dreams expressing eliminating attack. Often in a destructive hostile dream there is no reference to any specific anal sadistic aim. The emphasis lies only in the depreciation of the object, in dismembering it or cutting it into pieces. The destruction appears for its own sake. In such dreams there is neither oral sadistic incorporation of the object, nor reference to using the excrements for attack. It may seem somewhat arbitrary for these purely destructive dreams to be classified as anal sadistic, that is to say, as eliminative attacks. Nevertheless in classifying such dreams as eliminative attacks we are following the well established assumption of psychoanalysis that anal sadistic impulses are active in all types of fantasy of destruction in which no incorporation is expressed.

2.

CRITICAL DISCUSSION OF THE APPLIED METHOD

The fundamental assumption of this quantitative approach is that the relative frequency of different types of dreams classified according to the major dynamic tendency expressed by them is an indicator of the relative intensity of these dynamic trends. The validity of this assumption may be questioned for the following reasons:

1. At first we may ask whether there is a simple proportion between the occurrence of an unconscious tendency in dreams and the intensity of the underlying dynamic motive. How-

ever, we do not necessarily postulate a simple mathematical proportionate relationship but merely assume that a repeated occurrence of a certain sleep disturbing stimulus in dreams during a certain analytic period shows that this psychological tendency is under a permanent tension at that period. On the same assumption is based the generally accepted technical principle according to which we attempt to overcome the resistance to those unconscious tendencies which present themselves most conspicuously in the dream life, transference and free associations of the patient at a given moment.

2. Another objection is that the intensity of the different unconscious tendencies producing the dreams of the patient varies according to the status of the analysis. A patient may begin with violent depreciative (anal) aggressions which become gradually conscious and, in the course of the analysis, appear less frequently and are replaced by dreams of oral thwarting which motivated the anal attacks.

Therefore—one may object—in counting and classifying the patient's dreams over a long period, we do not receive a full picture of the intensity of his different repressed tendencies because different tendencies predominate in different phases of the analysis. Indeed our method will only give a full picture of the relative intensity of the repressed tendencies if we consider all dreams dreamed by the patient during his entire analysis. If parts only of an analysis are considered, obviously the quantitative figures will indicate only which repressed tendencies were most active in producing dreams during the period of observation. It seems to us, however, that the typical quantitative relationships become manifest relatively soon after the beginning of an analysis, and observations covering five or six months show a characteristic quantitative picture.

3. A last objection is of less fundamental but of considerable practical importance. It is a common experience that keenly sensitive patients in a phase of positive transference become aware of the pet theories of their analysts, and to please them produce a certain type of dream again and again. Almost every analyst will have to admit that during his preoccupation with

certain ideas his patients bring confirmation of his theories in an "unexpected" manner. This is unquestionably a factor which might somewhat influence the statistical figures in such studies. This disturbing factor becomes less significant however through recent developments in the psychoanalytic technique, according to which the interpretation of content becomes secondary to the more dynamic procedure of making conscious the interplay of repressed and repressing forces. As we use the technique today, our interpretations deal more with the dynamic trends themselves than with their ideational content. Furthermore every experienced analyst will soon discover in patients the tendency to please by producing material confirming previous interpretations and accordingly he will try to counteract this tendency by making the analysis of it a part of the transference analysis, at whatever cost to his own narcissism. Such a distortion of the quantitative relationships through transference phenomena, even if present, cannot fundamentally change the dynamic picture since the patient can manifest only tendencies which exist in him and his wish to please can precipitate only the display of his unconscious trends. Not so much quantitative relationships as the chronological order of the appearance of the unconscious tendencies will be influenced by this transference phenomenon.

The results of our quantitative study will demonstrate the validity of our assumption that the frequency of certain dreams are fundamentally characteristic for the different types of neuroses.

3.
QUANTITATIVE MATERIAL

Comparative Studies

We now turn to the presentation and evaluation of our quantitative material, the dreams of 18 patients during analysis over a period of from eight to twenty-four months. In the following tables the frequency of different types of dreams is expressed in percentage of the total number of dreams. It

seems of some importance that out of 18 cases studied only 7 have shown in their dreams a preponderance of eliminating as compared to intaking tendencies. (See Table XV.) The intaking dreams were more frequent in 9 cases and in two cases intaking and retentive tendencies were equally distributed. It should also be mentioned that of the 7 cases in which the eliminating dreams were in the majority, 5 were cases of constipation, one a case of depression with spastic colon and one a case of periodic diarrhœa combined with asthma. Two out of the 3 cases of duodenal ulcer, 2 cases of gastric neurosis, one case of chronic vomiting, one case of eating phobia and one case of petit mal, showed a preponderance of intaking over eliminating tendencies as expressed in their dreams. One duodenal ulcer case and one petit mal case, however, showed equal distribution. The most significant fact which this comparison shows is that in their dreams, the majority of constipated patients express eliminating more often than intaking tendencies.

Another general finding is the relatively small amount of retentive dreams in all cases. (See Table XII.) The most frequent appearance of retaining tendencies occurs with constipation. Constipation is characterized by a relatively high number of eliminative and retentive, and a lesser number of intaking dreams, as our tables will clearly show.

Table I shows a classification of patients according to the frequency of dreams expressing intaking tendencies. As will be seen with respect to intaking tendencies, the peptic ulcer cases appear at the top of the list together with one case of petit mal and one case of eating phobia. The cases with diarrhœa also appear in the upper range, whereas all cases of constipation appear in the lower range. The only exception to this rule is a case of periodic diarrhœa, complicated with asthma. In general, peptic ulcer and diarrhœa cases show a conspicuously high frequency, and constipation cases a conspicuously low frequency of intaking dreams.

It should be mentioned that the patient with petit mal is one of the most passive receptive individuals among our patients.

His petit mal attacks were of the flaccid type, and their meaning was revealed during analysis to be a regression to an infantile suckling situation.

It is noteworthy, too, that in the case with an eating phobia which occupies first place in frequency of intaking dreams, the phobia developed as a reaction to oral incorporating tendencies.

If we consider Table II, in which patients are classified according to their receptive tendencies as expressed in their dreams, we see that diarrhœa and ulcer continue to appear in the higher, constipation in the lower range, but the difference is not so marked, due to the fact that the high intensity of intaking tendencies in ulcer is derived from both intense receptive and aggressive taking tendencies.

Table III, in which patients are listed according to aggressive taking tendencies as expressed in their dreams, shows that the duodenal ulcers are still in the high range, whereas diarrhœa begins to move somewhat more toward the bottom. This table also demonstrates that constipation, which showed a relatively low amount of total intaking tendencies, if we consider only the aggressive taking tendencies, is higher in the list. This indicates that the constipated patients express in their dreams more aggressive taking than passive receptive tendencies in contrast to the diarrhœa cases, which show more passive receptiveness than taking.

It is of interest in Table III that the case of eating phobia, which ranked first in regard to receptive tendencies, here becomes the last on the list. This is due to the fact that her intaking dreams are exclusively of passive receptive nature and that there was not one aggressive taking dream during the entire analysis, an interesting quantitative expression of the degree of inhibition of oral aggressive tendencies. This is in accordance with the analytic finding that her eating phobia was based on the inhibition of oral aggressive tendencies in contradistinction to patients with peptic ulcer, who as we shall see are inhibited equally, both in passive receptive and aggressive taking tendencies.

In Table IV patients are classified according to the ratio of

satisfied to inhibited receptive dreams. We assume that the higher the number of inhibited receptive dreams as compared with satisfied receptive dreams, the greater the patient's conflict over his receptivity: the order of the cases in this table expresses an increase of the conflict. Here we see the previous order reversed. All cases with constipation appear at the top of the list, that is to say, show the least conflict regarding their receptive tendencies, whereas all those with duodenal ulcer appear in the lower range, thus exhibiting a high degree of conflict with reference to receiving. Three of the four diarrhœa cases, including the one combined with asthma, appear in the lower range, showing considerable conflict regarding receptivity, whereas one of them with chronic vomiting moved higher. This is probably due to the fact that this patient with his extensive oral and anal elimination succeeded in overcoming the conflict about his receptive tendencies by the method of overcompensation.

A similar picture is shown in Table VI which demonstrates the amount of conflict regarding taking tendencies. (This table is prepared in accordance with Table IV.) Here also the duodenal ulcer and two of the diarrhœa cases appear at the bottom, thereby showing the greatest conflict, whereas the constipation cases exhibit a lesser amount of conflict regarding their taking tendencies. The only exception is a case with constipation which, however, at the same time suffers from the symptoms of gastric neurosis. One of the petit mal cases exhibits in his dreams a relatively small amount of conflict regarding both intaking and receptive tendencies.

In summary, the peptic ulcer cases and the diarrhœa cases show in their dreams a relatively high amount of intaking tendencies, the ulcer cases both receptive and aggressive taking, the diarrhœa chiefly receptive. Both the diarrhœa and the ulcer cases show a conspicuously high amount of conflict about their receptive and aggressive taking tendencies, the diarrhœa cases more pronounced conflict in relation to aggressive taking. The one diarrhœa case in which the symptoms are combined with asthma does not follow this rule as closely as the other diar-

rhœas. The constipation cases have in their dreams the least amount of total intaking and the least amount of receptive tendencies. So far as they show intaking tendencies these are represented more by aggressive taking than passive receiving.

If we compare these figures with the dynamic formulations regarding gastro-intestinal cases in our previous publication,[1] we see that the quantitative study has confirmed the general statement that the peptic ulcer cases show a great amount of highly conflictful receptive and taking tendencies. It also confirms our former findings regarding the intense receptive and taking tendencies connected with great conflict in diarrhœa. Unexpected, however, was the fact that diarrhœa as a compensatory mechanism is so ineffective in overcoming the unconscious conflict provoked by these individuals by their receptive and intaking tendencies.

A most interesting confirmation of the formulations which we made with regard to our cases with constipation, is the fact that they show in their dreams so little conflict about their receptive and aggressive taking demands. This was to be expected because these cases have shown in clinical studies a readiness to dispose of their conflicts by means of projection. They feel entitled to demand and take because they have the conviction that people do not give to them sufficiently. Their strong tendency to project becomes manifest if we classify our patients according to the frequency of dreams containing projection mechanisms. In order to evaluate the tendency to project, we divided the non-satisfied receptive dreams into those inhibited by an inner conflict and those in which the inhibiting factor is projected on to the environment. We designate these, "dreams with thwarted receptive tendencies" ("conflict projected"). (See Tables P–I through P–VI.) In such dreams the patient himself thwarts the gratification of the receptive wish but attributes the thwarting tendency to the environment, whereas in the inhibited dreams the receptive wish simply remains unfulfilled. This type of dream we designate as a non-satisfied receptive dream ("inhibited by conflict"). We

[1] See footnote on page 372.

found a high percentage of such projection dreams among patients with constipation. (Table V.) To this classification certain exceptions might be noted in individuals in whom the projection mechanism depends on other factors. There are, for example, patients who have real reason for resentment, and who do not need to project; their life situation justifies their demanding attitude without need for projection.

As mentioned above, the eliminating tendencies predominate over intaking tendencies in 7 cases out of 18, 5 of whom suffer from constipation. (See Table XV.) If we consider, however, only the giving type of eliminating, we find that the first eight places are taken by the 3 diarrhœa cases (out of 4), 3 duodenal ulcer cases and 2 cases of petit mal, whereas the constipation cases are at the bottom of the list. (Table VIII.) In other words, we find the greatest urge to give in the dreams of the diarrhœa, peptic ulcer and petit mal patients and the weakest urge in the constipation cases. This relation is reversed if we consider the eliminating attacking tendencies, which practically coincide with anal sadistic impulses. (Table IX.) Here all the cases with constipation are in the upper part of the list, whereas those with duodenal ulcers and diarrhœa and the one with petit mal, are in the lower section.

This relationship becomes even clearer if we study the ratio between giving and attacking impulses as shown in Table XIV. All the patients with constipation without exception appear at the bottom of the list, the duodenal ulcer and diarrhœa cases at the top. All the constipation cases have a higher percentage of attacking than of giving dreams in contradistinction to the diarrhœa and ulcer cases who have a higher percentage of giving than of attacking tendencies. We interpret these figures to mean that anal sadistic impulses are stronger in cases with constipation, less strong in those with diarrhœa and ulcer. This corresponds to our clinical findings, that in diarrhœa cases the excremental act has more the meaning of gift or restitution, whereas in the constipation cases it has a soiling or destructive connotation. We consider this anal sadistic evaluation of the

excremental act as one of the psychogenic factors in the causation of chronic constipation. The constipation results from the inhibition of the anal sadistic investment of the excremental function. These quantitative relations also confirm our clinical findings regarding the compensatory significance of diarrhœa in cases of mucous colitis. We find in these cases a very high percentage of dreams representing intaking tendencies with a somewhat higher participation of receptive tendencies, but at the same time we find in these cases an equally large percentage of dreams revealing eliminating tendencies, for the most part expressing giving and *not* attack.

It may also be mentioned that, in comparing the frequency of occurrence of dreams of taking as compared with dreams of giving, the diarrhœa cases show the greatest preponderance of giving over taking dreams, an indication of the compensatory nature of their giving.

We have shown in Table XII that retentive dreams appear most frequently in cases of constipation, less frequently in peptic ulcer and in diarrhœa cases. There is a definite relationship between the frequency of intaking and retaining dreams. Those patients who rank high with respect to intaking tendencies are the same ones who rank low in regard to retentive tendencies, and those who have a small number of intaking dreams rank high in regard to retentive dreams. This relationship probably corresponds to the emotional formula, "I do not receive or take; therefore I am entitled to retain."

The frequency in constipation cases of dreams in which anal soiling is frankly expressed is best illustrated in Table XVI. In this table 26 patients are included. As will be seen, the percentage of such soiling dreams varies from 34.7% to 2%. The first 11 places are occupied by 9 cases suffering from constipation and only one constipated case did not frequently have dreams expressing impulses to soil. This woman patient, however, suffers chiefly from an eating phobia. Her constipation is a symptom expressing the inhibition of oral incor-

porating impulses ("I do not receive and therefore I need not give"), rather than to inhibition of the excremental function as an expression of anal sadistic impulses. In accordance with our clinical observations, we are inclined to differentiate between such compensatory constipation—a reaction to oral inhibitions—and a type of constipation which is a reaction against anal sadistic impulses.

Economic Analysis of Individual Cases

This quantitative approach not only makes it possible to compare the intensity of the major dynamic tendencies in different patients with each other but presents also a picture of the psychological economy in each individual case. It shows the relationship between the intensity of different dynamic trends in one individual. Such economic analysis of individual patients is even more convincing than the comparison of different individuals with each other.

We present here a few examples of dynamic analysis of individual patients:

Table P–I. C, a twenty-year-old male patient, suffers from active duodenal ulcer, and from periodic constipation. He is third highest in the degree of intensity of aggressive taking tendencies. (Table III.) In the distribution of his intaking tendencies between passive receiving and aggressive taking, he shows a somewhat higher proportion of taking as compared with receiving tendencies than the average. (See Table XIII.) He belongs to the group of patients who express in their dreams great conflict regarding their receptive tendencies, and he shows more conflict with reference to taking tendencies than the average. (Tables IV and VI.) His hostile eliminating (anal sadistic) tendencies are greater than the other peptic ulcer cases. In this respect comes nearer to the constipation group. (See Table IX.)

This quantitative analysis corresponds closely to the clinical picture. He shows the characteristics both of the peptic ulcer cases, and to some degree, of the constipation group. The

quantitative analysis, however, adds to the clinical picture certain data which could otherwise not be obtained. Before investigating his dream tendencies quantitatively, we knew his great conflict centering around taking and receiving but were not in a position to say that his conflicts were centered more around receiving than taking. Our figures convinced us that the narcissistic injury produced by his strong receptivity caused greater conflict than the feelings of guilt resulting from aggressive taking. (Tables IV and VI.) It is conceivable that the pain caused by his gastric ulcer served to assuage the feelings of guilt but that he had no similarly effective psychological means of counteracting feelings of inferiority engendered by his extremely dependent and receptive longings. His lack of psychosexual maturity prevented him from compensating with masculine potency for the sense of inferiority originating from his feminine receptive tendencies.

Table P–II. It is interesting to compare this quantitative analysis with that of a woman, B, suffering from duodenal ulcer. Here also we find a relatively high percentage of intaking dreams, the majority of which are of the inhibited receptive type (33%). The aggressive taking dreams too, are strongly inhibited. Only one patient shows more conflict with reference to receiving than this patient. (Table IV.)

Table P–III. F, a thirty-two-year-old male patient suffering from chronic diarrhœa and chronic vomiting, has a very high percentage of dreams expressing intaking tendencies (Table I) and an even higher percentage expressing receptive tendencies. In the latter respect he occupies third place among the 18 patients. (Table II.) His receptivity, however, is less a source of conflict to him than it is in the other cases with ulcer, but more so than is usual in cases of constipation. (Table IV.) It is noteworthy that among the cases with diarrhœa he has the least conflict about receptiveness, which might be explained by the fact that he has two different methods of restitution—diarrhœa and vomiting. A characteristic quantitative feature is a great preponderance of giving over attacking tendencies.

(Table XIV.) This corresponds exactly to his organic symptom. He is the most pronounced case of compensatory diarrhœa among all of our diarrhœa cases.[1]

Table P–IV. I, a forty-one-year-old patient, suffers from chronic constipation. She belongs to a group of patients with constipation which we classify at present in the depressive group. Our studies have shown that the constipated cases fall into two groups. There is a group of cases in which constipation is based more on the mechanisms that characterize depressions and another group in which the constipation is determined chiefly by the mechanisms that characterize paranoia. The depressed constipated patients take the position that nobody gives them anything, that nobody likes them, and that therefore they have to hold on to what they have. This mechanism corresponds to the tendency to substitute an incorporated love object for the lost real object. The constipation of the paranoid type represents the projection of anal sadistic impulses. The patients maintain not only that people do not like them and neglect them, but that people are attacking them. The constipation of these cases is conditioned by their suppressed anal sadism. They attribute their own anal sadistic impulses to others.

This patient's constipation is of the depressive type. She shows a relatively low percentage of intaking dream tendencies (Table II) but in comparison with receptive impulses, the taking tendencies are relatively high (Table XIII). She shows a higher percentage of attacking than of giving tendencies and in this respect exhibits the characteristic of the constipation group (Table XIV). Most important, however, is her high percentage of retentive dreams, in which she ranks first (Table XII). This is in striking correspondence with the clinical picture. Her constipation is probably more conditioned by retentive demands than by inhibition of the eliminating, attack-

[1] This case is described by Dr. Maurice Levine in his article, *Pregenital Trends in a Case of Chronic Diarrhea and Vomiting*, part of a symposium on *The Influence of Psychologic Factors upon Gastro-Intestinal Disturbances*. Published in this QUARTERLY III, 1934.

ing impulses which is more characteristic of the paranoid type of constipation.

Table P–V. Q is a twenty-four-year-old man suffering from petit mal and attacks of the flaccid type. These consist in brief loss of consciousness with flaccidity, often dream-like, twilight states of short duration. He ranks second in intaking tendencies (Table I) and in the preponderance of intaking over eliminating tendencies (Table XV), and second in the intensity of taking wishes (Table III). These quantitative relations correspond strikingly with the fact that clinically he shows a most pronounced regression to the infantile suckling period. His petit mal attacks have been understood analytically as a flight from all responsibility, a regression to a very early infantile period, expressing his great longing for the status of a nursing infant. In the majority of attacks his behavior is an imitation of the nursing babe; he gropes with his hands as if seeking for the breast, and at the same time he regurgitates and drools.

According to our quantitative studies he shows relatively little conflict regarding his receptive tendencies and even less conflict regarding his taking tendencies (Tables IV and VI). This finding corresponds with the clinical picture of an extremely spoiled young man, who was and still is the center of attention of parents who live for him only. He takes it entirely for granted that he should receive everything and exhibits some conflict only because he feels inferior as a result of his great receptiveness. His guilt for this egocentric attitude is largely compensated by his petit mal attacks which make him an invalid and deprive him of many social contacts and certain professional advantages, and permit him to indulge freely both his receptive and intaking demands for gratification. Some time before we had made a quantitative study of this patient's dreams, we had considered him to be an exaggerated type of receptive and demanding patient. The quantitative studies corroborating fully as they did our clinical impression, contributed largely to our conviction that this method of estimating the intensity of unconscious tendencies is reliable.

Table P–VI. O is a twenty-seven-year-old patient suffering

from a phobia concerning eating in the presence of others, especially of men. This patient occupies an exceptional place in our study in showing no taking and only a few giving dreams. She ranks highest regarding her receptive tendencies (Table II) and, as has been said, the greater number by far of her eliminating dreams have the attacking and few the giving significance. The clinical picture serves an interesting background for these figures. Her dreams disclose a high percentage of receptive tendencies and no taking tendencies: her chief neurotic symptom is the inhibition of eating in the presence of men, and her analysis revealed that eating has an aggressive castration significance for her. This accounts both for the phobia and the absence of aggressive taking in her dreams. Having deprived herself to such a degree of taking satisfactions, she does not feel any urge to give, hence the low number of giving dreams.

Summary and Conclusions

The results of the quantitative analysis of unconscious tendencies as expressed in dreams may be summarized briefly as follows:

1. With peptic ulcer there are intense intaking tendencies, both passive receiving and aggressive taking. These tendencies are reacted to with an unusual amount of conflict. These patients react also with a relatively frequently occurring compensatory giving.

2. In chronic diarrhœa there are intense intaking tendencies, more passive receiving than aggressive taking. The patients head the list in the frequency of their compensatory giving; in their eliminating, giving much outweighs attacking. They resemble peptic ulcer patients in their great conflict about their intaking tendencies.

It should be noted that on the basis of this quantitative picture it is difficult to draw a clear distinction between patients with peptic ulcer and patients with diarrhœa. Both are highly receptive, both have strong compensatory giving tendencies for the purpose of solving the intense conflict about their intaking

attitude, the only difference being that patients with diarrhœa appear to show a higher amount of compensatory giving than those with peptic ulcer. The real psychological difference in the two types lies in actual behavior: patients with peptic ulcer try to compensate for their receptivity with actual efforts and activity in life; those with diarrhœa attempt this compensation symptomatically. That this compensation is unsuccessful corroborates the validity of comparing neurotic diarrhœa with the over-moralistic ceremonies of compulsion neurotics. These are usually equally as ineffectual in overcoming the inhibitions and phobias resulting from destructive impulses, as is the diarrhœa of the organ-neuroses.

3. Patients with constipation have the strongest retentive tendencies of the 18 cases investigated. Furthermore they are characterized definitely by a relatively high percentage of aggressive eliminating (anal sadistic) urges and a lesser urge to give. Because they develop and use projection mechanisms, they show less conflict about aggressive taking than patients with diarrhœa or peptic ulcer, although the absolute intensity of their intaking tendencies is smaller. They do not incorporate so much in their dreams as do the first two groups, but they retain more.

This method is an attempt to obtain a picture of the economic distribution of the fundamental dynamic tendencies in a personality. It is not proposed, however, as a substitute for the usual clinical approach. It can be employed only in conjunction with the usual technique of psychoanalysis, without which it shows all the defects in statistical studies. It shows certain correlations without being able to account for the causal connections behind these quantitative correlations. The quantitative data obtained by this method can be evaluated and interpreted only in cases which have been competently psychoanalyzed. The method of quantitative analysis we have developed complements our analytic-clinical studies, inasmuch as it contributes quantitative data, obtained by a reliable method, for estimating the intensity of dynamic tendencies which otherwise can only be roughly estimated.

TABLE I

Classification of Patients According to Intaking Tendencies as Expressed in their Dreams

Patient	*Intaking Dreams in Percentage*	*Sex*	*Diagnosis*
O	58.0	f	Eating Phobia and Constipation
Q	56.5	m	Petit Mal
A	51.7	f	Duodenal Ulcer
B	50.7	f	Duodenal Ulcer and Mild Diarrhœa
F	50.5	m	Chronic Vomiting, Chronic Diarrhœa
R	47.9	f	Colitis (Diarrhœa Type)
N	45.7	f	Character Analysis (History of Chronic Constipation)
D	45.5	f	Chronic Diarrhœa, Occasional Constipation
C	44.7	m	Duodenal Ulcer, with Mild Constipation
S	42.0	f	Depression and Spastic Colon
P	41.7	m	Petit Mal
M	41.5	m	Mild Constipation, Attacks of Migraine
I	38.9	f	Constipation (Depressive Type)
H	36.4	f	Constipation with Occasional Diarrhœa
E	34.4	f	Periodic Diarrhœa and Asthma
K	31.1	f	Severe Constipation
J	28.0	m	Constipation (Spastic Type)
L	25.0	m	Constipation with Gastric Symptoms

TABLE II

Classification of Patients According to Receptive Tendencies as Expressed in their Dreams

Patient	*Receptive Dreams in Percentage*	*Sex*	*Diagnosis*
O	58.0	f	Eating Phobia and Constipation
R	43.3	f	Colitis (Diarrhœa Type)
F	40.4	m	Chronic Vomiting and Chronic Diarrhœa
Q	38.9	m	Petit Mal
S	37.7	f	Depression and Spastic Colon
B	36.7	f	Duodenal Ulcer and Mild Diarrhœa
N	34.0	f	Character Analysis (History of Chronic Constipation)
D	33.7	f	Chronic Diarrhœa, Occasional Constipation
P	30.0	m	Petit Mal
C	27.4	m	Duodenal Ulcer with Mild Constipation
A	26.8	f	Duodenal Ulcer
E	25.5	f	Periodic Diarrhœa and Asthma
M	24.4	m	Mild Constipation, Attacks of Migraine
J	24.0	m	Constipation (Spastic Type)
I	23.2	f	Constipation (Depressive Type)
H	21.1	f	Constipation with Occasional Diarrhœa
L	18.0	m	Constipation with Gastric Symptoms
K	17.7	f	Severe Constipation

TABLE III

Classification of Patients According to Taking Tendencies as Expressed in their Dreams

Patient	*Taking Dreams in Percentage*	*Sex*	*Diagnosis*
A	24.9	f	Duodenal Ulcer
Q	17.6	m	Petit Mal
C	17.3	m	Duodenal Ulcer with Mild Contipation
M	17.1	m	Mild Constipation, Attacks of Migraine
I	15.7	f	Constipation (Depressive Type)
H	15.3	f	Constipation with Occasional Diarrhœa
B	14.0	f	Duodenal Ulcer and Mild Diarrhœa
K	13.4	f	Severe Constipation
P	11.7	m	Petit Mal
D	11.7	f	Chronic Diarrhœa, Occasional Constipation
N	11.7	f	Character Analysis (History of Chronic Constipation)
F	10.1	m	Chronic Vomiting and Chronic Diarrhœa
E	8.9	f	Periodic Diarrhœa and Asthma
L	7.0	m	Constipation with Gastric Symptoms
R	4.6	f	Colitis (Diarrhœa Type)
S	4.3	f	Depression and Spastic Colon
J	4.0	m	Constipation (Spastic Type)
O	0 (No taking tendencies in dreams)	f	Eating Phobia and Constipation

TABLE IV

Classification of Patients According to the Ratio of Satisfied to Inhibited Receptive Tendencies as Expressed in their Dreams

(Order of Classification Expresses Increase of Conflict)

Patient	*Ratio of Satisfied to Inhibited Receptive Dreams*	*Sex*	*Diagnosis*
K	1.49	f	Severe Constipation
P	1.26	m	Petit Mal
M	1.00	m	Mild Constipation, Attacks of Migraine
Q	.74	m	Petit Mal
N	.68	f	Character Analysis (History of Chronic Constipation)
F	.51	m	Chronic Vomiting and Chronic Diarrhœa
J	.50	m	Constipation (Spastic Type)
I	.46	f	Constipation (Depressive Type)
O	.42	f	Eating Phobia and Constipation
H	.35	f	Constipation with Occasional Diarrhœa
L	.30	m	Constipation with Gastric Symptoms
C	.18	m	Duodenal Ulcer with Mild Constipation
S	.17	f	Depression and Spastic Colon
E	.16	f	Periodic Diarrhœa and Asthma
D	.16	f	Chronic Diarrhœa, Occasional Constipation
A	.15	f	Duodenal Ulcer
B	.11	f	Duodenal Ulcer and Mild Diarrhœa
R	.06	f	Colitis (Diarrhœa Type)

TABLE V

Classification of Patients According to their Dreams Experssing Projection of the Inhibition of Receptive Tendencies on to the Environment

Patient	*Frequency of Dreams Expressing Projection of Inhibition of Receptive Tendencies in Percentage*	*Sex*	*Diagnosis*
O	14.0	f	Eating Phobia and Constipation
B	12.1	f	Duodenal Ulcer and Mild Diarrhœa
I	11.6	f	Constipation (Depressive Type)
K	11.1	f	Severe Constipation
J	10.0	m	Constipation (Spastic Type)
P	8.3	m	Petit Mal
R	7.9	f	Colitis (Diarrhœa Type)
H	7.8	f	Constipation with Occasional Diarrhœa
C	6.5	m	Duodenal Ulcer with Mild Constipation
F	5.8	m	Chronic Vomiting and Chronic Diarrhœa
Q	4.7	m	Petit Mal
D	4.6	f	Chronic Diarrhœa, Occasional Constipation
A	4.5	f	Duodenal Ulcer
S	4.5	f	Depression and Spastic Colon
L	3.9	m	Constipation with Gastric Symptoms
N	3.2	f	Character Analysis (History of Chronic Constipation)
E	2.0	f	Periodic Diarrhœa and Asthma
M	0	m	Mild Constipation, Attacks of Migraine

TABLE VI

Classification of Patients According to the Ratio of Satisfied to Inhibited Taking Tendencies as Expressed in their Dreams

(Order of Classification Expresses Increase of Conflict)

Patient	*Ratio of Satisfied to Inhibited Taking Dreams*	*Sex*	*Diagnosis*
N	2.66	f	Character Analysis (History of Chronic Constipation)
Q	1.15	m	Petit Mal
J	1.00	m	Constipation (Spastic Type)
H	.64	f	Constipation with Occasional Diarrhœa
K	.51	f	Severe Constipation
P	.41	m	Petit Mal
F	.40	m	Chronic Vomiting and Chronic Diarrhœa
M	.40	m	Mild Constipation, Attacks of Migraine
R	.39	f	Colitis (Diarrhœa Type)
I	.36	f	Constipation (Depressive Type)
S	.34	f	Depression and Spastic Colon
A	.27	f	Duodenal Ulcer
C	.26	m	Duodenal Ulcer with Mild Constipation
L	.25	m	Constipation with Gastric Symptoms
B	.16	f	Duodenal Ulcer and Mild Diarrhœa
E	.15	f	Periodic Diarrhœa and Asthma
D	0	f	Chronic Diarrhœa, Occasional Constipation
O	0 (No taking dreams)	f	Eating Phobia and Constipation

TABLE VII

Classification of Patients According to Eliminating Tendencies as Expressed in their Dreams

Patient	*Eliminating Dreams in Percentage*	*Sex*	*Diagnosis*
L	58.9	m	Constipation with Gastric Symptoms
N	54.3	f	Character Analysis (History of Chronic Constipation)
K	53.3	f	Severe Constipation
J	52.0	m	Constipation (Spastic Type)
E	50.6	f	Periodic Diarrhœa and Asthma
H	47.7	f	Constipation with Occasional Diarrhœa
S	46.3	f	Depression and Spastic Colon
D	42.2	f	Chronic Diarrhœa, Occasional Constipation
C	42.2	m	Duodenal Ulcer with Mild Constipation
P	41.7	m	Petit Mal
M	39.1	m	Mild Constipation, Attacks of Migraine
R	37.5	f	Colitis (Diarrhœa Type)
I	36.8	f	Constipation (Depressive Type)
B	35.1	f	Duodenal Ulcer and Mild Diarrhœa
F	35.1	m	Chronic Vomiting and Chronic Diarrhœa
A	34.0	f	Duodenal Ulcer
Q	28.2	m	Petit Mal
O	27.0	f	Eating Phobia and Constipation

TABLE VIII

Classification of Patients According to Giving Tendencies as Expressed in their Dreams

Patient	*Giving Dreams in Percentage*	*Sex*	*Diagnosis*
D	36.2	f	Chronic Diarrhœa, Occasional Constipation
E	32.0	f	Periodic Diarrhœa and Asthma
P	26.7	m	Petit Mal
C	25.5	m	Duodenal Ulcer with Mild Constipation
F	24.4	m	Chronic Vomiting and Chronic Diarrhœa
A	24.1	f	Duodenal Ulcer
Q	23.5	m	Petit Mal
B	22.1	f	Duodenal Ulcer and Mild Diarrhœa
J	22.0	m	Constipation (Spastic Type)
L	21.5	m	Constipation with Gastric Symptoms
N	21.3	f	Character Analysis (History of Chronic Constipation)
R	20.4	f	Colitis (Diarrhœa Type)
H	19.9	f	Constipation with Occasional Diarrhœa
K	17.7	f	Severe Constipation
M	17.1	m	Mild Constipation, Attacks of Migraine
S	16.3	f	Depression and Spastic Colon
I	15.8	f	Constipation (Depressive Type)
O	4.0	f	Eating Phobia and Constipation

TABLE IX

Classification of Patients According to Attacking Tendencies as Expressed in their Dreams

Patient	*Attacking Dreams in Percentage*	*Sex*	*Diagnosis*
L	37.4	m	Constipation with Gastric Symptoms
K	35.6	f	Severe Constipation
N	33.0	f	Character Analysis (History of Chronic Constipation)
S	30.0	f	Depression and Spastic Colon
J	30.0	m	Constipation (Spastic Type)
H	27.8	f	Constipation with Occasional Diarrhœa
O	23.0	f	Eating Phobia and Constipation
M	22.0	m	Mild Constipation, Attacks of Migraine
I	21.0	f	Constipation (Depressive Type)
E	18.6	f	Periodic Diarrhœa and Asthma
R	17.1	f	Colitis (Diarrhœa Type)
C	16.7	m	Duodenal Ulcer with Mild Constipation
P	15.0	m	Petit Mal
B	13.0	f	Duodenal Ulcer and Mild Diarrhœa
F	10.7	m	Chronic Vomiting and Chronic Diarrhœa
A	9.9	f	Duodenal Ulcer
D	6.0	f	Chronic Diarrhœa, Occasional Constipation
Q	4.7	m	Petit Mal

TABLE X

Classification of Patients According to the Ratio of Satisfied to Inhibited Giving Tendencies as Expressed in their Dreams

(Order of Classification Expresses Increase of Conflict)

Patient	*Ratio of Satisfied to Inhibited Giving Dreams*	*Sex*	*Diagnosis*
R	14.7	f	Colitis (Diarrhœa Type)
O	4.0	f	Eating Phobia and Constipation
Q	4.0	m	Petit Mal
N	3.0	f	Character Analysis (History of Chronic Constipation)
J	2.7	m	Constipation (Spastic Type)
S	2.5	f	Depression and Spastic Colon
H	1.5	f	Constipation with Occasional Diarrhœa
M	1.3	m	Mild Constipation, Attacks of Migraine
I	.90	f	Constipation (Depressive Type)
F	.62	m	Chronic Vomiting and Chronic Diarrhœa
P	.60	m	Petit Mal
K	.59	f	Severe Constipation
L	.52	m	Constipation with Gastric Symptoms
A	.48	f	Duodenal Ulcer
D	.41	f	Chronic Diarrhœa, Occasional Constipation
C	.39	m	Duodenal Ulcer with Mild Constipation
B	.38	f	Duodenal Ulcer and Mild Diarrhœa
E	.32	f	Periodic Diarrhœa and Asthma

TABLE XI

Classification of Patients According to the Ratio of Satisfied to Inhibited Attacking Tendencies as Expressed in their Dreams

(Order of Classification Expresses Increase of Conflict)

Patient	*Ratio of Satisfied to Inhibited Attacking Dreams*	*Sex*	*Diagnosis*
K	4.3	f	Severe Constipation
B	3.3	f	Duodenal Ulcer and Mild Diarrhœa
Q	3.0	m	Petit Mal
H	3.0	f	Constipation with Occasional Diarrhœa
J	2.7	m	Constipation (Spastic Type)
C	2.5	m	Duodenal Ulcer with Mild Constipation
E	1.4	f	Periodic Diarrhœa and Asthma
D	1.4	f	Chronic Diarrhœa, Occasional Constipation
L	1.3	m	Constipation with Gastric Symptoms
M	1.2	m	Mild Constipation, Attacks of Migraine
A	.83	f	Duodenal Ulcer
N	.72	f	Character Analysis (History of Chronic Constipation)
F	.67	m	Chronic Vomiting and Chronic Diarrhœa
O	.65	f	Eating Phobia and Constipation
I	.54	f	Constipation (Depressive Type)
R	.45	f	Colitis (Diarrhœa Type)
S	.28	f	Depression and Spastic Colon
P	.28	m	Petit Mal

TABLE XII

Classification of Patients According to Retaining Tendencies as Expressed in their Dreams

Patient	*Retaining Dreams in Percentage*	*Sex*	*Diagnosis*
I	17.9	f	Constipation (Depressive Type)
J	14.0	m	Constipation (Spastic Type)
M	12.1	m	Mild Constipation, Attacks of Migraine
H	10.4	f	Constipation with Occasional Diarrhœa
P	10.0	m	Petit Mal
K	8.9	f	Severe Constipation
L	8.4	m	Constipation with Gastric Symptoms
A	7.2	f	Duodenal Ulcer
Q	7.1	m	Petit Mal
D	7.1	f	Chronic Diarrhœa, Occasional Constipation
E	6.9	f	Periodic Diarrhœa and Asthma
F	5.8	m	Chronic Vomiting and Chronic Diarrhœa
B	4.9	f	Duodenal Ulcer and Mild Diarrhœa
C	4.8	m	Duodenal Ulcer with Mild Constipation
O	2.5	f	Eating Phobia and Constipation
N	0	f	Character Analysis (History of Chronic Constipation)
R	0	f	Colitis (Diarrhœa Type)
S	0	f	Depression and Spastic Colon

TABLE XIII

Classification of Patients According to Ratio of Receptive to Taking Tendencies as Expressed in their Dreams

Patient	*Ratio of Receptive to Taking Dreams*	*Sex*	*Diagnosis*
O	58.0	f	Eating Phobia and Constipation
R	9.4	f	Colitis (Diarrhœa Type)
S	8.8	f	Depression and Spastic Colon
J	6.0	m	Constipation (Spastic Type)
F	4.0	m	Chronic Vomiting and Chronic Diarrhœa
N	2.9	f	Character Analysis (History of Chronic Constipation)
D	2.9	f	Chronic Diarrhœa, Occasional Constipation
E	2.8	f	Periodic Diarrhœa and Constipation
B	2.6	f	Duodenal Ulcer and Mild Diarrhœa
L	2.6	m	Constipation with Gastric Symptoms
P	2.5	m	Petit Mal
Q	2.2	m	Petit Mal
C	1.6	m	Duodenal Ulcer and Mild Constipation
I	1.5	f	Constipation (Depressive Type)
M	1.4	m	Mild Constipation, Attacks of Migraine
H	1.4	f	Constipation with Occasional Diarrhœa
K	1.3	f	Severe Constipation
A	1.1	f	Duodenal Ulcer

TABLE XIV

Classification of Patients According to the Ratio of Giving to Attacking Tendencies as Expressed in their Dreams

Patient	*Ratio of Giving to Attacking Dreams*	*Sex*	*Diagnosis*
D	6.0	f	Chronic Diarrhœa, Occasional Constipation
Q	5.0	m	Petit Mal
A	2.4	f	Duodenal Ulcer
F	2.3	m	Chronic Vomiting and Chronic Diarrhœa
P	1.8	m	Petit Mal
E	1.7	f	Periodic Diarrhœa and Asthma
B	1.7	f	Duodenal Ulcer and Mild Diarrhœa
C	1.5	m	Duodenal Ulcer and Mild Constipation
R	1.1	f	Colitis (Diarrhœa Type)
M	.78	m	Mild Constipation, Attacks of Migraine
I	.75	f	Constipation (Depressive Type)
J	.73	m	Constipation (Spastic Type)
H	.71	f	Constipation with Occasional Diarrhœa
N	.64	f	Character Analysis (History of Chronic Constipation)
L	.57	m	Constipation with Gastric Symptoms
S	.54	f	Depression and Spastic Colon
K	.49	f	Severe Constipation
O	.17	f	Eating Phobia and Constipation

TABLE XV

Classification of Patients According to Ratio of Intaking to Eliminating Tendencies as Expressed in their Dreams

Patient	Ratio of Intaking to Eliminating Dreams	Sex	Diagnosis
O	2.1	f	Eating Phobia and Constipation
Q	2.0	m	Petit Mal
A	1.5	f	Duodenal Ulcer
F	1.4	m	Chronic Vomiting and Chronic Diarrhœa
B	1.4	f	Duodenal Ulcer and Mild Diarrhœa
R	1.3	f	Colitis (Diarrhœa Type)
M	1.1	m	Mild Constipation, Attacks of Migraine
D	1.1	f	Chronic Diarrhœa, Occasional Constipation
I	1.1	f	Constipation (Depressive Type)
C	1.0	m	Duodenal Ulcer with Mild Constipation
P	1.0	m	Petit Mal
S	.90	f	Depression and Spastic Colon
N	.84	f	Character Analysis (History of Chronic Constipation)
H	.76	f	Constipation with Occasional Diarrhœa
E	.68	f	Periodic Diarrhœa and Asthma
K	.58	f	Severe Constipation
J	.54	m	Constipation (Spastic Type)
L	.42	m	Constipation with Gastric Symptoms

TABLE XVI

Frequency of Dreams Expressing Soiling with Excrement in their Manifest Content

Patient	Dreams Expressing Soiling in Relation to Total Dreams %	Sex	Diagnosis
H	34.7	f	Constipation with Occasional Diarrhœa
N	33.3	f	Character Analysis (History of Chronic Constipation)
G	27.0	m	Character Analysis
J	26.3	m	Constipation (Spastic Type)
K	24.0	f	Severe Constipation
M	24.0	m	Mild Constipation, Attacks of Migraine
T	23.3	m	Chronic Constipation with Conversion Symptom Localized in the Mouth
U	21.0	m	Essential Hypertension
L	20.4	m	Constipation with Gastric Symptoms
I	19.0	f	Constipation (Depressive Type)
C	16.0	m	Duodenal Ulcer with Mild Constipation
B	16.0	f	Duodenal Ulcer and Mild Diarrhœa
E	15.0	f	Periodic Diarrhœa and Asthma
V	14.0	f	Spastic Colitis (Diarrhœa Type)
P	13.0	m	Petit Mal
W	13.0	m	Manic Depressive
X	12.0	f	Gastric Neurosis and Colitis
Y	10.0	f	Spastic Colitis (Diarrhœa Type)
A	10.0	f	Duodenal Ulcer
D	8.4	f	Chronic Diarrhœa, Occasional Constipation
S	7.9	f	Depression and Spastic Colon
F	6.0	m	Chronic Vomiting, Chronic Diarrhœa
Q	5.6	m	Petit Mal
R	3.9	f	Colitis (Diarrhœa Type)
O	2.5	f	Eating Phobia and Constipation
Z	2.0	m	Manic Depressive, Psychoneurosis

TABLE P–I

Case C

Diagnosis: Duodenal Ulcer with Mild Constipation

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 168

I. INTAKING	44.7%	A. Receptive	27.4%	Satisfied	4.2%	
				Non-satisfied	23.2%	Inhibited by conflict 16.7%
						Conflict projected 6.5%
		B. Taking	17.3%	Satisfied	3.6%	
				Inhibited by conflict	13.7%	
II. ELIMINATING	42.2%	A. Giving	25.5%	Satisfied	7.1%	
				Inhibited	18.4%	
		B. Attacking	16.7%	Satisfied	11.9%	
				Inhibited	4.8%	
				Self-attacking (eliminating with meaning of self-castration)	0.0%	
III. RETAINING	4.8%			Satisfied	3.6%	
				Inhibited	1.2%	
IV. UNCLASSIFIED	8.3%				8.3%	
	100%				100%	

TABLE P–II

Case B

Diagnosis: Duodenal Ulcer and Mild Diarrhœa

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 163

I. INTAKING	50.7%	A. Receptive	36.7%	Satisfied	3.7%	
				Non-satisfied	33.0%	Inhibited by conflict 20.9%
						Conflict projected 12.1%
		B. Taking	14.0%	Satisfied	1.9%	
				Inhibited by conflict	12.1%	
II. ELIMINATING	35.1%	A. Giving	22.1%	Satisfied	6.1%	
				Inhibited	16.0%	
		B. Attacking	13.0%	Satisfied	9.3%	
				Inhibited	3.7%	
				Self-attacking (eliminating with meaning of self-castration)	0.0%	
III. RETAINING	4.9%			Satisfied	1.3%	
				Inhibited	3.6%	
IV. UNCLASSIFIED	9.3%				9.3%	
	100%				100%	

TABLE P–III

Case F

Diagnosis: Chronic Vomiting and Chronic Diarrhœa

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 134

I. INTAKING	50.5%	A. Receptive	40.4%	Satisfied	13.7%	
				Non-satisfied	26.7%	Inhibited by Conflict 20.9%
						Conflict projected 5.8%
		B. Taking	10.1%	Satisfied	2.9%	
				Inhibited by conflict	7.2%	
II. ELIMINATING	35.1%	A. Giving	24.4%	Satisfied	9.3%	
				Inhibited	15.1%	
		B. Attacking	10.7%	Satisfied	4.3%	
				Inhibited	6.4%	
				Self-attacking (eliminating with meaning of self-castration)	0.0%	
III. RETAINING	5.8%			Satisfied	2.9%	
				Inhibited	2.9%	
IV. UNCLASSIFIED	8.6%				8.6%	
	100%				100%	

TABLE P–IV

Case I

Diagnosis: Constipation (Depressive Type)

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 95

I. INTAKING	38.9%	A. Receptive	23.2%	Satisfied	7.4%
				Non-satisfied	15.8%
					Inhibited by conflict 4.2%
					Conflict projected 11.6%
		B. Taking	15.7%	Satisfied	4.2%
				Inhibited by conflict	11.5%
II. ELIMINATING	36.8%	A. Giving	15.8%	Satisfied	7.4%
				Inhibited	8.4%
		B. Attacking	21.0%	Satisfied	7.4%
				Inhibited	13.6%
				Self-attacking (eliminating with meaning of self-castration)	0.0%
III. RETAINING	17.9%			Satisfied	2.1%
				Inhibited	15.8%
IV. UNCLASSIFIED	6.4%				6.4%
	100%				100%

TABLE P–V

Case Q

Diagnosis: Petit Mal (Flaccid Type)

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 84

I. INTAKING	56.5%	A. Receptive	38.9%	Satisfied	16.5%
				Non-satisfied	22.4%
					Inhibited by conflict 17.7%
					Conflict projected 4.7%
		B. Taking	17.6%	Satisfied	9.4%
				Inhibited by conflict	8.2%
II. ELIMINATING	28.2%	A. Giving	23.5%	Satisfied	18.8%
				Inhibited	4.7%
		B. Attacking	4.7%	Satisfied	3.5%
				Inhibited	1.2%
III. RETAINING	7.1%			Satisfied	4.7%
				Inhibited	2.4%
IV. UNCLASSIFIED	8.2%				8.2%
	100%				100%

TABLE P–VI

Case O

Diagnosis: Eating Phobia and Constipation

DYNAMIC TENDENCIES EXPRESSED IN DREAMS

Total Number of Dreams: 40

I. INTAKING	52.5%	A. Receptive	52.5%	Satisfied	12.5%	
				Non-satisfied	40.0%	Inhibited by conflict 35.0%; Conflict projected 5.0%
		B. Taking	0.0%	Satisfied	0.0%	
				Inhibited by conflict	0.0%	
II. ELIMINATING	35.0%	A. Giving	5.0%	Satisfied	5.0%	
				Inhibited	0.0%	
		B. Attacking	30.0%	Satisfied	15.0%	
				Inhibited	15.0%	
				Self-attacking (eliminating with meaning of self-castration)	0.0%	
III. RETAINING	5.0%			Satisfied	2.5%	
				Inhibited	2.5%	
IV. UNCLASSIFIED	7.5%				7.5%	
	100%				100%	

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A PSYCHOANALYTIC STUDY OF THE SIGNIFICANCE OF SELF-MUTILATIONS

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Before beginning a discussion of the various conditions under which self-mutilation is performed it will be helpful to outline the problem. In self-mutilation the self-destructive tendencies familiar to us in many clinical manifestations are directed upon a part of the body. We must try to determine the reason for the increased power of the destructive element and the reason for its direction back upon the self; we must also study the significance of the sacrifice and why a particular part of the body is selected for this function. We must examine on the one hand how inexorably the unconscious is bound to the talion principle of an eye for an eye and a tooth for a tooth, and on the other hand how it is that substitutions can be made in this demand.

I will first illustrate the phenomenon by a case paradigm. A rather pretty woman of thirty developed a severe depression with the delusion that all life was full of sorrow for which she was chiefly responsible. She was confined in a hospital and showed some improvement, whereupon her mother came one day and removed her against advice, insisting that she understood her daughter better than did the physicians and knew that she was well. She took her daughter home where a few nights later the patient arose while the rest of the household slept and murdered her own two-year-old child by beating it in the head with a hammer, saying that she wanted to spare the baby the suffering that she herself had endured. This led to her commitment to a state hospital, from which she escaped one day long enough to run to a railroad track and there to

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place herself in such a way that an oncoming train passed over and amputated the forearm. After this she made a rather rapid and complete recovery and has been well since.

Although this case was not studied psychoanalytically it is possible to make certain general reconstructions in regard to the unconscious mechanisms in her behavior on the basis of clinical experience. It is strongly presumptive here that this woman was driven to make a spectacular atonement for an equally spectacular crime. By injuring herself in this terrible way, she paid the penalty for having murdered her child; she cut off the offending arm, faithful to the Biblical command that "if thy right hand offend thee, cut it off". But the child whom she murdered was apparently her chief love object, and, in spite of the poet's comment that "each man kills the thing he loves", we know that he only does so if that love has become too strongly tinctured with (unconscious) hate. Destruction is not the fruit of love but of hate.

Then what is the explanation for so much hate as to drive this woman to murder? Some time after her recovery I talked to her. She seemed singularly unconcerned and unabashed about her forearm stump. But when I asked her about the death of her child, she showed more emotion, and with tears gathering in her eyes she said, "You know, I shall always feel that my mother was really responsible for that, some way. She and I never got along together."

This, I think, was undoubtedly the correct clue. The patient's mother was indeed responsible for the murder, actually, since she had been apprised of the patient's condition and disregarded experienced advice. It is easy to understand how a woman with such a mother should feel hatred toward her. But we know from everyday experience that when such hatred cannot be vented upon the person who has given rise to it, it is often transferred to someone else. We know, too, from psychiatric and psychoanalytic experience that in depressions, the disease from which this patient was suffering, the victims stew in the caldron of their own hate, turned back upon themselves from some unrecognized external object.

Whether this external object was the mother or the daughter is really of secondary importance here. What we clearly see is that this woman hated someone so much that she committed murder, for which she then offered propitiation by mutilating herself. In other words, in her unconscious thinking and feeling this woman's mother, her daughter and her own self were all partially identified. If she killed her child to punish her own mother, she also cut off her own arm to punish herself.

The psychological mechanisms of this instance of self-mutilation, therefore, are like those of suicide [1] to this extent, that hate directed against an external object was turned back upon the self and reënforced with self-punishment. It differs from suicide in that this punitive self-attack, instead of being concentrated upon the total personality, as in suicide, was divided into two parts, upon the baby and upon the arm, one of which was played off against the other. Lacking, also, is any convincing evidence for a wish to die, which we found reason for assuming in the case of suicide.[2]

But the reader may feel that this is very interesting speculation, logical enough but quite unsusceptible of proof. How can one be sure that these interpretations are correct? Other explanations might be constructed that would seem equally convincing, at least in a particular case that one might select. Such a question is entirely justified. I cannot prove the application of these explanations to this case except by analogy, because the case was not accessible to study. It is appropriate, therefore, to proceed immediately to a consideration of self-mutilations in more accessible clinical material.

[1] Menninger, Karl A.: *Psychoanalytic Aspects of Suicide.* Int. J. Ps-A. XIV. P. 376.

[2] Compare the following item: "In Gavardo, Italy, having signed promissory notes for several friends, Giuseppe Mazzolini, 36, was obliged to pay them when his friends defaulted. When the last defaulted, he laid on a table the hand with which he had signed the notes, pulled out a pruning knife, hacked the hand off."—(*Time,* October 3, 1932.) Here again we have hate of an outsider reflected upon a part of the self.

1. Neurotic Self-Mutilations

It is convenient to begin with self-mutilation as it appears in the course of or as a part of a neurosis, first, because such cases have been quite thoroughly studied and reported upon by many authors, and secondly, because the behavior of neurotics is always much more closely akin to that of so-called normal people and therefore more easily understandable by them. Psychoanalytic treatment of neurotic patients affords us the advantage of using the combined aid of the subject's intelligence and the observer's experience to pierce the disguises which cloak the motives and the methods.

I say "methods" because it is actually true that neurotics often disguise the method by which they accomplish the self-mutilation; in this particular they are like malingerers rather than like the psychotic patients that make no effort at such concealment. This arises from the fact that the neurotic is far more loyal to reality than the psychotic patient. The neurotic patient rarely mutilates himself irrevocably. It is only with great difficulty that he can directly commit such absurd acts. Substitutive and symbolic forms of self-mutilation are therefore very common and neurotics frequently demand and obtain mutilation at the hands of a second party, for example in the form of surgical operations.[1]

The explanation for this, according to our psychoanalytic conception, lies in the very nature and purpose of the neurosis, namely, that it is a compromise device intended to save the personality from such direct and serious consequences of the demands of the instincts and of the conscience. The ego, that is, the discriminating intelligence of the personality, has the task of adjusting these demands and if it finds itself failing it makes the best bargain possible. It concedes as little as possible to the insistence of the conscience upon self-punishment. The result may be silly and it may be serious but it represents the best that the ego of the neurotic can do. The psychotic

[1] Menninger, Karl A.: *Polysurgery and Polysurgical Addiction.* This QUARTERLY III.

patient, on the other hand, ceases to attempt any such bargaining, and hence one sees the extreme and bizarre self-mutilations common to them.

This element of bargaining—making the best possible compromise—is the essence of the whole matter. The normal person is normal because he can make so much better a bargain than the neurotic; he can do so because he is not so much at the mercy of his stern or cruel conscience and this in turn is partly due to the fact that he is not so strongly moved by destructive urges. Compared to him the neurotic makes a bad bargain but compared to the total surrender of the psychotic person the neurotic's bargain is not so bad.

In the case cited above, for example, the woman whose right arm had killed her child would have been obliged, had she been wholly dominated by the demands of her conscience, to have killed herself in atonement. Indeed, this very thing happens daily, as we know from observation and also from the study of suicide. In the vernacular, this woman was "not so crazy" as to do that. There is no use in punishing one's self if one ceases to live, since the ostensible object of self-punishment is to enable one to live thereafter in peace.[1] When the priest assigns to the penitent a certain task he defeats his own aim if he makes that task impossible of performance. His object is to make life tolerable and endurable without the dragging sense of guilt which the unatoned offense arouses.

What this woman did, therefore, was to substitute a self-mutilation for suicide; instead of offering up her life she offered up her arm, which was quite logical since it was the guilty organ. It was logical if one assumes the personification or autonomy of various organs of the body, and this, as we shall see, is one of the devices of the unconscious for unloading guilt. "It is not I but the arm that was guilty, therefore I shall sacrifice the arm, my guilt is expiated and I have saved my life." It will be recalled that the woman got well quite promptly after this event.

[1] I do not refer to punishment in the legal sense as this entails elements of deterrent action, detection, etc.

But it must be obvious that the more normal person will have made an even better bargain with his conscience than this. He would have said, "I regret what I have done more than I can say, but to injure myself would not make matters any better. I cannot bring my baby back to life but I can raise another child, or I can provide out of my earnings enough to make some other child happier, or I can do something to promote the prevention of such ignorance concerning mental disease as my mother exemplified and I will do so and so or give such and such." This would have been the more intelligent solution but it would have been possible only to one far more normal, that is, less burdened by hate and less tyrannized over by conscience than the woman described.

The compromises made by neurotics [1] are usually not so extreme as that of the woman who offered up her arm nor are they so intelligent as the normal examples I have suggested. Sometimes, and that is what we are now interested in, they are self-mutilations. As I have already indicated, these mutilations are apt to be disguised or indirectly achieved; they are also subject to the confusing element of the patient's false explanations of them.

We can observe this in such a familiar clinical example as "nail-biting". Such a mild degree of self-injury may seem scarcely to merit such a formidable designation, but after all, it is the nature of the act rather than its degree of seriousness which determines its classification. For that matter all of us have seen quite severe and even serious mutilation from nail-biting. I have had patients who gnawed off every vestige of

[1] The following are only a few of the psychoanalytic reports on the subject: See Stärcke, A.: *Castration Complex.* Int. J. Ps-A. II, 1921.

Horney, K.: *Genesis of Castration Complex in Women.* Int. J. Ps-A. V, 1924.

Farrow, E. P.: *Castration Complex* Int. J. Ps-A. VI, 1925.

Oberndorf, C. P.: *Castration Complex in Nursery.* Int. J. Ps-A. VI, 1925.

Bryan, D.: *Speech and Castration; Two Unusual Analytic Hours.* Int. J. Ps-A. VI, 1925.

Lewis, N. D. C.: *Additional Observations on Castration Reaction in Males.* Psa. Rev. XVIII, 1931.

Alexander, Franz: *Castration Complex and Character.* Int. J. Ps-A. IV, 1923.

nail from every finger. Indeed some "biters" actually gnaw the fingers themselves.

A little girl of my acquaintance had developed the habit of biting her finger nails severely. From this she went to her toe nails, which she bit so savagely that she twice tore a nail completely from the toe. An infection resulted and she was taken to a surgeon for treatment which was necessarily painful. The child, however, bore the treatment stoically without tears or struggle. She appeared entirely absorbed in watching the physician's head, which was quite bald, and when he had finished the treatment her only comment was: "I don't like your hair-cut".

The outstanding fact about the case is the extent to which this child carried the common habit of nail-biting. There is no doubt that in this case the biting resulted in a severe mutilation. A second interesting feature is the child's apparent indifference to pain, both in regard to the original mutilation and its treatment. This is surprising because it seems to correspond to the indifference to pain of adult hysterical people, who can be moved so strongly by psychological motives as to be unmoved by physical sensation accompanying their self-punitive acts.

Finally, the child's apparently pointless remark to the surgeon leads to some interesting conjectures as to the connection which the child may have made between her own denuded toe and the surgeon's hairless head from which, be it noted, the child thought the hair had been *cut*. The child, who did not flinch from bearing the full consequences of her own act, looked with fastidious distaste upon the havoc which the surgeon, as she evidently thought, had wreaked upon his own head.

One need only recall the distress, the anxiety, the impotent rage, which the habit of nail-biting on the part of their children creates in mothers, to realize how great the satisfaction of the child must be, and how correct the unconscious intuition of mothers. Nothing but a satisfaction of a sort about which the mother herself feels guilty could possibly excite the uneasy and

irritable intolerance with which they view this and similar habits.

The fact that the child *bites* its own fingers and finger nails suggests that it represents a punishment no less than an indulgence. The mother cannot see or welcome this evidence of contrition, however, because she senses that such self-punishment must be of the nature and spirit as that of the little girl who slapped her own hand before she stole candy from the buffet (Brill). The punishment actually permits the continuance of forbidden indulgences and in this way becomes in itself a kind of indulgence.

Clinical investigation has shown quite definitely that there is a close association between nail-biting and a less conspicuous but similar "bad habit" of childhood—masturbation. Mechanically the parallelism is obvious; the fingers instead of being applied to the genitals are now applied to the mouth, and instead of the genital stimulation there is the labial stimulation accompanied, as we have already pointed out, by the punitive (mutilative) element of biting.

How do we know this? In the first place, we know it from the observations of many clear-headed, intelligent mothers who have observed their own children without panic. In the second place, we know it from the scientific observations of children made by the child analysts and by those engaged in child guidance work.[1] Finally, we know it from the study of

[1] Wechsler (Wechsler, David: *The Incidence and Significance of Finger-nail Biting in Children.* Psychoanalytic Review, *18,* 1931, pp. 201–209), from observations on some 3,000 children between the ages of 1 and 17 years, deduced that there is a close relation between the incidence of finger-nail biting and the various stages of psychosexual development and that it varies in intensity according to these phases, reaching its peak at the onset of puberty, when the œdipus situation is revived and the guilt feelings reactivated. Two years later there is a sudden and significant drop corresponding to the adolescent's final disposition of the œdipus situation. He found that more than forty per cent of girls between the ages of 12 and 14 and of boys between the ages of 14 and 16 were nail-biters. In boys and girls two years older the proportion of nail-biters dropped abruptly to less than twenty per cent. The rise occurs at different ages for boys and girls, the difference corresponding to the age difference in the onset of puberty for boys and girls.

adult neurotics who in the course of analyzing their own childhood are able to recall clearly the details of and the connections between their nail-biting and their masturbation.

One patient of my own, for example, during the course of her analysis suddenly felt impelled to pursue a course of finger training which required arduous finger exercises. She practiced assiduously for many hours a day, giving her fingers the most severe discipline even to the point of pain. At the same time she became greatly worried because her little daughter persisted in the habit of nail-biting. She became increasingly excited over this and spoke much of the danger of letting a child develop bad habits, etc. Also, she feared—she felt sure—that this child was masturbating.

I asked her why she jumped to this conclusion. She replied by confessing, or recalling, that she, herself, as a child had had an intractable nail-biting which her mother had vigorously combated, not knowing of her masturbation. Then she added reluctantly and only after evident resistance that recently she had yielded to a strong impulse to masturbate. It was pointed out that this must have been closely associated in point of time with the vigorous finger punishment she had been indulging in; she was startled to realize this, and intelligent enough to see immediately that the association was more than chronological.

One must put several things together now in order to understand what this meant. What this woman did was to confess the punishment in order to conceal the offense, i.e., she told me all about the practicing but concealed from me the fact that she had masturbated. She concealed even from herself the fact that she had punished her fingers in this way because she felt guilty about masturbation. One knows that to be the case, however, from the fact that she brought up from her childhood the memory that she was to punished by her mother for nail-biting at the time she was masturbating. To cover this up, as a smoke screen so to speak, she accuses her own child of masturbating, an accusation which was probably correct but for which her only basis was the nail-biting. "My child is doing just what I am doing", she thought. But behind

this lay a deeper truth, "What I am now doing and what my child is now doing is only what I once did as a child, except that I escaped detection".

Common as nail-biting is, we don't yet know all the unconscious meaning of it by any means. David Levy has recently shown, for example, by experimental work with dogs and babies that those who get an insufficient amount of suckling are prone to substitute, later, oral gratification of the type of thumb-sucking, and possibly also nail-biting. It is as if the child who does not get enough gratification at the mother's breast seeks to find it from any source, without discrimination. This does not contradict the connection with masturbation, because masturbation is a later and entirely natural stage in the child's pleasure development. In other words, the normal child gives up sucking as a chief form of pleasure and learns to masturbate; the neurotic child because of his fear of punishment stops masturbating and substitutes nail-biting, or some other similar substitute, which is regressive in the sense that it harks back to the earlier days and ways of pleasure, namely, oral instead of genital. It is then a substitute kind of gratification and a concomitant punishment simultaneously, enacted both of them in attenuated forms.

More vigorous attacks upon the body than that of nail-biting may be observed in many forms of neurotics, particularly in the attacks upon the skin which the dermatologists call neurotic excoriations. These are cases in which the individual seems impelled to pick or dig at his skin with the finger nail, sometimes ascribed to an uncontrollable desire to relieve itching or to rid the skin of what they believe to be a parasite, but more frequently for no reason which the patient can explain. I saw several of these patients with Dr. Joseph V. Klauder in Philadelphia early in 1932. In one case Dr. Klauder had been able to ascertain that the intolerable itching, which the patient relieved by digging out these chunks of flesh, occurred chiefly on two days of the week which he subsequently discovered were the two days upon which her husband had lain in a dying condition.

The most remarkable case of neurotic self-mutilation I have seen (and I am here definitely excluding malingering) was that of an automobile mechanic of thirty-five.[1] He had as early as twelve or fourteen exhibited some twitchings and jerkings of his arms which were at that time regarded, at first, as chorea. When, however, they continued growing gradually but steadily worse, this diagnosis was doubted by subsequent consultants and by most of them contradicted.

When seen by us twenty years after the onset of the affliction he presented a most extraordinary clinical picture. He had developed an amazing variety of sudden jerks, twists, lunges, grimaces, kicks, wriggles, and even barks and whoops, which came suddenly in the midst of a period of calm during which he gave an intelligent account of his affliction. For a few moments he would be at rest and continue his conversation only to be insufferably interrupted by involuntary spasmodic misbehavior of the sorts indicated. His arm would fly up, his leg would kick out, his head would twist halfway around, his diaphragm would apparently contract sharply, so that in the midst of the conversation, which, however, he bravely attempted to carry forward, he would be thrown out of his chair, or he would be obliged to gasp, grimace or shout in a totally irregular and unpredictable way.

Such, at least, was our first impression. It gradually became evident, however, that his involuntary movements, in spite of their wide variation, had one very definite point of agreement. As he himself had long recognized, they all seemed directed against himself, that is, either against his body or against the carrying out of his conscious wishes. Thus his arm jerks, carefully observed, proved nearly always to be body blows; in kicking it was his own leg and foot that suffered; frequently he kicked the other leg. Often he would slap or jab his face with his thumb; there was a large open lesion on his forehead of which he remarked, "It seems like if I get a sore started, I

[1] This case was presented by Doctors Elliott and Bills of Kansas City before the Missouri-Kansas Neuropsychiatric Society in January, 1930; I acknowledge my indebtedness to these colleagues.

pester it nearly to death", and as he said this he punched it a half dozen more times in rapid succession. Three of his front teeth were missing as the result of backhand blows given himself in the mouth while working with heavy wrenches. (In spite of his affliction he held a responsible position in a large garage in Kansas City.) His hands were covered with the scars of minor injuries. "Whenever I get a knife in my hand", he said, "and naturally I have to do that a lot, I always cut myself; it never fails."

This patient certainly fulfils all of the requirements of the characteristic motives of the suicidal act. His attacks were fierce, his submission heroic. And as to the contribution of the sense of guilt, it is rather significant that in the course of the one brief conversation with him he remarked spontaneously that he and his mother had never gotten along very well because she was always reproaching him, particularly for his propensity for going out with girls, of which he rather modestly boasted. In spite of his affliction, he said, he had many friends and was active both socially and sexually. "But she says I'm getting my deserts . . . that I would never have gotten this way if I hadn't run around with girls so much!"

We can only surmise what the connection is between his compulsive acts and the sense of guilt he betrayed by his boasting and his citation of his mother's threats. We know that the affliction began in childhood, when the sexual activity is not "running around with girls" but masturbation. It is this for which some mothers scold, punish and threaten their children, and that this was such a mother we have the patient's testimony. The assumption might well be that his physical self-abuse is a direct descendant of his genital "self-abuse"—a substitute for it in which the punitive element is far greater (to our notion) than the gratification. It persists in spite of more satisfactory sexual opportunities because of some unknown crisis of childhood which defied solution then, and hence remains unsolved except in this reiterated neurotic pattern. I have since learned that this man, who is a member of a respectable family, has now for some time been living with a prostitute and

also that in the course of a number of involuntary attacks upon himself he has nearly blinded himself. We see how inexorable the demands of the conscience may be.

Less spectacular cases I have seen frequently. I was once consulted about a successful young woman who had suddenly developed a compulsion to pull out handfuls of hair *(Trichotillomania)*[1]. It was impossible to get her coöperation in studying or relieving this compulsion because whenever the matter was mentioned to her she became exceedingly angry. It was remembered, however, that this compulsion began immediately following the marriage of her younger sister of whom she had always been jealous. Instead of snatching her sister baldheaded she carried out this operation upon herself and accomplished in this way both the aggression and the self-punishment. In a personal communication, Dr. Henry W. Woltman, of the Mayo Clinic, described a case of *Trichotillomania* observed by him in which the act was directly and consciously associated with masturbation, which it accompanied. Compare this with the interpretation of nail-biting given above.

A case of self-mutilation which I had the opportunity to study over a period of many months and in great detail also concerns the hair. This was an educated, gifted business man of twenty-seven who used to seize a shears and chop away at his own hair until he produced a repulsively grotesque effect, with splotches here and there where he had come close to the scalp. The reason that he assigned for this at first was that being very poor he had to economize and could not waste money going to a barber but had to cut his own hair. Since in reality he was well-to-do, he acknowledged the necessity of a better explanation than this, admitted his stinginess, but could give—at first—no better one. He was positive that his hair was falling out and he shared the popular view that if one kept cutting hair its growth would be stimulated. This was a comforting rationalization in line with the previously observed

1 This affliction is sometimes epidemic in the same way the other hysterical affections are. See David, H.: *Pseudo-Alopecia Areata.* Brit. J. Dermat. *34,* May, 1922.

phenomenon of forestalling punishment by punishing one's self, i.e., in order that his hair should not be taken away from him by external agencies he cut it off himself.

Further analysis revealed the real reasons for his hair cutting compulsion. As a boy he had had luxurious black hair. But he had a blonde brother whom everyone preferred and of whom, therefore, he was exceedingly envious and jealous. Because of his hatred of this younger brother he would tease him and at times violently mistreat him, and as a result would be beaten by his father. In these beatings the father would seize the boy by his luxurious hair and so hold him while he administered the blows.

His entire adult life had been a series of disasters, the rough formula of which was this: he would enter a new project with high hopes and great promise. He made a good impression and because of his intelligence and likeability he would advance rapidly. But once established in someone's favor he would pick a quarrel, or make himself the object of justified retaliation so that in the end he would be thrown out, abused, sometimes attacked and always disliked. This had happened not dozens but scores and hundreds of times. In other words, he kept repeating over and over the formula of attacking his brother, defying his father and incurring for himself punishment. He either punished himself directly, or saw to it that he got himself punished for the aggressions he carried out on various people in lieu of his father and brother.

Cutting off his hair represented not only a reënactment of his wish to escape from his father but also—in a more realistic sense—a punishment of himself. It was the one physical asset of which he had had reason to be proud but it had not prevented him from being jealous. His savage self-administered hair slashing had another meaning. His family was Jewish, but his brother was not interested in religion and was of such a disposition that he was freely accepted socially by Gentiles. For this reason the jealous brother, my patient, did everything possible to accentuate and exploit his Jewishness. Although not so reared, he espoused that orthodox form of the faith

which entails leaving the hair unbarbered. He was for a time very meticulous in all the prescribed observances but his interest—as we see—was not dictated by piety so much as by less worthy motives—chiefly that of rebuking and shaming and being different from his brother. When he saw that it had no effect on his brother or upon his father he renounced it—he had been disappointed again. He could indicate such resentful renunciation very understandably by mutilating and discarding his hair.

A classical case of neurotic self-mutilation well known to those familiar with psychoanalytic literature involving the nose and teeth is the celebrated Wolf-Man case which was partially analyzed by Freud and reported in his series of case histories in 1918 [1] and later during a recrudescence of his neurosis analyzed by Dr. Ruth Mack Brunswick.[2]

2. Religious Self-Mutilation

Self-mutilation appears to have been practiced as a form of religious observance since the earliest times. If we include also mutilations which, while not actually self-inflicted, are submitted to willingly and even eagerly by religious aspirants, one is almost safe in saying that all religions contain this element. Precisely what its significance is we shall attempt to determine.

These mutilations represent sacrifice and usually, as we have seen in the preceding chapter, the sacrifice demanded of the holy man was that of his sexual life. It is sometimes alleged that this condemnation of the erotic life as incompatible with religious worship is a Christian innovation [3] but this is erroneous. Christianity made use of conceptions and attitudes

[1] *An Infantile Neurosis,* Coll. Papers III.

[2] Brunswick, Ruth Mack: *The Infantile Neurosis, Further Analysis.* Int. J. Ps-A., Oct., 1928.

[3] Origen (185–254 A.D.) castrated himself that he might be unhindered in his zealous devotion to Christianity, especially in the instruction of women. He was one of the foremost leaders and teachers in the early Church but his self-mutilation was given by the synod of bishops as one reason for depriving him of the honor of being a Presbyter.

implicit in religious faiths which were already many hundreds of years old at the time of Christ. Even in the mythology with which the Mediterranean religions were so closely associated there existed to some extent the conception that the religious leader must be asexual. Among the Phœnicians, for example, it was the legend that Eshmun, the beautiful god of spring, castrated himself in order to escape the erotic advances of the goddess Astronæ and his priests were obliged to do likewise. Similarly the Galli, self-castrated priests of Attis, according to Frazer [1] were common sights on the streets of Rome before the days of the Republic.

There are numerous legends about the cult of Cybele and Attis which originated in Phrygia after the sixth century B.C.[2] The gist of several of them is that the Mother-Goddess, Cybele, (or in some legends, Agdistis) was originally hermaphroditic and that the gods performed a surgical operation, cutting off the creature's external, i.e., male genitals, and leaving the female genital. She is represented as being related to Attis, either directly or indirectly representing his mother. Attis grows to manhood and is beloved by Cybele, but is persuaded by his friends to marry a king's daughter. At the wedding the mother-lover appears and drives Attis mad with frenzy. He castrates himself and his bride kills herself. Cybele mourns the deed and obtains from Jupiter the promise that Attis's body shall not decompose but that his hair shall continue to grow and his little finger to move.

Ovid, in his *Fasti,* gives a slightly different version of the legend. He relates how Attis, a Phrygian youth of great beauty, attached himself to the goddess Cybele. She made him keeper of her temples, pledging him to a vow of chastity. He sinned with the tree nymph Sagaritis whom Cybele destroyed. Attis then fell prey to fears, thinking himself attacked by torches, scourges and furies. He lacerated his body with a

[1] Frazer, Sir James George: *The Golden Bough.* New York: Macmillan, 1923.

[2] I am indebted for this investigation of the folklore and literature of the cult to Mrs. Bernice Engle, of Omaha, Nebraska, who gave me permission to abstract the material from her paper, *Attis: A Study of Castration.*

sharp stone and cut off his genitals, crying out, "Such are my deserts: with my blood I pay the deserved penalty; perish those which in me have been the sinning parts!"

Priests of Attis regularly castrated themselves on entering the service of the goddess Cybele. Catullus wrote his poem *Attis,* not about the god of the legend but about a chief priest of the cult. Like the original Attis whose name he bears, he castrates himself in a mad frenzy from (in the words of the poet) "utter abhorrence of love".[1]

The worship of Cybele and Attis was introduced into Rome where its orgiastic rites and bloody ritual became popular. From a description of these rites[2] one gets a very clear impression that the self-mutilation served the purpose of offering the supreme sacrifice of the sexual life in favor of the devotion to the highest (known) good. In essence these ceremonies, actually or symbolically, consisted in the sacrificing of virility, under the influence of religious fervor in a bloody and painful manner.

Such orgies of public self-torture have been adopted as a part of the religious worship of various sects since those early days and even up to the present time. In I Kings xviii, 28, there is a description of how the priests of Baal engaged in a rainmaking ceremony, gashing themselves with knives and

[1] Other examples of self-castration in ancient religions are found in the legends of Zeus and Hecate in Caria, Artemis in Ephesus, Atargatis and Adonis and Astarte (Hierapolis), Adonis and Aphrodite in Cyprus, Osiris in Egypt and Angustudunum in Gaul.

[2] ". . . The third day was known as the day of blood; the Archigallus, or high priest, drew blood from his arms and presented it as an offering. Nor was he alone in making this bloody sacrifice. Stirred by the wild barbaric music of clashing cymbals, rumbling drums, horns and flutes, the inferior clergy whirled about in the dance with waggling heads and streaming hair, until, rapt into a frenzy of excitement and insensible to pain, they gashed their bodies with potsherds or slashed them with knives in order to bespatter the altar and the sacred tree with their flowing blood. The ghastly rite probably formed part of the mourning for Attis and may have been intended to strengthen him for the resurrection. The Australian aborigines cut themselves in like manner over the graves of their friends for the purpose of enabling them to be born again. Further, we may conjecture, though we are not expressly told, that it was on the same Day of Blood and for the same purpose that the novices sacrificed their virility." (Frazer, *op. cit.*)

lances until the blood gushed out upon them. The Syriac word *ethkashshaph,* which means literally to "cut oneself" is the regular equivalent of "to make supplication". Westermarck [1] says that in some cases human sacrifices have been succeeded by religious practices involving the shedding of human blood without loss of life. For example, in Laconia the scourging of lads at the altar of Artemis Orthia was substituted for the sacrifice of men which had previously been offered her. Euripides represents Athena as ordaining that the festival of Artemis be celebrated by the priest holding a knife to a human throat until blood flows.

The ceremony called "Tootoo-nima", said to be common among the Tonga islanders, is also cited by Westermarck. It consists of cutting off a portion of the little finger as a sacrifice to the gods for the recovery of a sick relative and was asserted to have been such a prevalent practice in former days that "there was scarcely a person living in the islands who had not lost one or both little fingers or at least a considerable portion of them".

In Chinese literature there is frequent mention of persons cutting off flesh from their bodies to cure parents or paternal grandparents who were seriously ill. Westermarck *(op. cit.)* quotes Dr. de Groot as follows: "Often also we read of thigh cutters (in China) invoking heaven beforehand, solemnly asking this highest power to accept their own bodies as a substitute for the patients' lives they wanted to save; the mutilation thus assuming the character of self-immolation." Bleeding as a means of propitiating the gods was used in Bengal and among the Peruvian Indians.

Among the Semites and Tartars worshipers lacerate themselves before their God. Similar practices are carried on in America by the Flagellants. This sect arose and flourished in Europe in the thirteenth and fourteenth centuries, practicing public flagellation to appease the divine wrath. The observation of these ceremonies has been frequently noted and reported in New Mexico in recent years.

[1] Westermarck, Edward: *The Origin and Development of the Moral Ideas.* Vol. I, p. 649. London: Macmillan, 1906.

Self-flagellation is not, however, a very definite type of self-mutilation, and although mutilation frequently results from these orgies (Dr. T. P. Martin of Taos, New Mexico, informed the writer that he had frequently been called to save the life of an over-vigorous self-beater who had severed a blood vessel or otherwise injured himself quite seriously during these ceremonies) such self-mutilation is accidental and not a primary intention, and it is in actuality (if not in motivation) far removed from self-castration.

We may turn, therefore, to the consideration of a religious body which is contemporary with us and in which, nevertheless, essentially the same rites are carried out as in the ancient Phrygian and Syrian worship described above, including actual self-castration. I refer to the Skoptsi of Russia.

Skoptsi constitute a Russian religious sect of considerable size, founded about 1757. While its actual extent is not definitely known because of the secret character of the sect, it has been estimated by some at 150,000 members. For our purpose it is necessary only to establish the fact that its ceremonies were not limited to a few psychotic or eccentric individuals but seized upon the needs of a considerable community of people to the extent of achieving self-castration.

The Skoptsi believe that Adam and Eve, our first parents, sinned by entering into sexual relationship, and that the only way to atone for this evil and avoid further sin is to destroy the potency of human beings. They quote the passage, "If thy hand or thy foot offend thee cut them off and cast them from thee; it is better for thee to enter into life halt or maimed, rather than having two hands or two feet to be cast into everlasting fire. And, if thine eye offend thee, pluck it out and cast it from thee; it is better for thee to enter into life with one eye rather than having two eyes to be cast into hell-fire." The offending member, according to their founder, Szelivanov, was his organ of procreation.[1]

[1] Goldberg, B. Z.: *The Sacred Fire.* New York: Liveright, 1930. P. 345–350. See also Wall, O. A.: *Sex and Sex Worship.* St. Louis: C. V. Mosby Co., 1919, pp. 211–212; Leroy-Beaulieu, Anatole: *The Empire of the Tsars and the Russians, Part III.* London: G. P. Putnam's Sons, 1896, pp. 422–437.

Szelivanov baptised himself by fire, mutilating his body with a blazing iron. He baptised hundreds in the same way and worked untiringly to gain new converts. When the world contained one hundred and forty-four thousand Skoptsi the millenium would be at hand. At one time it appeared to be not far distant for the membership was rapidly increasing. Everyone was urged to secure new converts. He who brought in twelve mutilations was given the distinction of apostleship. In eastern Russia, entire communities went over to the Skoptsi. One such mass conversion consisted of seventeen hundred souls. The missionaries worked among the beggars and other lowly elements of society convincing them or bribing them to accept the new religion. Some were even forcibly mutilated. An appeal was also made to the curious, the adventurous element.

"The very fact that there were wholesale conversions to the sect and that each convert was to be mutilated, made it quite impossible for these operations to be performed with that great care and precision required to insure their effectiveness. Some of the women had to be satisfied with mere incisions upon the breasts. Others, mutilated much more, still possessed the capacity and the desire for the sexual function. There were, therefore, among the Skoptsi women prostitutes, enriching the communal treasury with fees received from 'gentiles', 'uncastrated ones'. Even men were not always entirely incapacitated, due largely to the fact that a good many of the converts performed the operation on themselves and halted in the process because of pain or fear. In fact, the Skoptsi religion took cognizance of this condition by establishing two degrees of mutilations, those of the Greater Seal and those of the Lesser Seal. There were many Skoptsi, then, in whose hearts still glowed the fire of passion and who were physically capable of satisfying their desires. They mingled with those who although incapacitated, still exulted in witnessing the sexual activities of members of the Lesser Seal. As a result we have the accounts of wild sexuality in the services of the sect and intense orgiastic rites." (Goldberg.)

The operations are described by Wall as follows:

"In males there are two methods, cutting out the testicles, or total expiration of penis and scrotum; these are removed with cutting implements and the bleeding is checked with a red hot iron. This is called 'baptism by fire'. Occasionally the parts are removed by burning them off with a red hot iron loop. In women the operations are varied: cutting off or burning off one or both nipples, amputating one or both breasts, cutting out the labia minora with the clitoris or the clitoris alone; or the extirpation as far as possible of the entire external genitals, labia majora, labia minora and clitoris; also the extirpation of the ovaries (spaying)."

Leroy-Beaulieu graphically describes one of these operations:

". . . One evening two men, one of them young and blooming, the other old and sallow and unnaturally smooth face, were conversing, while sipping their tea in a house in Moscow:—'Virgins will alone stand before the throne of the Most High,' said the elder man. 'He who looks on a woman with desire commits adultery in his heart and adulterers shall not enter the kingdom of Heaven.' 'What then should we sinners do?' asked the young man. 'Knowest thou not,' replied the elder, 'the word of the Lord? If thy right eye leadeth thee into temptation pluck it out and cast it from thee; and if thy right hand leadeth thee into temptation, cut it off and cast it from hee. What ye must do, is to kill the flesh. Ye must become like unto the disembodied angels, and that may be attained only through being made as white as snow.' 'And how can we be made thus white?' further inquired the young man.——'Come and see,' said the old man. He took his companion down many stairs into a cellar resplendent with lights. Some fifteen white robed men and women were gathered there. In the corner was a stove in which blazed a fire. After some prayers and dances, very like those in use among the Flagellants, the old man announced to his companion: 'Now shalt thou learn how sinners are made white as snow.' And the young man, before he had time to ask a single question, was seized and gagged, his eyes were bandaged, he was stretched out on the ground, and the apostle with a red hot knife

stamped him with the seal of purity. This happened to a peasant, Saltykof by name, and certainly not to him alone. He fainted away under the operation and when he came to himself he heard the voices of his chaste sponsors give him the choice between secrecy and death. Once they had undergone the ordeal, nothing remained to those initiated against their will but to accept the ever ready lavish bounty of the chiefs and make the best of it."

Self-castration as an expression of the moral sentiment of the community may be incorporated into legend and tradition instead of into religious practice—but its significance is thereby all the more easily discovered. For example, in his elaborate study of the sexual life of the savages of the Trobriand Islands, Malinowski [1] has collected numerous erotic dreams and fantasies of these people, some of which show the theme of self-mutilation and self-castration as a form of punishment and misdirected aggression exactly comparable with what we have seen of it in other places.

For example, there is the story of Momovala (Vol. 2, p. 411) who becomes sexually excited by the exposure of his daughter and yields to an incestuous impulse toward her. The girl, in her mortification, persuades a shark to eat her. To this the father reacts by first attacking his wife sexually so violently that she dies also (according to the story he tells the neighbors that she has been "speared" and when they ask where he tells them "in her vagina"). After this Momovala cuts off his penis and dies.

A longer and more specific tale is the legend of Inuvayla'u. Inuvayla'u was supposed to have been a great chief whose lecherousness led him to take sexual advantage of all the women of the village during the absence of their husbands under quite unfair circumstances. For example, the vegetable garden [2] in Melanesia is a tabooed place as far as sexual matters are concerned and women working in a garden are supposedly

[1] Malinowski, Bronislaw: *The Sexual Life of Savages in Northwestern Melanesia.* New York: Liveright, 1929.

[2] Cf. the Garden of Eden, and the intruding Serpent.

entirely immune to molestation from men. This villain, however, would stand outside of the garden and because of his long penis would be able to reach a woman at her task inside the enclosure. The native version of the story is quite Rabelaisian; it held that this penis was a terrific weapon of physical as well as sexual aggression and that Inuvayla'u could knock the woman down with it before cohabiting with her.

The men of the village finally watched him, caught him *flagrante delicto* and punished him by the disgrace of being ducked. This filled him with great shame and sorrow and he ordered his mother to prepare their belongings for moving to another village.

When all was packed he came out of his house in the central part of the village wailing aloud; he took his axe and cut off the end of his penis wailing and lamenting it as he did so. He threw this part of his penis to one side and it turned into a large stone which the natives believe to be still observable. Crying and wailing he went further, from time to time cutting off a piece of his penis and throwing it to one side where it turned into stone. Finally he cut off his testicles which became large white coral boulders and are still visible. He went to a village far off and lived there with his mother making gardens and fishing. There are some variations of the myth but the essential part, as Malinowski states, is the expiatory self-castration. He says the stones described in the myth still exist although "the similarity to their anatomical prototypes has worn away with time, while their size must have enormously increased".

In spite of the fact that self-castration is, as I have just recorded, an essential part of certain religious cults, ancient and modern, the practical-minded, present-day person can scarcely conceive of it as the act of a normal man. It is too much like the self-mutilations of psychotic patients which we shall consider shortly.

For the present let us examine what it is about them that seems insane. Is it that the sacrifice is so great or that it is so unnecessary?

I think we could easily agree that it is the former since the idea of renunciation of the sexual life is present in all religions, with greater or lesser emphasis. But the fact that self-castration as a religious rite exists and has existed for centuries is of the utmost theoretical importance, because it shows us what the extreme form of sacrifice may be. Of course it is not the only extreme form of sacrifice. We know religions have existed in which children were burned alive, property confiscated or ceded to the church and martyrdom of various types expected and approved. But in these other sacrifices it is not so much the sacrifice of the sexual life as the submission to pain or deprival which is emphasized. These we have already discussed. Many believe, however, that this renunciation of the sexual life, and in particular the infliction of some kind of self-mutilation upon the genitals, is the fundamental form of all sacrifice. There is some clinical evidence to support this. We know, for example, that surgical mutilation of the genitals is practiced by millions of people, both savage and civilized at the present moment, including the Jews, the Mohammedans, and many of the native tribes scattered over Asia, Africa, and Oceanica. A vast number of theories have been advanced to explain the origin of circumcision.[1] But all of them are what psychoanalysts call rationalizations, i.e., they attempt to explain something on the basis of some utility which is secondarily discovered. We can only expect to understand the origin of circumcision if we can understand the dynamic principles

[1] "A great many surmises and theories have been put forth on the origin and purpose of circumcision, which are to be found with a good classification in L. Gray (*Encyclopedia of Religion and Ethics,* III, 664ff). Hygienic considerations (Steinmetz), protection against sexual dangers (Crawley), test of courage (Zaborowski), sacrifice and hallowing of the sexual life (Barton, Jeremias, Valeton, Lagrange), intensification of the sensual pleasure (Burton), expression of the belief in resurrection (Frazer), have all been advanced as causes for the origin of circumcision. Most scholars, and among them those who have studied the question most intensively, R. Andree, H. Wilken, Ploss-Renz and L. Gray, consider circumcision to be a custom of initiation, serving as an introduction into the sexual life and to make procreation more certain by the removal of foreskin, which is considered to be a hindrance." (Schmidt, W., and Koppers, W.: *Völker und Kulturen,* Part I. Regensburg, 1924, pp. 239–243.)

which impel people to want to sacrifice a part of their bodily flesh.

We already have a clue as to what this may be derived from, taken from the more radical religious rites described above. If instead of cutting off the entire genitalia one can satisfy the religious requisites equally well by cutting off only a part of the genitals, namely the foreskin, he has managed an exceedingly practical substitution. That this general principle of a part for the whole operates in our lives is apparent on every side.

The point is that almost all religions which have survived have learned to make liberal use of symbolism and all the evidence points to the fact that circumcision is a symbol of a more radical mutilation. It is, however, a particular type of symbolism, that of a part for the whole which is so characteristic of unconscious thinking and conscience bribing which we have already discussed.

We get conclusive evidence for this, as for the other conclusions submitted in this book, from clinical data. I could cite many illustrations from psychiatric practice to show how in the unconscious circumcision and castration are equated. Because the fear of cutting in connection with the genitals is so widespread and apparently so basic in the formation of character,[1] any surgery in connection with the genitals is apt to be associated with strong emotional feeling which psychoanalysts, on the basis of their daily experiences with the language of the unconscious, recognize to be a "castration threat", i.e., a threat that the genitals are to be irremediably injured by the cutting. How correct this can be is rather well illustrated by the following incident from the life of a patient whom I recently saw. He had discovered at an early age that he had what he called a "rupture" but felt that he must keep it a secret from his parents until he was seventeen. Having become convinced by that time that he must have an operation he broached the matter to his father for the purpose of obtaining

[1] See for example Alexander's article, *The Castration Complex in the Formation of Character.* Int. J. Ps-A. IV, 1923.

money. The father became agitated, fearing that such an operation might ruin the boy in some way and after brooding over it for some days consented and that evening mentioned the matter to his wife. His wife flew into a terrific tantrum, saying that he had concealed something from her, that he had plotted something dreadful with reference to the boy and ended up by shooting and killing her husband that same night. Upon examination many years later we found the boy to have no "hernia" but an atrophied testicle on one side.

That circumcision like the threatened hernia operation represents symbolic castration is intuitively perceived by some people and quite inconceivable to other people. Actual castration, according to early Roman law, could be performed with the consent of the castrated or his guardian and this corresponds with the prevailing law in California, Kansas and some other states with reference to the sterilization of some defectives and insane. Later, however, castration was prohibited by the Romans (Domitian) both for free men and slaves even with the consent of the person involved and circumcision was also severely punished because it was considered to be a kind of castration.[1] Mommsen states that "Hadrian was the first one, not apparently for religious reasons, but because of the superficial similarity of the operations, to equate circumcision and castration, which was one of the reasons that led to a serious Jewish insurrection at that time. His successor granted it to the Jews and also the Egyptians. Otherwise, however, circumcision was considered equal to castration and equally punished."

3. Puberty Rites

A second source of evidence which at the same time further extends our field of religious mutilation is to be found in the various initiatory ceremonials inflicted upon adolescents among aboriginal tribes in many parts of the world. These are known in anthropological literature as puberty rites, and must be con-

[1] Theodor: Römisches Strafrecht; in K. Binding, *Systemat. Handbuch d. Deutsch. Rechtswiss.* V, Abt., 4. Teil, p. 637, Leipzig, as quoted by Bryk *(op. cit.)*.

ceived of as religious in nature. They are not *self*-mutilation and hence do not exactly belong here but they are coöperatively submitted to in such a way as to make it clear that while actually inflicted by a second party they gratify the wishes of the victim. (I should not say "victim" but "initiate" or "candidate" because heroic and sometimes horrible as these ceremonies are, they are usually the occasion of a festival and accompanied by the utmost rejoicing.)

The rites vary in different tribes. In some instances a tooth is knocked out, amid much noise and ceremony; more frequently the principal initiatory rite consists of circumcision performed with a sharp stone or piece of glass or with a knife; sometimes an incision is made in the penis and the blood is mixed with water which the boys and men drink. Following and preceding the circumcision the boys are compelled to go through various forms of torture. They are made to fast for many days, "feigned attacks are made upon them", so-called spirits appear to them in masks of animals and threaten to eat them; occasionally an actual fight takes place between the men and their sons. Sometimes the boys run the gauntlet while the men beat them violently. Among the Karesau islanders black ants are allowed to bite the novices. The Mandan Indians thrust a knife with a saw edge through the youth's arm, forearm, thigh, knee, calves, chest and shoulder and then push pointed pieces of wood into the wounds. All of these methods seem to carry the significance of death for the candidate followed by rebirth. This rebirth drama is also enacted by the novices after the ceremony when they appear to have forgotten all about their previous existence, do not recognize their relatives, and cannot eat or speak or even sit down without being shown how. If they do not adhere to this formality they must go through a second and much more severe ceremony which may result in actual death.

There is in these rites the purpose of detaching the youths from their mothers and of admitting them to the community of men.[1] Women are forbidden to attend the ceremony and

[1] Reik, Theodor: *Ritual.* New York: W. W. Norton & Co.

the feast under pain of death, or if they are allowed to witness the rites they must stand at a great distance. The women mourn and wail for the boys as if an actual death had taken place and there is rejoicing when the boy is returned to his home.

It is a common assumption that circumcision rites belong only to men but it is an assumption that contradicts the facts, since circumcision of women is widely spread among savage peoples and the unconscious motives are precisely the same as in males. The conscious motives, however, are quite different, as are also the techniques. All parts of the female genitals are attacked by the circumcisors of various primitive tribes, sometimes the clitoris, sometimes the labia majora, sometimes the labia minora, sometimes all of these. The reasons *ascribed* are to promote cleanliness, to decrease passion and therefore, more nearly insure virginity, for the promotion of greater pleasure to the man, for the promotion of vaginal, at the expense of clitoris, sensitivity, i.e., shifting of the erotogenic zone.[1]

It also serves the purpose, according to Bryk, of placing the sexual life of the girl under the control of human society. "It is quite remarkable", he says, "but also understandable in the light of the mentality and the inconsiderateness of the men, that the circumcised woman may not have intercourse with one who is uncircumcised, while on the other hand there is practically no law that prevents the *moran,* the uncircumcised warrior, from taking any girl who is not yet circumcised. (Bryk, p. 115.)

"Female circumcision could have originated only in a culture governed by maternal law. Woman, emancipating herself could not bear to be ignored, sexually, by the man. There was also the desire to have an external token of maturity and the obvious course was a parallel to the circumcision of boys. Just as our society women imitate the men by smoking, wearing their hair short and fencing, the shepherd woman did the same through circumcision. It was only thus that it became

[1] Bryk, F. I.: *Voodoo-Eros.* New York, 1933.

entirely feminine. Circumcised women are in fact vaginal in feeling, clitorism having been removed even somatically by clitoridectomy. Shifting of erotogenic centers went hand in hand with psychogenic repressions.

". . . In other respects also female circumcision offers analogies and parallels to the circumcision of boys. The girls are also exposed to the most horrible tortures and excruciations, even the ant test is not lacking. Dapper even mentions circumcision performed by ants: 'The boys are circumcised in the Mahometan manner, and the girls also have their special circumcision; for when they have reached their tenth or eleventh year they insert a stick, to which they have attached ants, into their genitalia, to bite away the flesh, indeed, in order that all the more be bitten away, they sometimes add fresh ants.'

"As with the boys, the amputated flesh is burned away from the evil eye, the girls are also separated until thep have completely recovered and go about muffled up to avoid the glances of men. Most striking of all are the coincidences of custom among the circumcision rites of the Nandi. Both sexes are now circumcised, the part to be removed is charred with fire, and both then wear the ornamentation of the opposite sex. The lion is the totem animal of both. We have likewise very little information on treatment after circumcision or the preparation of the novices. The most customary is bathing before circumcision and after convalescence and the shaving of the hair. Among the Kukuyu, in fact, 'to jump into the river' is synonymous with 'to be circumcised' (Cayzac). This bath later attained a secondary significance in religious purification.

"The circumcision of girls reflects similar motives as those discussed in detail under the circumcision of boys." [1]

Thanks to the collections of data made by Frazer, Malinowski, Bryk and other anthropologists and the other psychoanalytic constructions formulated by Freud, Abraham, Rank, Theodor Reik and the combination of observations and inter-

[1] Bryk, Felix: *Circumcision in Man and Woman.* New York: The Ethnological Press, 1934.

pretations made by Róheim, we have fairly definite ideas as to the psychological function of these rites.

Two views of the matter are held, both of which explain puberty rites as ceremonial devices for overcoming what is known in anthropology as the *incest taboo,* or to put it in psychoanalytic terms, for solving the œdipus complex. From one standpoint the genital mutilation administered to the adolescent can be seen to serve to gratify the hostility of the parents toward him for his secession from their authority, to punish him for his incestuous wishes and to intimidate him with respect to their (further) gratifications; that is, the suppression of the sexual and aggressive impulses of the adolescent with reference to the parents. The other aspect of the function of puberty rites is that of atonement not in retrospect, but in prospect, i.e., the circumcision and all the other mutilations used for this purpose are a price paid by the initiate for admission into the rights of adulthood.[1]

The castration fear, i.e., the boy's fear that his penis or his life would be taken from him by his elders were he to use it in the forbidden direction of sexuality would hang over him always were it not removed ceremonially by the symbolic castration represented in the puberty rites. Instead of cutting off the entire penis, a part of it is cut off, a part standing for the whole just as it does in all sacrificial offerings. Rather than have all their herds destroyed, the Jews offered up choice specimens from the flock as propitiations to be destroyed in the name of God so that God would spare the rest of the flock.

This significance of sacrifice, i.e., a technique of giving up a part in order to preserve the whole, has been worked out psychoanalytically by various writers. In addition to Rank,

[1] *In regard to circumcision as a permit for the beginning of sexual life;* A. LeRoy sees in circumcision an *interdit levé;* only through the blood sacrifice of mutilation of the penis can the *permis d'user* be bought. Reik is of the opinion "that the prohibition, the partial lifting of which is bound up with the rites of puberty, was first set up within the narrow frame of the family and only later extended beyond these limits". (LeRoy, A.: *La réligion des primitives.* Paris, 1906. P. 236.) (Reik, Th.: *Probleme der Religionspsychologie.* I., Leipzig und Wien, 1919, p. 981.)

referred to above, Alexander [1] has essentially the same thing in mind in his idea of conscience bribing and in a recent article [2] he describes the mechanism in terms of sacrificing anal values in order to save the genitals, and Rado [3] has referred to it as "the choice of the lesser evil".

There is really no conflict between these two aspects of the puberty rituals. Both are undoubtedly valid; one emphasizes intimidation, suppressive, and atonement element and the other the permissive, propitiatory elements. I cannot agree with Reik that the former are much the more important simply because they are unconscious, whereas the latter are conscious.

Money-Kyrle [4] refers to the more complicated rituals in which the severed foreskin or the extracted tooth is hidden in a tree. He quotes Frazer's opinion [5] that this may have originally been intended to insure the rebirth of the circumcised men and his own psychoanalytic inference that the circumcision may serve to relieve the neurotic fear of death.

"If this interpretation is correct, such mutilations, even when they are consciously intended to remove the fear of death and thereby to secure the hope of rebirth, are vicarious sacrifices.

[1] Alexander, Franz: *Psychoanalysis of the Total Personality.* New York: Nervous & Mental Disease Publishing Co., 1930.

[2] Alexander, Franz: *Zur Genese des Kastrationskomplexes.* Int. Ztschr. f. Psa., 1930.

[3] Rado, Sandor: *Fear of Castration in Women.* This QUARTERLY II, 1933.

[4] Money-Kyrle: *The Meaning of Sacrifice.* London: Hogarth Press, 1929. P. 161.

[5] *In regard to castration as a purchase of life rather than as a manifestation of the death instinct:* "Frazer believed that he had found the long lost key to the significance of circumcision in the fact that east African Kukuyu had formerly associated circumcision with the ceremonies of rebirth which are now celebrated separately and because in central Australia the amputated foreskins are put into the same totem trees, totem rocks and other totem centers in which human souls spend their time between the departure from the individual and their rebirth in a child. Renz, as quoted by Zeller (Moritz: *Die Knabenweihen,* in Arbeiten aus dem voelkerkundlichen Institut d. Universität Bern. I Heft, Bern, 1923, p. [1]–160) has also pointed out that the circumcision rites of savages, including as they frequently do a hut of isolation, in which the boys must spend a long time, are connected with ideas of rebirth from the belly or stomach of a spirit so that he supports this idea of Frazer's that circumcision represents a rebirth in numerous senses." (Bryk *op cit.*)

They are accepted by the superego in place of the self-castration that it would otherwise demand. Further, since a relation of identity often seems to subsist between the external soul and the soul of the ancestor, the foreskin that is hidden in the tree may, from one point of view, be regarded as made over to the ancestral spirit, which is itself nothing more than the projection of the superego. Such a sacrifice might well be combined with a pantomime of return to the womb."

4. Self-Mutilation in Psychotic Patients

The savages and the psychotic have this in common, that they act without deference to demands of a civilization which often modifies primitive tendencies almost beyond recognition. In a sense, what we call insanity is simply a regression to the savage state in which one does not have to consider these restrictions.

Among the many forms of psychotic behavior, self-mutilation is not one of the most frequent but is, on the other hand, quite typical. It is typical because it is so apparently senseless or justified by such irrational and illogical explanations. The type of injury inflicted is quite varied but generally tends to be more conspicuous, bloody and painful than serious from the standpoint of life. As we shall see, there is probably a very definite reason for this. Self-mutilation occurs in most of the major psychoses—paresis, mania, melancholia, schizophrenia, epileptic psychosis, delirium. Apparently, therefore, it bears no fixed relation to the clinical form of illness but is an expression of some more general tendencies. Let us make our discussion specific by citing an actual case.

A boy of twenty returned from the war to find that the girl to whom he had been engaged had married another man. This was the precipitating factor in the development of an acute schizophrenic illness with delusions, hallucinations, queer posturing, etc., which after a few relapses became chronic and necessitated continuous hospitalization. From the standpoint of care he was an exceedingly difficult patient in the hospital because of his persistent efforts to injure himself. He would,

for example, tie string tightly about his toes with the evident purpose of producing gangrene. He would slip up behind the heavy doors of the hospital as they were being closed after a physician or nurse and put his fingers into the cracks so as to have them crushed. Upon several occasions he snatched pins from the front of a nurse's uniform and attempted to jab them into his eyes. He would seize the fingers of one hand and by holding them with his leg attempt to pull them apart so violently as to tear the webs between them. With his thumb and fingernail he would pinch chunks out of his earlobes. He frequently dived or plunged from his bed onto the floor, head first, as if attempting to crush his skull. Once he was found nearly asphyxiated as a result of having forced several large stalks of celery deep into his throat.

In such examples as this, typical psychotic self-mutilation, all the aggressive tendencies seem to have been reflected upon the aggressor himself. We can only guess for whom they were originally intended unless the patient tells us—which this one did not. Undoubtedly they were originally directed against some external object, ostensibly loved but unconsciously hated.

I have cited this case in spite of its incompleteness for several reasons. First, it represents graphically some of the variety of psychotic mutilations.[1] Secondly, it demonstrates the entire absence of a real wish to die. Anyone strongly determined to kill himself could have done so with one-hundredth of the effort that this boy used to cause himself suffering. He is still alive aften ten years of it. Thirdly, there is here the disguised evidence of the sexual element. His psychosis was precipitated, it will be recalled, by a frustrated love affair and many of the attacks upon himself have a sexually symbolic character.

[1] Cf. also the following:

MacKenna, R. M. B.: *Extensive Self-Mutilation of Scalp, Presumably Following Tricophytic Infection.* Brit. J. Dermat. *42*, 1930.

Sharma, H. R.: *Self-Mutilation: Extraordinary Case.* Indian Med. Gaz. *65*, 1930.

Urechia, C. I.: *Autophagia of Fingers by Patient with General Paralysis and Cervical Pachymeningitis.* Rev. Neurol., March, 1931.

Conn, J. H.: *Case of Marked Self-Mutilation, Presenting Dorsal Root Syndrome.* J. Nerv. and Ment. Dis. *75*, 1932.

A fourth and the determining reason lies in the fact that instead of being single and clearly specific as in the case of the woman who cut off her arm, and on any of the others cited, his attacks upon himself were multiple and much less clearly localized. The woman, for example, had a guilty hand and arm; she had killed her child with it, so it was appropriate that she should cut off the offending arm. But this boy attacks himself all over and this we find disturbing to our assumption that there is something specific about the particular organ or part of the body attacked which leads to its selection as the object or focus of the self-destructive effort. There is probably in all cases some conditioning, i.e., some specific experiences involving that part of the body in either an actual or symbolic way which help to determine its selection.

For example, in the case which I cited previously in which my patient made violent attacks upon his own hair without knowing why, it will be remembered that as a child he had had beautiful hair, his only point of superiority over a brother of whom he was bitterly envious. In spite of this hair, however, his brother was preferred by his parents and by almost everyone else so that my patient came to feel that having such beautiful hair was of no avail in the struggle for the favors of the world. He felt, so to speak, as if his hair had "let him down", for not only did it win him no friends but it was by this luxuriant hair that his father was wont to seize him when he administered beatings, usually inflicted because of my patient's mistreatment of his envied brother. For these reasons he had, on the basis of his childhood thinking, good reason to be angry at his own hair (personifying a part of the body in this way is quite characteristic of primitive "prelogical" thinking).

Similarly we could probably show, if we had access to all the material, as is not infrequently the case, that a patient who attacks his ear, for example, does so because of certain auditory experiences of childhood of an unpleasant nature, or one who gouges out his eye does so because of some original visual shock which so enhances the value of this particular organ to him. It is as if he would say, "My eye was responsible for revealing

to me such and such a terrible (or forbidden) scene." [1] This, for example, was the reason that the surreptitious observer of the naked Lady Godiva were supposed to have gone blind only that here God, rather than the peeper, punished.

But we have still not answered the question provoked by the case of the boy who attacked all parts of his body without discrimination. It is scarcely likely that he could have had grudges against so many different parts of himself on the basis of experience only.

From this we conclude that there must be another element which determines the selection of the part of the body. This element has to do not with the real significance of the various parts but with the symbolic significance. The apparently indiscriminate attacks upon himself of the patient were actually not so indiscriminate. They always related to organs or parts of the body which experience has taught us represent the sexual organs. Indeed it would appear from clinical study that all attempts to cut off parts of the body represent substituted and therefore symbolic attempts to deprive one's self of his sexuality, i.e., to cut off or mutilate an organ symbolizing the genitals. The Skoptsi and others, as we have seen, actually did this directly instead of seeking a symbolic method of accomplishing it and, as we shall shortly see, the same is true of many psychotic patients.

Before we pass to these examples, however, let us discuss a little further the idea that in the unconscious various parts of the body may represent the genitals. We see this best in hysteria, but we also see it in the condition known as *fetishism,* in which the total personality, the body, the face, even the genital organs of the beloved are of no sexual interest to the

[1] Cf. the case reported by Hartmann. This was a woman who gouged out both her eyes, ostensibly "as a sacrifice to Christ" because "one sins mostly with one's eyes during such fantasies". It was discovered that she had always been excited by certain visual experiences including the sight of most any man. As a child she had slept in a room with her parents and had often observed her father's genitals; she had observed the parents having intercourse and was scolded by her father for "always watching". (Abstract by Keschner. Amer. Archives of Neurol. & Psychiatry, March, 1926.)

patient but only one isolated part of the body (and this part is never the genitals). Such individuals, for example, become sexually excited and ultimately gratified by the contemplation and caressing of a foot, a toe, a finger, the ear, the hair (and sometimes even objects which are not really a part of the body, for example, a shoe belonging to the loved one). When such patients trace completely the psychological connections between these things, connections which they themselves did not know, they reveal to themselves and to us that these parts of the body were unconsciously taken by them as substitutes for a part of the body which they were too repressed and too fearful to acknowledge frankly.

The unconscious symbolic substitution of one organ for another is by no means limited to hysterical persons or fetishists. It is only more obvious in them. But we all do it. A clear example of the substitution of hair for a more socially tabooed appendage was recorded some years ago by (psychoanalyst) Ernst Simmel, who observed understandingly his young son.[1] The boy had suffered from an inflammatory phimosis and, at two and a half years of age, was taken to a surgeon who relieved the stricture by means of stretching. The little fellow had behaved very well indeed and the surgeon praised him, giving him a piece of candy. After the child was dressed and was saying goodbye, the surgeon, still quite jovial, laughingly said to the little fellow hat he had been a pretty good boy this time but next time he would "cut the whole thing off for you with these", showing him a large pair of surgical scissors. The surgeon laughed in a friendly way but the child ran to his father with a cry of terror and "trembling with agitation sobbed in my arms". The parents endeavored in every way to assure the child that the surgeon had been joking and gradually he seemed to forget the episode. A year later the child had a slight inflammation of the penis which responded easily to local bathing; in connection with it he began of his own accord to speak of his experience of the previous year with the surgeon.

1 Simmel, Ernst: *A Screen Memory in Statu Nascendi.* Int. J. Ps-A. VI, 1925.

He recounted cheerfully and with remarkable accuracy all the *unimportant* details of what had happened in the surgeon's office, mentioning many items which the parents had forgotten. But concerning the final episode, the joke about the scissors, he did not say one word. Thinking that he might help to remove the painful impression of the experience, his father asked him if he did not remember anything else—something the doctor said. No answer. "Don't you remember the joke he made?" No answer. "Didn't he have a pair of scissors?" The child laughed, "Oh, yes, a pair of scissors. He made a joke about the scissors."

But in spite of prompting from his father he could not remember what the joke had been. Finally his father asked him if the surgeon had not talked of cutting off something. Immediately the child cried out merrily, "Oh, yes, I remember, he said he would cut my hair off."

This incident is most interesting because it shows so clearly how a child represses something painful and replaces the painful matter with a disguising joke. The merriment, excitement and laughing which the child exhibited served the purpose of denying or guarding against the anxiety which is so close to the surface and which would appear if the child accepted into consciousness the memory in its original form.

It is also interesting to note that the hair was selected as a symbol of the organ which the surgeon actually threatened to cut off. The child could laugh at this because it is not of such great consequence if the hair be cut off; it doesn't hurt and it will grow again.[1]

[1] Incidentally, as Simmel points out, the surgeon was unconsciously cruel in making the joke; he could laugh at it because he regarded it as so foreign to his real purposes. But for the little child this cruel tendency was wholly undisguised. He reacted not to the joke but to the cruelty. Later, when his unconscious disguised the memory by making it hair instead of penis, he was able to defend himself against the anxiety by a device very useful in present day civilization where we curb our cruelty and only allow ourselves to injure our fellowmen mentally. "Nevertheless there are many adults who remain all their lives helpless children in the face of attacks of this sort. They are saddened or wounded if people jest with them because, as we say, they do not 'understand a joke'—in reality they understand it only too well."

Now we can see how even in the case of the boy who mutilated his own hair because it had played him false there was probably a disguised element so that not only the unpleasant experiences with his brother but also the association with his sexual life dictated his behavior.

Let us now examine some of those psychotic cases who do not resort to symbolic means of punishing or rejecting their own genitals but mutilate themselves directly in the form of self-castration.

N. D. C. Lewis[1] has reported numerous such cases in detail and many other less complete reports are available.[2] From these a few typical cases may be selected.

The following case is one reported by Lewis from the records of St. Elizabeth's Hospital. Little is known about his earlier history. As seen in the hospital he was at first depressed, indifferent, very dirty and uncoöperative, taking but little food. He would reply to no questions and mumbled to himself incoherently. He sat with his eyes closed, the lids quivering and a silly smile on his face. All this is quite typical of schizophrenia.

[1] Lewis, Nolan D. C.: *The Psychobiology of the Castration Complex.* Psa. Review, *14* and *15*, and Ibid.: *Additional Observations on the Castration Reaction in Males,* Psa. Review, *18*.

[2] DeMassary, Leroy & Mallet: *Sexual Auto-mutilation in Schizophrenic case.* Ann. Med.-psychol. (pt. 2), *87*, 1929.

Ferrer, C. O.: *Self-mutilation of Hypochondriac Alcoholic Patient; case.* Semana Med., Jan. 9, 1930.

Galant, I. B.: *Masturbation and Autocastration in Cases of Paranoid Forms of Dementia Præcox.* J. Nevropat. i. Psikhiat. *21*, 1928.

For other references on self-castration see: Blondel, C.: *Les Auto-mutilations: la castration volontaire.* Tribune Med. Paris, 1906. N.S. XXXVIII, 533–536.

Eckert: *Zur Frage der Selbstentmannung.* Arch. f. Krim-Anthrop. u. Kriminalist, XLVI, 1912.

Ingegnieros, J.: *Un Caso de auto-castration en un degenerado hereditario con neurosthenia y sifilofobia.* Semana Med., Buenos Aires, VIII, 1901.

Näcke: *Über Selbstentmannung.* Arch. f. Krim.-Anthrop. u. Kriminalist. Leipzig, 1903, XII, 263.

Schmidt-Petersen: *Über Selbst-Kastration.* Ztschr. f. Medizinalbeamte, Berlin. XV, 1902.

Strock, D.: *Self-Castration.* J.A.M.A., XXXVI, 1901.

A year later he was still untidy and inaccessible but in addition also very destructive. He had begun to repeat profane phrases. Occasionally he would become excited, pacing up and down cursing. He began to strike at people occasionally, some of whom would retaliate. He broke out a few windows and became very noisy. During the next year or two his activity and combativeness increased. He developed the habit of throwing himself about the room, apparently in an effort to do himself harm which sometimes happened. He threw chairs at the attendants. It finally became necessary to transfer him to a locked ward where, however, he continued to injure himself in many ways so that he had to be restrained. He bit himself on various parts of the body, chewed the lower lip till surgical repair was necessary and finally, in spite of careful watching, lacerated and incised his scrotum with his finger nails and removed the testicles.

In this case we have nothing but the stark behavior from which to draw conclusions so that while we cannot say what the motives for self-castration may have been, we can see how the destructive tendencies were first external and then internally directed on various organs of the body and finally upon the genitals.

Another case will bring out more of the motives. A thirty-year-old naval officer, married, was brought to the hospital with a history of having mistreated himself and of contemplating suicide. He was quiet, neat, mildly depressed.

The history was that his father had been very religious, but very difficult to get along with and had deserted the family while the patient was yet small. The mother had been obliged to work very hard to support them. The boy himself was obliged to go to work at an early age but in spite of this obtained a fair education intermittently. He had joined the navy and had worked himself up to become an officer. A year before admission he noted that he worried about his work and asked his friends if they noticed that he was not doing so well. He became increasingly depressed.

Then he began to notice strange noises, thought he heard his shipmates talking about him and accusing him of perverted practices (i.e., of being homosexual). Finally he went to the bathroom and with a safety razor blade amputated his penis flush with the abdominal wall.

When questioned about it the patient said he had been confused and hadn't known what he was doing. He seemed, however, to show little concern or regret. Later he jumped overboard but climbed back aboard the ship on the anchor chain. He admitted, however, that the thought of drowning had always fascinated him.

The examination showed that he still suffered from auditory hallucinations with voices telling him to do odd things and commenting on what he did. Concerning the charge of homosexuality he was quite perplexed because he had never indulged in it but began his heterosexual life very early. Except for the mutilation his physical condition was excellent and his intelligence above average.

Later the patient announced that he was "ready for the supreme sacrifice" (suicide) and wrote a note saying, "I am a pervert and will pay the penalty". He became increasingly restless and disturbed and betrayed impulses to fight with patients and attendants.

Another case was a Polish man of twenty-eight. When first admitted to the hospital he spent most of his time on his knees praying. It was reported that he had frequently stopped on the street to kneel in prayer.

Later he was able to give a fairly coherent account of himself. He had been born in Warsaw and raised under trying circumstances. He had always been very religious and had been very despondent about his habit of masturbating which had begun at the age of eighteen—so despondent that he had attempted to castrate himself in an effort to cure himself of the habit. In this attempt he succeeded in cutting out his left testicle. At that time he was working in a Franciscan monastery and was sent to St. Elizabeth's when the friars refused to take

him back. In the hospital he showed many frankly homosexual characteristics, being very affectionate and submissive to his physician, kissing and holding his hand, smiling in a flirtatious manner, etc.

One day he was found in bed with the bed clothes covered with blood. He told the doctor that he had removed his left testicle seven years ago and that now he had cut off his right testicle because he wanted to become a priest. He deteriorated rapidly, losing weight and becoming rather anæmic. His voice became effeminate, thin and high-pitched, his manner of dress eccentric. He continued to assert that he was a priest and that his castration was God's will.

Many more such cases could be cited but those cited are sufficient to give us a composite picture which is quite definite. These patients, sometimes very mild and pious at first, became increasingly aggressive toward the outside world, then aggressive toward themselves, all of them emphasizing their sense of guilt about sexual sins. These sexual sins are sometimes related to women, sometimes related to other men (homosexuality) and sometimes to autoerotic indulgences (masturbation). In all instances sexuality is identified with the genitals and since these patients are psychotic, and therefore very direct and undisguised in their logic, they do the obvious thing of ridding themselves of the guilty part of their body.

There is, however, another element which we must not lose sight of. A man who feels guilty about his sex organs because of conscious or unconscious homosexual impulses, accomplishes two purposes when he cuts off his genitals. He punishes himself, but at the same time he converts himself by this deprival into a passive, penis-less individual, anatomically comparable with the female. By this anatomical identification, he comes closer to the homosexuality about which he feels guilty than he was before the act. He feels guilty about his homosexual wishes and by castrating himself appears to atone for and relinquish them, but in reality only changes himself so as to be

incapable of the active rôle but even more predisposed to the passive rôle.[1, 2]

This enables us to conclude, then, that psychotic self-mutila-

[1] *In regard to circumcision as an attempt to substitute femininity for masculinity:* Bryk, although not a psychoanalyst, suggests the following logic which while not in accord with psychoanalytic conceptions in its development, exactly confirms them in its conclusions. Having cited and demonstrated numerous amazing mutilations of the penis, practiced by savages, particularly that known as the *mica operation,* in which the penis is torn or cut open along its entire ventral surface, he develops the idea that circumcision, while decreasing hypersensitiveness of the penis, also acts as an insurance policy against impotence so that one day "Abraham, or any other man, notices that in spite of circumcision his erotic energy gradually begins to fail, then approximately the following thoughts take hold of him: 'A woman can always, at least from the physiological point of view, receive, but the maliciousness of fate often plays a man, in erotic equipment, a nasty trick. How fine it is for women. How would it be if I transformed myself into a woman?'

"This is, then, a purely bisexual thought which arose perhaps as a result of a homoerotic bent. He now further mutilates his sexual organ, seizes a stone knife, slits up the urethra with it from the scrotum to the glans, enlarges the wound with his fingers until finally his member is transformed into a vulva. Now he can be both man and woman.

"With the execution of introcision the circumcision idea from the physiological-erotic standpoint has reached the termination of its complete development; only in a psychic direction could it now change, be transformed, deepened, by suppressing the original purpose and putting in its place new factors, depending on which cultural unit is met with. In this manner during the course of a long time, the original sense of circumcision was changed, as it is most obviously shown in the Mosaic Yahveh cult. Quite correctly Gunkel says, 'We may only ask what historical Israel thought of this custom, but we must keep in mind from the beginning the possibilities that this later sense is quite different from the original one; further, that the conception of this custom has changed during historical times, and finally, that it was executed according to ancient usage, without much thought on the matter at all.'" (Bryk, Felix: *Circumcision in Man and Woman.* New York: American Ethnological Press, 1934.)

[2] This phenomenon falls into the formula first mentioned by Freud in *Totem and Taboo* where in regard to ceremonial feasts he pointed out that "the propitiation (ceremony) repeats the crime". This was discussed at greater length by Róheim in his article *Nach dem Tode des Urvaters,* and by Abraham in his studies on Melancholia. None of these writers mention, however, the possibility that it is a phenomenon directly related to, if not directly dictated by the repetition compulsion and certainly one of the clearest representations of it.

tion corresponds to the formula for a neurotic symptom in that an erotic goal and a self-punishment are both simultaneously achieved. It is as if a bargain had been struck between the instinctive and the repressing forces, and the symptom produced as a compromise which, however, could not be acceptable to any but a very sick and powerless ego. To the extent that such a symptom, i.e., such a compromise, is effected, however, a relative peace has been brought about. The symptom (even a mutilation) is, therefore, an attempt at self-healing, or at least self-preservation. This gives us a clue to the paradox that local self-destruction is a form of partial suicide to avert total suicide.

But in the psychotic self-mutilation, the attempt at self-healing is a very weak one. In this the self-mutilation of psychotic patients resemble the self-mutilation of the fanatical religious sects and differ from the self-mutilations of neurotic patients and of more familiar religious ceremonial mutilations in the following way: In the psychotic patients reality is enormously disregarded and the ego makes a particularly bad bargain, in fact almost no bargain at all, with the conscience. It sacrifices everything and gains almost nothing except punishment [1] and the secondary advantages of passivity. It surrenders

[1] It scarcely needs demonstration that castration, both actual and symbolic, has been used throughout the ages as a punitive device. The retaliation upon Abelard by the uncle of Heloise is, of course, classical. Such treatment of military captives was, of course, the rule with the Mohammedans and is said to be still used by the warring peoples of northern Africa.

Indeed, von Autenrieth over a hundred years ago (*Abhandlung über den Ursprung der Beschneidung bei wilden und halbwilden Völkern mit Beziehung auf die Beschneidung der Israeliten, mit einer Kritik von Prälat v. Flatt, Tübingen* [*1829*]) derived the origin of circumcision from the custom of certain peoples of bringing home the genitalia of killed or even living enemies as an invaluable trophy of victory, but who in order to avoid suspicion that these signs of victory might have been plundered from their own dead adopted this means of making certain.

"Marie Bonaparte (*Die Symbolik der Kopftrophäen,* Imago XIV, 1928) has given full particulars on the diffusion of this ancient war custom, especially in East Africa. That it has existed even in Europe in recent times is attested by Kraus (Krauss, H.: Münch. Med. Wochenschr. *55,* No. 10, p. 517, 1908) who writes 'Montenegrins are accustomed to castrate their prisoners during cam-

all active goals. The neurotic person also punishes himself by a sacrificial self-castration, but it is a symbolic castration, not

paigns and carry their penises with them as amulets. Many a warrior has a whole string of such amulets. The bandit wars of Macedonia, which for years have been taxing Europe's diplomatic art to the utmost, would probably long have died out if the occasional victors ceased from the fatal custom of mutilating their captured enemies and thus causing innumerable campaigns of revenge. Sicilian myths also mention similar mutilations.' King Saul's command that David bring him one hundred foreskins of the Philistines which David promptly fulfilled is possibly a reference to a similar war custom among the ancient Jews.

"Castration as a punishment is still customary today among many peoples in Europe. See, for example, Czekanowski (Dr. Jan, *Forschungen im Nil-Kongo Zwischen-Gebiet* V., p. 12, ff. Leipzig, 1927), and Pelikan, E., (Gerichtl.-mediz. *Untersuchungen über das Skoppentum in Russland.* Deutsche Übers. v. Nicolaus Iwanoff. Giessen, 1876)." (Bryk, Felix: *Circumcision in Man and Woman.* New York: American Ethnological Press, 1934.)

In American lynching episodes a common preliminary to the burning or hanging of the victim is the amputation of his genitals. In a recent article (American Spectator, March, 1933) fictional in form but based upon actual occurrences a female relative of the injured girl is permitted to burn off the penis of the still living negro with a gasoline blow torch.

The removal of other parts of the body as a punitive device is even more familiar. The blinding of the Princes in the tower and many similar punishments are well known. The lopping off of hands and arms is also common in criminal records. Peter the Great issued an edict that all those convicted of murder should have the flesh and cartilages of the nose torn away so that only the bones remained and no one could ever be in doubt as to the murderous history of the victim. Cutting out of the tongue was until relatively recent times a criminal code of many countries, including our own. The Quakers, it will be recalled, were frequently punished by the Puritans by ear-clipping. In the most celebrated of all executions, that of Damiens, who assassinated Louis XV of France, which was intended to be an everlasting example, after various other tortures had been inflicted the crux of the sentence was carried out in that four horses were attached to each of his four limbs and he was "pulled asunder". An interesting account described the great difficulty of this procedure: physicians suggested that the tendons should first be cut, which was done; "the horses began to draw anew and after several pulls a thigh and an arm were torn from the body. Damiens looked at his severed members and had some remains of sense after his other thigh was pulled off; nor did he expire until his other arm was likewise torn away". (Bierstadt, Edward H.: *Curious Trials and Criminal Cases.* New York, 1928. P. 161.)

Finally, one must think of actual castration as it is carried out at the present time in the form of sterilization of criminals and of the insane, and also in the fact that some surgeons still appear to believe that the proper treatment of sexual offenses and perversions is castration, apparently motivated chiefly by their moralistic and sadistic feelings rather than by scientific deductions.

a real one. Moreover, he uses it as a permit for active satisfaction of some tangible and real value. It has, therefore, an opportunistic, or one might almost say, prophylactic purpose. The psychotic person, however, mutilates himself without regard for the net reality gain, e.g., he freely offers up—or rather throws away—his genital organs or their most highly prized substitutes (e.g., the eyes [1]).

5. Self-Mutilations in Organic Diseases

What we have said about psychotic self-mutilation is also applicable to some acts of self-mutilation of extreme degree which are occasionally reported as occurring in physically ill people who, however, show no (other) indication of mental disease.

Goodhart and Savitski [2] report the case of a high school girl of sixteen who at the age of eight had developed what appears to have been epidemic encephalitis. Although she was well for a year after the acute attack, it gradually showed itself unmistakably in a chronic form characterized by sleepiness and left-sided parkinsonism. In addition, she had shown at the age of thirteen some changes in personality, chiefly in the direction of aggressiveness. She would lie, exhibit temper tantrums, tear her clothing, strike her mother and sisters, once even breaking some windows in the house. After such outbursts she would be remorseful and repeat, "Why do I do it? Why do I do it? I can't help it."

It was at this time that she began to lock herself in the bathroom occasionally and appear a short while afterward bleeding from the mouth from which teeth were missing. She said she "could not help taking them out". Over and over she did this until only nine were left which were subsequently removed by the dentist because of infection.

[1] Bryan, D.: *Blindness and Castration.* Int. J. Ps-A. II, 1921.

Harries: *Self-Inflicted Injuries of Eye by Insane Persons:* 2 cases. Psychiat.-neurol. Wochenschr. *31,* July 6, 1929.

Smith, J. Allen: *Voluntary Propulsion of Both Eyeballs.* J.A.M.A. *98,* Jan. 30, 1932.

[2] Goodhart, S. P. and Savitski, Nathan: *Self-Mutilation in Chronic Encephalitis.* Amer. J. of Med. Science *185,* 1933.

At the age of sixteen she was admitted to a hospital because of some swelling and redness of her right eye. That night of the day of admission the nurse found her *holding her right eye in her hand!* The patient insisted that it had fallen out while she was sleeping. She answered all questions unhesitatingly and appeared mentally clear and intelligent. She complained of no pain. The nurse described her behavior as quite normal except for her seeming indifference regarding the eye; she did not seem in the least disturbed.

The following morning she suddenly shouted; the nurse went to her bedside and was informed by the patient that now her *left* eye had fallen out and it was found in the bed by her side!

Again she did not complain of pain and showed no emotional disturbance. A psychiatrist, who examined her the following morning, found nothing abnormal except that she could not remember any details about her eyes being "popped" out.

Subsequently this girl was studied at Montefiore Hospital where she rubbed her cheek raw and repeatedly attempted to injure her face. She was kept in restraint for a month.

There seemed to be no emotional disorders and no delusions. Her intelligence quotient was 82. She showed good judgment and insight in everything except the episode of her eyes. She admitted other self-mutilations, saying that she was compelled by some peculiar force to do those "horrible things". She showed an intense reluctance to discuss them. About four months later she finally admitted that she had been untruthful in maintaining a lack of knowledge about the eyes, confessing that she had torn them out with her own fingers. "I was like hypnotized at the time. Something made me do it." There were no suicidal ideas and no reactive depressions. Later there were some paranoid ideas.

These authors cite many other reported instances of self-mutilation, a few of them superficially comparable to their own but most of them clearly episodes in a psychosis. They feel unable to explain the psychological basis for the act, although they refer to the appearance of compulsive acts in the course of other cases of encephalitis.

More comprehensible is the case reported by Conn.[1] This was a young woman who at the age of twenty-one suddenly began to complain of sharp pains in the back of the neck, later down her back. They became so severe that she screamed wildly and had to be forcibly restrained. The pain continued, unabated, and two months later there were several episodes of visual and auditory hallucinosis in which the patient saw members of her family who were not present and heard voices accuse her of masturbation.

About six weeks later, apparently still suffering from the sharp pains in spite of many drugs, she arose in the night and fractured the phalangeal articulations of her left hand and then of her right hand, using the bed springs to help accomplish this. She also fractured a phalanx of the left small toe and on the following night dislocated both thumbs. She gave as her explanation that this relieved her pains in the back. When her mother entered her room in the morning and saw her mutilated, bleeding hands which the patient exhibited in a "happy way", the mother fainted.

In the next three weeks the patient would scratch and tear at her wounds, if not restrained, and upon one occasion lacerated her right ear.

Six months after the mutilation episode, she was admitted to the Boston Psychopathic Hospital where careful examination was made. This was negative except for the mutilated hands, in spite of which she did work in occupational therapy. When shown before a clinic she "behaved admirably, delighted in the telling of her illness, giving details of how she broke her fingers, and was anxious to have her hands on display". Subsequently, however, she scratched at her ear until she lay bare the cartilage and made threats of rebreaking her fingers. She was dismissed after four months, improved, and a month later was reported to have returned to work.

Eight years later this same patient was admitted for a second time to the Boston Psychopathic Hospital for an illegitimate

[1] Conn, Jacob F.: *A Case of Marked Self-Mutilation Presenting a Dorsal Root Syndrome.* J. of Nerv. & Ment. Disease 75, 1932.

pregnancy, the reason for admission being that she had so proudly displayed her deformed hands before the other inmates of the Home for Delinquent Girls in which she had been staying that she had frightened them.

In the course of the mental examination at the admission she was asked as to what went on in her mind when she was breaking her fingers. She replied, "About going out of your mind. I had to see blood. I wanted to see blood come out. I wanted to keep the blood from reaching my head so I would not go out of my mind, as I had not menstruated."

The author recites the family history as being essentially negative, the patient being the oldest daughter and the third oldest child in the family of eleven French-Canadian siblings. At the telephone exchange, where she had worked for four years, she was described as "calm, quiet, dignified and managed the most difficult situation in an efficient manner".

The home attitude toward sex was a rigid one; she claimed that she had received no sex instruction and heard no sex discussion at home and was badly frightened when she first menstruated. She began to masturbate at fifteen, had strong feelings of self-reproach and ideas of "going crazy". She felt that she would be disowned if discovered and she was a terrible disgrace to her family. Notwithstanding this she had continued to masturbate up until the period of her self-mutilation at the age of twenty-one.

Conn points out that the girl's guilt about masturbation, the fear of losing her mind, her anxiety over her failure to menstruate and her wish "to see blood" (as if to see blood would reassure her that she had not been rendered abnormal by the masturbation), together with the hallucinatory episode in which she had heard voices reproaching her for this masturbation, are convincing evidence that this latter was the central theme for her guilt feelings. The sense of relief after her self-mutilation, her pride in exhibiting the bleeding hand (guilty and punished) to her mother and later scarred and deformed hands to other people confirm this interpretation.

It would certainly seem that in this case the combination of free associations, memories, compulsive acts and the shrewd observations of an intuitive psychiatrist had combined to give us a very clear example of precisely the mechanisms we find in other cases of self-mutilation, namely, the sense of guilt arising from masturbation, the fear of punishment, the need for a propitiatory or substitute punishment which is then self-inflicted and the results "happily and proudly" exhibited to the world (and in this case, first to the mother as the presumptive representative of the superego).

The author points out that the dorsal root syndrome may or may not have been an infectious disease, but assuming that it was, it served only to release unconscious self-mutilation tendencies which were normally inhibited.[1]

In a study made some years ago [2] I attempted to show that a comparable phenomenon takes place when schizophrenia appears to be precipitated by an infectious disease. The effects of the organic disease appear to be that of releasing unconscious tendencies which had been held in control only by a maximal integrative effort which could not sustain the additional burden imposed by the physical illness. This might tempt us to some speculations as to what the function of the physical illness may have been, but this we shall defer. We can say with definiteness that these self-mutilations under the conditions of organic disease do not appear to differ in motivation from those we have studied in connection with the psychoses, neuroses and religious ceremonials, further confirming

[1] In April, 1934, I saw a patient with Doctors Perry and Brian, of the Topeka State Hospital, who suffered from a chronic form of encephalitis and who continually bit his tongue so persistently and so severely that surgical measures were necessary at times to prevent dangerous hæmorrhage and the entire anterior third was severely scarred and mutilated. The patient could offer no explanation for the act except that he could not refrain from doing it. The psychological motives were not investigated.

[2] The Schizophrenic Syndrome as a Product of Acute Infectious Disease, in *Schizophrenia (Dementia Præcox): an Investigation by the Association for Research in Nervous and Mental Diseases,* pp. 182–204. New York: Hoeber, 1928.

our conception of the essential uniformity of all unconscious processes.[1]

Dr. Burrows [2] has reported a case of infantile trichotillomania in which a three-year-old child wet its fingers, plucked out a hair, examined the plucked hair and threw it away. He had continued this conduct over a period of fifteen months. Dr. Maitland Jones, who saw the patient, was of the opinion that the child was suffering not from a disease but from a defect of conduct. Dr. Burrows wrote the superintendent of the Zoological Society Gardens inquiring if the habit was present to any extent among the higher apes or monkeys and received the reply that nothing of the same nature had been observed among the Primates. The child in this case sucked his thumb. It is recorded that he seemed mentally normal but was rather restless.

Dr. Holdin-Davis (see reference to Burrows above) said that in 1914 he had reported an epidemic of hair-pulling in an orphanage in which two or three genuine cases of alopecia areata had occurred. The children who had alopecia became the central figures in the orphanage and the others in order to obtain attention took to hair pulling.[3]

6. *Self-Mutilation in Normal People: Customary and Conventional Forms*

There are certain forms of self-mutilation which have become so well known to us in everyday "normal" social life that we

[1] Self-mutilation and attempts at self-castration have been observed among the lower animals with direct reference to emotional conflicts. Tinklepaugh (Tinklepaugh. O. L.: *The Self-mutilation of a Male Macacus Rhesus Monkey.* Journal Mammalogy, 1928, *9*:293) at Yale describes in detail an experience with a monkey at the primate laboratory at the Institute of Psychology who showed marked antagonism toward the introduction of certain female monkeys and the substitution of one which he did not like for one he did like. He bit his feet, tore huge jagged places in his legs, tore a three-inch gash in his hip, ripped open his scrotum, lacerating and exposing one testicle and mutilating the end of his tail. For about four months following this he seemed to be in a "state comparable to the depression of some psychoses".

[2] Burrows, A. (for Dr. W. J. O'Donovan): Proceedings of the Royal Society of Medicine. *26:* 836–838. May, 1933.

[3] For complete report see British J. of Dermatology, 1914, *26:* 207–210.

find it difficult to think of them as directly related to the more radical self-mutilations observable in the savages, the psychotics, neurotics and others. Indeed, we are no sooner conscious of an act as being definitely self-destructive than we think of such an individual as belonging to one of these categories. The fact remains, however, that all of us practice self-mutilation in the sense that we cut off parts of our body, for example, the finger nails, out of deference to custom and convention if not to deeper unconscious demands. The advantages of these conventionalized forms of self-mutilation are so obvious and so great that the original motives are difficult to trace. From what we have seen, however, in connection with nail biting, on the one hand, and the unconscious dominant law of claw and fang, on the other, we can scarcely avoid suspecting that the custom of nail trimming has unconscious determinants related to the restraints on these tendencies demanded by civilization. One might say that the civilized practice of trimming the nails may represent not only a gesture of repudiation of those primitive tendencies which demanded their use, but also a self-protective device against yielding to the temptation of indulging these tendencies.[1] We all know that these gestures and protective devices are sometimes ineffective.

It is in relation to the hair that conventionalized self-mutilative practices prevail most commonly among civilized peoples. The widespread practice of shaving can be seen to be a deliberate cutting off of a part of the self, i.e., a self-mutilation. Here again it is a form in which the æsthetic value for society has become much greater than the subjective value for the individual but this need not prevent us from estimating what the unconscious subjective value really is and why the social value has become so great.

Some of the historic significances of hair cutting make it apparent that this seemingly casual process has been associated

[1] There is a legend that the impurity of the serpent which caused Adam's fall was *under the nails!* (See Hasting's *Encyclopædia of Religion and Ethics.* Scribners, 1910.)

in the past, at least, with deeper meanings.[1] Egyptian travelers, for example, did not cut their hair until the end of a journey and then shaved their heads as a thankoffering to their god. Greek youths offered their hair to the local river on reaching manhood. Achilles kept his hair uncut because his father had vowed it to the river Spercheius if his son should come home from war. Both in Arabia and Syria it was customary to cut the hair as a puberty rite. This custom was also followed at Rome where the hair was dedicated to some patron deity. Nero is said to have dedicated his first beard to Jupiter. Orestes offered hair at the tomb of his father and this seems to have been a common practice among mourners. The Roman sailors' most desperate vow was to offer their hair to the sea god. A Nazarite was commanded to let his hair grow while under a vow. Afterwards he shaved his head at the door of the tabernacle and burned the hair as a sacrifice. There was a rule prohibiting hair and nail cutting during a religious festival. In many of these cases it is thought the offering of hair is a substitution for the whole person.

The American Indians, like the Greeks, seemed to regard the hair as the seat of life. The scalp lock was supposed to represent the life of the individual and it was regarded as a grave insult to touch the lock lightly. The Pawnee Indian cut the hair close except a ridge from forehead to crown which he stiffened with fat and paint and made to stand erect and curved like a horn. Other tribes decorated the scalp lock with ornaments that marked achievements and honors.

Difference of rank was often shown by cutting the hair, the shorn hair being characteristic of the slave as contrasted with the long locks of the free man. Among the Franks only the kings wore their hair long.

Cutting off the hair was a punishment for adultery in India and among the ancient Teutons and for other offenses among the Assyro-Babylonians. Compare this with the time-honored

[1] For the following illustrations I am indebted to the article on hair cutting in Hasting's Encyclopædia of Religion and Ethics.

custom of cutting the hair of criminals to distinguish them from law-abiding citizens.

That hair may represent sexual virility is apparent from the popular conception of the hairy chested man, such themes as O'Neill's *The Hairy Ape,* the story of Samson and many others. Furthermore, the vast extent of the hair dressing business, the acknowledged importance of hair of certain color and texture to the pride of women and the satisfaction of men, the embarrassment or even shame concerning baldness, all bear witness to this.

But certain exaggerated instances with which psychiatrists are familiar have the value of bringing this out much more clearly. Tendencies which are probably inconspicuously present in all of us can be readily recognized from those unfortunate individuals in whom they become disproportionately emphasized. In *hair fetishism* for example, the most intense consciousness of pleasure is associated with this isolated part of the body. Hair fetishists may be content to admire or caress the hair of the beloved person, but more typically they transfer all of their desire to the hair itself and wish to possess it which they often do by cutting it off. They get the pleasure from this act of obtaining the hair and are quite satisfied in the joy of possessing the hair detached from the person to whom one might expect the love to really belong. The police in all cities are familiar with these hair-stealers or "clippers" who often surreptitiously cut hair from the heads of total strangers.[1]

A case recently reported by Bunker[2] describes very completely a man who in very early childhood had found great pleasure in braiding his mother's hair, which seemed to have been one of the factors which conditioned him in an abnormal interest in hair throughout his life. Seeing a little playmate's hair cut off caused him great excitement and when he became older and began making regular trips to the barber he experi-

[1] The American Indians did essentially the same thing, of course, in scalping their conquered foes. But here the erotic element was lacking, or at least more completely disguised in the sadistic destructive satisfactions.

[2] Bunker, Henry A.: *The Voice as Female Phallus.* This QUARTERLY III, 1934.

enced definite sexual excitement of extreme degree each time. The average person can scarcly conceive of such a prosaic experience as having one's hair cut affording sexual excitement or satisfaction but that is because the sexual value of hair has been so diluted and disguised by the process of civilization. Neurotics and psychotics throw aside these screens and reveal the primitive feelings to their own embarrassment but to our enlightenment.

A somewhat similar but even more striking case was studied by Dr. R. P. Knight of our clinic, who kindly gave me the following data. This was a young man who became sexually excited the first time he attempted to shave at about fourteen years of age and at each subsequent attempt thereafter. He would rise at four o'clock in the morning in order to have the bathroom to himself for two hours before his father arose at six o'clock and in this time he would carry out extensive rituals connected with the removal of the beard. One of these, which was associated with severe pain, was the application of a hot depilatory substance to his face and the peeling off of the mask thus formed with the hair clinging to it. At the same time the patient began picking at the stubble with his fingernails, trying to gouge out the hairs of the beard. This led to the development of a severe acne which the patient aggravated by pinching the acne lesions to express the pus. The eruption became chronic so that at the age of twenty-one when the young man came for treatment his face was marred by an *acne indurata.*

This case is particularly interesting not only because of the sexual significance attached to shaving, but also because it shows the exploitation of a conventional form of self-mutilation in association with a definitely neurotic form (gouging out the hairs with the fingernail), both evidently carrying the same significance to this individual.

Casual reflection upon the barber shop rituals of both men and women will show us that their significance is not completely disguised even in normal people. The extreme satisfaction that many women and some men find in the varying

tonsorial maneuvers, the gossipy or jovial atmosphere of the barber shop or hair dressing parlor, the touchiness about having women in men's shops and vice versa—these and other details which will occur to the reader indicate that hair dressing and hair cutting still retain much of their unconscious erotic value. (This is most interesting as it pertains to cutting off the hair as opposed to merely combing it or dressing it.) Cutting off hair represents a partial renunciation of the virility and power, for example in the story of Samson and the prostitute Delilah. It is a surrender of primitive tendencies in favor of the more desexualized requirements of civilization. Someone has said that the extent of the use of the razor is an index of civilization.[1] It is not without significance that surgery and barbering had a common origin.

We know that this partial renunciation is done for the purpose of an ultimately greater fulfilment. The unshaven man may give some evidence of greater virility but he has less chance in the modern temper of winning feminine admiration. Hence for his minor sacrifices the man who shaves really makes a greater gain.

Additional confirmation is to be found in the cutting off of the Chinese men's queues when, under the influence of Sun Yat Sen, a centuries old custom was abolished almost literally within a few months. This, again, would seem to indicate some wish to be accepted by civilization in return for the sacrifice of a totem or badge of virility.[2]

[1] Hárnik (Eugen J.: *Pleasure in Disguise, the Need for Decoration and the Sense of Beauty*. This QUARTERLY I, 1932) relates an Arabic Jew's traditional Biblical myth about Adam and Eve: "And when they had eaten of the tree, their hair fell off and they stood naked." (*Die Sagen der Juden*. Frankfurt, 1913) which further illustrates the significance of hair as a symbol of sexuality.

[2] For a stimulating discussion of the symbolism of dress, including hair dressing, see *The Psychology of Clothes* by J. C. Flügel, Int. Ps-A. Library, No. 18. London: Hogarth Press, 1930.

Flügel makes the very important point (p. 45) that these accounts of self-mutilation relating to the hair and nails are to be differentiated from other forms of self-mutilation by reason of the fact that they are not permanent, since new hair replaces old, new nails replace those trimmed off, whereas the mutilations of savage tribes are permanent.

It was suggested to me by Dr. Leo Stone that the fact that hair and the genitals are as closely identified as these studies have shown them to be explains the reasons why the ancient and orthodox Jews required of their male members not only circumcision, on the one hand, but the abstention from barbering, on the other, i.e., the hair was retained as if to counterbalance the loss of a part of the genitals. I am not sufficiently familiar with the details of Talmudic instruction and ritual to know whether this is further supported by the textual matter of the original prohibitions.

One distinguishing characteristic of those forms of self-mutilation which we have noted in normal people is that they are not irrevocable. Hair and nails grow again. In fact, women often use the argument when contemplating having their hair cut that if it is not becoming cut short they can let it grow again. Sometimes this process of cutting and growing again is repeated over and over according to the individual's psychological pattern and the change of styles.

Conventional forms of self-mutilation also differ radically from most of the forms we have described in that they are rarely painful. The normal person is able to accept pleasure without guilt and therefore does not feel compelled to make the self-punitive personal atonements of the neurotic and psychotic persons. Finally, the very fact that these so-called "normal" self-mutilations are customary and conventional distinguishes them from other self-mutilations, most of which contain a large element of exhibitionism and usually subject the individual to derision, pity, or at least embarrassing conspicuousness.

Summary

Let us now try to get together the evidence contained in these studies that points to the motivation for self-mutilation and attempt to answer some of the questions raised in the beginning.

We see that self-mutilation is to be found under widely varying circumstances and conditions, including psychosis,

neurosis, religious ceremony, social convention, and occasionally as a behavior symptom in certain organic diseases. From representative examples of all of these we are able to detect certain motives in a fairly consistent pattern.

It would appear that self-mutilation represents the surrender or repudiation of the active rôle, accomplished through the physical removal or injury of a part of the body. Even if there were not already abundant psychoanalytic evidence to the effect that the prototype of all self-mutilation is self-castration, there would be strong reasons for inferring this from our material, in which we frequently find self-castration to be undisguised; and in the cases in which another organ or part of the body is substituted for the genital, the associations, fantasies and comparable analogies make it clear that the substituted organ is an unconscious representative of the genital. This may be, as we have seen, either the male or female genital but has the significance of activity generally associated with the male genital. This sacrifice of the genital or of its substitute appears to satisfy certain erotic and aggressive cravings and at the same time to gratify the need for self-punishment by a self-inflicted penalty.

The aggressive element in self-mutilation can be of both the active and passive variety. The act of self-mutilation can be directed toward an introjected object, as in the examples of those persons who, hating someone else, cut off their own arm, a process epitomized in the familiar expression of "cutting off one's nose to spite one's face". The passive form of aggression is even more conspicuous because it is directed toward real rather than fantasied objects; the provocative behavior of nail-biting children or of malingerers, who so exasperate their friends and physicians, clearly illustrate this.

The erotic gratification achieved by the surrender of the active in favor of the passive rôle is partly dependent upon the innate bisexuality of everyone and the unconscious envy on the part of men of the female rôle. There is also a tendency, how-

ever, on the part of the erotic instinct to make the best of a bad bargain and to exploit the consequences of this rash expression of the aggressive, destructive tendency by erotization. In this sense the erotic gratification of self-mutilation is both primary and secondary.

Finally, there is the self-punishment implicit in self-mutilation, which has the curious Janus-like property of looking both forward and backward. The self-mutilation atones or propitiates by sacrifice for the aggressive acts and wishes of the past, and it also provides an anticipatory protection as if to forestall future punishment and permit further indulgences by the advance payment of a penalty. Incident to the latter, self-mutilation by the sacrifice of the aggressive organ safeguards the individual against the possibility (and therefore the consequences) of further active aggressions.

Our material does not enable us to dilate upon the nature of the aggressive fantasies from which the sense of guilt arises beyond saying that they are connected with castrating or mutilating fantasies originally directed toward the parents and siblings. We know from the work of many analysts that these are usually connected with the œdipus complex and arise from the wish to kill or castrate the father and take the mother, or to kill or mutilate the mother for "faithlessly" preferring the father or a sibling.

It would appear from this summary that self-mutilation is the net result of a conflict between (1) the aggressive destructive impulses aided by the superego and (2) the will to live, whereby a partial or local self-destruction serves the purpose of gratifying irresistible urges and at the same time averting the prelogical but anticipated consequences thereof. The reality value of the self-mutilation varies greatly; the symbolic value is presumably much the same in all instances. To the extent that the psychological needs can be met by a symbolic self-mutilation with minimum reality consequences, as in such socialized forms as nail-trimming or hair-cutting, for example, the device is a useful one; but in those individuals whose

reality sense is diminished or whose conscience demands are inexorable the device is harmful.

In any circumstance, however, while apparently a form of attenuated suicide, self-mutilation is actually a compromise formation to avert total annihilation, that is to say, suicide. In this sense it represents a victory, sometimes a Pyrrhic victory, of the life instinct over the death instinct.

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Primal Scene, Play, and Destiny

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PRIMAL SCENE, PLAY, AND DESTINY

BY GUSTAV HANS GRABER (STUTTGART)

Present day psychology tells us that the play of children is a cover for the serious things of life, but psychology does very little by way of uncovering the secret meaning of this first encounter between the child and the world. For this we need a genetic point of view, which takes into account unconscious strivings and unconscious mental processes. Psychoanalysis has attempted not alone to interpret the meaning of play as such but also to deduce from a uniform, repeated game the mental structure, dynamics, and economics of the child's mind. It has found that in play not only are simple wishes gratified, but conflicts too are averted, old traumata are repetitively reactivated, and intrapsychic mechanisms such as regression, reaction-formation, identification, introjection, projection, and the rest become manifest as overt behavior. A children's game completely understood, like a completely analyzed dream, could tell us much concerning the destiny of a human being. The following material, taken from the successful analysis of a thirty-year-old woman, will be used to show certain relationships that obtain between an early infantile trauma (the primal scene), games, and later destiny.

The patient, whom we shall call Julia, had been one of those children who do not play with others, who have an impulse to play only when they believe themselves alone and unobserved, and who in addition cannot bear to see others play. She was a frank spoil-sport, who frantically interfered and interrupted and who was as if compelled to disturb any companionship. The child of wealthy parents, born after the death of a sister, she had been spoiled thoroughly by parents, relatives and servants. She slept in her parents' bedroom, and would cry half the night or all night, so that her parents alternately took her up and walked about, or took her into their bed for fear that she would choke. Whooping cough in her second year

gave them more incentive for renewed care and petting. When she was three a brother was born and when she was four a sister; after this she got very little attention. But her need to be loved persisted, was augmented indeed and demanded gratification, which she soon learned to supply for herself by means of various illnesses. Once she became well, she would be truly insupportable; she crept from her crib into her parents' bed every night. Or else, she demanded to be put on the chamber-pot and would weep and shriek until this was done, whereupon she would make her father or mother wait for hours until she was willing to get off. There was moreover nothing to be found in the pot, and in a short while the whole story would begin again. There was nothing for her parents to do about it. She was transferred to another room and for her parents this was an improvement, for they heard less of her; but for Julia it was much worse. She was often rebuffed by her father during this period, but she could not quit appearing over and over again in her parents' bedroom.

She often heard her parents in bed laughing, groaning, and scuffling. She wished to know what they were doing. If it was an interesting game she wanted to play too; she wanted father to amuse her the way he amused mother. But since she was never permitted to play with them, she came to wish at least to disturb them. This remained a guiding idea for her for the rest of her life, as though she thought, "Everyone plays with someone, and this activity somehow is like the curious, mysterious game that my parents play in bed. But I am excluded, and so I shall disturb them, disturb them with every means at my disposal." This compulsion became part of her character and her life's task.

It would not be entirely correct to say that Julia did not understand what her parents were doing. Once she was fortunate. When she was a little over four, she stole into their bedroom one night, and as she opened the door she saw her father, with a startled face, lift his head from between her mother's legs. All sorts of confused ideas coursed through her head. Was her mother's head between her father's legs? What

were they doing? Sucking? She had seen that her little brother had a different sort of genital (referred to in the family as the "popo") than herself. Could one suck on it? Surely father and mother possessed one of that sort, and as for herself she hoped that one would grow. Or, she thought, perhaps they were urinating into each other's mouth. In that case father must do that with her. What a secret and what a pleasure! Her imagination literally flew; but thinking thus was too much for her. She did not want to know more. Therefore she repressed; she left her parents in peace more and more, but nevertheless not for long, for a new symptom appeared that gave them more trouble. We shall refer to this later.

Her impulse to disturb was transferred from her parents to other persons in her environment, to her brother and sister, the servants, the children of the neighborhood, her uncle, all of whom she struck and harassed; and besides this to animals such as dogs, cats, and rabbits, which she tortured and killed. Whenever she saw two persons agreeably occupied with each other, she rushed between them like a Fury. A frenzied, dominating and sadistic little girl, she made herself unwelcome and unloved.

She often visited at the home of one of her poor neighbors. "Something" made her do this. These people had a boy and girl about her own age. One day she was playing with them quietly in a room that contained two beds and it was explained to her that in one bed the little girl slept with her father and in the other the little boy with his mother. This was too much for Julia. She thought, "Then they do what my parents do!" and she pictured how nice it would be if she too . . . But she could go no further with these thoughts. She was seized by envy and brought to a high pitch of hate and rage. She stamped her foot, shrieked and commanded, pulled the beds away from each other and started a *new game,* which later was to be repeated again and again and recur as if it were the *Leitmotiv* of her life. She seized a whip, sprang upon the bed, trampling wildly, trying to stamp it to pieces. This she was unable to do, and she stood quietly as if to control her wild

passions, thinking then whether it might not be that the boy and girl did to each other what the parents did with them. She became tense. The game was invented: she commanded the little girl to get on the bed and then to get off on the other side. The little boy was supposed to catch her; he had to climb over the bed too. But while he was doing so, Julia chased the little girl under the bed and through on to the other side again, then on top, making the brother pursue her throughout this circular course. She however stood on the bed like an animal tamer, encouraging the chase but seeing to it that they were never together, that when one was on the bed the other was under it.

One day nevertheless this game came to an unhappy end. The mother of the two children insisted that Julia, who was departing, should eat a bit of sour bread. Julia smelled it, hesitated, tasted it. But as the mother insisted, Julia had to eat it. An idea came into Julia's mind that the woman, or her husband had urinated on the bread, giving it its acid odor and taste, and that this was done to get rid of her. They did not approve of her "game", she thought, and were taking this means of showing her they did not want her to come over any more.[1] Julia raced away—and vomited violently. So far as she can remember this was the first time she had done so; it signified for her not alone a punishment for her naughty game, but a punishment as well for her wish, already repressed, that her father (or mother) should urinate into her mouth. But in the punitive act itself the wish returned from repression, for the bread substituted for her father's penis that was to supply the urine.

Julia visited her neighbors no more. She vomited every day, especially after drinking her milk, which she took from a bottle up to her sixth year. That is to say, it is as though she continued to suck a substitute penis to obtain the milk-urine, and then vomited. Especially was this true at night. She had "discovered" a new symptom with which to disturb her parents and separate them from each other. But to repress her oral

[1] The legend of Blümlisalp is based on the same theme.

incestuous desires she needed more effective defensive measures. Her intolerance, imperiousness, aggressiveness, as well as her symptoms, became more and more acute. Julia behaved as though she really had taken her father's penis into her mouth, or had swallowed it, and was consequently forced to vomit it up. Perhaps too her id wished to try something new to accomplish the same end. At any rate she developed a scrofulous rash on her neck for which she had to undergo an operation. Later, as an adult, she always produced with particular ease such things as abscesses, furuncles, dermoid cysts, and imaginary pregnancies, in order to have something cut out of her body. In her unconscious there persisted effectively the wish to bear her father a child conceived through her mouth with his urine. A young playmate reënforced her wishes by telling her that a child was begotten by a man's urinating on a woman: this was her first sexual enlightenment. But from this time on she did not want to think of these matters, and indeed she remained ignorant of sexual facts until she married. She put everything into her mouth: pebbles, buttons, insects, lizards, and one day swallowed a blue diamond, enjoying hugely her mother's anxious search for it in her stools. At the table, especially when eating meat, she would be afraid of choking. Here too she did not permit her father and mother to sit together. Yet in spite of her severe eating difficulties and in spite of the fact that she often refused to eat and vomited, she became more and more "greedy", more and more envious of her brother's and sister's food, and began to identify herself with the Bad Wolf in the fairy tales who ate up the little goats and Little Red Riding Hood.

Unusual ideas, connected with this development, were to a good extent a projection of the forbidding superego: "Everyone is withholding from me; it is impossible that I am really my parents' child; perhaps Gypsies left me here—I hope they take me away again, for then I will be allowed to do everything". A variant of these ideas depicted her as Cinderella, or Sleeping (i.e., not yet brought to life) Beauty, poisoned Snow-white (the poisoned apple repeating the idea of the urine soaked bread,

unconsciously the penis). A prince will come to my rescue some day!

Julia's other games all resembled the one she played with her little neighbors. She did not indeed take much pleasure in her play, and only played intensely the game she had invented (her own initiative was an indispensable condition for her playing at all), in which she ruled, tormented, separated or killed, disturbing thus the quiet play of the other children. She was repeating an interference with the primal scene, but with this she was usually able to obtain a certain amount of gratification of the instincts she had repressed on that occasion.

She possessed a large doll, which she did not love. She would tear out the doll's hair, which had come from her mother's head. Then she would pretend to take the doll to the doll hospital. Julia did only two things with this doll: she baptized her and operated on her. In the baptism game the doll was taken to "church" and squirted with water; Julia unconsciously experienced in this game the activity forbidden her; identifying herself with her father she was inseminating her child by sprinkling the doll as her father had done with her mother—at the head end, in the mouth. But then the doll had to submit to the same punishment that Julia herself had experienced: an operation. This operation too was not purely punitive; it was possible that blood played some part in the parents' queer game, for Julia had once actually seen some blood in their bed. She then nursed the operated doll affectionately, though at the same time she enjoyed the doll's pains. She resolved that she would become a trained nurse, a resolve which persisted up to her analysis.

Even more cruel were the games she played with animals. Her favorite game was "butchering". She caught worms, beetles, snails, frogs, salamanders, lizards, and flies, dissected them and elaborately ceremoniously burned them. For Julia quite early in life was a philosopher: she knew that the dead are well off and are more beloved than the living. Her mother's behavior proved this; she always wept for the little sister who died before Julia was born.

Larger animals that were not so easy to kill were "trained". Julia could not bear cats and believed that she had once strangled one. Her parents also kept rabbits. She once saw a rabbit pursue another one, catch it, bite it, and cover it. Thus the primal scene was repeated before her eyes. She was enraged, seized a stick and beat the two rabbits until they were dead. Quite early she was obsessed by a fear that she would have to kill someone, and later she fled from this idea as if it were a delusion. If anyone about her fell ill, she always believed that her death wishes were at work and shunned the real situation as she would an impulse to kill.

She became seclusive. Even before she attended sshool she avoided any companionship with children unless she was forced into it, and in that case insisted on dominating and directing, and usually suggested that they play "doctor". She was the doctor. She operated, squirted water as in her game with the doll, and as her most important function took the children's rectal temperature, obtaining pleasure from giving them pain in so doing. This is an obvious identification with her father performing the sexual act. She also repeated her animal games with the children: they had to be the animals, and she played "trainer".

For a while Julia played at another game that she invented—"going to the toilet". At her bidding a hut of boards with a partition in it was built in the yard with a sign over the entrance to each compartment, to indicate that on the right the toilet was for girls and on the left for boys. Julia gave the orders. The interest in the game resided in the pretense that the children always wanted to go to the toilet *together*. Julia however would use a stick to combat this intention. She would allow one boy to enter, and only after he came out might a little girl enter the other compartment. Otherwise, the idea was, they might peep at each other through cracks between the boards. Julia herself always looked in through cracks in the outer wall, but forbade the others to do so. In this game there was thus a mixture of forbidding and permitting that Julia apportioned to herself and to the others, which again reflected

the primal scene in its anal-urethral activities and the appropriate scoptophilic aspects of seeing and exposing.[1]

Julia now found her school a place of torture. Each morning she vomited. She was purposely tardy so that she would not have to take part in the children's play before lessons began. For at school she could no longer dominate everyone. During recess she hastened to the toilet. She took no part in school excursions or picnics; on the days these took place she was always ill, with a headache, or a diarrhœa, or a sore throat, or because of vomiting. When she was alone she devoured stories of criminals and detectives. Combats of all kinds with her schoolmates and teachers were part of her daily routine. Even when she was fourteen or fifteen years old, for months she would play robber knight and lady in distress with a girl friend in a "castle" that she herself built. She was of course the knight. Her identification with her father resulted in a marked tendency to homosexuality. In the game she always kidnapped a damsel that belonged to someone else. "To separate" remained her motive. Later, after puberty, which she resented so that she furiously beat her menstruating genital with her fists, she tended to have "crushes"—in which to be sure not even a kiss was exchanged—but in which she could steal some other girl's admirer. She did not love for the sake of love, but to wreck some other person's love affair. She tortured her admirers almost bloodily. By a trick of fate several of them died; she felt guilt for this and believed that a curse rested on her.

She would become engaged and break the engagement. Finally she married, dominated her husband, tormented him because of constant jealousy, was usually frigid sexually, and preserved all her old childhood symptoms, to which a few new ones came to be added. Marriage was another game that had to be broken up, but she was more afraid of life outside of her home. Social anxiety made its appearance. Somewhere out-

[1] The present essay purposely neglects any exposition of Julia's anal instinctual gratifications, which were of course in evidence, as well as the reaction formations that arose from her training in cleanliness.

side there menaced her a dreadful punishment for her hostility to life. And the same menace was within herself as well: she feared hypochondriacally to die of cancer, tuberculosis, venereal disease, leucæmia, and insanity. But she persisted in her rôle of disturber and destroyer of all companionship and of all affection.

As we see, Julia's fundamental orientation to the world about her had not altered much as she grew up, or only to the extent that she had become passive instead of active and turned more of her aggression against her own self. Julia herself is responsible for the statement: "Life is a game that has to be broken up". She took care in good measure that this should be true. Where activity was required of her she was sadistic; in the presence of excessive obstacles or dangers she was passive and masochistic, retreating from reality. She did not want to "play" the game, at any rate not unless she was completely certain of having a pedestal on which she might maintain her superiority. Her neurosis, which was an unclear mixture of compulsive, hysteric, and particularly actual-hypochondriacal character traits, fulfilled this purpose and drove her into more isolation.

In her analysis the patient came upon an apt figure of speech to describe her way of playing at life (also applicable, it seems to me, to other neuroses)—a game of seesaw (double mill—*Mühlspiel*). She referred by this to the fact that in life she had known how to dodge or "play safe trick". She was always the apparent winner. She did not have to reflect or compete. She played automatically and with each move stole a position from her opponent. Every person and every thing was forced into the rôle of a losing opponent. Yet in the end she had to recognize that she was playing a dishonest game; in her later life she had to spoil games in the same way as she had been compelled to spoil the "game" her parents played in bed, and she saw that in this she was merely the football of her own destructive instincts and had become an enemy of life.

After many vain attempts at cure through other methods, she finally resorted to psychoanalysis, and today she is capable of securing for herself a better destiny.

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A Note on the Psychogenesis of Organic Symptoms

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A NOTE ON THE PSYCHOGENESIS OF ORGANIC SYMPTOMS

BY LEON J. SAUL (CHICAGO)

Some psychogenic organic symptoms such as tremor or blushing are the *direct* expressions of emotions or conflicts, while others are only their *indirect* results. Examples of the latter are (1) the effects of acting out, such as catching cold from throwing off the bed clothes during sleep, (2) the incidental soreness of an arm due to an hysterical tremor. This indirect type was described by Deutsch in 1922.[1] He stated that psychogenic organic symptoms were not necessarily "conversions", but often represented a result of an organic process initiated by emotional disturbances. This distinction was stressed and clarified by Alexander in his theory of the etiology of peptic ulcer.[2] His evidence indicates that the ulcer may be the more or less incidental result of years of gastric dysfunction arising largely from emotional tension of a specific kind. The clinical notes here presented illustrate this mechanism (emotion—appropriate physical expression—organic pathology) with special reference to activities during sleep.

They are taken from the analysis of a very intelligent married man of forty. The patient's surface attitude was a show of great superiority and independence. This was a compensation for hurt masculine pride—hurt by the fact that actually he was very dependent, always got people to make decisions for him and to give him things—the "get something for nothing" type. These desires, as expected, were expressed in his dreams in the infantile language of eating, being fed, aggressive biting, etc.,

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[1] Deutsch, Felix: *Biologie und Psychologie der Krankheitsgenese.* Int. Ztschr. f. Psa. VIII, 1922. P. 290. [*Studies in Pathogenesis: Biological and Psychological Aspects.* This QUARTERLY II, 1933.]

[2] Alexander, Franz: *The Influence of Psychologic Factors upon Gastro-Intestinal Disturbances: A Symposium.* This QUARTERLY III, 1934.

i.e., getting via the mouth—typical "oral receptive" and "oral aggressive" trends (Alexander).

During the end phase of his analysis this man developed a mild sore throat. It was always worse upon awakening in the morning, and usually practically disappeared after eating breakfast or during the following few hours. The patient's wakeful wife noticed that at this time the patient slept on his back and breathed through his mouth, although he had always previously lain on his side and had never been a mouth breather. Hoping to prevent the formation of a habit of mouth breathing, she awakened him on one of these occasions and thus allowed him to make two observations, the relationship between which he did not then realize: the first was that he had been dreaming of being fed, and the second was that his throat felt very sore, due obviously to its dryness caused by the mouth breathing. Although not adequately proven and substantiated until later, this simple mechanism is best described immediately: the analysis had reached a phase of dawning insight into oral trends, which, particularly strong in this patient, began to express themselves quite frankly in his dreams. During a dream of being fed, the patient acted out this passive infantile desire in his sleep to the extent of lying on his back with his mouth open, and breathing through his mouth. This resulted in dryness of the throat for a sufficient number of hours to cause soreness. Upon awakening in the morning the soreness alone was apparent. This soreness was then secondarily utilized by the patient's masochistic trends, chiefly to ease oral guilt by suffering, and to justify desires to be passive, which he had indulged by stopping work.

Further evidence for the part played by such a direct process in producing the so-called "conversion symptom" of sore throat was obtained easily and amply. For the ten days, approximately, during which this oral material appeared intensively in the analysis, the patient presented many symptoms in the mouth region. This period was marked by oral aggressive dreams such as getting a salad out of the body of a woman. The sore throat, appearing in the morning and disappearing

by evening, became constant and worse at this time, and new symptoms developed: bleeding gums, two stomatous ulcers, sore left jaw joint, and mild laryngitis. A clue to all this again came from the patient's wife who observed that the patient had suddenly begun to grind his teeth at night, so loudly as to awaken her. She awakened him on several occasions to stop this, and he thus made some further observations. Once, grinding his teeth while awakening, he found that he was using such great force that it was impossible to exert it voluntarily when entirely awake. The occurrence of this symptom in the setting of intense oral aggressive impulses was made clear by the analysis; and so far as it could be correlated with the dreams of these nights, especially dreams during which it occurred and from which the patient was awakened by his wife, it appeared to be a direct expression of rage at oral thwarting, at having to cut loose from mother's apron strings and relinquish to some degree the pleasure of dependence and receiving. This unusually powerful oral attachment the patient unconsciously struggled to retain, while his masculine narcissism was forcing him to relinquish it; grinding of the teeth was frequently associated, as the patient noticed on awakening, with tensing of the throat muscles; these activities resulted in the morning in soreness of the throat, mild laryngitis, easily bleeding sore gums, and sore left temporo-mandibular joint.

A dramatic climax illumined the process still further. With increasing insight and resistance, these symptoms were exacerbated, and one day all appeared in rather severe form. The patient came to the analytic hour with all the signs of coming down with a severe infectious sore throat and laryngitis, including slight nausea, malaise, and loss of energy. During the hour there occurred a burst of insight into the oral desires and destructive aggressions. The nausea and asthenia disappeared within an hour or two. (The nausea was evidently a reaction against these oral impulses.) What appeared to be a febrile reaction was a typical mild depression. (The patient's temperature was not elevated.) That night the patient slept better than any night of the preceding few weeks, felt markedly

relaxed, and on awakening during the night felt by striking contrast how relaxed his jaws and pharynx were. In the morning his throat was not worse, as usual, but very much better, and by that evening not a single symptom of the incipient cold or grippe was in evidence.

Before proceeding it may be well to make a few remarks by the way. The first is the obvious one that infections usually improve over night, and that it is therefore very suspicious of unconscious nocturnal activities to find such a condition worse in the morning rather than better.

Secondly, to avoid any possible misunderstanding, the fact must be borne in mind that biological phenomena are rarely comprehensible in terms of single simple cause and effect, although this may be the most useful approach for the scientific study of isolated problems. In biology we are dealing with an extremely complicated dynamic mechanism, in sensitive internal and external equilibrium, the intrinsic detailed workings of which are functionally related. We must therefore usually be content to succeed in establishing the relative importance of certain factors in producing a condition which obviously has many interrelated determinants. Thus the clinical observations made above indicate only one of the causal sequences at work. Under other individual and environmental conditions (immunity, etc.; climate, etc.) our patient might not have developed a sore throat at all. Or, such determinants might serve only to exacerbate an already present infection. This mechanism (emotional state—appropriate activities during sleep—organic consequences) is only one of the determinants, and may be either of subsidiary or of critical importance in different cases.

A third remark concerns the relationship between oral material and upper respiratory symptoms. This relationship is not surprising when one considers their intimate physiological association in the adult (swallowing, vomiting, "down the wrong pipe", air-swallowing, etc.). Also, recent work [1]

[1] Peiper, A.: *Die Atmung des Neugeborenen.* Jahreskurse f. ärztl. Fortbildung, 1933, 24.

indicates that in infants sucking, swallowing and breathing form a single reflex mechanism.

We now return to the patient, for he afforded clues to three more symptoms. One of these appeared along with the other oral symptoms described, and was omitted merely to facilitate simplicity of presentation. This was a small ulcer of the tongue ("stomach sore") near the right margin, opposite the second molar tooth. That it, too, was probably of traumatic nocturnal origin, the result of biting his tongue during sleep, was strongly suggested by the following incidents: about ten days after the analysis of the oral material referred to above, when the patient had rather good insight into it, he twice bit his tongue at this same point. On both these occasions he was at dinner with his wife and was in the middle of a sentence suggesting a new and delectable dessert. This resulted in a small "stomach sore", just like the first one which persisted for two days. Thus it is probable that the first ulcer was also caused by biting, but by biting during sleep in response to oral aggressive dreams. Its greater severity and persistence was doubtless due to repeated traumata during that period and consequent lowered resistance of the mucosa, for it disappeared on the day that followed the burst of insight and "relaxed" night's sleep.

Further evidence was obtained when the patient developed a soreness of the right cheek at the ampulla of the parotid duct, and the following night was awakened by his wife because of grinding his teeth. He found that he was chewing, and because he was lying on his right side, that he was severely biting and rubbing this region.

Thus, closer observations of the same patient yielded further examples and confirmation of the validity of this simple process of (1) emotion, (2) direct, appropriate and readily comprehensible expression of it (although unconsciously and usually during sleep), and (3) a consequent organic condition. Further verification is readily obtained from other cases, and other symptoms become more intelligible. A few examples may be mentioned briefly:

A young male patient with strong oral trends complained bitterly that his teeth and the left side of his jaw pained him although his dentist found no oral pathology. At this time the patient dreamt of battling a rapidly growing snake, to which he associated his fear of snakes and antagonism to them, his belief in the strength-giving qualities of the snake's flesh, his having eaten a snake as a child, the penis, and his envy of his father's strength and possessions. In response to the interpretation of his oral aggression he said that he had just come from the dentist, who had told him that the teeth were worn down more than could be accounted for by eating and that nocturnal teeth grinding must be frequent with him. The dentist remarked that teeth grinding in sleep is very common, as he sees it through his practice, "and is caused by nervous tension". A few weeks later this patient was thwarted by a woman and reacted with intense rage and with conscious wishes to kill her. That night he had an overtly cannibalistic dream of eating a woman. He awoke from this dream grinding his teeth with great force. His dentist, whom he saw at this time, told him that his teeth showed twenty-five more years of wear than they should, due undoubtedly to nocturnal grinding. To prevent further soreness, aches and damage from nocturnal grinding, the dentist prescribed a rubber guard for the patient to wear during sleep over the teeth of his lower jaw.

After nearly two months of this, the patient's teeth and jaw, especially on the left side of the maxilla, were constantly sore, and his whole head felt congested. He found himself grinding or clamping his teeth together even when working during the day. The annoyance became so great that ideas of suicide occurred (chiefly, of course, because of the unconscious aggression due to oral thwarting). He got no relief from his dentist, who found no organic etiology. One analytic hour the patient reported a dream of holding his little sister up in the air at arms length while a big woman stood by him. Associating, he reluctantly admitted what for two months he had struggled so hard to deny: that his unbounded show of strength and superiority was a denial to himself and the world of a feeling of inner weakness due to strong oral claims. As in the dream,

part of his life technique was to be supported by strong substitute mothers while demonstrating his strength in relation to the weak (young boys and girls). This insight touched the patient deeply, particularly the realization of his hostility when orally thwarted. At the next visit the patient reported spontaneously and with great astonishment that almost immediately after the preceding analytic hour, he had experienced a noticeable relief of the pain in his teeth and jaw. That evening about six hours later, he could eat comfortably and he realized to his amazement that the ache was almost gone. It disappeared completely that evening and since then (five months) he has felt relaxed and able to work effectively with no trace of pain.[1]

The following material illustrates the same mechanism operating through the involuntary nervous system. A male patient developed a pain in his right testicle for which the urologist whom he consulted found no organic source. A simple explanation came to light following the analysis of a rather frank œdipus dream, in which the patient got into bed with an older woman. He related that he awoke from this dream on the verge of an orgasm, and that this occurred although he had had intercourse only a few hours before. Moreover, he just then realized that for the past week or so, despite regular intercourse, every time he awakened at night his penis was in rigid erection and probably was so all during his sleep. With changing dreams and disappearance or diminution of nocturnal sexual excitement, erections and emissions, the ache also disappeared and has not returned. The ache had been merely the usual result of prolonged erection, but this erection had occurred in response to sexual fantasies during sleep so that only the ache was noticed.[2]

[1] Cases of teeth grinding have been observed and symptomatically cured by non-freudian methods. See: Frohman, B. S.: *Occlusal Neuroses.* Psa. Rev. XIX, 1935.

[2] A detailed discussion of urological cases was presented by Dr. Karl Menninger *(Psychogenic Factors in Urological Disorders)* at the American Psychoanalytic Society at Chicago in 1934. In this connection see also Menninger, Karl: *Some Unconscious Psychological Factors Associated with the Common Cold.* Psa. Rev. XXI, 1934.

The material here presented merely stresses the point observed by others, namely, that psychogenic organic symptoms, although related to emotional conflicts, need not be primarily symbolizations of these, but only incidental results of appropriate and readily comprehensible emotional expressions. Recognition of this mechanism robs the "jump from the psychic to the physical" of some of its mystery.

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Lactation in a Virgin

Walter Briehl & Ernst W. Kulka

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LACTATION IN A VIRGIN

BY WALTER BRIEHL *and* ERNST W. KULKA (NEW YORK)

The title first thought of for this paper was Lactation in a Psychogenic Pregnancy. But Lactation in a Virgin was chosen because it is more correct. The elements of the psychogenic pregnancy were overshadowed by other elements which were invested by the patient with greater cathectic charges. What these were will become clear later on. Physiologically and anatomically, the title Lactation in a Virgin is correct. Lactation figures in the title, because the secretion from the breast is milk. This was confirmed by Dr. E. W. Kulka microscopically and chemically. And the designation "virgin" is also correct. The nearest approximation to intercourse that this patient ever had was at the age of nineteen, when while taking a carriage ride in the country her companion attempted to put his arm around her, and again at the age of twenty-three when another man attempted the same thing in a moving picture theater. From the psychoanalytical viewpoint, however, it is to be noted that the title is inadequate and inappropriate. From this viewpoint, the title would be Lactation, Urination and Ejaculation at the Breast in a Polymorphous Perverse Hysteric.

There are several unusual points of interest in this case. This appears to be the first reported case where lactation in a virgin occurred during the analysis itself, and as a *conversion symptom*. Furthermore, in analytic and gynecologic literature, lactation in a virgin and nullipara as a conversion symptom has never been mentioned. Dr. G. E. Daniels has remarked that in a case of which he knew, lactation had persisted after an abortion and this continuance of the lactation seemed to be due to psychogenic influences. Interesting as Dr. Daniels' case was, the fact that there had been conception and pregnancy

Paper presented before the New York Psychoanalytic Society, May 21, 1935. The section entitled "Somatic Aspects" was presented by Dr. Ernst W. Kulka.

does alter the clinical picture. In the chapter, *Psychogene Störungen der weiblichen Sexualfunktion* of the book *Psychogenese und Psychotherapie körperlicher Symptome,* Prof. A. Mayer of Tübingen tells of similar cases. He says that psychic factors play a rôle in galactorrhea but in connection either with nursing mothers or in those who have recently nursed or in those who have had an abortion. He saw galactorrhea persist in women who continued to think of their baby lost at birth or as the result of an abortion. Even Ferenczi, with his brilliant clinical insight, does not mention lactation as a conversion symptom, though in his enumeration of conversion symptoms he seems all inclusive.

In nonanalytic literature there is considerable material on lactation in nonpregnant states. (Dr. Kulka reports on this literature from the medical standpoint.) This literature and the history of these cases, however, neglect to make any reference to psychological factors. It is possible—in fact we can be reasonably certain—that there must have been some psychological factors present, especially in cases with less pronounced physical findings. Cases such as the one presented here are rare, but they must exist from time to time. When we have studied a number of cases of this kind, it will become possible to generalize an etiological factors.

This paper concerns a patient whose chief symptom was hysterical blindness, or marked limitation of the field of vision.[1] The patient is a woman in the early thirties, unmarried, by occupation a missionary. She lives at a church residence with colleagues. Her work consists in visiting the members of the congregation, trying to increase the church membership, teaching a Bible class, coaching the children for Easter and Christmas Bible plays, taking sick children to clinics for treatment and consultation, and doing executive work for the parish. In general, the work is a combination of social work, visiting nurse, Sunday School teacher, secretary to the minister, and

[1] The material of this case was presented twice in 1932 in Dr. Rado's seminar at the New York Psychoanalytic Institute.

hostess at church functions. Her remuneration is small but it includes maintenance.

At times she is quite inefficient in her work, antagonistic and insolent toward her supervisors. There have been numerous complaints. These have caused her some concern and she has repeatedly dreaded being called before the Board of Managers of the Parish, but this has never occurred.

Her world is not a large one. She has little interest in world affairs. There is no reference to newspaper events, street occurrences, music, the theater or politics—not even reference to religious activities outside her immediate environment. She had, when she came to analysis, only a surface understanding of the problems that she had to deal with in her work, such as alcoholic intemperance among some members of the congregation, family problems, and the behavior and sex problems of the Sunday School children. Her attitude at one time was—"If everyone went to church and was a good Christian, these problems wouldn't arise". There was in her a strong missionary proselytizing tendency, but she lacked the initiative of the dynamic evangelist. The patient has been known by the analyst about four years, and the aforementioned deficiencies in her work have in this period of time been modified as the analysis proceeded. That is, as she became more involved in her own symptoms and conflicts her object relationship to the alcoholic who needed saving and to the boy who played truant from Sunday School became more distant. She was content, to a degree, to let bad enough alone.

Furthermore, in the latter part of the analysis there were expressions to show that her superego was becoming vulnerable. For example, she declared: "I have the missionary stigma on me. I can't go to the movies or to a night club. We are only supposed to go to see the plays that teach a lesson, or those that have a moral in them. I might want to smoke a cigarette just to see what it's like, but if the supervisor smelled tobacco on my breath I would be asked to leave. I might taste alcohol too, but I'm afraid that if I had one drink I might like it and then I would be lost. So it's best not to be tempted by the

first drink." Though she said this with laughter, she knew how much truth there is in the supposition.

The patient spent her childhood and adolescence in a small town in Canada. She remembers little about her mother who died when the patient was five years old. The patient's general impression is that her mother was not particularly punitive. However, one incident about her mother stands out clearly. While her mother was in her coffin the patient remembers uncovering her feet, and feels that she was prompted by some desire to investigate. She remembers being rebuked by her father because she disturbed the shroud.

Her father, a general store owner, was always a good provider for the family of five children, of which the patient was the second oldest. She has an older sister and a younger sister and two younger brothers. The father was a drinker, at least in the eyes of a sister of his. This sister was a spinster missionary and she came from a distant state to manage the family after the death of the mother. She immediately established missionary discipline. One of her first acts was to put an anti-drinking compound into her brother's coffee—the patient's father—to cure him of drinking. She cured him of this for a while and even succeeded in making a churchgoer out of him, but one may opine that the cure came as the result of her temperament rather than the result of her magic medicine. The children also had to reform. Previous to the aunt's regime the children behaved quite without inhibition in the hayloft, where there was rampant exhibitionism and swearing, but the appearance of the aunt cut this short immediately. Thereafter there were Bible lessons and lectures and our patient became a hypocritical little angel. The children managed to get in a little forbidden pleasure, but the patient and her siblings wore such innocent faces that even the aunt believed in their innocence. This aunt put into the patient's head the idea of becoming a missionary. A reason the patient took so readily to this idea is furnished by the remark of the older sister, who at the age of fourteen seems to have sensed the patient's scoptophilic interests, when she chided her with such remarks as, "You want to

be a missionary so you can go to Africa and see all the naked people". At about the age of five there is an early recollection of the patient's seeing her father's penis while he was in a night shirt.

The missionary aunt stayed with the family until the patient was nine and the children celebrated her departure (she left to marry in her home town) with a bonfire. Her rule was followed by a dynasty of housekeepers for two years, a period in which the children were so completely unmanageable that for their welfare the father married a second wife who bore him eight children, making thirteen in all. The stepchildren and their stepmother were incompatible and as they matured the children left home, our patient going to a missionary school.

The whole childhood of the patient was permeated with scotophilic interests and activities. She missed no opportunity to see the genitals of a girl or boy. At seven she remembers unbuttoning the trousers of a child to see its genitals; at ten and eleven she recalls always lacing and unlacing the middy blouses of girls and looking down them. Bedwetting persisted until twelve. Her conception of the origin of children at this time was that they were the result of swallowing pills. At thirteen and a half she began to menstruate. Her conception of the sexes at this time was, "Boys were all alike, girls puzzled me". Thus at puberty she was still confused about the penislessness of girls. Two symptoms appeared at puberty: (1) ocular disturbances (the nystagmus) in the form of eye rolling to which her father first called her attention, (2) itching of the genitals. These two symptoms persisted for years and there is a close connection between them.

The eye symptoms and the vulvar irritation occupied the attention of physicians for years. She told her father that if he obtained glasses for her eyes she would stop rolling them. From that time on there is a constant history of eye testing and visiting opticians, prescriptions of eye glasses, eye shades and lamp shades. One optician would prescribe glasses and the next one would cancel the prescription. She would have her eyes tested one week and the next week, when she returned

to get the glasses, her eyes would see differently. In all, she had six pairs of glasses, but none improved her vision, until in the end she wore no glasses.

She always thought of her genitals as associated with pathology. With the vulvar irritation there was also a long history of treatment—both self-treatment and treatment at the hands of dermatologists. Self-treatment began at puberty when for months she smeared lard on the organ. Later the condition induced the patient to go to physicians but their findings were either negative or only a mild redness. Practically every time she visited a physician for this condition some other condition was diagnosed. For example, at the age of eighteen, a physician told her that her uterus was not large enough and that an operation would be necessary before marriage; at twenty-five she was told she had a hooded clitoris and an operation by electrocautery (which was very painful) for this condition was actually performed. After all these procedures, the itching remained as before.

At the age of twenty-eight the patient came to Toronto and her desire at this time was to be an undertaker, but this was a purely scoptophilic interest buried in her unconscious. However, she secured an appointment at her regular missionary work. Previous to this she had worked in church hospitals elsewhere, and her particular task seemed to be giving enemas she went to visit a mental hygiene clinic in Toronto. At this time the eye symptoms were chronic irritation of the lids, photophobia, blepharospasm, limitation of the field of vision (the patient said she could see only straight ahead), and rolling of the eyes like a vertical nystagmus. A better name would be "heavenly nystagmus", because of the expression of a penitent virgin. Other general unspecific symptoms were inability to concentrate on her work, fatigability, shyness and timidity, self-consciousness, irritability, and disagreeableness in relation to her co-workers.

One year previous to the beginning of analysis an incident occurred, which because of the anxiety outbreak it occasioned can be called a precipitating factor. While supervising a group

of orphan girls on the roof of their institution, she was called to the telephone. One of the girls, aged about twelve, out of curiosity climbed over a parapet wall to look down a skylight of a studio in the adjoining building but the child lost her balance, fell through the skylight, dropped thirty feet, and was instantly killed. The patient was called by the horrified children, and as soon as she reached the body of the child, her first impulse was to raise its clothing and look at its genitals, an impulse which she repressed with difficulty and with a sudden feeling of shame. Later a policeman came and put a cloth over the girl's body, but the patient, when unobserved, removed the cloth from the girl's face to look at it. She felt that had the child not been so curious she would not have met her death.

The patient's scoptophilic impulses as part of her eye symptoms were particularly embarrassing to her. Though she suffered limitation of vision, whatever vision was left centrally always seemed directed at a man's genitals—not only at those of men on the street but especially on those of the minister of the church. When she played tennis with him, she had to give up playing because she could not follow the tennis ball while her eyes were fixed at his genitals. Then as a sort of self-protection, to hide her staring, the nystagmus would set in.

ANALYTIC ASPECTS

The patient began her analysis in October 1931, more than three and a half years ago. Treatment had to be interrupted on April 1, 1935, for external reasons. Of the forty-two months of this period the patient was in analysis only about twenty-five months and then only averaging three times per week, so that in all, on a full time basis, the duration of the analysis is a little more than a year.

Her symptoms became obvious in the initial interview even before she had the opportunity to enumerate them. The "heavenly nystagmus" was evident at a first glance, and associated with it was a smile which she could not repress. She had to make an effort to keep serious. When she is looked at

she either keeps her head still and her eyes disappear upwards, until only the white sclera is visible, or she turns her head aside and represses a smile. She will look at a person only when she is not looked at.

Some of the material of the first month was the story of the child who was killed. With greater resistance, she also told the story of uncovering her mother's feet.

One of her first dreams, which was a transference dream, dealt with a man of middle height, dressed in brown, breaking into her room. Subsequent analysis revealed scoptophilic aims that the patient had in relation to the analyst. She talked considerably about the minister of her church—how, for example, at a summer picnic his white trousers showed urine spots as he came from the toilet. Around Christmas time she was given the task of making top dresses for the dolls which were to be given to the children as Christmas presents, but she had no mental rest until she clothed them in underwear first.

The patient also gave some associations directly in connection with her symptoms; for example, she said of her blepharospasm, "My eyes close tightly; I cannot keep them open—if I keep them open I see sexual organs—closed I see nothing."

There was also material very early in the analysis about the relation between the eyes and vagina. She said, "My eyes draw and press in—like forcing a penis in (blepharospasm=vaginitis). Sometimes I get a drawing-in sensation in the clitoris and vagina." During this period the patient began to masturbate on the clitoris, but she did this "only when the clitoris itched and to relieve the itch". She made the discovery that manipulating the genitals relieved the eye spasms as well as improved her vision. But she maintained, "I cannot masturbate all my life though, to keep my eyes clear."

She really did not consider this masturbation for pleasure. She considered it therapeutic masturbation, and wondered whether she would ever learn to really masturbate. As she said, "I have a fear of masturbation. I wouldn't know how. Years ago I wondered whether I should learn it. I believe it is like a sharp needle with suction pain." On one occasion

when she had no itch the patient tried to masturbate for pleasure's sake. She tried it for two hours but it did not work. Henceforth she said she would not masturbate and would touch the clitoris only when it itched. Another reason for giving up pleasure-masturbation was the fear that she would be caught.

During this first period of the analysis she showed an interesting phenomenon in relation to penis envy. The connection between her scoptophilic tendencies and her penis envy has already been mentioned. This penis envy in the phenomenon about to be described manifested itself in another form. She realized that the two small openings (hymen septus) that she had in her hymen would not permit the insertion and subsequent possession of a penis, and she was deeply grieved about this condition. The following are some of her approximate verbatim statements about this situation: "I cried because the openings were so small. I tried again and again to force my finger through, but I could only get it as far as the second joint. There was an indentation around my finger like a rubber band. These are two small openings close together. I want to put a scissors in and clip the bridge between them. I would have it done at Saint X Hospital but they would find out that I had masturbated, so I will clip it myself. Or I could put a thread around it and tear it. Tears ran down my cheeks. I cried because the opening was so small. I don't like masturbation but I will get myself deflorated in order that I will be able to masturbate. There was a tiny bit of blood when I masturbated. I was scared—thought that it was menstruation. I am not very keen about this. I have it every four to six weeks. I'd just as soon not have it at all."

The patient actually did snip the tissue between the two openings. Afterwards she had a sense of relief. In this behavior we see that defloration had a double significance. First, there is the element of castration anxiety in relation to masturbation, and second, and what seems more important, is that it permits her to possess a penis because a penis can now be introduced. If she can make the opening large enough a penis can enter, which then becomes hers. Her associations about

her vagina fit in perfectly well with her desire to have a penis—she always referred to the drawing-in, suction feeling in her vagina—an oral characteristic.

Intermingled with these associations of defloration she also had the most vivid fantasies of being raped, but a deeper interpretation behind these fantasies was the desire to acquire a penis thereby. As she associated: "Once a girl went to a dentist and he put her against a wall and had intercourse with her. She wanted to sue him, but her lawyer told her to drop the case because she was neurotic and seemed to have provoked the proceedings. Once a missionary visited a man to get him to go to church. He locked the door after she had entered the room and she pretended not to be alarmed. She talked to him in a matter-of-fact way about going to church as she worked her way over to the door. Once I was in an apartment with an intoxicated man and I felt relieved when I got out."

The patient's desire to be deflorated and her telling how easily it could be done at a hospital with a knife and wire like a tonsil operation, recalls Menninger's article Polysurgery and Polysurgic Addiction.[1] Menninger enumerates four motives for the "morbid neurotic craving on the part of the patient to have something done surgically". First, the desire of an individual to avoid something else which he fears more than he does surgery. Second, a father transference to a strong dynamic surgeon. Third, an ungratified wish for a child. Fourth, the wish to be castrated. In our case we could add a fifth motive, namely, the desire to remove impediments to the incorporation of a penis. A few weeks after this material about masturbation and defloration, her behavior to the analyst changed. Her fantasies of being raped now changed to frank statements of castrating the analyst and others. This was during the summer and early fall of 1932 when the patient's eye symptoms—the blepharospasm, the pain, and the limitation of vision were at their worst. At the same time her scoptophilic interest and sadism were at their highest point.

[1] This QUARTERLY III, 1934. Pp. 173–99.

At this time it was thought advisable to have another perimeter examination, and she was referred back to the hospital where the first test had been made ten months before. The objective findings showed her eye condition to be worse. There was practically pin point vision for green, the field of vision being less than ten degrees. The following are random statements from notes on this period:

"I want a man's penis, not the man. I want to cut off your penis and scrotum. I had you flat against a wall and I made your face flat, then your abdomen. Then I took your penis and stretched it like a hose, and the penis began to squirt like a squirt gun. You haven't any courage to fight. Then I throw you flat on your back and force your penis into my vagina. I can do this only after I get rid of your face. You see my doing this. I want to pound out your eyesight so that you can't see me. Your nose bleeds—your face is out of the way—then I felt free. (Patient always hid her face.) After I pummelled you I felt like a warrior. I had a gun on my shoulder (the analyst's "squirt gun") and I felt that I had conquered the world—I conquered man. I want to cut open dogs and you to see your genitals. Do you know where I can see dissection of cadavers in a hospital or medical school? I want to see all the organs—the heart, the lungs, the uterus—and I don't want any anatomy books either—the organs don't move. I'd like to cut off a woman's breast to see how they are fastened on. I would cut the labia too. I would look at your liver and heart and the sexual secretion that goes to your brain and gives you energy. I haven't got what you got. I want to beat up the colored janitor like you—he's got a penis—I'd throw it in his face—he has no business having any. My eyes give me fits. I'm getting so nervous I don't know what to do. I'm nearly wild. I'm no good for anything, no money, no clothes. A penis is making me all the trouble. I wish there were no such thing. They ought to be cut off all dead people and given to me. Then I would be satisfied. There should not have been things like boys—they should all be alike. I'd like to cut off my father's penis—he must have had one, he had so many youngsters. I'm not going to work until I find out why I haven't a penis. I won't work for Mrs. A.

until she shows me her penis. I want to find out whether girls have penises. My father had a penis and my mother pubic hair, and I have none. My eyes drive me mad. You must get a penis for me from someone who died. I will sew it on. People make fun of me without a penis. I'm ashamed of myself. I will sit on my father's lap and say: 'I will be nice to you father—I will cut off your penis and I will put it on my doll. I will run a wire through it and make the water flow.' "

Her later associations and behavior clearly showed that she was orally incorporating her father's penis and swallowing his semen in her oral pregnancy. She had a cannibalistic attitude toward his penis—as a symptom of this she became ill from the sight of raw meat especially when it had a vein in it. Her unconscious sense of guilt in relation to castrating her father is shown in the anxiety that she had about the payment of the premiums on her $1,500 insurance, of which her father was the beneficiary. She feared that she would die and not leave him anything. None of the other children carried insurance in favor of their father, and in addition the economic position of the patient was the worst in the family.

A number of transient symptoms followed this phase of marked penis envy and aggression towards men. These symptoms were thumb sucking, the most unusual oral sounds and at times aphonia. The oral sounds were executed most rapidly. She swallowed and sucked and retched. She complained that she felt nauseated. On several occasions she thought she would have to go to the bathroom to vomit. Some of her associations were: "I have been belching semen from my stomach, my vagina, my rectum, my eyes, nose and mouth. It's running all over me. I can't get the penis out of my mouth. It sticks there. It is slimy semen. It poisons my stomach. I tried to suck my breast but it wasn't long enough. I was able to touch it with the tip of my tongue. My mouth is dry, I must suck. . . . The more I throw up the more I get spanked. Why do they spank me? My father gave me a spanking for laughing—it wasn't my fault—they shouldn't have done it. Am

I going to be awake every night? My mother and father will spank me for it. They had intercourse and they tied me up in a sheet. They think they're smart."

During this time the patient wriggled on the couch constantly as if she were trying to free herself from some restraint. In this period of retching and belching there was repeated pseudocyesis, especially on those occasions when her oral symptoms were severe. Her abdomen was distended and she groaned about the distress that she had. It was unmistakably a fantasy, an experience of an oral pregnancy.

Such was the condition of the patient in April 1933. On three occasions thereafter she resumed the analysis but as she came only for a few weeks and only twice a week there was little new material. Each time she returned there would be a repetition of the previous situation. When she came back to analysis for the last time she was still swallowing air and belching and feeling nauseous from semen. She stated that for some time she had masturbated on her breast and found it less painful than genital or clitoris masturbation which seemed to be connected with her eye disturbances. On some occasions, however, she rubbed the breast and clitoris simultaneously. She also practised touching her breast with her tongue.

On one occasion after telling about the manipulation of her breasts she made a surprising statement: "Say, there's milk or something coming out of my left breast since last Saturday. About one year ago I began to press out something like water with a salty taste, but now it is milky". No particular attention was paid to this statement when she first expressed it because she had the habit of making statements in an infantile fashion. She would first fool the listener and then later, after she felt that the first statement was believed, would come out with the truth, saying, "See, I fooled you". Sensing that the analyst might doubt the milk from her breast as just another of her pranks, she added, "I guess you don't believe it, but look, I'll show it to you." It was still uncertain whether the patient was continuing the prank or whether there was actually something being secreted from the breast, which might either be pus or

milk. No effort was made to interfere with her gesture. She exposed her breast and with slight pressure was able to force out several drops of a secretion resembling milk. At the breast there were no signs of any acute inflammatory process, and the patient complained of no localized pain from a possible retromammary condition. At the time she said, "See, now you will believe me."

Further associations during this hour and during the few following hours on this phenomenon were: "I like to suck the milk out of my breast. Saturday I did it for five minutes. I can reach it with the tip of my tongue but I want to suck it harder. I can give milk and you can't. You have a breast but you can't use it. You can have my milk if you will give me your penis. My breast or my nose or my finger would make a penis like yours. Yesterday I squeezed my breast and the milk squirts six feet. It makes me mad that it doesn't squirt more. . . . The right breast now gives milk too—for a few days only salty water came out but now it squirts milk too. I'm better than you now because I have two penises and you have only one. A week ago I felt myself pregnant, felt I was going to give birth—get big. . . . The semen still gags me in my throat. The last two or three days I had gagging spells. I am choked up with the semen stuff. I can't eat. I rubbed vaginal secretion on my breast to make it a penis. Then I wanted to suck it." At no time in her association about her discharging breast did she show anxiety about a possible pathologic process. She was quite exhibitionistic and proud of her breast.

From the patient's association we see the many rôles the breast plays and the numerous things which are equated with it.

First: The breast as hers, i.e., nursing her baby. The baby of her pseudocyesis seemed never to have gotten to her breast. It seemed that the child died and was vomited out dead. The patient has a very weak cathectic charge in relation to nursing a baby. This is easily understandable in view of her own strong oral incorporation tendencies.

Second: As the breast of her mother. With this determina-

tion the patient characterizes her regression to the oral stage. Earlier among the patient's conversion symptoms she had at one time developed a sucking ridge along the inner side of her lips. In the oral sounds made by the patient there was a distinct element of greedy sucking.

Third: The breast as a penis substitute for her. This determination is obvious from her urinary envy and from her desire for restitution for her castration at the genital level.

Fourth: The breast as her father's penis. This is also an attempt for restitution for a penis through oral incorporation—castration of the father. At the same time there was oral impregnation.

Naturally, in these equations the secretion from the breast—the lactation—becomes equated with milk, urine and semen.

These would seem to be the psychic factors responsible for the libidinalization and high cathectic charge of her breast, which we recognize as the displacement upward. But in addition to the psychic aspects of the case it seemed desirable that the phenomenon be investigated from the physical angle too. The analyst really had no objective facts about the nature of the somatic process. All he knew was that the patient was exploiting some somatic condition in the interest of her psychoneurosis, i.e., that the patient was using the organic for the expression of her unconscious repressions. To the end of investigating this somatic factor, to learn what it was, and to what degree there was "organic compliance", the analyst referred this aspect of the case to his colleague, Dr. Kulka.

SOMATIC ASPECTS

True lactation in a virgin is a rare occurrence though the phenomenon has been known since ancient times (Hippocrates, Avicenna).

When the case presented herewith was referred for gynecological examination, two questions were to be answered: (1) Is the secretion really milk? (2) If so, are there any organic reasons for the pathologic lactation?

The first question can be answered definitely in the affirma-

tive. The secretion was proven to be milk, chemically and microscopically.

The second question presented a much more difficult task, because the mechanism of lactation is as yet not fully understood in spite of an enormous literature on the subject. As far back as 1899, H. de Rothschild in his Bibliographia Lactaria already enumerated 8,375 publications. Much of the literature dates back to pre-endocrinological times. Therefore we have to evaluate the case histories of lactation without pregnancy accordingly. Suffice it to say, that in the main three groups of individuals with pathologic lactation have been reported in these histories: (1) the new-born, (2) nonpregnant women, (3) men.

Lactation in the New-born. This phenomenon is so well known that it does not need to be discussed at length. It belongs to a group of hormonal reactions, which parallel those in the mother, like hypertrophy and hyperemia of the uterus, etc. In both sexes, usually around the fourth day after birth, some secretion can be expressed from the breasts of these infants. After two or three weeks, the secretion disappears though sometimes it can last several months. Children of profusely lactating mothers seem to have more secretion than others.

Lactation in the Male. Lactation in the male, though rare, has nevertheless been reported by several authors. There are references to it in fairy tales and in mythologies such as in the Icelandic Saga, Floámanna. It is known to veterinarians, who described cases among goats and deer. A survey of the ancient and medieval literature is found in Polycarpus Fredericus Schacher's *De Lacte Virorum ac Virginum,* 1742. In one of the earlier cases, a Venezuelan man is said to have had sufficient milk to nurse his baby for several months after the death of its mother. In more recent literature, however, we are familiar with lactation in males where there was a testicular, adrenal, pineal or especially a pituitary tumor, and in association with acromegaly and gigantism.

Lactation in Women without Pregnancy. Numerous old

authors have reported on women lactating in the nonpuerperal state. More recent cases are described by Halban, Gellhorn, and others, but these cases seem chiefly to be those of women after castration, in the climacterium, or in those with tumors of the endocrine glands. In modern literature on lactation in virgins, there as practically no case mentioned without some organic pathology. We say "practically", because in the few cases which were found about lactation with no mention of organic pathology the endocrinology was not reported and was probably not investigated.

In order to understand the physiological basis for the lactation reported in these three groups we have to concern ourselves briefly with the theory of lactation.

Lactation is due to a hormone of the pituitary gland. It is called the lactogenic hormone of the pituitary. This hormone, present in both sexes throughout life, can exert its influence only under two circumstances: (1) the mammary gland must be adequately developed and prepared, (2) the follicular hormone produced by the ovaries, which has an inhibitory effect on the secretion of the mamma, must be depressed. Such follicular hormone produced by the ovaries is also produced by the placenta and even normally in small amounts in the testes.

Let us briefly detail point one, namely, that the mammary gland must be adequately developed and prepared. The breast consists of two functional parts, the secretory alveoli and the excretory lactiferous ducts. The development of these two parts is brought about by two types of hormones. The first, the follicular hormone, brings about the development of the excretory lactiferous ducts. Injected experimentally in certain animals, both male and female, normal and castrated, it produces hypertrophy of the duct system. Even adenomatous growth could be produced in some species. The second type of hormone brings about the development of the secretory alveoli. This hormone is the corpus luteum hormone of the ovary and the pituitary luteinizing hormone. Its injection into animals causes hyperplasia of the secretory system. But with pregnancy the placenta produces this type of hormone in enor-

mous quantities—hence we can understand the pregnancy hypertrophy of the breasts. That in pregnancy the breast changes are due to the hormones of the pituitary and placenta respectively, and not to the hormones of the ovaries, has been proven repeatedly by castration during pregnancy. Such castration interfered neither with the pregnancy nor with the lactation. But hypophysectomy does prevent lactation.

Let us now proceed to the second point, namely, that the follicular hormone, so essential for the development of the mamma, must be depressed for the secretory functioning of the mamma. Follicular hormone counteracts the lactogenic hormone. Lactation cannot occur as long as there are large amounts of this follicular hormone circulating in the organism. But as soon as it disappears with the expulsion of the placenta, lactation starts. If a woman does not lactate when she should, we can suspect a partial retention of placenta or membranes.

Our conception of normal lactation therefore is: during pregnancy the breasts are prepared by the hormones of the placenta. With the expulsion of the placenta the inhibitory influence of follicular hormone is eliminated and then can the lactogenic hormone produce lactation.

In order not to complicate the matter, no mention has been made of the fact that adrenalectomy also prevents lactation. Hence we must also assume the existence of an adrenal lactogenic hormone. We are thus in a position to understand lactation in hyperadrenal states.

This theory also allows a satisfactory explanation of pathologic lactation. In the fœtus the breasts develop under the hormonal influence of the mother. As soon as the connection with the placenta is severed, the inhibitory influence of the follicular hormone ceases and lactation can start in the new-born. In males the breast development is due to folliculin produced by the testes. In men with gynecomastia and tumors of the testes, this hormone has been found in large quantities in the urine. This folliculin, however, inhibits lactation. Only if its quantity is reduced by castration or disease of the testes can lactation occur. The main condition,

however, is overproduction of lactogenic hormone, as in certain pituitary and adrenal tumors.

In women with normally developed breasts, the factors necessary to produce lactation are, (1) increased lactogenic hormone production, (2) low level of follicular hormone due to deficient ovarian activity. It is this latter condition which explains lactation after the climacteric, after castration, and as a result of degenerative or destructive changes in the ovaries.

That neurological factors play no necessary rôle has been proven experimentally. Mammary transplants, which naturally have no nerve connection, lactate after parturition. Almost complete removal of the spinal cord does not interfere with pregnancy or lactation. On the other hand, sympathectomy may inhibit lactation in rats and cats to some extent.

Leaving the field of endocrinology for the moment, let us investigate the question, whether mechanical irritation alone can cause lactation. In the analytic part of this paper mention was made of mammary masturbation. Now, it is well known that mechanical irritation maintains and improves an existing lactation. But attempts to induce lactation by mechanical irritation alone are usually unsuccessful. It varies with the species. In goats for instance it is usually possible. In women who have lactated before, it seems to be relatively easy to provoke lactation again, particularly after the climacteric, when there is no more inhibitory follicular hormone production from the ovaries. Bartels reports of the Kaffirs that women of sixty and even eighty often nurse the babies of the tribe, and Reiss says the same of the Javanese. But these cases of course do not deal with virgins but with mothers. In virgins of the human species only very few instances are reported of lactation following mechanical stimulation. Richer reports the case of a negress eighteen years of age, who, taking care of a baby, put it to her breast regularly and then began to lactate. A similar case is reported by Baudeloque.[1] As a rule, it is not possible in

1 In the discussion of this paper at the New York Psychoanalytic Society, when referring to its nonanalytic clinical aspects, Dr. Feigenbaum mentioned a case of psychogenic lactation recorded in the 1832 volume of the *Magazin für*

the human to bring about lactation mechanically. Such experimentation is pursued outside of a scientific laboratory on a large scale in modern sex practices involving manipulation and sucking of the breasts but without result. Where, however, mechanical irritation is successful, we must assume an endocrine imbalance, consisting in either overproduction of lactogenic hormone or a low ovarian hormone-level, or both. Sucking, in women at the end of pregnancy, produces collostrum. Suction in gynæcomastia produces a thin serous fluid which is neither milk nor collostrum.

That psychic circumstances influence the endocrines and the vegetative nervous system is well known. One need only mention the onset of diabetes or Basedow after psychic trauma. That on the other hand the endocrines definitely influence psychic behavior is known from everyday observation. New experimental evidence was recently given by Wiesner and Sheard, who injected virgin rats with pituitary and placental extracts. The psychic behavior of the injected animals then resembled that of mother-animals; they built nests and began to carry the young of other rats into such nests.

Up to this point, we have discussed the literature on the theory of lactation as well as the endocrinology of normal and abnormal lactation. Let us now go to our case.

This case concerns a woman in the early thirties, Canadian born, of English descent. The history which the patient gave the gynæcological consultant is as follows: She is the second child of five. The family history is irrelevant. With the exception of the usual diseases of childhood, that is, whooping

philosophische, medizinische und gerichtliche Seelenkunde, edited by J. B. Friedreich, quoted from the Lancet, 1831. "A forty-nine-year-old woman, mother of nine children, prematurely somewhat cachectic, lost her daughter-in-law during the lying-in period. She took the baby under her care and one night, in order to quiet it, put it to her breast. The infant took the nipple into its mouth, felt comforted and fell asleep. From time to time this means of calming the baby was resorted to by the woman, and as she herself related, there arose in her 'wonderful maternal feelings', and she felt as if she herself had given birth to the child. Thereupon her breasts became painful and swollen, and very soon contained milk secretion in the same amount as prevailed in the case of her own nursing periods years before."

cough, chickenpox and measles, she has never been organically sick. About six months before her first menstruation, which began at the age of thirteen and a half, however, she developed symptoms of a nervous disorder. Her menstruation has always been irregular with intervals of 28 to 35 days. The duration was only one or two days, scant in amount and sometimes very painful. For the past year the patient noticed a varying amount of thin yellowish discharge from the vagina. Her appetite is fair. Her weight has been rather constant, varying around 118 pounds. There is chronic spastic constipation. She reported that a basal metabolism test in 1931 gave normal values, and that a blood sugar and blood calcium test were low. There is no history of urinary disease. Her living habits are regular; she does not smoke or drink. Of the local condition about her breasts, she says that they were always sore before menstruation. Two weeks before she came to the gynæcologist she noticed some secretion from the breast and was able to express more by manipulation.

The history that she gave could be considered quite reliable. In her manner she was friendly and coöperative. She did not seem to be particularly distressed by the secretion from her breast and there were no signs of anxiety about the condition.

Physical Examination. A well nourished woman in apparent good health. Weight 55 kg. (about 122 lbs.). Height 157.5 cm. Anthropometrical measurements and indices are within normal limits. There are no characteristics which would allow the patient to be put in one of the well-defined groups of constitutional body types, like pycnic or asthenoptotic, or which would indicate an endocrine disturbance. The fat distribution is normal. The skin is somewhat pale, pasty, and dry. Poor circulation in the extremities. No localized œdemas. Visible mucous membranes pale. No palpable glands. No visible or palpable abnormalities of the skeleton. The hair distribution is very unusual; there is an increased growth on the upper lip, and an oval hairy area over the larynx region. There are a few coarse hairs on the breasts, circumareolar, and in a peculiar ring around the navel. The linea alba and the lower abdomen

are entirely free, the upper borderline of the pubic hair being typically feminine. However, there is an extensive hair growth at the crana ani, circumanal and on the legs. The blood pressure was 105 over 65. The eyes showed an absent corneal reflex and the pharyngeal reflex was also absent. The ophthalmological symptoms have been mentioned earlier in this paper. Thyroid not enlarged. Breasts are of medium size, disc shaped, nipples and areola normal in size and shape but of somewhat darker pigmentation. A milky fluid is easily expressed from the mammæ. Specimens were taken for laboratory examination.

The gynecological examination shows hypoplastic external genitalia, small clitoris. An intact annular hymen, a III° retroflected hypoplastic uterus, ovaries and tubes not palpable, parametria free.

Laboratory Findings. The microscopic examination of the vaginal discharge shows a third degree of cleanliness (numerous leukocytes, gram negative mixed flora) indicating a poor ovarian function. Urine examination negative. Blood count showed figures within normal limits for erythrocytes, hemoglobin, color index and leukocytes; the differential count shows a mild eosinophilia (6%) and lymphocytosis (35%). Wassermann test negative. Blood sugar normal. Blood calcium normal. The basal metabolism rate minus 20. Specific dynamic albumen action normal. Sugar tolerance test normal.

The secretion from the breast was examined microscopically and chemically as mentioned. The microscopic appearance was typical of early milk. There were only fat droplets and about one collostrum corpuscle in every other low power field. Chemically the total albumen and nitrogen content determined by micro-Kjeldahl gave a percentage characteristic of milk. An Aschheim-Zondek test was negative as we expected.

This was as far as we could go with the physical and laboratory findings. In order to see to what depth the somatic process went it would have been desirable to determine lactogenic hormone and follicular hormone, qualitatively and quantitatively, but they cannot be determined by our present methods

from blood or urine. Dr. Riddle, an authority on lactogenic hormone, who originated the crop gland test in pigeons, informed us that the preliminary tests led him to doubt that the quantities in the blood are sufficient to give a positive test for clinical use.

Dr. Frank was of the opinion that the Frank and Goldberger test for pituitary and ovarian hormone in the blood would not lead to any conclusions in view of the fact that the woman was menstruating.

Conclusion. The examinations did not reveal the presence of any tumor or other gross changes of the pituitary or adrenal gland, which could account for an over-production of lactogenic hormone. While the unusual hair distribution might have some connection with a hyperadrenal condition, yet in the absence of other findings, there was no reason to believe this gland diseased and responsible for the lactation. We were, however, able to find indications of an ovarian underfunction. As stated in our theoretical considerations, such an underfunction with reduced follicular hormone is one of the necessary requirements for lactation. And this in Dr. Kulka's mind, predisposes this individual to lactation.

As a supplement to Dr. Kulka's gynecological findings we have available the X-ray report of Dr. William Snow, Director of the X-ray department, Harlem Hospital, and the neurological report of Dr. Nathan Savitsky, adjunct neurologist at Mount Sinai Hospital, to whom the authors wish to acknowledge their appreciation.

The X-ray report is as follows:

"Stereoscopic examination of the skull shows no abnormality. The sella is small but within the normal. The vascular and digital markings are normal. There is no evidence of increased intra-cranial pressure."

The neurological report reads:

"The ocular examination showed: oval left pupil; right eccentric pupil; pupils equal in size and both reacting to light

and somewhat less to accommodation; no ocular palsies; no diplopia with the red glass test; fundi showed some pallor on the right with a small spot of pigment without retinal changes in its immediate neighborhood superior and temporal to the disc; the macula was normal; left eye showed slight temporal pallor less than on right; macula normal on left; vessels showed no changes; there was evidence of mild myopia bilaterally; fields were normal to confrontation test; perimetric studies did not show any constant field defects; a so-called fatigue field was noted in both eyes especially on the left.

"The ear examination showed: normal external ears and canals; drums showed good light reflex; no retraction and all landmarks visible; no lateralization of the Weber; air conduction was greater than bone conduction bilaterally; bone conduction was somewhat diminished qualitatively on the left; no diminution of acuity in any of the frequencies; bone conduction lasted ten seconds on the right and twenty seconds on the left.

"The neurological examination showed: diminished knee-jerks; ankle jerks were not obtained even with reënforcement; the tendon reflexes were active and lively in both upper limbs; no Babinski or confirmatories; no constant sensory changes; there were no other positive neurological findings; abdominals were all lively.

"There are two facts which are important from the point of view of diagnosis of possible focal disease: (1) History of pains in both lower extremities for a few years up to two or three years ago; (2) Sudden diminution of visual acuity lasting three or four months about ten years ago.

"There was no definite evidence of focal disease of the nervous system. The diminished bone conduction on the left side in the absence of lateralization and in the absence of diminished acuity for even the highest frequencies is probably functional. The peculiar visual fields are probably due to fatigue inasmuch as I examined her about 9:00 P.M. The absent ankle jerks are somewhat puzzling but with the history of pains in the lower extremities for a number of years they may

be the residuals of a peripheral neuritis. (A blood serology should be done. Perimetric examination should be repeated when the patient is not fatigued.)

"The significance of the diminished vision ten years ago is not clear. The temporal pallor is perhaps within physiological limits. Before a definite opinion can be given regarding the significance of this pallor, I think central fields should be done with a stereocampimeter. There are no other clinical findings suggesting the presence of disseminated sclerosis. Blurring of vision may be functional. The somewhat defective accommodation reaction is I think related to her myopia."

These are the psychological and medical history of this case. Before drawing conclusions we may quote Felix Deutsch and Ferenczi on conversion symptoms. In his article, On the Formation of Conversion Symptoms,[1] Deutsch says: "Before a conversion symptom can make its appearance, a minutely detailed preparation, not only in the psychic, but also in the organic sphere is necessary. Frequently, the changes in the organ involved in the conversion take place quite unnoticed and it is therefore difficult, or actually impossible, to investigate them in their initial stages. For this reason they are often overlooked. When, as occasionally happens, they are discovered, they serve to prove that the transformation from the psychical into the organic is by no means a sudden one and that the transition is not made at a single bound, as it were. To prove this is to take from the process of conversion something of its mysterious character. The attempt to give a complete explanation of this process leads us into the realm of metabiology where psychical and physical meet, and such an attempt is hopeful only if it takes as its starting point the simplest cell-processes. Our as yet imperfect knowledge of the simplest biological processes imposes certain limits upon this undertaking which at the present time can be attacked only from the standpoint of speculation."

[1] *Zur Bildung des Konversionssymptoms.* Int. Ztschr. f. Psa. X, 1924.

And Ferenczi in The Phenomena of Hysterical Materialization [1] says:

"Conversion hysteria genitalizes those parts of the body at which the symptoms are manifested.

"The unconscious will of the hysteric brings about motor manifestations, changes in the circulation of the blood, in glandular function, etc., which the conscious will of the non-hysteric cannot achieve. He can bring about individual innervations for instance of the musculature of the eyes—that are impossible for healthy persons; his capacity for manifesting local hæmorrhages, blisters and cutaneous and mucous swellings, though rarer, is also well known.

"One might therefore say that in hysterical conversion the earlier auto-erotisms are charged with genital sexuality, that is, erotogenic zones and component impulses are genitalized. This genital quality shows itself in the tendency to turgescence and œdema of the tissues, compelling friction and thus the removal of the irritation.

"In hysterical symptoms we see, to our no small amazement, that organs of vital importance subordinate themselves entirely to the pleasure principle, regardless of their own particular function in utility. And there is no organ nor any part of the body that is proof against being employed for such pleasure purposes."

As a close to this article Ferenczi writes: "At the same time even the propounding of these problems shows us that, contrary to the current view, according to which biological research is the precondition of psychological advance, psychoanalysis leads us to biological problems that could not be formulated from the other side."

CONCLUSIONS

1. In this case the secretion from the breast is milk. The only ascribable physical reason for this was ovarian hypofunction with oligomenorrhea and a diminished basal metabolism.

[1] Included in *Further Contributions to the Theory and Technique of Psychoanalysis*. London: Institute of Psycho-Analysis and Hogarth Press, 1926.

2. There were some other physical findings such as the atypical hairiness and numerous hysterical stigmata, for example, the oval and eccentric pupils, the hysterical blindness, limitation of the field of vision and the fatigue field and the functional ear disturbance. The neurologist's report of the diminished knee jerks and the ankle jerks which could not be obtained even with reënforcement, while in both upper extremities the tendon reflexes were active and lively, is extremely interesting. Dr. Savitsky thought of the residuals of a peripheral neuritis, of which, however, there is no history. Is it possible that the diminished reflexes below and the active and lively reflexes above are part of the "displacement upwards"?

3. With the first perimeter reading done in January of 1932 and the other in October, 1932, which showed a still further limitation with pin point vision for green, we see the psychophysical parallelism between the objective findings and the patient's subjective state during her penis envy. As Rado says in his Fear of Castration in Women [1]: "Her eyes are pinioned to the penis and her field of vision restricted to this one object of perception. From her emotional chaos emerges the strident desire: 'I want it' which is immediately followed in fantasy by 'I have it'." Has our patient found a penis in the breast which gives her narcissistic gratification so that now she no longer gazes at a penis? Is this adequate to explain the neurologist's statement, "perimeter studies did not reveal any constant field defects"? The patient also reported the improvement in her vision. She could really thereafter look at a person without the eye rolling and nystagmus.

4. The changeableness in both the psychic and somatic picture is noteworthy; for example, her changeable eye condition. Again, three years ago, she had a basal metabolism which was normal, and now it is minus twenty. It is significant that whoever examines the patient wants her to return for reëxamination. This happened repeatedly for her eyes during adoles-

[1] This QUARTERLY II, 1933. Pp. 425–75.

cence. Three weeks ago at the eye hospital the patient was advised to return for reëxamination for her unusual fields. Dr. Savitsky also notes in his report, "Perimetric examination should be repeated when the patient is not fatigued". We can without any hesitation say that our patient has a most labile vegetative system.

5. It is the analyst's opinion that the origin of this abnormal lactation does not go back *only* to the period of puberty when her ovaries did not begin to function adequately. It is his contention that due to her infantile fixations—her strong orality and her scoptophilia—large amounts of psychic and physical energy were directed away from the genital system where it should have been utilized for normal development. Instead, such energy was used to cathect other genital substitutions. The problem is no different from that of the atrophy which occurs in an arm, hysterically paralyzed, except that the former process began very early.

In this case, though there is an organic substratum which contributes or might even be largely responsible for the lactation, yet such a substratum, which ordinarily is considered a relatively fixed quantity of organicity, can in turn be chiefly the elaboration and result of psychogenic factors working on a nucleus of somatic compliance.

6. In view of the ovarian deficiency we can think of glandular therapy. Dr. Kulka believes that if 50,000 follicular units were injected into the patient the lactation would probably cease. Dr. Briehl fears that, though this would be an endocrine triumph, it would be a psychotherapeutic tragedy. It would act as a castration at the breast and the patient already has had a rather complete one in childhood. Dr. Briehl believes any kind of organotherapy contraindicated at present. After the end of the analysis we may be able to see what organic conditions remain requiring treatment.

7. With further analytic investigation we may better understand other factors in this lactation, both psychic and somatic,

after more material has come from the unconscious and from the vegetative systems of the patient.[1]

[1] In her recent book Sex and Temperament, Dr. Margaret Mead mentions the following interesting observation from a primitive tribe in New Guinea which has bearing on lactation in nonpregnant states: "In addition to adopting one of a pair of twins, ordinary adoption is a very common occurrence. Even women who have never borne children are able in a few weeks, by placing the child constantly at the breast and by drinking plenty of coconut-milk, to produce enough or nearly enough milk to rear the child, which is suckled by other women for the first few weeks after adoption. . . . I was able to compare the weight and health of two sets of twins, one of each pair being suckled by its own mother, the other by an adopted mother in whose breasts milk had been artificially stimulated. . . . In each case the adopted twin showed as high a development as the twin suckled by its own mother." Dr. Mead communicated to the author that a similar phenomenon was mentioned in the preliminary report of a field worker among the Comanche Indians.

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William Julian Spring, M.D.1903-1935

Raymond Gosselin

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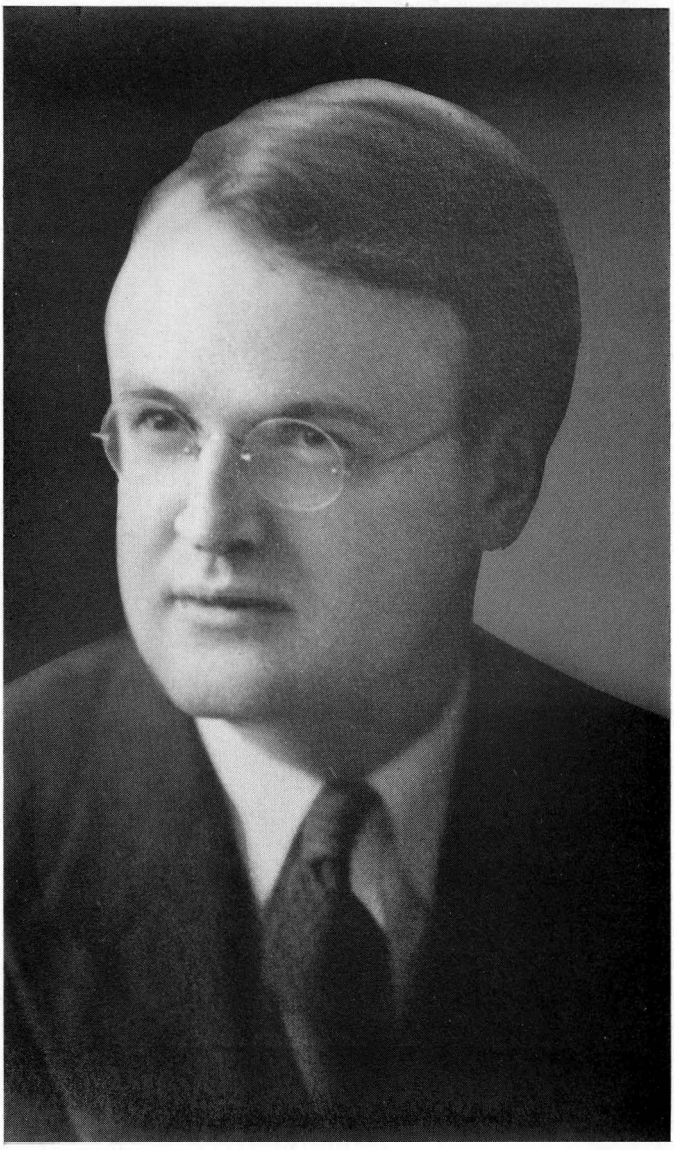

WILLIAM JULIAN SPRING
1903 - 1935

IN MEMORIAM

William Julian Spring, M.D.
1903-1935

We are shocked and saddened to learn of Dr. Spring's sudden, untimely death on July 12, 1935.

Only recently become a member of the New York Psychoanalytic Society, Dr. Spring brought to his work a keenness of intelligence and a fine critical judgment that had already won for him the high regard and professional respect of his colleagues.

He was born in Dresden, Germany, on April 23, 1903, of American parents. He lived in Germany attending the König Georg Gymnasium until he was eleven years old, at which time his parents returned to live in the United States. Here he attended the Collegiate School in Lawrenceville, and entered Columbia University at an early age. He graduated from Columbia University Medical School when he was just twenty-two years old. The high quality of his scholastic achievements was attested by his election to the honorary societies, Phi Beta Kappa, and Alpha Omega Alpha. After six months in pathology at Presbyterian Hospital, he entered St. Luke's Hospital where he worked as interne and resident for two years. Not finding medical practice to his liking, he engaged in a research project in the study of bone tuberculosis which occupied him for two years. This work was done in the Presbyterian Hospital, and the results were published in a series of papers. During this period, partly as a result of ill health, he traveled and studied abroad in Denmark and in Switzerland, and made an extensive trip in South America.

Becoming interested in psychiatry, he worked for two years in the Manhattan State Hospital, following which he obtained an appointment to the staff of the New York State Psychiatric Institute and Hospital, where he had continued as a member of the staff during the past three years. While engaged in this work, he completed his training in psychoanalysis, and was admitted to membership in the New York Psychoanalytic Society in the spring of this year.

. . . . . .

In addition to the personal loss that those who had the privilege to know Dr. Spring as a friend must feel, his death is an inestimable loss to that field of endeavor to which he had chosen to devote his unquestionable talents and ability.

RAYMOND GOSSELIN

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Allgemeine. Neurosenlehre Auf Psychoanalytischer Grundlage. Mit einem Geleitwort von Prof. Sigm. Freud. By Herman Nunberg. Bern-Berlin: Verlag Hans Huber, 1932. 339 p.

Robert Fliess

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BOOK REVIEWS

ALLGEMEINE NEUROSENLEHRE AUF PSYCHOANALYTISCHER GRUNDLAGE. Mit einem Geleitwort von Prof. Sigm. Freud. By Herman Nunberg. Bern-Berlin: Verlag Hans Huber, 1932. 339 p.

The present work belongs in a certain sense among the classics of psychoanalytic literature. Freud's foreword—since published in Volume XII of the *Gesammelte Schriften*—is sufficient sponsorship for the author's name and for his work; and since in that foreword Dr. Nunberg's book is described as the "most complete and conscientious presentation of a psychoanalytic theory of neurotic mechanisms that we thus far possess", the reviewer has no choice but to take this pronouncement as a guiding point to be followed in any critical evaluation of the work. For the "thus far" in Freud's statement serves as a warning that at the present time it is only with respect to isolated portions of psychoanalytic theory that our knowledge is sufficient for the requirements of a systematic presentation, and that at the same time the author would be the last to seek to gloss over the "thus far" inevitable and necessitous lacunæ in his presentation. And indeed, it is one of the chiefest virtues of Dr. Nunberg's work that it studiously avoids all oversimplification.

Dr. Nunberg worked for many years in personal contact with Freud, and the reader will sense Freud's influence from the clarity and the penetration with which the problems treated are set forth, and from the way in which the author leaves problems unsolved wherever their solution is unattainable on the basis of clinical observation. Even the table of contents, in the nonhomogeneous character of its headings and the incoherence, so to speak, of its subheadings, is evidence of the insuperable difficulties that beset any attempt at systematization. One may quote the following by way of illustration:—Chapter 1: The Unconscious in the Neuroses; Chapter 2: The Topodynamic Conception of the Neuroses; Chapter 3: The Instinctual Life of the Neurotic; Chapter 4: Psychology of the Ego; Chapter 5: *Aktual* neuroses; Chapter 6: Anxiety; etc., etc. Or, from Chapter 3 (following the "oral", "anal-sadistic" and "phallic" phases): The œdipus complex—The castration complex—Fantasies—The latency period—Puberty—Developmental disturbances of the sexual instinct—etc., etc. He who would attempt to commit this table of contents to memory would be rather hard put

to it to do so; but whether it would be possible to devise a better arrangement of topics is very much open to question. At all events, after such a table of contents as this we are hardly to expect a simple book, easy to read; as a matter of fact, the book is a distinctly difficult one. For the author speaks a language of his own, a language for the most part devoid of metaphor, one not altogether easily grasped, and yet one possessing a reflective character, with a diction carefully chosen. He has, besides, an original way of formulating things. Finally, as a psychiatrist of long experience, he can observe psychotic phenomena with the same perspicuity as neurotic. Unfortunately, however, he does not supply references to specific articles in the literature; and this is a disadvantage, since it makes it impossible to look up his references in Freud and other writers. One may allow the author of such a systematic work the right to exercise a subjective point of view in its compilation, and when the author possesses the mastery of his material that Dr. Nunberg does, to treat the data as his own as a matter of course; nevertheless, and for that very reason, he ought to append to his text a scrupulously ordered bibliography—this latter for the purpose not only of drawing a clear line of definition between his own personal views and those of Freud and others but in particular of facilitating for his readers a further penetration into the subject through study of the original sources. Thus, in the chapter entitled The Development of Object Choice and the Restraining of Aggression (Fusion of Instincts), the author says, on page 69, ". . . by means of identification an object in the environment is taken into the ego. *As my analyses have shown* [italics the reviewer's], there develops a tendency to expel the incorporated object", etc. Thereupon defæcation is termed by the author the material or factual prototype of this expulsion, and the significance of this excretory product (especially fæces) as something hostile is discussed. There is no mention in this connection of Abraham, whose classical monograph on the developmental stages of the libido contains the original treatment of this matter in exhaustive form.

It is true that the student for whom this book is intended should not be thought of as a beginner. Yet the fact that the book, as the foreword mentions, is based upon various lecture courses at the Institute in Vienna arouses the expectation of an introductory textbook. This expectation is not fulfilled, and indeed, nobody could expect that the "most complete and conscientious" exposition

should be at the same time the simplest one. A comparison with other similar expositions, for this reason, does not take us very far; Hitschmann's and Ferenczi's preparatory essays belong to such an early period of analysis as to render it useless to compare them with this book, while Helene Deutsch's succinct clinical introductory work makes no claim to being a systematic textbook. One might rather consider the present volume as a pendant to Fenichel's clinical outline, regarding it as the general, as opposed to the special, study of the neuroses. Whereas in the case of Nunberg the emphasis is upon his own formulations, Fenichel in his capacity as author retreats rather into the background, cites the literature *in extenso,* and is of course more accessible to the less advanced student.

What makes a critical evaluation of Dr. Nunberg's volume so extremely difficult is the unevenness of its content. We find brilliant descriptions such as hold the reader spellbound, penetrating formulations such as point out to the more experienced analyst distinctions and relationships which he had never previously thought of, side by side with diffuse descriptions which can be recognized after repeated and careful reading as material which Freud has set forth from another and more appropriate starting point and in less cumbrous fashion. An example of felicitous description is the exposition of the process of becoming conscious, in the chapter on The System of the Conscious, as a special case of defense against stimuli. (Since within the system of the conscious the energy applied thereto is entirely used up in the act of making conscious, the level of tension is lowered in this act and thereby a defense against the stimulus has been created.) Further, we note the discussion of the concept of regression, with its penetrating differentiation between topical, temporal and "formal" regression. (Topical regression: Displacement from a higher to a lower psychic system, with consequent elaboration of the content in question in accordance not with the secondary but with the primary function. "Formal" regression: the attainment of the character of consciousness on the part of a psychic act by avoidance of its passage through the system of the preconscious; for example, in hallucinations. Temporal regression: Reactivation of infantile or archaic "ideas, modes of thought, fantasies, attitudes, etc."). A particularly fortunate touch is evident in the author's description of all material lending itself to further psychiatric elaboration, but the author is

less fortunate in his selection of illustrative cases. As an example of this last is the first case, which deals with a peasant girl who had severe vomiting attacks without any organic basis. Dr. Nunberg, called in consultation, asked her whether anything in particular had happened to her, but to this question received a negative reply. On pressing the inquiry he learned of a walk she had taken three hours before with an elderly man, and from this imagined "what might have happened in the woods". He intimated as much to the patient, who was very much surprised and asked how he knew, eventually admitting a sexual experience. The author continues: "She unburdened herself to me, whereupon her symptoms disappeared. She suddenly felt quite well, stood up and went to lunch." In this case, Dr. Nunberg remarks, "the girl had suffered a sexual assault, the memory of which escaped her for the time being. She had no suspicion of any connection between the vomiting and the sexual experience. Here," he continues, "we come straight upon the most important problem in psychoanalysis: Some psychic element causative of the symptom is temporarily unconscious. . . . Hence the symptom is a substitute for an important experience that has become unconscious." Undoubtedly; but how is it "hence"? If such an example occurred in one of the only too numerous textbooks on psychotherapy in existence and was meant to illustrate what the author understood by psychoanalysis, one would be less surprised. For from the present account one gathers only that the girl had completely forgotten the experience which she had undergone some three hours before, and that the recollection of this, which she achieved with the help of the physician, had cured her vomiting. Yet this was not the actual case. Indeed, the author himself interprets the matter differently by emphasizing that it was the connection that was not conscious. This connection implies, as we all know, not the experience *in toto* and something objective, but refers to a part of the experience, and that in its subjective aspect. This part, which must certainly stand in a definite relationship to the earlier vicissitudes of the orality of the patient, was "worked out" by the physician, with the help of a quickly established positive transference and in a discussion based on very definite and specific technical principles, to the extent that the conversion, which had been productive only of discomfort, could be given up. Of course it is perfectly clear what Dr. Nunberg had in mind. It was not his purpose to enter into the matter *in extenso,* but

merely to illustrate the substitution of the memory of a fragment of experience by means of symptom formation, as Freud has done in the well-known example of defloration and red ink in his Introductory Lectures. But should it be done in this way? Does not such an example really force a misunderstanding upon the student? And the same is true of other illustrative material in this valuable work. One further indication may be cited. Nothing is easier than to give an idea of what is meant by the preconscious. If I ask some one, "When was your mother born?" and receive an answer, the date was indeed not at the moment in consciousness but immediately subject to recollection, that is, capable of acquiring the quality of consciousness at any time. We call psychic content of this kind "preconscious". Dr. Nunberg's formulation: "Ideas which are not at the moment conscious but capable of easily becoming conscious we call preconscious" is certainly acceptable. But from what does he derive it? From the following quite unfortunate example (page 9): "A woman patient suffered from a compulsive fear of seducing children. She had an older brother who was psychotic and committed suicide. When he died, there was a rumor that he had seduced children. During analysis the patient recovered the long forgotten memory that at that time she had had the fear that people were saying the same thing of her. She further recalled that in childhood she had induced various playmates to indulge in sexual 'misbehavior'. These were memories *which after a brief analysis* [italics the reviewer's] were brought readily into consciousness." It is to be feared that this may easily rise to misunderstanding.

In the second chapter, on the topico-dynamic concept of the neuroses, the three systems, Ucs, Pcs, and Cs, are discussed in separate paragraphs. The system Ucs is characterized with regard to content and mode of action. With respect to the former it consists of instinctual drives and representations of objects. The relation of the instinctual drive to instinct representation, to affects, and to their appearance in the form of conversion symptoms and of catatonic attacks is discussed. "In addition to the affects," the author continues, "the unconscious includes the objects proper towards which the affects strive as instinct representations." This sentence is quoted as again a typical example of the less fortunate of Dr. Nunberg's formulations. And at the same time it shows the difficulties by which the critical reviewer is embarrassed. For he does

not know whether to take the statement literally or in an approximate sense. In such a sense it is of course perfectly correct; literally, however, it is objectionable. For affects are neither instinct representations nor do they strive for something, nor does the unconscious contain objects. Other statements, such as "Word representation belongs to the system Pcs, object representation to the system Ucs", are perfectly acceptable but insufficiently documented.

The examples which we have cited above in order to illustrate the principles behind our criticisms have been drawn from the first tenth of a work of 300 pages. In the following paragraphs we shall limit ourselves in the main to the actual contents.

In the third chapter, on the instinctual life of neurotics, there is developed the topic of what psychoanalysis understands by sexuality; then comes a general discussion of the instincts, "a field in which we are still painfully struggling for orientation and insight" (Freud).

The instinctual life of neurotics, in Chapter 3, is led up to by a description of the dualisms Eros-destruction instinct and pleasure-unpleasure principle, and is continued with the simultaneous introduction of further highly important psychological concepts as derived from the theory of instincts. A description follows of the erotogenic zones, component instincts, infantile sexuality, and in particular the developmental stages of the libido, whence the topic of genitality forms a transition to the discussion of the œdipus and castration complexes. Then follows a chapter on fantasies, with a discussion of the motives and sources of the primal scene fantasy and the infantile theories of sex. Then the latency period and the developmental disturbances of puberty are described, preparing the way for a rather lengthy concluding chapter on the Developmental Disorders of the Sexual Instinct. Here the concept of fixation is introduced and illustrated by an example of fixation on a predominantly anal-sadistic level, together with a discussion of genitalization of organs and its significance for apparently nonsexual symptomatology, such as stuttering, occupational neuroses, etc.

In the second division of this chapter, entitled The Destruction Instincts, the latter are introduced with emphasis upon the psychological arguments in support of them, and the relation of primary to secondary masochism and their relation to sadism is discussed. And here we find an original piece of exposition, that of the Relation of the Destruction Instincts to the Stages of Libido Organiza-

tion, which reaches a peak—somewhat daringly, in our opinion—in the statement that the instinctual life of the child "is dominated in the first two stages of sexual organization by the destruction or ego instincts". The rest of the chapter on the instinctual life of the neurotic supplies, or rather repeats, the discussion of those phenomena upon the recognition of which—at least in Freud's and in Dr. Nunberg's opinion—the hypothesis of instinctual dualism depends. The author discusses *in extenso* the development of object choice, what we may assume regarding the process of "fusion of instincts", and the result of this process (in essence still awaiting complete clarification) he summarizes in the statement that in the normal course of development "the destruction instincts are to a considerable extent dammed back, if not completely paralyzed, by the sexual instincts". Then follows a discussion of projection and identification as a means of mastery of the object, sublimation as a means of gaining mastery over the instincts, together with their significance in relation to the crucial periods of life, particularly for the overcoming of the œdipus complex. In this way the author reaches the point where he can describe more fully the disorders of object choice in the light of what he has previously said of fixation, regression and the development of the instincts. This then leads to more general conclusions, such as for example the statement that the intensity of withdrawal of libido depends on the capacity for resistance on the part of the cathexis, but the depth of regression upon the condition of the sexual organization, that is, upon the fixation obtaining at the given time; and furthermore to individual flashes of insight into the several types of neurosis and psychosis.

The fourth chapter, The Psychology of the Ego, enjoys the advantage that the various systems of the psychic apparatus have already been described. The ego is described both as perception ego and as equipped with the faculty of reality testing and as such delimited from the id. Allo- and autoplasticity, magic and omnipotence, are discussed *in extenso* (following Ferenczi), in which connection we find the extremely thought-provoking statement that it appears as if "the ego derives its sense of omnipotence, the erotogenic zones magic, from narcissistic libido". The terms "ideal ego" and "ego ideal", used synonymously in Freud's writings (together with the later introduced "superego"), have in Nunberg different meanings: ideal ego "the as yet unorganized ego which regards itself as

one with the id and feels as yet no opposition to it"; ego ideal-superego—which we would regard as desirable of retention.

The next chapters are among the best in the book. In the first of these, entitled Adaptations to Reality, there is not only a description of how, normally, the individual develops his later ego, by means of mentation (through evaluations and denials), and functions in accordance with the reality principle, out of his earlier narcissistic pleasure principle controlled ideal ego; we also see in this chapter how the psychotic individual, who has completely lost his adaptation to reality, manages to regain it. (Thus in schizophrenia, chosen here as a kind of paradigm, there is a progression from the stupor under the leading destruction instincts, *via* the ambivalence-conflict phase of transitivism, to reconstruction. In this stage, the Eros instinct—often in the form of a component instinct—recathects the external world and enables the ego to reëstablish its most primitive functions—perception, recognition of reality, etc.—that is, to reëstablish itself.) After a brief consideration of depersonalization and self-observation there follows an equally excellent and thorough treatment of the superego, in which is to be found practically everything we know at present about the subject: its onto- and phylogenesis, its metapsychology and the clinical phenomena related to its functioning. The next chapter, concerning the Synthetic Function of the Ego, consists of an exceptionally clear presentation of the topic, and of a discussion of causality in thinking regarded as part of the synthetic function. (The causal connection of two perceptions is here ascribed to the uniting tendency of Eros, and the need for causality is called the "sublimated expression of the procreative drive of Eros"—a stimulating, convincingly developed, and indeed clinically supported hypothesis of the author's, which can of course be regarded only as a hypothesis.) The rest of the chapter is almost wholly devoted to a consideration of the Reaction Formations of the Ego: shame and disgust are briefly, and the sense of guilt extensively, treated; the latter is approached with the entire equipment of metapsychology. Dr. Nunberg is not content to derive the sense of guilt from the reversal of sadism, which is turned back against one's self, but discusses its origin from the time of superego construction and in addition its primal derivation from reality anxiety ("social anxiety") and its later relation to the œdipus complex (the primal horde hypothesis) and to the superego, both these relations con-

spiring to make the content of the sense of guilt such as it appears in analysis. Dr. Nunberg almost develops a clinic on the sense of guilt in his tracing out of its manifestations in the special forms of the neuroses. And from this point the discussion of The Criminal From a Sense of Guilt and The Need of Punishment leads him to a systematic presentation of masochism. Finally the author presents, with the addition of a hypothesis of his own, the interplay of ego and superego enacted after the pattern of ego-object relationship. The closing section of the entire chapter, Disturbances in the Harmonious Functioning of the Psychic is a masterpiece of presentation, and consists of brief but exceptionally stimulating formulations regarding the psychological structure of the neuroses.

It is rather difficult to understand why Chapter 5 is in the present book. It deals with the *aktual* neuroses, "Neurasthenia", "Hypochondria", "Anxiety Neurosis", etc.—in other words, with clinical topics which properly belong in a book such as Fenichel's.

The sixth chapter is devoted to anxiety, which is perhaps the most difficult subject of all to be presented in a book like Dr. Nunberg's. The manner in which the problem of anxiety is approached from numerous angles can be best indicated briefly by citing the titles of the various sections of the chapter: Anxiety and Danger, Anxiety and Affect, Anxiety and Trauma, Anxiety and Self-Observation, Anxiety of Birth, Transformation of Birth Anxiety, Anxiety and Pain, Anxiety and the Destruction Instincts, Neurotic Anxiety, Anxiety Conditions. The chapter is chock full of worthwhile material, and in its totality it must not be judged without considering that it was written before the great synthesis given by Freud three years ego in his New Introductory Lectures. Especially notable is the comparison of the conditions pertaining to the rise of anxiety and pain which leads, above all, to the assumption that there exists in both cases a separation between subject and object—that is, a tearing apart of libidinal bonds. (If the object is assimilated by the ego by means of identification, then it plays—due to the impossibility of real satisfaction of the prevailing tension [stimulus]—the rôle of a "body zone cathected by accretion of stimulus".) And this leads Dr. Nunberg to the formulation: "Psychic pain is the specific reaction to the *trauma* of object loss, while psychic anxiety is the specific reaction to the *danger* of object loss." The section on Anxiety and Destruction Drive establishes this instinctual origin of anxiety still further and develops the

opinion that not only erotic but also destruction drives find their discharge in the anxiety affect. The concluding section, Anxiety Conditions, adds the specific formulation that while the *content* of anxiety depends on the developmental stage of the libido, its *form* (that is, the symptomatology of the anxiety affect) is determined by the developmental stage of the ego on which the fixation has taken place.

The seventh chapter deals with Defense Mechanisms. Following what seems to this reviewer a somewhat debatable introduction bearing the ambiguous title, Defense as a Protection against the Emergence of the Stimulus, the discussion turns to the individual defense mechanisms. This reviewer finds it difficult to summarize the chapter briefly due to his disagreement with much of its content. A fundamental objection may be illustrated: The author, having outlined the metapsychology of suckling, writes: "The object of introjection of the mother's breast is achieved when the introjection succeeds in removing unpleasant tension. Identification (introjection) is thus the most primitive means of defense against tensions which exceed certain intensities and which could have a traumatic effect if they broke through the barrier of protection against stimulus." Here he is not only carrying over the psychology of suckling, a part of which may be the psychology of oral introjection, to identification—a procedure the advisability of which is not above suspicion—but, above all, he broadens his concept of defense so greatly that every gratification of instinct would thereby become a defense act, inasmuch as it removes a tension. Such an extension of the boundaries of a concept—no matter whether this is effected explicitly or implicitly—impoverishes it to such an extent that it ceases to be serviceable.

The next section is also not without a few formulations with which complete agreement is difficult. For instance: "The difference between hysterical (phobic) and paranoid projection is clear: in the first-mentioned the object is retained; in the second the object is lost." Or in the comparison between the dynamics of identification and projection: "In the former there is a reduction of the distance between object (representation) and ego, in the latter the distance is increased." In both formulæ it is possible to agree only with the first half of the statement.

The next two sections discuss Displacement, Transformation into the Opposite, and Conversion of Activity into Passivity. Here,

among other ideas, there is the extremely stimulating and fruitful opinion "that there are defense situations which have no specific basis and are equally independent of the superego and the environment . . . defense on its most primitive level seems therefore an automatic occurrence perhaps corresponding to the original repression". Another section, Defense as a Narcissistic Protection and the Repetition Compulsion, attempts to reason that in every defense the object libido is transformed into narcissistic libido (which however applies obviously only to some of the situations described by Nunberg as defense forms); that as a result, since the narcissistic condition is after all the original one, "the law of inertia" is active here, and that "since in psychic matters the principle of inertia expresses itself in the repetition compulsion, a drive that requires the barrier of defense will have, above all, the tendency to repeat itself". From this deduction (which seems to this reviewer to be highly suspect) the author moves unexpectedly to a truly superb brief consideration of the subject, the Metapsychology of the Instinct Defense.

The next section, a longer one, deals with Repression. A critical evaluation of this eminently valuable portion of the book is precluded by limitations of space. Beginning with the topics of Denial and Depersonalization (regarding which the author makes a few statements that seem rather debatable), Dr. Nunberg proceeds to a description of the metapsychology of repression. Compared with Freud's work this description has the disadvantage that in it the object of the removal of cathexis is seen to be not the representation but the system, as a result of which we find formulations which in spite of their acuteness seem strange to us until we recognize that it is the *system* that is being dealt with. The next sections discuss regression, the reaction formations of the ego, undoing and isolation, as well as topo-dynamic situations in which the establishment of counter-cathexis. The dominant point of view in this discussion is the question of what those mechanisms can contribute toward the support of the repression and the insuring of its results. Here the presentation seems to us a trifle unsystematic, and the constant comparisons with the special forms of neurosis give rise to somewhat debatable formulations. One would welcome a chapter on the psychology of character at this point in the book. Regarding the remaining sections of the chapter, which treat the subjects of Resistance and Transference with marked dependence on *Hem-*

mung, Symptom und Angst, one may make a comment which applies to so many of the other sections: the penetrating presentation provides stimulating reading only for the advanced student.

The content of the comprehensive and fruitful eighth chapter, The Morbid Process, can be best indicated by a citation from the author's conclusion: "One must differentiate between a primary and a secondary morbid process. The primary one consists in exaggerated reactions of the ego to instinctual danger and to the closely related neurotic conflict. These reactions express themselves as neurotic, not realistically motivated anxiety. The symptoms produce a secondary morbid process, represent an attempt at a solution of the neurotic conflict, and subjugate the neurotic anxiety. In most cases, with the possible exception of conversion hysteria, a solution is arrived at only after considerable difficulty. The symptom is a substitute for an inhibited discharge of instinct and is a compromise construction between the threatening instinctual drive and the defense against it. What is being defended against is the drive; the defense and the motivation for it originate within the ego. With the formation of a symptom the neurotic conflict reaches a temporary standstill. In conversion hysteria the result is a definite one; with the development of the symptom the morbid process comes to a standstill. In phobia and compulsion neurosis, however, the morbid process does not generally come to a standstill, because continually new solutions of the neurotic conflict are being attempted and therefore new symptoms are constantly appearing. Still more productive are the schizophrenias in which the continually accumulating symptoms finally overrun the remainder of the intact personality.

"The purpose of symptom formation is, then, the removal of the danger situation. The symptom offers two advantages, for on the one hand the ego evades the instinctual demands and, on the other hand, the ego is in a position to put a stop to the anxiety. The symptom deceives both the ego and the environment. The symptom enables the ego to defend itself against the dangers entailed by the instinctual drives. But since the ego is closely connected with the id, it can defend itself against the instinctual drive only by altering its own organization and establishing a synthesis with the drive. The end result of the attempted solution of the neurotic conflict differs in accordance with the nature of the ego and the instinctual drive. At all events the result is a more or less well-

defined break with reality. The solution leads to neurotic suffering which is multifariously, though not invariably, compensated by secondary morbid gain. We therefore find the ego, the id and the superego participating in the development of a neurosis. The superego becomes intolerant toward the drives of the id; the drives of the id become demobilized and the ego loses its independence with respect to the id; it escapes, besides, from reality, and its synthetic function becomes disturbed."

Among the sections of this chapter, which consist of largely excellent expositions, the last section is especially commendable for its superlative presentation of the Rôle of the Synthetic Function of the Ego in the Genesis of Neurosis. One of its most important formulations is the following: "The symptom becomes the carrier of the repressed instinctual demands not ego-directed, as well as of a part of the ego which is not adapted to reality." It is to be hoped that a new edition of the book will include the topological graph for the superego from The Ego and the Id, as modified in Freud's thirty-first Introductory Lecture.

The brief ninth chapter, The Causation of Neurosis, again is one of the best portions of the book. In it we have a historical survey of our knowledge to date of the etiology of the neuroses. The original trauma theory (Dr. Nunberg defines trauma as "a mass of tension which cannot be overcome by the ego in the usual unit of time, variable in different individuals") is discussed, with the conclusion that "an external trauma is not constant, whereas an inner trauma, in the sense of instinctual danger, must always be present". The etiological chain between fixation and experience is developed and weight is given to the weakness of the ego and its hypersensitiveness to unpleasure. A discussion of the three basic factors—a biological factor (the helplessness of the child in its initial period of life), a phylogenetic one (the diphasic nature of sexuality), and a psychological one (the imperfection of the psychic apparatus)—leads to a metapsychological exposition of the etiology of neurosis. The final etiological factor, both qualitative and quantitative, is seen as: the inadequate fusion of Eros and death drives, and an inadequate psychic assimilation of the energy masses.

The tenth and concluding chapter treats the Theoretical Principles of Psychoanalytic Therapy. A certain prepossession produced by the unfavorable criticism to which this chapter was subjected in certain quarters (the Berlin Psychoanalytic Society) upon

the appearance of the book made it encumbent upon the reviewer to give this chapter several careful readings. These, however, have inclined the reviewer to commend this portion of the book. Certain rash formulations of minor importance may lead to misunderstanding; and, since everything quantitative in psychoanalysis depends upon judgments, other authors may arrive at somewhat different results in their quantitative evaluations of the factors involved in the process of cure. But, on the whole, the author's presentation of the general run of treatment is both clinically and metapsychologically correct, and is in the main written with distinction. The difficulties and presuppositions of the treatment, the utilization of the will to recovery, the overcoming of the anxiety and the dynamics of the coöperation between physician and patient are given a place in the discussion, along with the process of making unconscious conflicts conscious and the rôle of ego-transformation in the cure. (A formulation of the therapeutic result is the following: "The energies of the id become more mobile, the super-ego becomes more tolerant, the ego is relieved of much of its anxiety and its synthetic function is restored.") Only the experienced analyst can read this very condensed chapter independently. The less expert reader will read it to advantage only (as the author intended it to be read) after he has carefully gone through the rest of the book.

ROBERT FLIESS (NEW YORK)

THE PROBLEM OF MENTAL DISORDER. A Study undertaken by Madison Bentley and E. V. Cowdrey, the Committee on Psychiatric Investigations, National Research Council. New York and London: McGraw-Hill Book Company, 1934.

The plan of this book is one that must appeal to all who are interested in approaching the problems of psychiatry from a broad and well grounded scientific point of view. The gathering together of short summaries by leading investigators in fields that could have important bearings upon the problem of mental disorder is a challenging project and one that arouses hopes of an exceedingly valuable orienting survey. It is perhaps partly due to the high hopes that such a project awakens that one is apt to find the performance of it somewhat disappointing. The individual chapters are many of them very stimulating and offer interesting and varied suggestions as to possible approaches to a better understanding of mental

disorders. However, the gaps between many of the fundamental "supporting" sciences and the problem of understanding mental disease are very great. What one misses in this book is an orienting survey to bring these accounts of the "supporting" sciences into some sort of relation with what is already known about mental illness. Instead of this the authors discard the existing knowledge in the field of psychiatry as not worth consideration and proceed to build a fantasy of how a really scientific psychiatry could be built up by workers in other fields.

The reason for this is not hard to find. The editors of this book reject psychoanalysis as a "cult" and regard the existence of unconscious forces as a "speculative theory". In so doing, and quite without considering the evidence, they push to one side what is quite certainly the most significant development in psychiatry in recent years—the attempt to understand the content of the patient's utterances and behavior in terms of his life history and of a detailed study of his emotional development. To plunge immediately into chemical and physiological tests or psychological experiments without first orienting one's self as to what the patient's conflict is all about might be compared to the procedure of some hypothetical pathologist who might begin studying microscopic sections without taking the trouble to make a gross examination of the organ from which the sections were taken.

Kubie's chapter on psychoanalysis, which is somewhat grudgingly included in the first part of the book as one "point of view" on psychiatry, is a conservative, carefully thought out analysis of the scientific basis for the psychoanalytic method. Its chief defect, in the reviewer's opinion, is Kubie's underemphasis of the fact that psychoanalysis represents the first really fundamental attempt to pay attention to exactly what the patient is saying and doing and to understand his behavior in terms of the actual facts of his emotional development.

Every science has its own necessary growth sequence which must be based upon the character of the facts it is studying. Psychoanalysis represents the first attempt to study psychology by a method really adapted to the phenomena studied. Attempts to leap at once to the experimental precision that has been attained in the physical sciences without paying attention to what is really disturbing the patient might be compared to a little boy's imitation of building a house by very carefully driving nails into a board.

THOMAS M. FRENCH (CHICAGO)

MENTAL DEFECT. By Lionel S. Penrose, M.D. New York: Farrar and Rinehart, 1934. 205 p.

This title is sufficient to cause the psychiatrist to consider the book as not meriting his time and serious attention, an attitude not without justification; for when the subject is given consideration in text books of psychopathology, it is disposed of in a chapter stressing the constitutional and unalterable aspects of the disorders classified, and the studies appearing in current literature and the infrequent books on the subject, are usually dull compilations of statistics or descriptions of tests devised for the accumulation of more statistics.

With this expectation, Dr. Penrose's work is a stimulating surprise. He is the Research Medical Officer of the Royal Eastern Counties Institution of Colchester, England. He regards the study of mental deficiency as a branch of human biology, considers that it provides a fruitful field for research when approached from this angle, and subjects all current theories of the nature and origin of mental deficiency to critical examination with admirable scientific impartiality. In the light of such criticism, most of the sweeping generalizations based on the biased or faulty interpretation of statistics are shown to be erroneous in their conclusions. It is apparent throughout the book that Dr. Penrose brings to his subject a thorough training and the breadth of cultural equipment demanded by a subject requiring excursions into—or in most instances a comprehensive grasp of—such varied special fields as psychopathology, medicine, biology, sociology, education, genetics, statistics, criminology.

It is instructive to learn how far the interests of the psychiatrist and the specialist in mental defect are identical. For instance, the condition *dementia præcocissima* is a psychiatric rarity apparently because the children afflicted are usually found in institutions for mental defectives; and with many adult disorders, it is a matter of chance whether the patient be placed in a psychopathic hospital or in an institution for the feebleminded. Similarly, the group described in this book under the heading *subcultural amentia,* is synonymous with, or includes those patients who fall in this country in the classification *constitutional psychopathic inferiority.* Of the treatment of a type in this group, he writes: "A special type of problem is presented by persons who are able to perform mental tests fairly satisfactorily, or perhaps even very well, but who, by

reason of difficulties in their personal temperament and character, are either unable to learn or unable to respect the usual canons of behavior current in the society in which they live. Such persons, if they become adult before they fall under observation of medical authorities, may become confirmed criminals—perhaps being convicted over and over again for petty thefts—and they end up either in gaol or in an institution for mental defectives. If recognized at the school age, they may be very accessible to psychoanalysis."

Of the alleged enormous benefits which enthusiastic eugenicists and others claim would accrue to society after the sterilization of existing mental defectives and criminals, the author is strongly sceptical, and he presents cogent facts and arguments to support his position. He demonstrates the impracticability of putting such schemes into effect, and gives evidence to show that the eugenic effect of such measures will be exceedingly small as compared with the labor expended in making them operative; moreover, he questions the motives behind overwhelming popularity of sterilization in so many quarters as contrasted, for example, with the great resistance to legalized abortion. He concludes that the motive is an unconscious sadistic one (a view, incidentally, strikingly supported by the emphasis given to sterilization in Nazi Germany). The wording of some legislative acts overtly expresses the aggressive and punitive intent. Referring to Freud's *Civilization and Its Discontents,* he concludes this topic saying, "The greatest psychiatrist of modern times, Sigmund Freud, has pointed out very clearly that some of the most serious troubles affecting civilization come from man's imperfect mastery over his aggressive impulses against his neighbor.——An excuse for viewing mentally defective individuals with abhorrence is the idea that those at large enjoy themselves sexually in ways which are forbidden or difficult to accomplish in the higher strata of society. The association between the idea of the supposed fecundity of the feeble-minded and the need for their sterilization is apparently rational, but it may be emphasized by an unconscious desire to forbid these supposed sexual excesses. It has been pointed out that the advocates of sterilization never desire it to be applied to their own class, but always to some one else."

Not written to advance any new theories or to draw new conclusions from known facts, but intended rather, as a study and survey of the problem, and a guide to avenues of investigation

likely to yield results, this book succeeds admirably in its purpose. Added to the text are a glossary of terms and an index of authors referred to in the text. Its value as a book of reference or as a text for students, would be greatly enhanced by a subject index.

RAYMOND GOSSELIN (NEW YORK)

SEX HABITS: A VITAL FACTOR IN WELL-BEING. By A. Buschke and F. Jacobsohn. Translated from the German by Eden and Cedar Paul. Foreword by Gerald L. Moench. New York: Emerson Books, 1933. 204 p.

Of the large number of books on sex enlightenment from the physical point of view that appear daily, this book should certainly rank among the best. It is a sane, straightforward and thorough exposition of the subject, and there is a series of plates that would for clarity and general excellence grace any scientific work on anatomy and embryology. The book deals with the structure and the functions of the reproductive organs, and includes an excellent chapter on semen-menstruation, fertilization and development of the embryo. A chapter each is also devoted to tubal pregnancy and the Aschheim-Zondek test, which is admirably discussed. What makes the book particularly important is the candid and courageous treatment of puberty. Here the authors show themselves to be men of wide experience, and no parent should fail to make a careful study of this valuable chapter.

In the chapter on sexual impotence in men, students conversant with the freudian doctrine will find much to be desired; how little acquainted the authors are with psychoanalysis can be seen from the following: "Still, when cure [of impotence] results, it must not be forgotten that this may be the outcome of the psychotherapeutic powers of persons who are able to exercise a suggestive influence, even though the doctrine on which their analytic method be based is false. In a word, the undeniable practical successes of many psychoanalysts can, in our view, be often enough secured by the application of other psychotherapeutic methods."

Before Freud, urologists having a new instrument in their hands, the cysto-urethroscope, noticed that the colliculus presented a different appearance in different individuals. They attributed all forms of impotence to so-called pathology of the caput, not knowing that it can normally vary considerably in shape and size. The authors agree with countless urologists still treating the caput with

silver nitrate, obviously unaware that the results, if any, are purely suggestive. The authors maintain that: "In other cases the cause of ejaculatio præcox, painful erections, or complete impotence is inflammation of the prostate, usually accompanied with slight hypertrophy of the colliculus seminalis. Diseases of the vesiculæ seminales are also occasional causes of disorders of potency." This is, as analysts know, not commensurate with clinical experience.

Van de Velde is adversely criticized by the authors for advising the male to prolong intercourse in order that the female may achieve adequate gratification. They state: "It would be far better to advise the men of today, already inclined to be neurasthenic, over-stimulated, and injuriously affected by the intensity of the economic struggle, to enjoy sexual intercourse in normal fashion, without extensive preliminaries, and without any attempt at artificial prolongation, but proceeding as quickly as may be to orgasm and ejaculation. In this way the wholesale production of psychical impotence would be avoided." Likewise, "Marked, persistent, and general incapacity for sexual enjoyment is exceptional in women; and when it exists is usually associated with the before-mentioned infantilism of the reproductive organs—which, as already said, can often be relieved by skilful treatment." Analysts will find much to criticize here, as also later in the chapter on advice concerning marriage. Here, too, the authors would have been able to provide a more searching picture had they been possessed of psychoanalytic knowledge and experience. It is a pity that the chapters with those subjects that have been already worked out by Freud and his school, should not have been written by competent analysts, as the authors' knowledge of psychoanalysis is evidently limited to superficial reading, and as they are obviously all too innocent of clinical psychoanalytic training and experience.

One serious omission must be noted. A comprehensive exposition of the contemporary point of view on masturbation should be a *sine qua non* in a book of this character.

JOSEPH J. ASCH (NEW YORK)

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CURRENT PSYCHOANALYTIC LITERATURE

The International Journal of Psycho-Analysis. Vol. XVI, Part 2, April, 1935.

EDWARD GLOVER:	A Developmental Study of the Obsessional Neurosis.
MELANIE KLEIN:	A Contribution to the Psychogenesis of Manic-Depressive States.
HANS BEHN-ESCHENBURG:	The Antecedents of the Oedipus Complex.
ELLA FREEMAN SHARPE:	Similar and Divergent Unconscious Determinants underlying the Sublimations of Pure Art and Pure Science.
EDMUND BERGLER:	An Enquiry into the 'Material Phenomenon'.
IMRE HERMANN:	The Use of the Term 'Active' in the Definition of Masculinity.

Zeitschrift für psychoanalytische Pädagogik. Vol. IX, Number 2, March-April, 1935.

SIGM. FREUD:	Psycho-Analysis.
HANS ZULLIGER:	Versager in der Erziehung *(Mishaps in Education).*
EDITHA STERBA:	Ein Fall von Esstörung *(A Case of Disturbance in Eating).*
EDUARD HITSCHMANN:	Der Vater als Eindringling *(The Father as Intruder).*
ALICE BÁLINT:	Märchen und Phantasie *(Fairy Tales and Fantasy).*
OTTO FENICHEL:	Über Erziehungsmittel *(Educational Methods).*
DOROTHY TIFFANY BURLINGHAM:	Mitteilungsdrang und Geständniszwang *(Drive to Communication and Compulsion to Confession).*
HANS ZULLIGER:	Schwierige Schüler *(Difficult Pupils).*

Arbeiten aus dem Psychiatrischen Institut der Tohoku Kaiserlichen Universität. Vol. II, Numbers 1-2.

HEISAKU KOSAWA:	Alternierende Charakter- und Symptomneurose *(Alternating Character- and Symptom-neurosis).*
	Magische Mimik bei einer Zwangsneurose *(Magical Gestures in a Compulsion Neurosis).*
	Psychoanalyse einer sogenannten Neurasthenie *(Psychoanalysis of a so-called Neurasthenic).*

The Psychoanalytic Review. Vol. XXII, Number 3, 1935.

KAREN HORNEY:	The Problem of Feminine Masochism.
THEODORE SCHROEDER:	What is Psychologic Recovery?
PAUL SCHILDER:	Psychoanalysis and Philosophy.
AGNES CONRAD:	Analysis of a Case of Chronic Invalidism with Hysterical Mechanism Complicating Organic Disease.
JACKSON E. TOWNE:	Carlyle and Œdipus.
MARTIN W. PECK:	A Psychiatrist Views the Drama.

The American Journal of Orthopsychiatry. Vol. V, Number 2, April, 1935.

EDWARD LISS: Libidinal Fixations as Pedagogic Determinants.

The American Journal of Psychiatry. Vol. XCI, Number 5, March, 1935.

A. A. BRILL: Remarks Introductory to the Symposium on the Relation of Psychoanalysis to Psychiatry.

ROSS MC C. CHAPMAN: Psychoanalysis in Psychiatric Hospitals.

LELAND E. HINSIE: The Relationship of Psychoanalysis to Psychiatry.

LOUIS J. BRAGMAN: The Case of John Ruskin.

CLARENCE O. CHENEY & CARNEY LANDIS: A Program for the Determination of the Therapeutic Effectiveness of the Psychoanalytic Method.

The Family. Vol. XVI, Number 5, July, 1935.

MAURICE LEVINE: Psychoanalytic Comments on Community Planning.

Almanach der Psychoanalyse. 1935.

SIGM. FREUD: Psycho-Analysis.

IMRE HERMANN: Das psychoanalytisch Sinnvolle *(The Significant Associations in Psychoanalysis).*

RICHARD STERBA: Die psychoanalytische Therapie *(Psychoanalytic Therapy).*

SANDOR RADO: Das Angstproblem *(The Anxiety Problem).*

PAUL FEDERN: Zunahme der Süchtigkeit *(The Increase of Drug Addiction).*

OTTO FENICHEL: Zur unbewussten Verständigung *(Unconscious Mutual Understanding).*

ALEXANDER SZALAI: Die ansteckende Fehlhandlung *(The Contagious Parapraxia).*

ANNA FREUD: Die Erziehung des Kleinkindes vom psychoanalytischen Standpunkt *(The Education of Infants from a Psychoanalytic Standpoint).*

HEINRICH MENG: Die richtige Behandlung scheinbar straffälliger Kinder *(The Correct Treatment of Apparently Culpable Children).*

HANS ZULLIGER: Pädagogen erliegen dem Fluche der Lächerlichkeit *(Teachers are Accursed by Ridicule).*

FRITZ REDL: Gedanken über die Wirkungen einer Phimoseoperation *(Thoughts on the Effects of a Phimosis Operation).*

HELENE DEUTSCH: Don Quijote und Donquijotismus *(Don Quixote and Donquixotism).*

FRANZ ALEXANDER: Bemerkungen über Falstaff *(A Note on Falstaff).*

MARIE BONAPARTE: Das magische Denken bei den Primitiven *(Magical Thinking among Primitives).*

HENRI CODET: Das magische Denken im Alltagsleben *(Magical Thinking in Everyday Life).*

EDWARD GLOVER, MORRIS GINSBERG, JOHN RICKMAN: Symposium über die Psychologie von Krieg und Frieden *(Symposium on the Psychology of War and Peace).*

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Notes

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NOTES

THE NEW YORK PSYCHOANALYTIC INSTITUTE offers the following training courses during the academic year 1935–1936, beginning the first week in October, 1935. *First trimester* (October–December): Psychology of the Oral and Anal Functions, by Dr. Sandor Rado; Seminar for Advanced Case Study, by Dr. Sandor Rado; Seminar on "The Interpretation of Dreams", by Dr. Lillian D. Powers; Unusual Defense Mechanisms against Homosexuality, a seminar, by Dr. Fritz Wittels. *Second Trimester* (January–March): Micro-Analysis of Dreams, by Dr. Sandor Rado; Seminar for Advanced Case Study, by Dr. Sandor Rado; Technical Difficulties in Psychoanalytic Work, a seminar, by Dr. Sandor Lorand; Paranoia—Historical Aspects and Present Trends, a seminar, by Dr. Dorian Feigenbaum. *Third Trimester* (April–June): Lectures on Technique, by Dr. Sandor Rado; Seminar for Advanced Case Study, by Dr. Sandor Rado; The Psychology of the Ego, by Dr. Herman Nunberg; Systematic Survey of Psychoanalytic Terminology, by Dr. Bertram D. Lewin; and An Introductory Course in Social Pathology, by Dr. Abraham Kardiner. In addition, Dr. Lawrence S. Kubie will give a course entitled Psychosomatic Problems, once a month throughout the year. The Extension Division of the Institute is also preparing a program; the first trimester will consist of The Application of Psychoanalysis to Social Work, by Dr. I. T. Broadwin, and Psychoanalysis and Medicine, by Drs. Brill, Lehrman, Lorand and Oberndorf.

THE CHICAGO PSYCHOANALYTIC SOCIETY, during the first half of 1935, had the following program of papers at its scientific meetings:—Theoretical and Practical Considerations in the Analysis of a Minister, by Dr. Robert Knight; A Case of Schizophrenia, by Dr. Thomas Ratliff; Defect in Ego Development and Character Neurosis, by Dr. Ives Hendrick; Conflicts Related to the Feminine Rôle in a Case of Constipation and Bulimia, by Dr. Catherine Bacon; Psychotherapy in Childhood, by Dr. George J. Mohr; A Note on the Psychogenesis of Organic Symptoms, by Dr. Leon Saul; A Case of Obsessional Neurosis, by Dr. Hyman Lippman; Notes on the Acting out of Incest Urges, by Dr. Maurice Levine; Interpretation of the Panic Reaction, by Dr. Maurice Levine.

THE CHICAGO INSTITUTE FOR PSYCHOANALYSIS announces an intensive educational program for the year 1935–1936. The program will include a series of Introductory Lectures on Psychoanalysis, a Case Seminar, a lecture course on the Theory of Dream Interpretation, and a seminar on the Technique of Dream Interpretation by Dr. Franz Alexander; lecture courses on the Psychoanalytic Technique and the Structure and Mechanisms of the Individual Neuroses, a Case Seminar, and seminars on Psychoanalytic Literature, the Psychoanalytic Interpretation of Psychotic Symptoms, and Psychoanalytic Literature by Dr. Thomas M. French; a seminar on the Psychoanalytic Literature by Dr. Karl

Menninger; a seminar on the Application of Psychoanalysis to Literature by Dr. Helen V. McLean; a course on the Application of Psychoanalysis to Social Sciences, lecturer to be announced later; and a special course for psychoanalysts engaged in research work on Psychogenic Organic Disturbances to be given by a number of as yet unannounced lecturers, which will include lectures on Physiology and Clinical Pathology of Gastro-Intestinal Disturbances, Physiology and Clinical Pathology of Essential Hypertension, Allergy and Bronchial Asthma, Psychogenic Skin Lesions, Present Status of the Physiology of the Endocrine Glands, and Endocrine Disturbances.

THE BOSTON PSYCHOANALYTIC SOCIETY has decided to found a Psychoanalytic Institute for the purpose of forwarding psychoanalytic education in the community. Beginning next fall, all the educational activities will take place in the Institute. Notice of the various courses and seminars will be given in the near future.

A PSYCHOANALYTIC STUDY GROUP has been established in Los Angeles for the study and dissemination of psychoanalytic knowledge and for encouraging the application of psychoanalysis to other branches of science, under the presidency of Dr. Ernst Simmel. The chief aim of this group, which does not purport to be a member of the International Psychoanalytic Association, is to further the theoretical psychoanalytic education of its own members. Its immediate program is to discuss the fundamental conceptions of psychoanalysis by means of papers by the members. The group has a restricted membership.